Validation and Invalidation during Psychotherapy:
Implications for Affect and Treatment Attendance

Dissertation

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Abstract

Much has been theorized about the putative benefits and harms of validating and invalidating interactions, yet these constructs have only recently begun to receive empirical attention. The present study fills a gap in the current research literature by examining the associations among clients’ perceptions of their therapists’ validating and invalidating responses and several relevant psychotherapy variables. A sample of 55 outpatient clients from the Psychological Services Center at The Ohio State University was asked to complete a battery of questionnaires, prior to and immediately following each of a subset of their regular therapy sessions. Hierarchical regression models including the validation and invalidation subscales of the Self-Reported Validation and Invalidation Scale (SRVIS-C) were tested to examine their associations with 1) pre- to post-session positive and negative affect, and 2) session attendance failures. Invalidation was found to associate positively with post-session negative affect and negatively with post-session positive affect, even after controlling for pre-session affect, while validation was not. Neither invalidation nor validation was related to session attendance failures. These results provide an important descriptive first look at the validation and invalidation reported by real-world psychotherapy clients, and inform the extant clinical theory linking invalidation and validation with pre-to post-session positive and negative affect, and session attendance failures.
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Chapter 1: Introduction

Empirical research has convincingly demonstrated the efficacy of an expanding array of psychological treatments. A growing body of evidence has demonstrated the overall efficacy of psychotherapy, with particular treatments earning particularly robust support for particular problems (e.g., Butler, Chapman, Foreman, & Beck, 2006; DeRubeis & Crits-Christoph, 1998). Yet, the effectiveness of any treatment rests, at least in part, on clients’ willingness to participate in them. Despite effective treatment protocols and the best intentions of skilled, caring therapists, an alarming percentage of treatment-seekers withdraw from treatment without having received a sufficient dose of therapy.

Fortney, Harman, Xu, and Dong (2010) found that only 36.3% of clients received an “adequate dose” of psychotherapy (defined in this study as 8 or more sessions over the course of a year). Similarly, Hansen, Lambert, and Forman (2002) reviewed the clinical trials literature, and reported that, based upon a large national sample of more than 6,000 adult psychotherapy clients, the average client attends fewer than 5 sessions. This stands in stark contrast to the “general consensus” they observed in their view of the literature that “between 13 and 18 sessions of psychotherapy are required for 50% of patients to improve.”

Making matters worse, only about 20% of clients receiving this “average” number of 4 to 5 total sessions demonstrated significant improvement, creating the potential for dissatisfied former clients to report that a treatment was ineffective for them, when in
fact, the lack of improvement may have been due instead to not having received an adequate “dose” of the psychotherapy by the time of termination. Recent data suggests that more than one in five individuals who seek treatment for mental health issues quits treatment prematurely (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009). Whatever the reason, a large percentage of treatment-seeking individuals are not receiving sufficient psychotherapy for their symptoms, unnecessarily prolonging clients’ distress by interfering with therapists’ efforts to address problems of living.

Over the past half-century, researchers have begun to examine which facets of the psychotherapy experience may contribute to negative treatment outcomes. Several major aspects of treatment have been identified as potential reasons why therapy might fail, including: the efficacy of the treatment itself, client-specific characteristics, therapist qualities and behaviors, and the interaction between therapist and client. Client-specific factors may include: severity and type of symptoms, resources available to devote to treatment (such as money, emotions, and time), motivational factors, and level of initial interpersonal functioning (Edlund et al., 2002). Characteristics unique to the therapist may include verbal communication style, level of experience, or the presence or absence of specific in-session characteristics (such as formality or warmth) and behaviors (such as reflection or validation).

In addition to these individual-level factors, process-level variables such as the style and content of in-session interactions between therapist and client can also impact treatment outcome. Such interpersonal interactions have been highlighted in the literature as important targets to improve clinical interventions and enhance the treatment experience for clients (e.g. Horvath, 2001). Yet, much remains unknown when it comes
to understanding which forms of interaction facilitate a more effective and rewarding treatment experience, and which factors hinder therapeutic efforts and progress toward goals.

The major aim of the proposed study is to examine the impact of clients’ perceptions of their therapists’ validating (understanding, normalizing, or accepting) and invalidating (criticizing, pathologizing, or rejecting) in-session responses on pre-to-post session affective changes, and next-session attendance. Invalidation is theorized to occur in virtually all forms of human interaction, including psychotherapy interventions (Linehan, 1993). In a treatment setting, invalidation may hold the potential to damage the therapeutic relationship and hinder treatment progress. However, such effects are largely theoretical at present and have not yet received much empirical study, let alone in-depth examination in real-world treatment settings.

What limited experimental research does exist has demonstrated invalidation’s potential to impact clients’ in-session emotional and physiological arousal, comfort with emotion, and willingness to remain in treatment, as well as, on the other hand, validation’s potential to improve treatment adherence. I examined the associations between validating and invalidating experiences and 1) session attendance and 2) post-session positive and negative affect. I also compared the concordance between client-reported experiences of validation and invalidation, and their therapists’ report of these same constructs, to examine two different perspectives on the quantity and severity of validation and invalidation being noticed and experienced in-session. I also investigated whether one’s level of BPD features was associated with one’s self-report of validating and/or invalidating experiences.
I will first present an overview of pre-treatment client and therapist characteristics which have been theorized and/or shown to impact treatment outcomes, then move on to a discussion of several process-level predictors of treatment outcome. I will conclude this section with a detailed review of the current theoretical and empirical literature regarding validation and invalidation, and the presentation of my primary study hypotheses.

**Pre-Treatment Predictors of Treatment Outcome**

**Client characteristics.**

Researchers over the past half-century have investigated a variety of putative clinically-relevant client characteristics to determine which aspects of a treatment-seeker, if any, might impact what goes on during a course of psychotherapy. Psychological treatments can be greatly improved by an increased understanding of the client, beyond their psychiatric diagnoses (Norcross & Wampold, 2011). I will outline several such client characteristics that have received empirical support as predictors of the strength of the alliance and/or later outcomes.

Norcross and Wampold (2011) summarized the extant literature pertaining to client characteristics that have been shown to impact treatment outcomes, identifying six individual client characteristics with medium-to-large effect sizes across multiple studies. The impactful characteristics included: the client’s cultural background, coping style, current stage of change, treatment style preference, religious/ spiritual background, and reactance level (a construct they defined and assessed along a continuum ranging from defiance to compliance). Such factors, whether or not they are intentionally addressed by the therapist, may account for significant variance in eventual treatment outcomes.
Knowing which client characteristics are associated with poorer treatment attendance and less active participation in therapy tasks can assist therapists in identifying cases where special attention should be paid to prevent missed sessions and treatment interruptions. Younger age, male gender, and history of previous psychological treatment have all been shown to predict poorer treatment retention (López-Goni, Montalvo, Illescas, Landa, & Loria, 2008). Examining the potential for baseline characteristics to predict later alliance scores, Hersoug, Hoglend, Havik, von der Lippe, and Monsen (2009) reported that interpersonal relationship functioning and a measure of “global functioning” at baseline were both associated positively with eventual therapeutic alliance scores. Clients with better interpersonal functioning at the start of treatment may see better outcomes manifest via a stronger initial ability to form a solid, therapeutically-beneficial helping relationship with their therapist, which may in turn facilitate keeping those clients in treatment for longer periods of time, and thus maximize outcomes.

There is also evidence that clients’ initial expectations for treatment significantly influence the process of psychotherapy. Greenberg, Constantino, and Bruce (2006) completed a review of the literature on patient expectancies and their impact on the treatment process and eventual outcomes. They concluded that clients’ treatment and outcome expectancies contribute significantly to the effectiveness of various psychotherapies. Greenberg et al. also pointed to the fact that many proven treatments already include interventions meant to explicitly address client expectancies (such as realistic goal setting and debunking common psychotherapy “myths”), suggesting that such interventions contribute to successful outcomes.
The presence of personality symptomatology is another important client characteristic worthy of consideration; in addition to the affective and interpersonal difficulties inherent in such diagnoses, it may also be the case that personality-disordered individuals experience the prospect and process of psychotherapy differently than clients without these difficulties. Individuals high in BPD features frequently continue to report significant difficulties post-treatment, including low social adjustment, poor overall functioning (including employment), and low global satisfaction with life (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). These difficulties complicate, and are further compounded by, treatment for other comorbid psychological diagnoses (e.g., Swartz, Pilkonis, Frank, Proietti, & Scott, 2005).

Many of these same deficits have also been demonstrated for other forms of personality dysfunction. Mulder (2002) conducted a review of the literature on depression treatment outcomes for individuals with comorbid personality disorder diagnoses. He reported a variety of associations between personality dysfunction and outcome, ranging from a moderately worse outcome to no difference, depending on which measure of personality dysfunction was utilized. He found that high Neuroticism scores consistently predicted poorer outcomes, particularly over longer-term studies.

Mulder also reported that, compared to depressed clients without personality pathology, depressed patients with comorbid personality disorders were, on the average, significantly less likely to obtain “adequate treatment” in “uncontrolled studies” (which they defined as including clients who were randomly assigned to one of several different treatment groups, rather than providing the same treatment to all clients). In terms of treatment outcomes, he found that personality disordered clients in the “uncontrolled”
studies had poorer outcomes. Acknowledging the methodological limitations of his approach, particularly given that he did not find evidence for poorer outcomes for clients with personality disorders in the “controlled” studies, Mulder emphasized the need for new, well-conducted randomized studies to clarify these relationships.

Several additional factors have been suggested to inhibit clients’ ability to obtain sufficient treatment, including: fewer resources to pay for treatments, pessimistic expectations for treatment effectiveness, impulsivity, and general disorganization (Edlund et al., 2002). Understanding where clients fall on these predictive factors may help treatment providers to better understand which client characteristics have the potential to impact outcomes. A detailed review of client characteristics is beyond the scope of this project; see reviews by Petry, Tennen, and Affleck (2000) or Groth-Marnat, Roberts, and Beutler (2001) for a more comprehensive look at the topic.

**Therapist characteristics.**

Just as for clients, certain therapist attributes and behaviors are believed to impact the outcomes of psychotherapy. Factors such as the therapist’s interpersonal style, perceived level of caring and competence, clarity of verbal communication, and use of specific therapeutic techniques all play a role in determining clients’ perceptions of and reactions to their therapist, and to treatment (Castonguay, Constantino, Boswell, & Kraus, 2011; Horvath & Greenberg, 1994). A recent study of the impact of therapist-specific variables on treatment estimated that therapist effects accounted for 17% of the variance specific to level of patient improvement (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). There is clear evidence that the therapist him- or herself can significantly influence the treatment process and impact the overall effectiveness of interventions.
In a comprehensive review of therapist characteristics shown to positively impact the therapy alliance, Ackerman and Hilsenroth (2002) reported that the therapist attributes of flexibility, honesty, respectfulness, trustworthiness, confidence, warmth, interest, and openness were all associated with positive therapeutic alliance ratings by the client. Similarly, the ability to express understanding of and support for clients’ experiences and perspectives has been repeatedly demonstrated to be beneficial to treatment (Diamond, Liddle, Hogue, & Dakof, 1999; Tryon & Kane, 1993).

Another study by Dunkle and Friedlander (1996) examined therapist characteristics and their impact on treatment alliance for a sample of 77 therapists, ranging in age from 22-64 years of age. They reported that therapists’ levels of perceived social support and degree of comfort with attachment both predicted the bond component of the therapeutic alliance. Therapists’ level of “self-directed hostility,” defined as the level of negativity in one’s “intrapersonal experiences,” was negatively associated with the bond component of the alliance. In other words, therapists with a positive self-image, strong social support, and ease in cultivating interpersonal relationships are likely to create stronger bonds with clients.

In an exploratory study, Diamond et al. (1999) tracked several theoretically beneficial alliance-building interventions, to identify the forms of interaction that were most helpful for improving the working relationships in dyads with poor initial alliance scores. Pulling from a larger treatment study sample, researchers selected a subsample of 10 participants, 5 whose alliance improved over the course of the study, and 5 clients whose alliances did not improve, in an attempt to qualitatively describe the two groups’ interaction styles. They reported that the early sessions for therapeutic relationships with
improved alliances were characterized by the following therapist behaviors: attending to the client’s experience, generating personally-relevant goals with the client, and presenting oneself as the client’s ally. These exploratory results, while limited in terms of age range and sample size, do highlight the potential for specific therapist behaviors to strengthen weak therapeutic bonds and repair alliance ruptures, thus improving alliance quality.

On the opposite end of the spectrum, therapists can also behave in ways that negatively impact treatment. Rejecting or critical interactions between therapist and client have consistently been shown to harm the treatment relationship (Horvath, 2001). Therapists can also display symptoms of burnout, including emotional exhaustion, depersonalization of clients, and lack of feelings of accomplishment (Maslach & Jackson, 1981), all of which may negatively impact the effective delivery of treatment interventions. Hersoug et al. (2009) found that more professional training was associated with poorer client ratings of the therapeutic alliance, perhaps due to greater perceived detachment or disinterest in the client, or a higher likelihood of insisting on a particular therapeutic agenda or clinical opinion. Further research should determine the circumstances under which certain therapist attributes and behaviors enhance or harm the therapeutic alliance. A better understanding of treatment providers’ contributions to client improvement can be utilized to assist clinicians in maximizing helpful interactions and minimizing preventable damage to the treatment relationship.

**Process Variables with the Potential to Impact Treatment Outcomes**

Certain aspects of the interaction between therapist and client may positively or negatively influence the outcome of treatment. Furthermore, therapists’ in-session
interactions hold the potential to impact clients’ level of comfort and motivation during treatment, which in turn may influence their degree of participation in the specific treatment techniques implemented in-session. For example, Ackerman and Hilsenroth (2002) identified several in-session therapist behaviors that were associated with positive alliance ratings, including: noting past therapy successes, reflecting and offering (accurate) interpretations which facilitate expression of affect, and actively attending to client in-session experiences. Two specific types of therapist communications, which have only recently begun to receive attention in the research literature, are validation and invalidation. I will now examine these two categories of interaction in detail, to highlight what is currently known about the effects of such responses on clients’ in-session emotional experiences and responses to treatment.

**Invalidation.**

Invalidating responses communicate a lack of understanding or acceptability, or a rejection of the actions, thoughts, emotions, and desires of an interaction partner. Invalidation occurs within virtually all human relationships, including in-session therapist-client interactions. Certain therapist behaviors, such as inattention to the client, insisting on a particular interpretation of a situation or behavior, criticizing the client’s decision or course of action, or ignoring clients’ emotional disclosures, are thought to occur with some frequency within psychotherapeutic relationships (Linehan, 1993). Behaviorally speaking, invalidation punishes the behaviors preceding it (Thorp, 2001). The experience of being invalidated by one’s therapist has been hypothesized to damage the therapeutic relationship and potentially delay or even halt progress toward therapy goals (Fruzzetti, 1996; Linehan, 1993; 2001). Invalidation can complicate clients’
attempts at emotion regulation, increasing the likelihood that clients will engage instead in problematic coping or avoidance behaviors (Nock & Mendes, 2008). In other words, therapists who invalidate their clients during attempts to problem-solve or regulate painful emotions may in fact be “shooting themselves in the foot” by creating additional obstacles for the client.

*Levels of invalidation.*

Invalidation has been conceptualized to take a variety of forms, both verbal and non-verbal. Linehan (1993) first defined and described six separate levels of invalidation, which Fruzzetti (1997) then expanded to seven levels and operationalized in his Validating and Invalidating Behavior Coding Scale (VIBCS). In the VIBCS, Fruzzetti (1997) defines seven levels of invalidating responses, with levels starting at the lowest intensity (i.e., level one) and building in strength through level seven, which is considered to have the greatest potential impact on interaction partners. In the following level descriptions, I refer to the person providing the invalidating responses as the “therapist” and the person receiving the responses as the “client,” while acknowledging that these forms of communication can take place between the members of any dyad.

The first level of invalidation is *inattention*, which can include distractedness or lack of interest. The second level of invalidation is *missed opportunities*, also referred to as functional unresponsiveness. Missed opportunities can include failure to respond to critical or vulnerable client self-disclosures, or simply insufficient contribution to the therapeutic dialogue. *Insisting* on a particular way of feeling or thinking is the third level of invalidation. This level can include telling the client what they should think, want,
feel, or do, regardless of the desires and feelings reported by the client, or insisting heavily upon a particular therapy technique or agenda item.

The fourth level of invalidation in Fruzzetti’s conceptualization is *increasing negative valence*. When the therapist agrees with or even heightens a client’s self-invalidating thoughts, such as feelings of worthlessness, the client’s negative affect is likely to increase further. Behaviors such as agreeing with clients’ self-invalidation are likely to increase negative affect and, subsequently, the likelihood of maladaptive coping strategies, rather than assist the client in thinking differently about the situation or modifying problematic behaviors. The fifth level of invalidation is *pathologizing*, or treating the client’s acceptable or understandable self-disclosures as unusual, strange, or erroneous. A therapist can pathologize their client by criticizing his or her reasonable behaviors, or treating those behaviors as problematic or wrong when, in fact, they are not.

*Fragilizing* is Fruzzetti’s sixth level of invalidation. Fragilizing can include acting as if the client is too fragile to solve his or her own problems, or treating him or her as incompetent or unable to handle negative emotions. This level also includes attack behaviors, such as harsh, cruel, or contemptuous responses. Finally, Fruzzetti’s seventh level of invalidation is *indifference to vulnerability*. Nonresponse to vulnerable client self-disclosures (i.e. leaving them “out to dry”) or assuming a superior stance or increasing emotional distance by hiding behind the therapist “role” are two examples of this level.

*Invalidation in psychotherapy.*

As in all other interpersonal relationships, invalidation is also believed to occur within the treatment context (Linehan, 1993). When considering therapist behaviors that
may be experienced as invalidating, it is important to keep in mind that therapists’ intentions often mismatch their clients’ reactions to those same interventions, even for experienced therapists (Hill, Helms, Spiegel, & Tichenor, 1988). Hill and colleagues also reported that therapists sometimes perceive clients’ emotional reactions inaccurately, resulting in further opportunities for inadvertent invalidating responses. The authors further suggest that treatment success is likely predicted by the level of agreement between therapists’ intentions and client’s reactions, reporting evidence that therapist intentions matched client reactions much more frequently in successful treatment courses than in non-successful ones. The authors suggest that therapists should make particular efforts to be supportive and receptive to client concerns, especially when treating highly distressed and/or emotionally dysregulated clients, to maximize the likelihood that clients accurately understand therapists’ in-session intentions and interventions.

One common way therapists may inadvertently invalidate is by attempting to reassure clients in ways that may be perceived as dismissive of the seriousness of their symptoms (Linton, Boersma, Vangronsveld, & Fruzzetti, 2012). Another way therapists may invalidate is by demonstrating a lack of understanding, interest, or willingness to engage with clients’ specific cultural or personal values (Ishiyama & Westwood, 1992). Imposing one's own point of view, value system, or preferences onto a client can be an invalidating experience, especially if the client feels they are struggling to be heard and understood. Similarly, clients who described their therapist as taking “strong control” over the content of therapy sessions also rated the therapy relationship less positively (Lichtenberg et al., 1988), suggesting that heavy-handed direction of session agendas and topics may be experienced by clients as invalidating.
Validation.

Just as invalidating comments from therapists can impact therapy, so too can validating ones. Validation can include a broad array of verbal and non-verbal responses, including “anything that communicates acceptance and understanding of the other person’s thoughts, wants, emotions, actions, goals, or other behaviors in a clear and non-judgmental manner” (Hayes, Follette, & Linehan, 2004). The essence of validating responses is that they communicate understanding and acceptance of the reasonable, legitimate aspects of an individual’s experiences, given the context in which they occurred. Such responses may be small or large in focus, acknowledging the validity of the entire experience being communicated or of a small portion (i.e., the “kernel of truth;” Linehan, 1993).

Validating behaviors can take a variety of forms: non-verbal indicators, ranging from open body posture or supportive facial expressions, to short utterances of support (“yep,” “mm-hmm,” etc.), to explicit verbal expressions of understanding and acknowledgment. Linehan (1993) described validation as a three-step process, starting with active observation (of both explicit and implicit content), reflection of these observations back to the client, and, finally, direct indications of understanding and support for the client’s emotions, thoughts, or behaviors.

Levels of validation.

Fruzzetti (1997) also delineated seven levels of validation in the VIBCS. The following section includes a brief description of each level.

Attentive Listening, the first and most basic level of validation, consists of simply paying attention and demonstrating interest in what the client has to say. This first level
is called *Staying Awake* in Linehan’s model. The second level is *Functionally Responding*, in which the therapist acknowledges and/or accurately reflects the client’s disclosures back to him or her. Functionally responding can also take the form of problem-solving behaviors or otherwise assisting the client in determining and taking the next step toward accomplishing their goals. Linehan’s term for this level of validation is *Accurate Reflection*.

*Clarifying* the client’s experience is the third level of validation. In this level, the therapist attends to the client’s disclosures and makes special efforts to understand their directly stated experiences, and, at times, infer those which are not explicitly indicated (“mindreading”). Clarifying may include asking questions to ensure and expand the therapist’s understanding of the client’s thoughts, emotions, or actions.

Fruzzetti’s fourth level of validation is *Recontextualizing*, in which the therapist communicates acceptance of the client’s emotions, behaviors or thoughts, because they make sense given the context in which they took place (i.e., “because many of your other relationships have ended painfully”). Linehan’s (1993) fourth level of validation, which she terms *validating in terms of sufficient (but not necessarily valid) causes*, is defined as validation given the client’s past learning experiences and/or biological vulnerabilities (i.e., “because you have depression”). The behavior or thought is validated given that person’s individual context, even if the behavior or thought would not necessarily make sense in all contexts.

*Normalizing*, the fifth level of validation, communicates that other people would also feel or behave similarly in such a situation, including responses such as “of course” or “anybody would…..” The essence of normalizing is to communicate that a behavior or
emotion was normal and reasonable, that other people would have behaved or felt similarly in that same situation. Fruzzetti’s sixth level of validation is Radical Genuineness, which centers upon treating the client as a worthy, equal and competent ally in solving his or her own problems. Radical genuineness may take the form of caring expressions of hearty support, emphasizing the therapist’s belief that the client “has what it takes” to better their situation. It may also take the form of simply treating the client as competent and equal, regarding him or her as capable of engaging in the difficult work of solving the problems at hand, even while in the midst of emotional pain.

Radical genuineness is the final level in Linehan’s conceptualization; Fruzzetti adds a seventh level of validation, termed Reciprocal Vulnerability. In this level, the therapist joins the client in a position of vulnerability by revealing his or her own vulnerabilities through appropriate and clinically-relevant self-disclosures. The essence of this level is to equalize the power in the relationship and foster a supportive environment for the client to feel secure while disclosing sensitive or difficult information.

**Validation in psychotherapy.**

Validation can be a valuable and effective therapeutic strategy. Theoretically, validation can fulfill at least four functions to enhance the process of therapy and facilitate effective outcomes (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). First, validation can be used to provide feedback on progress toward treatment goals. For example, a client might struggle to complete an assigned homework task, and return to the next session with only a small portion of the task completed. The therapist could use validation to highlight understanding of the client’s emotional experience (including the
challenging parts of the assignment), and reinforce the utility of attempting the assignment. Such efforts are likely to reduce in-session negative affect, strengthen the client’s confidence in their ability to successfully complete therapy tasks, and increase the likelihood of subsequent attempts.

Second, validation can be used to teach clients to self-validate, through which they may learn to view themselves more positively, engage in less self-criticism, and observe their own thoughts and emotions as valuable signals. The ability to self-validate has been associated with better overall adjustment, greater awareness of emotional state and personal values, and more realistic appraisals of one’s current resources (Ishiyama & Westwood, 1992). Because validating responses by the therapist can encourage clients to self-validate (Lynch et al., 2006), such interactions may assist the client in building skills to regulate their own negative emotions and develop effective interpersonal behavior patterns (Ishiyama & Westwood, 1992).

Third, validation can be utilized to encourage the client to engage in change-oriented interventions while feeling supported and understood. The intentional use of validation, in conjunction with calls for change, can provide clients with a sense of acceptance and support during treatment. Because validation is thought to reduce the frequency, intensity, and duration of in-session negative emotional states (Fruzzetti & Shenk, 2008), it may be utilized to keep the client “on track” and prevent intense emotions from derailing helpful change-oriented strategies.

Within the context of the therapist-client relationship, this could mean that highly validating therapists may be more effective at quickly reducing emotional dysregulation and returning to therapeutically useful techniques. Indeed, individuals within
interpersonal relationships that are high in validating responses have been found to have lower levels of emotional dysregulation (Shenk & Fruzzetti, 2011). Furthermore, Ackerman and Hilsenroth (2002) highlighted the important role of intentional therapist validation for cultivating understanding and positive regard, as well as repairing ruptures in the client-therapist relationship, and re-establishing mutual trust.

Lastly, validation may serve as a source of encouragement and reinforcement (Thorp, 2001), increasing the likelihood that clients will remain engaged in treatment and continue to come to sessions, particularly if the content being discussed is distressing. Validation may facilitate behavioral change by fostering greater opportunities for helpful self-disclosure and skill development (Linton et al., 2012), as well as in-depth understanding and regulation of emotional states (Fruzzetti & Shenk, 2008).

**Clarifying the nature of the relationship between validation and invalidation.**

When considering the potential influences of validating and invalidating therapist responses on the treatment process, it is important to keep in mind that validation and invalidation are not necessarily opposite ends of the same uni-dimensional spectrum, with validation on one end and invalidation on the other (Thorp, 2001). Rather, an interaction partner could behave in ways that are perceived as both validating and invalidating, or neither validating nor invalidating.

*Is validation always good? Is invalidation always bad?*

One common assumption is that validation is always “good” and, conversely, that invalidation is always “bad.” However, the real-world picture is much more nuanced, and such broad generalizations are often inaccurate. Invalidation, as it is typically conceptualized, occurs when an interaction partner invalidates another person's valid and
reasonable thoughts, emotions, or behaviors. The evidence is clear that such communications are associated with increased emotional and physiological arousal. However, the picture gets less clear if, for instance, the behavior or thought being invalidated is in fact *invalid*. There is reason to believe that, in some circumstances, invalidation of invalid behaviors might be used therapeutically to increase awareness, facilitate motivation for change, and help the client learn to discriminate between helpful and unhelpful behavioral choices (Sells, Black, Davidson, & Rowe, 2008). For example, one common (and often effective) change strategy in psychotherapy is to "invalidate the invalid." Stated more simply, therapists may highlight the unhelpful or inaccurate parts of a client's maladaptive thoughts, actions, or behaviors, to encourage and assist in problem-solving and solution generation.

On the other hand, validation, as it is typically conceptualized, centers upon validating the valid, expressing one’s support and highlighting shared experiences. However, as mentioned previously, attempts to validate the *invalid* hold the potential to be harmful, not only to the individual whose actions are being discussed, but to the relationship between the interaction partners. To validate an ineffective behavior, rather than help the client notice its negative impact, may reinforce negative or avoidant behaviors, and does little to assist the client in building a better life. In situations such as these, invalidation may serve a helpful and even caring purpose, making it clear to the client that the problem is the behavior and not the client him- or herself (Linehan, 1997).

While there is much theory and some empirical support for the relationships among validation and invalidation, the quality of the therapy relationship, and treatment outcomes, there is also evidence that the picture may be more complicated than has been
initially conceptualized. For example, the type of treatment provider may impact the effect invalidation has on outcomes. One study compared perceived validating and invalidating qualities in “traditional service providers” and “peer providers” as they delivered “intensive case management” to a sample of 137 outpatient clients with severe mental illnesses (Sells et al., 2008). The clients had all been diagnosed with at least one severe mood and/or psychotic disorder; most (70%) also met criteria for one or more substance use disorders. The sample was randomized to receive services from either a traditional provider or a peer provider. The peer providers were mental health professionals who chose to disclose their own history of and recovery from mental illness and/or substance use disorders as part of the treatment process.

Participants were assessed 6- and 12-months into treatment, reporting their perceptions of the validating and invalidating qualities of their treatment providers, which were assessed using the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). Validating qualities included characteristics such as positive regard, empathy, and unconditional acceptance, while invalidating qualities included expressing dissatisfaction with the client, refusing to understand their point of view, or ignoring relevant self-disclosures. Clients also completed questionnaires on current quality of life and self-reported obstacles to recovery.

The authors reported an association between perceived invalidation by peer providers and improved outcomes at the 6-month assessment, an effect that was not found for traditional treatment providers. Participants who were treated by peer treatment providers who were perceived as invalidating also reported improved quality of life, fewer psychological and physical health problems, and better relationships with
family members at the 6-month assessment. This benefit was not maintained at the 12-month assessment for either type of treatment provider. Sells and colleagues’ results provide some evidence that invalidation may be associated with benefits in earlier, but not later, phases of treatment, at least if the invalidation comes from a peer. Perhaps invalidation coming from a caring collaborator who has dealt with the same problems previously is generally interpreted less negatively (or even more positively) by clients than would typically be the case for a traditional provider. It is possible that individuals in an equal power relationship are more likely to accept the constructive feedback provided by invalidation of invalid responses. These results highlight a gap in the current understanding of clinically appropriate uses of invalidation within specific treatment contexts.

One limitation to this study was that participants rated therapists’ “perceived invalidating qualities” rather than specific forms of invalidating communications and behaviors, allowing for wide variability in the forms and degrees of invalidation perceived and reported by participants. Future studies should carefully define the types of invalidation being assessed, as well as their effects, to maximize the specificity of clinical recommendations for the appropriate use of validating and invalidating strategies. The authors themselves also highlighted the current lack of specific empirical data in this area, calling for future research to specify 1) when and how frequently invalidation occurs in actual treatment settings, and 2) invalidation’s particular effects on treatment outcomes.
The importance of interpretation.

Another key consideration when examining the impact of validation and invalidation is that a comment must first be perceived and interpreted as validating or invalidating before it can be expected to have any effect on emotion, cognition, or interpersonal relationships. The degree of emotional response to such perceptions will vary from topic to topic and dyad to dyad. Occasionally, an attempt to validate might actually be perceived as invalidating. To provide an example, an employer might heartily validate their employee for what that employee views as a minor or irrelevant achievement (“What a solid report- no grammatical errors whatsoever!”). If that employee viewed the report as containing a groundbreaking, novel idea worthy of further discussion, his boss’ attempts to validate could be interpreted as conveying a lack of understanding of his true capabilities and potential, leading the employee to feel invalidated, despite his boss’ original intention to validate him. Just as with any form of human interaction, validation and invalidation may take a variety of forms, may co-occur, and may be perceived in a different way than was originally intended.

Outcomes Potentially Impacted by Validation and/or Invalidation

Now that validation and invalidation have been defined and explained within the therapy context, I will next discuss three major categories of treatment outcome which have the potential to be impacted by clients’ experiences of in-session invalidating or validating responses.

The Therapeutic Alliance.

One way invalidation may harm treatment is through damage to the therapist-client working relationship. The therapeutic alliance, also referred to as the working
Alliance, has been defined as “the collaborative and affective bond between therapist and client (p. 438)” (Martin, Garske, & Davis, 2000). The ability to form a sympathetic, accepting relationship with the client has long been highlighted as an important aspect of successful therapeutic relationships (Horvath, 2001). As with any human interaction, the alliance serves not only as a platform for information exchange, but also as a resource for learning and practicing new skills in real-time (Simmons, Roberge, Kendrick, & Richards, 1995).

The clinical picture can look very different when one or both parties holds a more negative view of the relationship, or when some type of interpersonal exchange or event takes place which serves to rupture the alliance and threaten the entire enterprise of psychotherapy. Indeed, much attention has been devoted in the literature to the construct of relationship repair following the occurrence of a rupture, which is defined as “an emotional disconnection between client and therapist that creates a negative shift in the quality of the therapeutic alliance” (Daly, Llewelyn, McDougall, & Chanen, 2010).

When it comes to ruptures in the therapeutic alliance, Safran and Muran (2000) conceptualize two main types of alliance ruptures: withdrawal ruptures and confrontation ruptures. Withdrawal ruptures involve the client “shutting down” or acquiescing while withholding important aspects of their experiences, whereas confrontation ruptures involve high-emotion disclosures of dissatisfaction or distress, either at the therapist, at the therapy process, or both. The potential exists for either or both of these types of ruptures to occur within a therapy session (or over the course of several sessions), with an experience of invalidation holding the potential to be the catalyst. However, little is
known about how these specific forms of interaction between therapist and client may impact their relationship.

In terms of how the constructs of validation and invalidation may be similar to or different from the concept of the therapeutic alliance, much remains uncertain, given the relatively low number of empirical studies in this area. It is likely that validating responses from one’s therapist fall within the category of alliance-boosting events, and similarly that experiences of invalidation from one’s therapist are likely to serve as alliance-threatening events, given sufficient repetition or severity, particularly if they lead to or serve as a rupture in and of themselves (i.e. ‘this therapist just doesn’t understand where I am coming from’). However, where validation differs from the alliance is by its emphasis on the internal experiences and the therapists’ attempts to connect with the individual’s own valid, reasonable choices and point of view.

Put differently, validation goes beyond agreement on a set of tasks (although it can include this) or how well the therapist and client get along, to include a more fundamental, human-to-human understanding which facilitates not only the alliance but also that person’s feeling of worth and normalcy. This highly internal focus, likely contributes to the difficulty in assessing the presence of these experiences objectively, and in teasing apart the highly related concepts of validation and invalidation from the more general concept of the therapeutic alliance.

Similarly, while little is known currently about how invalidation may lead to negative perceptions of the therapeutic alliance, it may also be the case that the specific experience of invalidation is again a highly internal one. Where a negative alliance might center upon perceptions of treatment goal mismatch or the feeling that one doesn’t
“click” with one’s therapist, invalidating experiences are those stemming from a more personal, internal view of oneself as inherently incomprehensible or wrong. It goes beyond the negative effects on the therapeutic relationship to also speak to the individual as a person, as was the case for validation. In this way, invalidation relates strongly to the alliance, but specifically extends beyond it to include highly internal experiences of self-rejection, doubt, or judgment of one’s adequacy. As was the case for validation, the highly internal nature of invalidation lends complexity to current efforts to assess its occurrence, separately from the strength of the alliance.

**Does alliance predict outcome?**

The strength of the therapeutic alliance’s relationship with treatment outcomes has been hotly-debated for decades. Some researchers have gone so far as to say that non-specific factors, such as the therapeutic relationship, may contribute more to treatment outcomes than specific techniques (e.g., Wampold, 2001), while other studies have cast doubt on the central role of the alliance in determining outcomes (e.g., Clark et al., 2006; Feeley, DeRubeis, & Gelfand, 1999). The impact of alliance on outcomes appears to vary so significantly in the literature that some authors have suggested that the strength of the alliance’s impact on outcomes varies across treatment types (e.g., Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998). Furthermore, the alliance may be more important for the treatment of some groups than for others; in particular, for individuals with personality disorders, establishing a secure working relationship may be essential before achieving therapeutic gains.

One commonly-cited meta-analysis by Martin et al. (2000) found a modest yet consistent association ($r = .22$) between the strength of the alliance and treatment
outcomes across 79 studies. While this correlation is considered small (Cohen, 1988), it indicates that the therapeutic alliance, alongside other relevant factors, may impact the outcome of treatment in a noticeable way. Klein and colleagues (2003) examined the role of alliance on outcomes for the Cognitive-Behavioral Analysis System of Psychotherapy (CBASP), a treatment where the alliance is a central focus; they found that the quality of the alliance did predict treatment outcomes, even after controlling for prior symptom improvement.

It appears that the therapeutic alliance contributes a small but robust effect on treatment outcomes. Further studies of the role of the alliance across a variety of settings, treating a wide variety of presenting concerns (including personality disorders), would add valuable information to this ongoing discussion, and expand it beyond the limited scope of clinical trials. The following section reviews the literature as it pertains to the specific contribution of a strong alliance in and of itself to treatment retention and adherence.

**Alliance and treatment retention.**

Because treatment disruptions, such as missed and/or cancelled sessions, are such a common problem in psychotherapy, and because such interruptions serve as a potent obstacle to the effective utilization of treatment resources (Ogrodniczuk, Joyce, & Piper, 2005), efforts to maximize session attendance and minimize cancellations are likely to pay off for clients. Several studies have demonstrated the importance of a positive therapeutic alliance in reducing the incidence of premature treatment termination. In one study examining the role of the therapeutic alliance early in treatment for a sample of adults (n = 187) receiving inpatient drug treatment (Meier, Donmall, McElduff,
Barrowclough, & Heller, 2006), therapist ratings of the strength of the alliance during sessions 1-3 were found to be one of the strongest predictors of treatment retention. The authors emphasized the importance of therapist assessment of their clients’ “risk of disengagement” early in treatment, including the strength of the therapeutic alliance, to facilitate regular treatment attendance and participation.

Tryon and Kane (1995) examined the impact of two factors — involvement (how actively the therapist or client participates) and relatedness (how well the therapist or client communicates) — at intake on clients’ later ratings of the alliance at session three. Their sample consisted of 109 college students seeking psychological treatment. Therapist ratings of their clients’ involvement and relatedness were both associated with higher client-reported alliance scores later in treatment. They also found that clients’ ratings of relatedness were associated with higher therapist-reported alliance scores. Most importantly, weaker ratings of the alliance by client and therapist were both predictive of eventual early termination by the client. These results yield further support for the importance of a strong alliance (see also: Tryon & Kane, 1993). Building a solid working alliance in the early phase of treatment may be an important step to increasing clients’ session attendance and participation.

Alliance and treatment adherence.

A strong therapeutic alliance has also been demonstrated to improve adherence to several types of treatment. Loeb and colleagues (2005) examined the role of the therapeutic alliance on adherence to two separate treatments for Bulimia Nervosa: Cognitive Behavior Therapy (CBT) and Interpersonal Therapy (IPT). Alliance, as assessed with a modified version of the Vanderbilt Therapeutic Alliance Scale (VTAS;
Hartley & Strupp, 1983), was shown to predict later adherence to the treatment protocol, although they did not find support for their prediction that greater adherence would lead to better outcomes. They did find some support for early treatment alliance as a predictor of post-treatment purging behaviors. Finally, Principe, Marci, Glick, and Ablon (2006) reported that the bond component of the therapeutic alliance (as measured by the Working Alliance Inventory; Horvath & Greenberg, 1989) was associated with greater likelihood of the client returning for additional sessions, suggesting that a closer therapeutic alliance may facilitate adherence in its most basic form—coming to sessions. These results suggest that a strong therapeutic alliance is likely to benefit clients in multiple ways, including a greater likelihood of treatment adherence and retention, as well as greater reductions in maladaptive behaviors.

**Interaction between Alliance and Specific Therapeutic Techniques.**

In addition to contributing positive effects to treatment retention and engagement, a strong therapeutic alliance also likely interacts with specific therapeutic techniques (such as challenging automatic thoughts or building distress tolerance skills), such that an improved therapist-client relationship likely assists in the delivery of those specific therapeutic techniques. Some researchers have suggested that the alliance can be conceptualized to operate in parallel to, and perhaps independently from, a particular treatment approach’s specific techniques (e.g., Green, 2006), contributing to treatment outcomes in both direct and indirect ways. Moreover, the strength of the alliance may mediate the relationship between some of the predictive client characteristics discussed previously and that client’s eventual outcomes (Howard, Turner, Olkin, & Mohr, 2006).
When it comes to the impact of the treatment relationship, it is clear that further studies are still needed to clarify which situational and interpersonal factors are associated with a strong therapeutic alliance, on their own or in conjunction with specific therapeutic strategies. Ackerman and Hilsenroth (2002) specifically called for studies to determine the impact of different forms of interpersonal exchange between therapist and client on the quality of the therapeutic alliance. Further research is also needed to understand the specific mechanisms of action driving any benefits that may be observed.

It is important to note here that the relationships among validation and invalidation and the therapeutic alliance have not yet been clearly identified in the literature. Invalidation and validation may fall within the umbrella of the therapeutic alliance, in the sense that such experiences would be a part of the alliance, and as such would negatively or positively associate with one’s perception of the therapeutic bond (and possibly with agreement on tasks/methods of achieving them). It is also possible that these concepts are so similar that they are not, at least while using the SRVIS in its current form, practically distinguishable from one another for research purposes; further work is needed to determine whether or not a separation between validation and invalidation and the larger alliance is possible, or even desired, for future research in this area, given the possibility that clients’ report of validation and invalidation associate so very strongly with their report of the quality of the alliance.

**Treatment Participation and Adherence.**

**In-Session Participation.**

Another way invalidation may harm the process of therapy is through reductions in clients’ willingness to fully engage in the process of psychotherapy, including degree
of engagement with in-session work, regularity of session attendance, and compliance with tasks. Similarly, efforts by therapists to validate are likely to facilitate effective therapy by increasing clients’ willingness to participate fully in treatment (Linehan et al., 2002). Consistent with transactional models of dyadic interaction (i.e., Fruzzetti, Shenk, & Hoffman, 2005), efforts to validate clients’ emotions and experiences are likely to increase participation with treatment, to the degree they feel supported and accepted by their therapist. The therapist is likely, in turn, to respond more positively and fully to an engaged and actively-participating client, and the benefits continue to accumulate.

Validation has also been shown to facilitate successful cognitive processing of emotions during treatment of anxiety and depression. Leahy (2002) examined a sample of 53 adult psychotherapy clients, comparing their depression and anxiety scores with their score on the Leahy Emotional Schema Scale (LESS; Leahy, 2002). One subscale of the LESS is “Validation by Others,” which includes items such as “Others understand and accept my feelings.” Examining the 14 subscales of the LESS individually, Leahy reported an association between the validation subscale and greater use of both cognitive and conceptual forms of emotional processing, including: feeling greater control over one's own emotions, experiencing a shorter duration of negative emotions, feeling less guilty about one's own emotions, and viewing one's own feelings as comprehensible to others (i.e., self-validation). Feeling safe and understood by one’s therapist appears to lay the foundation not only for a stronger working alliance, but perhaps also for fuller understanding of one’s emotions and engagement in solution-oriented in-session collaboration.
**Treatment Adherence.**

Another way that validation may significantly benefit treatment is through its potential to increase clients’ motivation to persist in the often-difficult process of psychotherapy. Validation may increase clients’ motivation and willingness to remain in therapy (Linehan et al., 2002), potentially improving treatment retention by providing a safe environment for self-disclosure and acquisition of difficult skills. In a study of the effects of validation on emotions and treatment adherence, Linton et al. (2012) randomized a sample of participants to receive either validation or invalidation from an experimenter in between four consecutive trials of a pain tolerance task. As a proxy for treatment adherence, participants were then asked to engage in one additional pain tolerance test following the series of four. Their most striking finding was that the rate of agreement to complete the extra trial (a proxy for treatment adherence) was twice as high for the validation condition as it was for the invalidation group.

While they found significant benefits for validation in terms of increased positive affect and reduced worry compared to the invalidation group, the validation and invalidation groups did not differ in terms of negative emotion. Both groups reported reductions in negative affect across the trials, but did not differ significantly from one another on self-reported negative affect or pain. These results suggest that validation can facilitate positive emotional states during challenging activities, reduce worry, and increase participants’ willingness to persist in a challenging and even painful task. Two limitations to this study, however, were their use of a non-clinical sample and an experimental proxy for treatment adherence. These effects must be examined with real-
world clinical samples and actual treatment protocols to improve our current understanding of the impact of validation and invalidation in treatment contexts.

There is some empirical evidence that validation may increase client retention across the course of treatment. In a study on validation in real-world clinical settings, Linehan and colleagues (2002) compared the efficacy of two treatment approaches, Comprehensive Validation Therapy plus concurrent 12-step treatment (CVT+12S) and Dialectical Behavioral Therapy (DBT), with a sample of women with Borderline Personality Disorder (BPD) who were also addicted to opioids. CVT centers upon validating the client and creating a supportive therapy environment that bolsters clients’ confidence and perceived ability to learn skillful behaviors. CVT relies heavily upon the acceptance-based strategies of DBT, such empathy and supportive therapist responses, and purposely excludes any active behavioral or cognitive change strategies. The primary aim of the study was to determine which treatment approach would lead to greater reductions in opiate use.

They found similar rates of success in reducing opiate use for the DBT (73% tested negative for opiates) and CVT (67%) groups at 16-month follow-up. However, the overall study retention rate was significantly higher for the CVT condition (100%) than for the DBT condition (64%). One interpretation of these findings is that CVT may be experienced as less aversive/more pleasant than DBT, contributing to the higher likelihood of remaining in therapy through the full course of treatment (in this case, one year; Linehan et al., 2002). Validation may serve an important function in therapy, fostering support for the client as they struggle, increasing the client’s trust in their
therapist, and perhaps helping the client see the potential benefits of continuing treatment, even when sessions may at times be uncomfortable for the client.

**Symptom Reduction.**

*Affect and Emotional Arousal.*

A third way invalidation may impact the process of psychotherapy is through reductions in the efficacy of specific therapeutic aims, such as the reduction of negative affect or symptoms of depression. While validation has been shown to reduce negative affect (Shenk & Fruzzetti, 2011), invalidation is believed to increase negative affect, thereby delaying participants’ return to normal emotional and cognitive functioning (Fruzzetti et al., 2005). The impact of negative emotion on both emotional and physiological arousal has been well-established (Gomez, Zimmermann, Guttormsen Schär, & Danuser, 2009; Zellars et al., 2009).

Researchers have only recently begun to empirically test the myriad relationships posited to exist among validation, invalidation, and the resulting emotional responses. Shenk and Fruzzetti (2011) established a line of research to test these relations in an empirical, laboratory-based context. They utilized a longitudinal design featuring repeated invalidating (e.g., “there’s no need to get upset”) or validating (e.g., “lots of people feel that way”) responses from the experimenter as participants completed a mental arithmetic task. Shenk et al. reported that, in terms of affect, people who were invalidated reported significantly higher levels of negative affect, whereas the validated group did not experience any increase in negative affect across the experimental protocol. Physiologically, whereas invalidation was associated with an increase in heart rate and skin conductance from pre-task to post-task, participants who were validated experienced
reductions in heart rate over the course of the protocol. Furthermore, they also found that repeated invalidation prolonged and even increased emotional arousal over time; similarly, continued validation had an additive effect, contributing to continuing reductions in emotional arousal over time. This study provides evidence that validating and invalidating experiences may impact emotional as well as physiological arousal in lasting ways.

Shenk and Fruzzetti highlighted the importance of intentional therapist efforts to increase validation and reduce instances of invalidation, to facilitate interventions aimed at increasing clients’ emotion regulation abilities. One limitation of these studies, however, was their use of an undergraduate sample; studying the emotional impact of validation and invalidation in real therapist-client dyads (using a clinical sample) will provide important information on the real-world impact of such communications.

We have begun a line of research to empirically test the theory that experiences of invalidation negatively impact clients’ ability to learn new information (Stigen & Cheavens, 2011). We provided a sample of undergraduate participants with either validating or invalidating feedback following a four-minute disclosure of an angry personal story. We then asked them to complete two learning tasks: a modified, emotion-word version of the Wisconsin Card Sorting Test (WCST; Berg, 1948), and a paired associates recall task using angry-neutral word pairs. We found robust differences in self-reported invalidation across feedback condition, suggesting an effective manipulation. In terms of affect, we found an interaction between condition and time (pre/post) for self-reported positive affect, such that invalidated individuals reported significantly larger decreases in positive affect across the experimental protocol. We did
not find any effect on self-reported negative affect across feedback conditions (validation or invalidation).

Regarding affect, our results differ somewhat from those obtained by Shenk et al. (2011); it may be the case that invalidation increases negative affect and/or decreases positive affect in some contexts but not others. These mixed results highlight the limitations in our current understanding of the nature and impact of validating and invalidating interactions. It is possible that, in certain contexts, invalidation may yield negative effects through reductions in positive affect. Positive affect has been consistently associated with approach-oriented behaviors such as interest, engagement, and willingness (e.g., the broaden-and-build model by Fredrickson, 2004), all of which likely facilitate treatment participation. If invalidation reduces positive affect, it may negatively impact client participation in treatment.

**Invalidation and Borderline Personality Disorder**

I now draw attention to one last relevant factor to consider: the impact of Borderline Personality Disorder (BPD) symptoms on the relationship between invalidation and the above therapeutic outcomes. Researchers studying the treatment of BPD were among the first investigators to devote significant attention to the impact of validating and invalidating responses and therapist behaviors.

BPD is a pervasive, highly-impairing personality disorder that is characterized by intense and unstable affect, chaotic interpersonal relationships, impulsive behavior, an uncertain and shifting sense of self, and self-harm or suicidal behavior (Linehan, 1993; Lynch et al., 2006). In particular, two central deficits, emotional dysregulation and interpersonal instability, can severely hinder the establishment of a trusting therapeutic
relationship, and are particularly relevant to the current study. A growing body of literature, as well as our own earlier research, suggests that individuals with BPD may be particularly negatively impacted by experiences of invalidation. In that same vein, validation may become especially important when working with individuals with any of the personality disorders, due to the shared difficulty in establishing and maintaining effective working relationships that characterizes personality psychopathology, to facilitate the establishment of an effective working relationship.

**Interpersonal difficulties.**

Individuals with personality disorders, including, and especially, BPD, often report difficulties in establishing and maintaining lasting relationships (Hersoug, Monsen, Havik, & Hoglend, 2002; Lingiardi, Croce, Fossati, Vanzulli, & Maffei, 2000). Relationship ruptures are common occurrences in the treatment of individuals with BPD, due in part to biases in interpersonal evaluation and difficulties with emotional dysregulation (Barnow et al., 2009). Because of the particular emotional difficulties that are hallmarks of BPD, such as the tendency to experience emotions more intensely and have more difficulty controlling negative emotions (Levine, Marziali, and Hood, 2007; Yen, Zlotnik, & Costello, 2002), clients with BPD are especially likely to experience ruptures in the therapeutic relationship. Intentional therapist efforts to build and maintain a supportive and understanding therapeutic relationship are particularly important for the treatment of clients with BPD (Spinhoven et al., 2007; Yeomans et al., 1994), to increase the likelihood of successful management of a notoriously difficult-to-treat disorder.
Bias toward threat.

Empirical studies on the decision-making abilities of people with BPD have also demonstrated a tendency toward negative interpersonal biases; specifically, individuals with BPD may be prone to perceive neutral or ambiguous facial expressions as negative or threatening. Domes, Schulze, and Herpertz (2009) reviewed the literature on emotion recognition in individuals with BPD, and reported an enhanced sensitivity to negative emotions, such that they are especially likely to perceive social threats and anticipate rejection from social partners. Other researchers have also provided evidence for a negative interpersonal evaluation bias, with individuals with BPD judging other people to be more negative and aggressive, and less positive, than controls (e.g. Barnow et al. 2009), with a higher likelihood of withdrawing from treatment (Russell et al., 2007). Thus, it is possible that one’s level of BPD features will associate significantly with perceptions of validation and invalidation.

The Current Study

This study investigated the associations among validating and invalidating experiences during psychotherapy and several relevant treatment measures. I assessed the level of validation and invalidation that clients reported experiencing during psychotherapy, to describe how often (and in what forms) validation and invalidation occur in-session, as well as determine whether or not these constructs associate with affect and session attendance, as the extant literature and theory would suggest. Of course, the client-reported data we examined was impacted by the degree of insight and honesty of the participants completing the form; nonetheless, examining the incidence and impact of invalidating experiences from an active therapy client’s perspective
provides useful information which allows us to better understand invalidation as it naturally occurs. I examined self-reported invalidation and validation and their associations with post-session affect, treatment attendance failures, and satisfaction with one’s therapist and the treatment overall. Our primary hypotheses were as follows:

**Study Hypotheses**

**Hypothesis 1.**
Client-reported invalidation will be associated with an increase in negative affect, and a decrease in positive affect, from pre- to post-session.

**Hypothesis 2.**
Higher mean invalidation at sessions 3 through 6 will be associated with a higher number of treatment attendance failures at those same sessions.
Chapter 2: Method

Participants

Client Sample. The final sample included 52 participants, recruited from the various clinics of the Psychological Services Center (PSC) at The Ohio State University (OSU). Participation was offered to all new clients in several clinics within the PSC, including the general clinic (graduate student therapists in their first year of clinical training), as well as the Dialectical Behavior Therapy (DBT) clinic and the Anxiety and Stress Disorders Clinic (ASDC; the latter two are staffed by more advanced student therapists). The DBT clinic and ASDC are specialized clinics offering manualized treatments delivered by intermediate-level student therapists for specific concerns, whereas the general clinic is comprised of primarily second-year student therapists, who treat a diverse group of relatively low-severity presenting problems. Inclusion criteria were: age 18 or older and receiving weekly psychological treatment at the PSC. Exclusion criteria were: suicide risk severe enough to preclude outpatient treatment, severe psychotic symptoms, or primary substance dependence.

Fifty-five patients were recruited and completed the intake questionnaires, but three were omitted from analyses due to very early dropout (i.e., they completed the intake and baseline questionnaires, but terminated from treatment prior to session 3). Participants largely identified as White (82.9%), followed by Bi- or Multi-Racial (5.8%), African-American (3.8%), Asian/Pacific Islander (3.8%), and Latino/Hispanic (1.9%).
One person (1.9%) declined to provide her racial/ethnic demographic information. 78.8% of the sample was female. The mean age was 27.4 years, with a standard deviation of 10.5 years. See Table 2 for a summary of the overall demographic characteristics of this sample, presented by clinic [DBT, N=19; ASDC, N=17; and General/other clinics, N=16].

A power analysis was conducted to estimate the necessary sample size for the regressions I planned to conduct for the present study. Based on our previous data examining the impact of invalidation on positive and negative affect, I anticipated a small-to-medium effect size ($R^2$ values ranging from .02 to .09 were observed in an earlier sample of undergraduate students). Allowing a type-1 error rate of .05, I recruited 55 participants to conduct the regressions necessary for this project with adequate power ($1-\beta = .80$).

**Therapists.** Therapists were also asked to provide feedback throughout the treatment process. The therapists of clients who agreed to enter the study also completed questionnaires at each assessed therapy session. All therapists were current graduate student trainees at the PSC, ranging in level of experience from less than one year to their fifth year of clinical training. The participating study therapists (N =22) were largely female (68.2%) and White (86.4%), and were treating clients in the DBT clinic, ASDC, and/or the general clinic as part of their supervised clinical training.

**Measures**

The following measures were administered.

*Client Satisfaction Questionnaire- 8 Item Version (CSQ-8; Attkisson & Larsen, 1979).* The CSQ-8 was used to measure clients’ self-reported satisfaction with the
clinical services received up to that point in treatment. The CSQ-8 includes eight items, and total scores can range from 8 to 32, with higher scores indicating higher levels of satisfaction. The CSQ-8 has been shown to have good internal consistency, with Cronbach’s alphas ranging from .83 - .93 (Attkisson & Zwick, 1982). Attkisson and Zwick also reported that the CSQ correlates positively with both symptom reduction and completion of treatment.

**Demographic Questionnaire.** A brief questionnaire was administered to obtain basic demographic information from clients, including: age, gender, ethnic group, level of education completed, and psychological treatment history.

**Personality Assessment Inventory- Borderline Symptoms Scale (PAI-BOR; Morey, 1991).** The 24-item borderline scale of the Personality Assessment Inventory (PAI-BOR) was designed to measure features of BPD. The PAI-BOR has been found to have high internal consistency (α = .90; Baer & Sauer, 2011) in a variety of samples, and has been shown to correlate with the assignment of a BPD diagnosis (Jacobo, Blais, Baity, & Harley, 2007). In an unselected college sample, Trull and colleagues (1997) reported good test-retest reliability across a two-year follow-up period; additionally, the authors reported some evidence of external validity, finding an inverse correlation between borderline features and academic and interpersonal outcomes at follow-up.

**Positive and Negative Affectivity Schedule (PANAS; Watson, Clark, & Tellegen, 1988).** The PANAS was designed to measure positive and negative affect. It consists of ten positive affect (PA) words (e.g., determined, excited) and ten negative affect (NA) words (e.g., hostile, guilty). For each affective word, participants rate the intensity at which they were experiencing that word on a scale from 1 (not at all) to 5
Participants were asked to rate how they are currently feeling using the instructions “at this moment.” The PANAS has been found to be stable, highly internally consistent, and the two affective factors are largely uncorrelated (Watson et al., 1988).

**Self-Reported Validation and Invalidation Scale- Client Version (SRVIS-C; Stigen & Cheavens, 2011).** The SRVIS-C is a ten-item, four-point Likert-scaled measure of perceived levels of validation and invalidation. The original wording was modified for use in this study, changing “experimenter” to “therapist” to match the dyad being assessed during a session of psychotherapy. The scale is based on Fruzzetti’s (1997) VIBCS, and includes items such as “Did the therapist see your responses as abnormal or inaccurate?” and “How much did you feel the therapist was paying attention to you?”

*Validation of the measure.*

Reliability analyses suggest adequate-to-good internal consistency for the validation and invalidation subscales. In a sample of 193 prior administrations of the SRVIS, the six-item invalidation subscale was found to have good reliability (Cronbach's alpha = .83), and the four-item validation subscale was shown to have adequate reliability (Cronbach's alpha = .76). Also, an exploratory factor analysis was conducted using the Comprehensive Exploratory Factor Analysis program (CEFA 3.02; Browne, Cudeck, Tateneni, & Mels, 2008). Following the procedure suggested by Browne (2011), two techniques were used to obtain initial approximations of the number of factors to retain. We first examined the number of eigenvalues greater than zero, as suggested by Kaiser (1960), and also examined a scree plot of these eigenvalues, which displayed two data points preceding the “bend” in the plot. Both of these measures of approximation pointed to the presence of two distinct factors.
We then examined goodness of fit for models containing one, two, and three factors, comparing the point estimate and 90% confidence interval of the root mean square error of approximation (RMSEA). Model fit for a single-factor model was unacceptable (RMSEA = 0.20), whereas the RMSEA point estimate for a three factor model indicated a better fit to the data (RMSEA = 0.04), but an examination of the resulting factor loadings indicated the presence of potentially problematic over-factoring, with no high item loadings, and only one of the ten items, “Did your therapist take your responses seriously?”, exhibiting a (low) loading (.25) onto the third factor. Comparing model fit (while vigilant for evidence of over- or under-factoring), and considering overall interpretability, our overall results suggest that a two factor model (RMSEA = 0.08), corresponding to the constructs of validation and invalidation, best balances the need for parsimony with model fit.

In the two-factor model, the following four items loaded onto the validation factor: “Was your therapist paying attention to you?”, “Was your therapist interested in what you had to say?”, “Did your therapist take your responses seriously?”, and “Was your therapist responsive to your emotions?” The remaining six items loaded onto the invalidation factor, including: “Did your therapist tell you what you should think or feel?”, “Did your therapist see your responses as abnormal or inaccurate?”, “Did your therapist increase your negative feelings?”, “Was your therapist condescending or contemptuous toward you?”, “Did your therapist see you as more fragile than you really are?,” and “How much of the time were you understood by your therapist?” (reverse-coded). The two factors were negatively correlated, \( r = -.21 \). Therefore, the SRVIS-C
was analyzed as two subscales (validation and invalidation), to most accurately reflect the inversely, obliquely related nature of the two constructs observed in the factor analysis.

**Tracking Forms.** Additional information was also collected for each participating client as he or she progressed through treatment; therapists completed a tracking form after each session, including how many times the session was missed or rescheduled, or if the client arrived late for the therapy session. These data were used to assess ongoing participation in treatment.

**Study Procedure**

**Timing of assessments.** For this study, I examined clients’ validation and invalidation scores at the third through sixth sessions of psychotherapy, corresponding with time points 2 through 5 in the present study. The decision was made to assess in-session invalidation and validation at sessions 3 through 6 because these sessions provide a representative “snapshot” of that client’s routine sessions. While I do believe that the potential for therapists to validate and invalidate begins with the first session, I chose to examine sessions 3 through 6 because I was most interested in learning about the session-to-session processes associated with validating and invalidating experiences during regular therapy sessions, rather than at the often primarily evaluation- and goal-generation-focused introductory sessions, where therapists may be more restricted in their ability to validate and invalidate. For instance, the manual for Cognitive Therapy states that sessions 1 and 2 often tend to focus on evaluation, psycho-education and goal generation (Beck, Rush, Shaw, & Emery, 1979). Starting at session 3 also minimizes the impact of practicum-specific differences in content unique to the introductory and second sessions, while at the same time occurring early enough so that I was able to observe
clients’ perceptions of validation and invalidation as the therapist-client relationship is still being formed.

These decisions are supported by an analysis of the mean validation and invalidation subscale scores and standard deviations obtained from pilot SRVIS-C data from an early clinical sample of 15 clients. I compared total client-reported validation and invalidation subscale scores at sessions 3 through 6; SRVIS validation subscale scores ranged from 10 to 16 (out of 16 possible points) and. SRVIS invalidation subscale scores ranged from 0 to 11 (out of 24 possible points). The greatest mean levels of invalidation occurred at sessions 4 and 6 ($M = 2.21$ and 2.00, respectively). Sessions 3 and 5 had the next highest mean invalidation scores ($M = 1.79$ and 1.71, respectively). While these mean invalidation scores are relatively low with regard to the span of the entire subscale, it must be kept in mind that these scores are based upon clients’ experiences during actual sessions of psychotherapy, rather than an experimental manipulation, and therefore the expectation for client-reported invalidation would be lower. Mean levels of validation remained fairly constant across sessions 3 through 6 ($M = 15.00 - 15.57$).

The variance in clients’ self-reported invalidation appeared to increase somewhat as sessions progressed, from session 3 ($SD = 1.72$), to session 4 ($SD = 2.46$), to session 5 ($SD = 2.30$), to session 6 ($SD = 3.02$). These results provide initial support for the prediction that observable invalidation is occurring during sessions 3 through 6 and that there is variance in reports of invalidation, perhaps increasing with time. Variance in clients’ self-reported validation also appeared to increase over time, from session 3 ($SD = 0.65$), to session 4 ($SD = 0.94$), to session 5 ($SD = 1.34$), to session 6 ($SD = 1.81$).
Therefore, I believe that sessions 3 through 6 provide good representation of invalidation and validation for use in assessing their association with post-session affect across a session of psychotherapy and subsequent session attendance, in part because of the increasing variation in these subscale scores as sessions progress. See Appendix A for a table listing the measures administered at each time point.

**Client procedure.** PSC clients were provided at intake with a handout containing a description of the study and contact information for the study coordinator (at the latest, this occurred at the second therapy session). Once a client expressed interest in participating in the study, an initial meeting was scheduled with the study coordinator to further describe the research, answer any questions the potential participant may have had, and obtain informed consent. At this baseline assessment (time point 1), clients completed a battery of questionnaires, to obtain information on baseline characteristics such as age, gender, and prior treatment history, as part of participation in the parent study.

Clients were then asked to complete a short battery of questionnaires *before* and *immediately following* sessions 3, 4, 5, and 6. They first filled out one pre-session questionnaire (the pre-PANAS) prior to the start of their session, then returned following the session to complete a short packet of questionnaires prior to leaving the clinic (including the post-PANAS, SRVIS-C, and CALPAS-C). At all time points, clients were instructed to place the completed questionnaires in a collection box near the clinic front desk, and were reimbursed $5 per half hour for their time.
Therapist procedure.

Therapists also completed post-session questionnaires at sessions 3 through 6, and tracked their clients’ degree of participation in the treatment at each session, including: missed or rescheduled sessions, and whether or not clients arrived on time to sessions. Therapists were also paid $5 per session for study participation.
Chapter 3: Results

Data Cleaning and Preparation

Once data collection was completed, the questionnaire data were double-entered, and any observed discrepancies were then checked and corrected to ensure accuracy. The data were then examined to ensure that assumptions of normality were met. All predictor and outcome variables were analyzed for skewness and kurtosis. Of these variables, only the distribution of the mean SRVIS-C-V (client version of the SRVIS, validation subscale) had significant skew and kurtosis. Transformations were performed in an attempt to approximate a normal distribution, and a log 10 transformation yielded non-significant skewness and kurtosis values. Analyses which include mean SRVIS-C-V are presented using the transformed data.

I then examined the descriptive data to ensure that the scale means, ranges, and standard deviations all fell within expected ranges, based on previous research. Regarding missing data, by far the largest proportion of lost data stemmed from participants not completing the later assessments (i.e. terminating from therapy prior to sessions 5 or 6 and simply not completing any of the questionnaires). Two cases were missing all SRVIS data for session 3 and were thus not included in analyses, 4 cases total were lost due to treatment attrition by session 4, 2 additional cases were lost to attrition at session 5, and 3 additional (for a total of 11) cases were lost to attrition by session 6.

Regarding any questionnaires that were partially-completed, these data were estimated using mean-substitution to utilize as much of the available data as possible; up
to 10% of the total items on a given scale were allowed to be missing before omitting the case from that analysis. Examining the SRVIS, no cases were omitted due to incomplete data for session 3 or 4, 2 cases were omitted from analysis for session 5, and no further cases were omitted for session 6.

To identify potential outliers in the data set, the outcome variables were standardized, and any data points further than 3.3 standard deviations from the sample mean for that variable were identified as potential univariate outliers, as suggested by Tabachnick and Fidell (2001). Four potential outliers were identified, each of whom reflected an extreme, but possible, score on their respective measures, and each of the analyses were run with and without the relevant potential outliers; because we did not obtain any differences in the pattern of statistical significance with any of these outliers omitted, and because unusual responses were not necessarily inaccurate in this sample (but instead reflecting actual experiences on the part of clients), these cases were retained in the dataset for analysis.

Multivariate outliers were examined by calculating Malanohbis’ distances for the primary independent and dependent variables (mean SRVIS-C-I, mean SRVIS-C-V, mean Post-PANAS-PA, mean Post-PANAS-NA), and again I used the 3.3 standard deviation cut-off as a guide to identify any potential multivariate outliers. Once these were identified, tests were run with and without these 9 cases, and similar results were obtained. As was the case for the univariate outliers, these cases, while extreme compared with the rest of the dataset, are not necessarily inaccurate; thus, these cases were retained in the final dataset.
Analytic Plan

My primary independent variables for these analyses were the total scores on the validation and invalidation subscales of the SRVIS-C. Because one item on the SRVIS-C-I assesses negative affect (“Did my therapist increase my negative emotions?”), analyses were run using the total subscale (6 items), as well as with a score omitting this item (5 items), to guard against improper inflation of the relation between SRVIS-C-I scores and outcome (in particular, negative affect as measured by PANAS-NA).

For hypothesis 1, there were two dependent variables: post-session positive affect (as measured by the positive affect subscale of the PANAS), and post-session negative affect (using the negative affect subscale of the PANAS). Hierarchical multiple regression models were utilized to examine the associations between SRVIS-C-I and SRVIS-C-V and two outcome variables: Post-PANAS-PA and Post-PANAS-NA. For these affect analyses (hypothesis 1), pre-session score on that outcome variable was included in the first step of the regression model to control for pre-session affect. For example, for the test with Post-PANAS-NA as the criterion variable, I entered Pre-PANAS-NA in the first step of the regression model, then the SRVIS-C-I and SRVIS-C-V in the second step of the same model.

For hypothesis 2, the dependent variable was the number of session attendance failures. Session attendance failure scores were calculated to reflect how many of that client’s scheduled therapy sessions were missed, cancelled, or rescheduled, with higher numbers indicating a greater degree of session attendance failure. For the overall model, the number of treatment attendance failures for the period spanning sessions 3 through 6 was also assessed, and mean SRVIS-C-V and SRVIS-C-I were tested in a regression
model with the number of overall session attendance failures across this four-session time period as the dependent variable.

To examine individual session-to-session relationships, three point-biserial correlations were also examined; the dependent variable, session attendance, was a binary “Yes/No” measure of session attendance; if the participant attended the session as scheduled, they would receive a 0 (“No” for session attendance failure), and if there was a reschedule, cancellation, or no-show logged for that session, they would receive a 1 (“Yes”) for session attendance failure. Three correlations were examined, including the invalidation subscale of the SRVIS-C at session 3 (the first assessed session) predicting attendance at session 4, and separate correlations testing SRVIS-C-I at session 4 to predict attendance at session 5, as well as session 5 SRVIS-C-I predicting session 6 attendance. This allowed me to assess the presence of any immediate associations between experienced validation or invalidation and next-session attendance.

Descriptive and Psychometric Data for the SRVIS-C

To better understand the specific types of invalidating experiences most commonly reported by clients in this sample, we reviewed the mean scores for each item on the SRVIS-C, by session. Because scores were highly similar to one another across sessions (i.e. item 1 on the validation subscale ranged from a mean score of 3.90 ($SD = .37$) to 3.95 ($SD = .21$)), the descriptive data below are based upon item means averaged across sessions 3 through 6. Of the ten items, the validation items were the most similar to one another, in terms of frequency; all validation items were endorsed an average of 3.70 or greater (out of 4 points possible) across all sessions.
The most strongly endorsed validation item (each was Likert-scaled with a maximum of 4 possible points) was whether the therapist was “paying attention,” which received an average rating of 3.93 ($SD = 0.30$, range across sessions of 3.90 to 3.95). Whether the therapist was “responsive to my emotions,” which, with an average rating of 3.72, was the least strongly endorsed item, yet was still relatively frequently endorsed overall ($SD = 0.55$, range = 3.64 - 3.81). There was a clear ceiling effect for the validation subscale, with nearly all responses falling at the top end of the possible points allowed by the SRVIS-C.

Regarding the invalidation subscale, the most strongly endorsed items assessed whether or not clients “felt understood” by their therapists (reverse-scored $M = 0.88$ (out of 4 possible points), $SD = 0.87$, range = 0.59 – 0.88) and whether the therapists “increased negative feelings” (after reverse-scoring this item; $M = 0.88$, $SD = 0.87$, range = 0.60 - .077). Less-strongly endorsed items included feeling that the therapist was “condescending or contemptuous” ($M = 0.24$, $SD = 0.86$, range = 0.20 – 0.30), “saw me as more fragile than I really am,” ($M = 0.35$, $SD = 0.76$, range = 0.24 – 0.50), and “viewed my responses as abnormal or inaccurate” ($M = 0.36$, $SD = 0.67$, range = 0.33 – 0.42). These descriptive data are among the first to shed light on the forms of invalidation experienced most frequently during real-world therapy sessions.

Reliability.

To examine the internal consistency of the SRVIS-C invalidation and validation subscales, I calculated Cronbach’s alpha for each subscale. Examining all 50 administrations of the SRVIS-C at session 3, the SRVIS-C-I subscale yielded an alpha of .63. While alphas of .60 and higher may be acceptable for exploratory purposes,
expansion of the invalidation subscale, perhaps to include a greater number of items to span a wider range of internal invalidating experiences, to improve the specificity of the measure and increase its utility as a clinical and research measure.

Looking at all 48 available administrations of the 4-item SRVIS-C-V subscale at session 3, an alpha of .68 was obtained. This subscale would also likely benefit from the addition of theoretically relevant items to more fully address the myriad forms validation may take during psychotherapy, to more closely measure the underlying construct, and thus, ensure a higher degree of internal consistency.

Correlations among mean SRVIS-C-V, SRVIS-C-I, and selected demographic variables (i.e., age, gender, and number of previous psychotherapists, psychiatrists, and psychiatric hospitalizations) and baseline questionnaire scores (including AIM, DERS, IIP, and PAI-BOR) are presented in Table 3. Somewhat surprisingly, given the aforementioned literature in this area establishing a strong theoretical (and in some cases empirical) link between baseline affective intensity, level of interpersonal difficulties, and one’s likely experiences of validation and invalidation, there was no pattern of association between these subscales and any of the baseline or demographic data that were collected.

The baseline measures were otherwise found to correlate in the expected directions, both with each other and with theoretically related demographic variables [i.e., to provide one example, PAI-BOR was significantly correlated with number of previous psychotherapists ($r = .44, p = .001$), number of prior hospitalizations ($r = .22, p = .02$), and with the IIP ($r = .52, p < .001$), and DERS ($r = .63, p < .001$)]. Correlations among the primary outcome variables are presented in Table 4.
Generally speaking, mean SRVIS-C-I was significantly associated with nearly all of the other outcome variables, as well as with SRVIS-C-V, while mean SRVIS-C-V was associated significantly only with Post-PANAS-NA. The correlations obtained are in the expected directions based upon existing theory.

**Comparing Data across Clinics**

One-way analyses of variance were performed to test for mean differences in demographic baseline characteristics across clinics. Tukey post-hoc tests were then performed to identify if groups differed significantly from one another; see Table 2 for a breakdown of these differences by clinic. The only significant difference between clinics was on the number of previous hospitalizations ($p = .03$), although another treatment history variables, the number of previous therapists, differed at a non-significant trend level ($p = .05$). See Figure 1 for a comparison of the baseline treatment history variables (number of previous therapists, psychiatrists, hospitalizations) divided by clinic.

To further explore any differences by clinic on outcome variables, one-way analyses of variance were performed to examine clinic differences in mean reported validation, invalidation, both positive and negative affect, and number of session attendance failures. There were no significant differences, although the differences in post-session negative affect were nearly significant [$p = .08$]; further post-hoc testing confirmed that there were no significant differences across clinic groups for post-session negative affect. See Figures 2 and 3 for further breakdown of these variables by clinic. Because there was no evidence of any significant differences between the clinics that would merit separate analyses by clinic, all collected data were analyzed together. To assess for the possibility of clinic interacting with invalidation to affect the tested
associations, for each regression model, an interaction term, SRVIS-C-I*Clinic was included in the third step.

**Hypothesis 1**

**Changes in Affect from Pre- to Post-Session.**

To test the prediction that invalidation would be associated with increases in negative affect and decreases in positive affect from pre- to post-session, I examined the contributions of mean validation and invalidation to the overall variance in affect post-session, using two separate hierarchical regression models.

**Positive Affect.**

The regression model for post- PANAS-PA, including pre-PANAS-PA in the first step, and SRVIS-C-I and log10-transformed SRVIS-C-V in the second step was significant, $F(3, 48) = 35.42, p < .001$, adj. $R^2 = .67$. The first step of the model was significant (adj. $R^2 = .64$), and including SRVIS-C-I and log10-transformed SRVIS-C-V in the second step improved the fit of the model ($\Delta R^2 = .04$). The full results are presented in Table 6. Examining the beta coefficients, both pre-PANAS-PA score ($\beta = .77, p < .001$) and SRVIS-C-I ($\beta = -.21, p = .02$) were significantly associated with post-PANAS-PA, but SRVIS-C-V was not ($\beta = -.03, p = .74$).

When the regression was performed with only SRVIS-C-I in the second step, significant results were again obtained. The overall model was significant, $F(2, 49) = 53.97, p < .001$, adj. $R^2 = .68$. The first step of the model was significant (adj. $R^2 = .64$). Adding SRVIS invalidation scores in step 2 significantly improved the model ($\Delta R^2 = .04, p = .02$). Examining the beta weights, pre-session PA was the strongest contributor to the overall effect ($\beta = .77, p < .001$), and SRVIS-C-I was also significant ($\beta = -.20, p = .02$).
Testing for the presence of an interaction between SRVIS-C-I and Clinic (DBT, ASDC, or General clinic) in the model for PA, an interaction term was computed and included in the third step of the regression model. After testing SRVIS-C-I and Clinic as predictors in step 2, adding SRVIS-C-I*Clinic to the model in step 3 did not improve the model ($\Delta R^2 = .00, p = .86$). Examining the beta weights, only pre-session PA ($\beta = .77, p < .001$) was a significant contributor to the overall model; neither clinic ($\beta = -.05, p = .70$), nor invalidation ($\beta = -.23, p = .27$), nor their interaction ($\beta = .04, p = .86$) were significant. Thus, there does not appear to be an interaction between invalidation and clinic.

These results indicate that average invalidation was significantly negatively associated with average post-session PA, after accounting for pre-session PA, whereas average validation was not significantly associated with average post-session PA. Thus, it appears that invalidation shares a modest, yet robust, association with post-session positive affect, providing support for this hypothesis. As such, hypothesis 1 was supported.

**Negative Affect.**

The model for average post-PANAS-NA with average pre-PANAS-NA entered in the first step and SRVIS-C-I and log10-transformed SRVIS-C-V in the second step was significant, $F (3, 48) = 20.84, p < .001$, adj. $R^2 = .54$. The first step of the model, testing pre-PANAS-NA score, was significant (adj. $R^2 = .47$), and the addition of SRVIS-C-I and SRVIS-C-V to the model yielded a $\Delta R^2$ of .09, indicating a significant addition (approximately 9%) to the model in terms of explanation of the variance in average post-PANAS-PA. Note that for this NA analysis, we utilized a version of the
SRVIS-C-I subscale which omitted item 2, which asks if therapists “increased my negative emotions,” to avoid any improper inflation of this association. Examining the beta coefficients, both pre-PANAS-NA score ($\beta = .63, p < .001$) and SRVIS-C-I ($\beta = .22, p = .03$) were significantly associated with post-PANAS-NA, but SRVIS-C-V was not ($\beta = -.14, p = .17$). Full details on these results can again be found in Table 6.

When only SRVIS-C-I was included in the regression model for post-session PANAS NA, the overall model remained significant, $F (2, 49) = 29.67, p < .001$, adj. $R^2 = .53$. The first step of the model was significant (adj. $R^2 = .47$). Adding SRVIS-C-I invalidation scores in step 2 significantly improved the model ($\Delta R^2 = .07, p < .01$). Examining the beta weights, pre-session NA was the strongest contributor to the overall effect ($\beta = .64, p < .001$), and SRVIS-C-I was also significant ($\beta = .27, p < .01$).

To test for the presence of a significant interaction between SRVIS-C-I and Clinic (DBT, ASDC, or General clinic) in the model for NA, an interaction term was computed and included in the third step of the regression model. After testing SRVIS-C-I and Clinic as predictors in step 2, adding SRVIS-C-I*Clinic to the model in step 3 did not improve the model ($\Delta R^2 = .00, p = .92$). Examining the beta weights, pre-session NA ($\beta = .61, p < .001$) is the only significant contributor to the overall model, whereas invalidation ($\beta = .32, p = .18$), clinic ($\beta = -.17, p = .20$), and the interaction term between invalidation and clinic were all non-significant ($\beta = -.03, p = .92$). Therefore, these results do not suggest a significant interaction between invalidation and clinic.

Taken together, these results suggest that experiences of invalidation have a modest but consistent association with both positive and negative emotional reactions from pre- to post-session, even when controlling for pre-session negative affect and
omitting the SRVIS-C item pertaining to negative affect. Thus, they support my prediction that invalidation was positively associated with post-session negative affect and negatively associate with post-session positive affect. Conversely, experiences of validation were not found to significantly relate to either positive or negative post-session affective ratings, yielding initial evidence that validation may not be associated with affective outcomes.

**Hypothesis 2**

**Session Attendance.**

I hypothesized that higher self-reported invalidation scores would be associated with a higher number of session attendance failures. Relatedly, higher self-reported validation scores were predicted to be negatively related to session attendance failures. For the overall sample, the mean overall number of session attendance failures was 0.86 ($SD = 0.97$, range = 0 - 3). I computed three point-biserial correlations, to examine the association of invalidation at session 3 with session attendance at session 4, as well as invalidation at session 4 with attendance at session 5, and invalidation at session 5 with attendance at session 6, as well as a hierarchical regression model testing mean invalidation at sessions 3 through 6 as a predictor of the total number of session attendance failures across this same time period. The first three correlations provide separate tests of any immediate association between recently-experienced invalidation and immediate, next-session attendance, while the overall analyses provide an overall estimate of any overall or cumulative associations between invalidating responses and attendance failures over this time period.
SRVIS-C-I at session 3 and attendance failures at session 4 were not significantly correlated, $r_{pb}(50) = -.13$, $p = .38$. Similarly, SRVIS-C-I at session 4 was not associated with session attendance at session 5, $r_{pb}(49) = .17$, $p = .25$. The correlation between SRVIS-C-I at session 5 and whether or not they failed to attend session 6 as scheduled was again non-significant, $r_{pb}(50) = <.01$, $p = .97$. These results do not support our initial hypothesis that invalidation and session attendance would be negatively associated, for any of the session pairs examined by these models.

Testing the correlation between SRVIS-C-V at session 3 and session 4 attendance failures, results were also non-significant ($r_{pb}(50) = -.04$, $p = .78$). Nor was session 4 SRVIS-C-V correlated with session 5 attendance failures, $r_{pb}(49) = .02$, $p = .87$. Examining SRVIS-C-V at session 5 and its association with next-session attendance failure (at session 6) yielded similarly non-significant results, $r_{pb}(50) = -.02$, $p = .89$. Neither SRVIS-C-I nor SRVIS-C-V were significantly correlated with subsequent session attendance failure at any of the tested session pairs; thus, the hypothesis that SRVIS-C-I (or SRVIS-C-V) would be associated with session attendance was not supported.

I then computed an average correlation, combining all three of these associations for invalidation and validation, and tested whether or not these average correlations were significantly different from zero, using Fisher’s $z$ tests. The average of the three correlations for SRVIS-C-I was $r = 0.07$, which yielded a non-significant $p$ of .94. Similarly, for SRVIS-C-V, the average correlation was $r = -.03$, which corresponded to a non-significant overall $p$ value of .98. Thus, these correlations were non-significant both
viewed individually, and when combined, yielding no support for the attendance failures hypothesis when examined session-to-session.

Looking at the overall association between mean SRVIS-C-I and the total number of session attendance failures during the period spanning sessions 3 through 6, there was a significant correlation \( r = .30 \quad p = .04 \). SRVIS-C-V and overall session attendance failures were not significantly correlated, \( r = -.16 \), \( p = .28 \). Examining the full hierarchical regression model for session attendance failures, including pre-session 3 session attendance failures in the first step, and SRVIS-C-V and SRVIS-C-I in the second step, the overall model was significant, \( F (3, 48) = 3.11, \ p = .01 \), adj. \( R^2 = .15 \).

Controlling for pre-session 3 session attendance failures in step 1 yielded significance (adj. \( R^2 = .14 \)), but adding validation and invalidation to the model in step 2 did not significantly improve the model (\( \Delta R^2 = .05, \ p = .27 \)). Examining the beta weights, neither validation (\( \beta = .03, \ p = .82 \)) nor invalidation (\( \beta = .22, \ p = .11 \)) were significant whereas pre-session 3 attendance failure was significant (\( \beta = .38, \ p < .01 \)).

To check for the presence of an interaction between invalidation and clinic (DBT, ASDC, or General clinic) in the model for session attendance failures, an interaction term was computed and included in the third step of the regression model. After testing SRVIS-C-I and Clinic as predictors in step 2, adding SRVIS-C-I*Clinic to the model in step 3 did not improve the model (\( \Delta R^2 = .003, \ p = .67 \)). Examining the beta weights, only the number of initial attendance failures (\( \beta = .38, \ p = .01 \)) was a significant contributor to the overall model; neither invalidation (\( \beta = .34, \ p = .30 \)), nor clinic (\( \beta = .05, \ p = .81 \)), nor their interaction term (\( \beta = -.16, \ p = .67 \)) was significant. These results do not suggest the presence of an interaction between invalidation and clinic.
Taken together, these results do not support an association between invalidation or validation at sessions 3, 4, or 5 and participants’ likelihood of failing to attend the subsequent therapy session. Similarly, I found no association between mean validation across sessions 3 through 6 and the total number of session attendance failures during this same time period, although the correlation between mean invalidation and average attendance behavior was significant. Thus, this hypothesis received partial support, in that overall perceived invalidation was associated with overall session attendance failures, but not for invalidation associating with significantly lower rates of next-session attendance at any of the tested session pairs.

**Concordance Between Client, Therapist Reports of Validation and Invalidation.**

I also explored the correlations between validation and invalidation subscales of the SRVIS-C and those same subscales of the SRVIS-T (Therapist version of the SRVIS). Mean validation and invalidation subscales were moderately negatively correlated for both SRVIS-C ($r = -.64, \ p < .001$) and SRVIS-T ($r = -.28, \ p = .05$). These correlations are significantly different from one another, as measured by a Fisher $z$ test, ($z = -2.33, \ p = .02$), suggesting a stronger inverse relationship between validation and invalidation according to client report compared to the therapist reported versions of these same scales. The correlations between the SRVIS-C-V and SRVIS-T-V ($r = .24, \ p = .09$) and the SRVIS-C-I and SRVIS-T-I ($r = .08, \ p = .56$) were not significant. These results show that the relationship between validation and invalidation was somewhat weaker for therapist-reported validation and invalidation (as compared to client-reported
scores). Further, significant agreement was not found, for either validation or invalidation, across the two perspectives.

For the SRVIS-T-V, the mean score was 17.44 (SD = 1.63; range = 10 – 20 (out of 20 possible points)); for SRVIS-T-I, the mean score was 4.20 (SD = 2.26; range = 0 – 12 (out of 20 possible points)). Interestingly, when comparing the means for these subscales, the SRVIS-T invalidation subscale was higher (M = 4.20) than the SRVIS-C mean for invalidation (M = 3.10). This difference may stem from over-reporting on the part of the therapist, or under-reporting on the part of the client, or both. Additional research on the nature of, and explanations for, these observed discrepancies in perceptions of validation and invalidation will improve our understanding of these constructs.

Examining SRVIS-T as a Predictor Variable

To further explore the association between therapist ratings of their own validating and invalidating behaviors (SRVIS-T) and the tested therapy variables, I then entered the SRVIS-T validation and invalidation subscales into these same regression models to test their association with overall session attendance failures and both positive and negative affect reported by the client post-session.

Session attendance was not correlated with either SRVIS-T-V (r = .05, p = .71) or SRVIS-T-I (r = -.18, p = .21). The overall regression model was not significant, $F(2, 49) = 0.73, p = .49$, adj. $R^2 = -.01$. Examining the beta weights, neither validation ($\beta = .006, p = .97$) nor invalidation ($\beta = -.17, p = .26$) were significantly associated with the total number of session attendance failures.
Testing SRVIS-T and positive affect, there was a significant negative correlation between the invalidation subscale of the SRVIS-T and client-reported post-session positive affect ($r = - .35, p = .01$). The association between SRVIS-T-V and post-session PA was not significant ($r = .09, p = .52$). Testing the hierarchical regression model that we tested for SRVIS-C, the overall model was significant, $F (3, 48) = 31.24, p < .001$, adj. $R^2 = .64$. The first step of the model, containing pre-session PA only, was, as before, significant (adj. $R^2 = .64$), but the addition of SRVIS-T-V and SRVIS-T-I in step 2 did not improve the model ($ΔR^2 = .01, p = .44$). Examining the beta weights, only pre-PA was significant ($β = .78, p < .001$), and not validation ($β = -.06, p = .53$) or invalidation ($β = -.11, p = .22$). Taken together, these results do not support an association between therapist-perceived validation or invalidation and client-reported post-session positive affect.

The invalidation subscale of the SRVIS-T was negatively correlated with clients’ reported post-session NA, ($r = -.30, p = .03$), while the SRVIS-T-V was not associated ($r = .21, p = .15$). Testing SRVIS-T in the regression model, the overall model was significant, $F (3, 48) = 240.45, p < .001$, adj. $R^2 = .48$. The first step of the model, as before, was significant (adj. $R^2 = .47$). Adding SRVIS-T validation and invalidation scores to the model did not significantly improve the model ($ΔR^2 = .03, p = .21$). Examining the beta weights, pre-session NA was the strongest contributor to the overall effect ($β = .71, p < .001$), whereas validation was not significant ($β = .06, p = .63$), although invalidation approached significance ($β = .19, p = .08$). Thus, therapists’ perceptions of their own invalidating behaviors are associated at a trend level with client’s reported post-session negative affect. Taken together, these analyses indicate
that, for this sample, SRVIS-T does not seem to hold the same association with these affective and attendance outcomes as was observed for the validation and invalidation subscales of the SRVIS-C.

**Satisfaction with Treatment**

To further explore other factors that may be related to the association between invalidation, validation, and session attendance, I also examined participants’ overall satisfaction with treatment, as measured at the CSQ-8 administered at session 6. The mean score on the CSQ for this sample was 28.83 (SD = 3.12, range = 22 - 32 out of a possible 36 points). SRVIS-C-V was positively correlated with satisfaction with treatment ($r = .37, p = .03$), whereas invalidation was strongly negatively correlated ($r = -.65, p < .001$), as would be anticipated based upon the putatively negative relationship with invalidation. Thus, clients’ satisfaction with treatment overall was associated with their mean levels of perceived validation and invalidation during this time period.

Interestingly, treatment satisfaction was not associated significantly with affect or attendance; treatment satisfaction was not correlated with mean post-session negative affect ($r = -.17, p = .33$), mean post-session positive affect ($r = .24, p = .17$), or any of the session attendance variables [e.g. with treatment attendance failures during the period spanning sessions 3 through 6 ($r = -.25, p = .16$)]. It is clear that one’s level of cumulative validating and invalidating experiences associate with perceptions of overall treatment satisfaction that are measured by the CSQ, but it is less clear why these perceptions do not then translate into observed differences in theoretically related therapy variables, such as post-session affect or session attendance behaviors, particularly given
that the CSQ explicitly measures concepts such as one’s willingness to return for further treatment in the future. It may be the case that participants are coming back for sessions despite the presence of some level of dissatisfaction with the therapy process, particularly during the relatively early sessions that are assessed for the present study.

**Satisfaction with One’s Therapist (Alliance Ratings)**

I also examined the association between clients’ ratings of the therapeutic alliance and their perceptions of invalidation and validation by their therapist, as measured by mean CALPAS-C scores over the assessed time period. I also tested the association between alliance strength and both affect and attendance. First, examining their correlation with validation and invalidation, CALPAS-C scores were very strongly negatively correlated with invalidation ($r = -.80, p < .001$), and significantly positively associated with validation ($r = .40, p < .01$). This suggests that perceived invalidation was associated very strongly with a lower satisfaction with one’s therapist, as measured by an overall alliance rating. Unfortunately, because these values are correlated so strongly, this also suggests that the two measures are measuring very similar (and highly overlapping) constructs, highlighting the ongoing difficulty in distinguishing this new measure of validation and invalidation as one subset of therapeutic alliance-related experiences in treatment, from existing overall measures examining the alliance overall.

To examine the association between alliance strength and affect and attendance, mean CALPAS-C total score for sessions 3 through 6 was added in the third step of the three tested regression models for positive and negative affect and session attendance failures. Regarding negative affect, adding CALPAS-C to the model yielded a $\Delta R^2$ of .13, $p < .001$; an examination of the beta weights showed that pre-session NA was significant
in the model ($\beta = .65, p < .001$), as was CALPAS-C ($\beta = -.53, p < .001$), whereas SRVIS-C-I was no longer significant ($\beta = -.12, p = .32$). Thus, it appears that CALPAS is more strongly associated with post-session NA than SRVIS-C-I, given that once it is added to the model, SRVIS-C-I is no longer significant.

The addition of CALPAS-C did not significantly improve the model for session attendance failures ($\Delta R^2 = .001, p = .81$), although it was significant at the trend level for the positive affect model ($\Delta R^2 = .02, p = .09$). The beta weights for the post-session PANAS PA regression model show that pre-session PA was significant ($\beta = .75, p < .001$) and SRVIS-C-I was not significant ($\beta = -.02, p = .87$); as before, the addition of CALPAS-C did not significantly improve the model ($\beta = .23, p = .09$).

The beta weights for the session attendance failures regression model show that only initial attendance failures ($\beta = .37, p < .01$) contributed significantly to the model (SRVIS-C-I ($\beta = .25, p = .24$) and CALPAS-C ($\beta = .05, p = .81$)). These results indicate that the CALPAS did a better job than the SRVIS-C-I at explaining variance in post-session NA, but the same result was not found for PA or session attendance failures. It may be the case that our invalidation subscale is not measuring a distinct construct as was intended, but instead would benefit from further efforts to differentiate it from existing alliance measures, if it is to be clinically useful.
Chapter 4: Discussion

Summary and Interpretation of Findings

Invalidation was Associated with Both Positive and Negative Affect.

Supporting the first hypothesis, invalidation was significantly associated with post-session negative affect, with 7% of the variance in negative affect uniquely attributable to participants’ report of invalidation during psychotherapy, after accounting for pre-session negative affect. This represents a sizeable and potentially clinically meaningful contribution to the explanation of clients’ affective responses during treatment sessions. These results support the existing theory that experiences of invalidation are associated with increased distress for clients. Even after removing the item measuring the perception that one’s therapist has increased one’s negative affect from the analyses, these results remained significant, providing support for invalidation’s relationship with negative affect.

Client reports of invalidation contributed 4% of additional unique variance in the prediction of post-session positive affect, after controlling for pre-session positive affect. Thus, invalidation appears to have a smaller, yet still significant, association with the amount of positive affect experienced immediately following a psychotherapy session. This result provides support for invalidation’s link with decreased positive affect, which may damage the therapy process. This coincides with the results of previous work completed in this line of research, which found that invalidating responses led to decreases in positive affect post-interaction (Stigen & Cheavens, 2011).
Tying these results to the broaden-and-build model (Fredrickson, 2001; 2004), which posits that positive affect is related to beneficial, resource-building activities and attributes such as creativity, collaboration, and problem-solving, it may be the case that experiences of invalidation directly interfere with these helpful in-session behaviors, and thus contribute indirectly to the reduction in effectiveness of psychotherapy outcomes. Reduced positive affect stemming from in-session experiences of invalidation has the potential to reduce vulnerable self-disclosures in-session, hinder open communication with one’s therapist, lower one’s willingness to engage in stressful techniques such as prolonged exposure, or generally “narrow” one’s behavioral repertoire at that moment.

Thus, it may be the case that invalidation can harm the process of psychotherapy in two distinct ways: first, by eliciting additional negative affect which can disrupt the progress toward therapy goals and potentially damage the therapeutic alliance, and second, by reducing the magnitude of helpful, hopeful emotions such as creativity, cooperativeness, and openness that could otherwise contribute significantly to forward progress in treatment. It is not difficult to imagine a situation where feeling misunderstood or judged curtails effective communication and problem-solving, thus hindering some of the mechanisms thought to promote meaningful change.

Validation was not Associated with Affect or Attendance.

Looking at validation’s association with these same constructs, no support was found for a relationship with either positive or negative post-session affect. Contrary to our hypothesis, experiences of validation were not associated with lower post-session negative affect, as we had expected based upon the prevailing theory in this area. Thus, it does not appear that in-session validation was associated with clients walking out of the
session feeling any less negatively than when they walked in; perhaps validation is not always an effective emotion regulation strategy, in that validating one’s distress may serve to prolong or even intensify it in some cases.

We also did not find evidence to support an association between validation and positive affect. Given the extreme positive skew of SRVIS-C-V scores, also reflected in the very high average score on the SRVIS-C-V overall (mean of 14.63 out of 16 possible points, with a relatively low degree of variance ($SD = 1.15$) compared with the variance for the invalidation subscale ($M= 3.10$, $SD = 2.64$), these results are strongly indicative of a ceiling effect for the validation subscale, which limits the variability of the data and may reduce statistical power to detect correlations between SRVIS-C-V and potentially related variables.

It may also be the case that the therapy setting itself, with its inherent expectation of support, may actually serve to lessen the affective impact of validating comments and actions; if they are interpreted by the client as merely what is expected when one attends psychotherapy, receiving this feedback may not contribute much in the way of positive affect, and our results support this explanation. It is also certainly possible that it is those individuals who come to treatment expecting to feel understood, but who then receive invalidating signals from their therapist that they are instead being misunderstood, judged, or criticized, are then more likely to report greater negative affect post-session.

However, it should also be noted that the perceived lack of supportive and understanding feedback from one’s therapist did seem to increase one’s perception of invalidation (as evidenced by the reverse-scored loading of the SRVIS-C-I item pertaining to “feel[ing] understood” onto the invalidation factor, as was suggested by our
prior factor analysis of the scale items). Stated differently, reporting that one feels less understood by their therapist loaded more closely onto the construct pertaining to invalidation, than did the perception that one’s therapist understands them loaded onto the validation construct. This maps well onto other findings from this study, that validation, when expected (as would be the case during psychotherapy), has little association with affect, whereas feeling misunderstood is a potent source of invalidation (as it was one of the most strongly endorsed items on the invalidation subscale).

It could also be the case, though it was not tested in this study, that an expectation of validation and support which is not met by the therapist (even if their responses are not explicitly invalidating in and of themselves), could be perceived as invalidating, and, as such, be particularly damaging to the alliance, as well as the likelihood of returning for the next session. This corresponds with the notion of missed opportunities to validate/functional unresponsiveness, one of the existing levels of invalidation. Further research comparing expectations for validation during psychotherapy with clients’ actual in-session interpersonal experiences would be a valuable addition to our current understanding of these interactions and their impacts on the highly interactive interpersonal process of treatment.

**No Clear Evidence for an Association between either Validation or Invalidation and Session Attendance Failures.**

We found no evidence of a meaningful association between next-session treatment attendance and client self-report of invalidation or validation. It may be the case that validation and invalidation simply do not manifest in later attendance disruption; it is also possible that this association was not significant because the analyses
are restricted to too narrow of a window to detect an effect. It may also be the case that invalidation does in fact impact session attendance, perhaps in a cumulative manner, which is not picked up by examining pairs of sessions in manner as was done for this study. Or, perhaps treatment participation is in fact impacted, but not at the session attendance level; it could be the case that smaller portions of therapy participation are impacted, such as homework completion, level of honesty/self-disclosure, or degree of participation in in-session activities and tasks.

An important consideration when interpreting these results is that the direction of causality between session attendance failures and clients’ report of invalidation may in fact be reversed from the direction that was hypothesized for this study, such that that session attendance failures in fact lead to client experiences of invalidation, rather than result from them. A session that begins with a discussion of the reasons for the clients’ session cancellations holds the potential to be particularly invalidating for that client, especially if the therapist does not make careful efforts to express understanding of the reasons for these attendance failures. Alternatively, even if the cancellation is not explicitly discussed, the therapist may feel irritated with the client, and such, may inadvertently invalidate the client. Examining such an association, the point-biserial correlation between attendance at session 4 as scheduled (Yes/No) and invalidation at session 5 was not significant ($r = -.11, p = .50$), however, further empirical research remains needed to clarify the true direction of effect for any significant correlations among these constructs.

The results of this study did not provide support for the hypothesized link between validating or invalidating responses and next-session treatment attendance, and
do not support the traditional (largely untested) theory in this area that validation would positively associate with session attendance (or that invalidation would be negatively associated). Again, ceiling effects for the validation subscale might be another possible explanation, as by restricting variance it may also limit the power to detect any existing association between SRVIS-C-V and the number of reported attendance failures. Such a limitation in power may have reduced the ability to detect these relationships, particularly given that the session-to-session analyses utilize a smaller number of observations, and are, therefore, already less powerful than an analysis using the overall course of therapy. However, the overall hierarchical regression model, using all available observations, also showed that validation and invalidation did not contribute significantly to the model predicting session attendance failures, providing further support for these non-significant findings.

**Therapists Report More Invalidation than their Clients.**

Another meaningful finding from our exploratory analyses resulted from the comparison between clients’ report of validation and invalidation and their therapists’ reports of their own validating and invalidating behaviors during those same psychotherapy sessions. We found that therapists’ ratings did not correlate with their clients’ reports, and reported far higher mean invalidation scores than did their clients. In fact, their mean ratings for invalidation (4.20) were higher than their clients’ mean rating (3.10), suggesting the possibility that therapists could in fact be over-reporting such occurrences, identifying a greater number of potentially invalidating responses than are actually being perceived and/or reported by their clients. This pattern may, alternatively, be an artifact of low confidence, or low perceived competence, than of an actual over-
reporting problem, particularly given that the therapist sample was comprised of trainees. Additional research is needed in this area to determine which perspective most accurately reflects the overall clinical picture.

The finding that therapists identify themselves, on average, as being more invalidating in-session than their clients report has its own implications for clinical work, namely in the area of relationship ruptures and repairs. Given the weak agreement across these two perspectives as to when the invalidation is, in fact, occurring, this may mean the therapist is not easily able to accurately identify those instances when their client is, in fact, feeling invalidated, let alone be prepared to re-engage the client, reduce negative affect, and repair the relationship. Conversely, these data might even be taken to suggest that therapists may be justified in pushing harder for change, given the relatively low average invalidation scores reported by their clients.

Furthermore, these data show that clients are likely to view the constructs of validation and invalidation as more distinct from one another than are their therapists, as evidenced by a stronger negative correlation between the SRVIS-C-V and I \( (r = -.67) \) than for the SRVIS-T-V and I subscales \( (r = -.28) \). Clinically, this may contribute somewhat to the mismatch in perceptions of validation and invalidation that was observed in this study. Further research comparing change-oriented versus acceptance-oriented therapeutic approaches could yield interesting information related to clients’ perceptions of validation and invalidation as they participate in these therapies.

Invalidation may contribute to therapeutic alliance ruptures, may serve as a rupture in itself, or may in fact lead to/ worsen ongoing ruptures (i.e., when a dyad is already straining to understand one another and pursue progress towards meaningful
ends, it may be fertile ground for unintentionally invalidating responses to occur).

Further, validating responses may not yield much affective impact during early sessions, but may become more critical as time wears on and the potential for ruptures in the alliance arise. Tying in the results of the present study, validation may not pack much “punch” as the alliance is developing, but it is possible that validation serves a far more critical role in the repair of alliance ruptures later in treatment, to preserve clients’ willingness and motivation to return for further sessions.

**The Invalidation Subscale Appears to be Measuring the Strength of the Alliance.**

It is likely that the construct of invalidation falls within the umbrella of the overall alliance, serving as one of many forms of interpersonal interactions which continually shape it; however, due to the very high correlation \((r = -.80)\) between invalidation and the alliance obtained for this study, it also seems possible that the invalidation scale may not be measuring a distinct construct of invalidation so much as clients’ general perception of the strength of the alliance. If they feel they are getting along well with their therapist, clients may be reticent to mark negative experiences on their questionnaires; similarly, if the alliance is not going well, they may be much more likely to endorse that some of the “bad behaviors” listed were done during the session.

In essence, invalidation from one’s therapist may serve as one such event which could trigger a rupture, and as such the literature on the detection and client reporting of ruptures is particularly relevant, especially if clients are impacted by the current strength of the alliance when determining whether or not to disclose their experienced validation or invalidation immediately following the therapy session. Indeed, researchers in the
literature have called attention to this very problem, explaining that clients may not accurately identify ruptures on self-report questionnaires, due to unwillingness or inability on the part of the client to reveal their discomfort or dissatisfaction with the session or with the therapist him- or herself, or the wish to protect the therapist or the alliance by choosing not to report the rupture (Coutinho, Ribeiro, Sousa, & Safran, 2014).

Thus, the SRVIS-C-I may simply, in its current form, not be measuring a distinct construct pertaining to invalidation, instead functioning as an alternate measure of the perception of the current strength of the alliance, which would explain why it correlated so strongly with the CALPAS for this sample. It may be helpful to modify the SRVIS scale to focus less on what therapists were and were not perceived to do, and more on how participants were feeling internally during the session (i.e. “Did you doubt yourself?” or “Did you regret sharing your experiences for fear of being judged?”), to reduce reporting bias and shift the focus away from perceptions of therapists “misbehavior” during therapy sessions. Careful efforts to emphasize solely the internal experiences conceptualized to be unique to invalidation (versus reflecting increases in general negative affect) will be critical to any efforts to improve the specificity and utility of the SRVIS for clinical research and tracking purposes.

The validation subscale seemed to fare slightly better in this regard, as it was moderately positively associated with alliance ($r = .40, p < .01$), but far less strongly than was invalidation; such a relationship suggests that validation and alliance strength are related somewhat but have room to vary, providing less of an indication that the SRVIS-C-V and the CALPAS are simply measuring the same thing.
Validation and Invalidation Did Not Associate as Expected with Some Baseline Variables.

Lastly, we found little correlation between clients’ report of validation and invalidation and many theoretically related baseline variables. Neither validation nor invalidation was correlated with affect intensity, difficulties in emotion regulation, BPD features, or interpersonal problems. This lack of association was somewhat surprising, given the widespread theoretical connections between these particular constructs and how strongly individuals experience invalidation from others. In particular, the lack of an association between borderline features and perceptions of invalidation was especially unexpected, as perceptions of invalidation are thought to be a key facet of BPD-related relationship difficulties. Given that our BPD symptom measure did associate in the expected directions with other theoretically related baseline measures, it may be the case that baseline BPD features are simply not related to one’s experiences of validation or invalidation across early sessions; however, further investigation into which aspects of clients’ emotional and interpersonal functioning are predictive of a particular tendency to experience and report invalidation during psychotherapy is clearly warranted.

Limitations

One possible limitation for the present study was the use of a relatively small sample. Although our initial power analyses supported the use of a sample this size, these calculations were based at least partly on the anticipated strength of relationships that are still largely theoretical, and thus more open to error (leaving open the possibility of type 2 error). Further, these estimates were based upon the results of experimental manipulations of validation and invalidation, which, in all likelihood, were stronger in
intensity than would be observed when examining these associations within actual psychotherapy settings.

Second, the lack of agreement between client- and therapist- reports of validation and invalidation complicates comparison and speaks to the possibility of error in measurement and/or reporting. It is possible that therapists are over-reporting the level of invalidation they engage in during sessions, or that clients are under-reporting the same; it is also possible that some combination of the two is occurring. Without utilizing an outside observer’s ratings of objective session content, it is difficult to know for certain which perspective is “correct” in these cases, other than to suggest that the perception on the part of the client was more significantly correlated with the therapy variables we have tested in the present study.

In all of these analyses, the difficulty of meaningfully separating validation and invalidation from the closely-related (and highly-correlated) construct of therapeutic alliance was evident. It may be the case that the current version of the SRVIS does not yet effectively capture the unique, internal aspects of the experience of invalidation, instead capturing clients’ report of specific therapist behaviors; it may also be the case that in practical terms, invalidation and validation are not actually distinguishable from the overall alliance, that what the SRVIS is in fact actually measuring is essentially their overall view of the strength of the alliance, and not specifically their experiences of a separate construct of validation or invalidation.

Similarly, any of a number of other related relationship factors (i.e., therapist mood, severity of problems being addressed, likeability of client, etc.) may also be impacting clients’ validation and invalidation ratings. Further data collection, some of
which is currently underway, will allow for a valuable third-person perspective on the types of and associations among in-session validating and invalidating behaviors and these therapy variables, to contextualize these findings based upon the clients’ and therapists’ perceptions of these interpersonal events.

Also, the use of student therapists for this study limits the generalizability of these results to the practice of psychotherapy in general. Such trainees have fewer years of experience than the typical therapist, and practice under an atypical set of conditions (i.e., while being video-recorded and scrutinized by a supervising psychologist). However, it should be noted that, despite these atypical aspects, if student therapists are likely to exhibit greater variance in their level of invalidating (and validating, for that matter) responses during psychotherapy due to relative inexperience, they would actually be an ideal population to study, provided that the relationships among validation and invalidation and both affect and attendance are similar for novice and experienced therapists.

Likewise, the use of student therapists, practicing across several training clinics, contributes some variability in treatment structure, topics, and goals. We purposely chose sessions 3 through 6, to limit early session variation in clinical tasks, but there is still the possibility for variation in in-session activities, as well as average severity of presenting problems. These differences may be compounded further by the varying levels of expertise possessed by student therapists, particularly for the most severe subset of this client population.

Another possible limitation is the use of sessions 3 through 6 for analysis; while I am most interested in the general mechanisms of validation and invalidation (versus the
effects of these constructs at any given time point), it does stand as a limitation to examine only this specific subset of therapy sessions. In particular, we did not look at validation and invalidation at sessions 1 or 2, which does not allow us to draw conclusions about these constructs during the assessment process and at the very start of treatment. This would be a ripe area for future research, to test the effects of validation and invalidation specifically during assessment sessions and/or at the first few sessions of psychotherapy, as the therapeutic alliance is first developing.

It is also possible that study participants were atypically primed to think about and consider their emotional reactions, as well as their therapist’s behavior, during the session. We tried to minimize this effect by masking the specific focus of the study (i.e., using the phrase “emotional response” rather than “validation” or “invalidation”), but because they completed pre-session questionnaires, and knew they would be completing them again post-session, they may still have been atypically attuned to how they were treated in-session. This may or may not impact the study results, but it stands as a possible limitation to the present study. Similarly, if clients were cognizant of the fact that their therapists were being evaluated in this manner, some clients may have under-reported their actual levels of experienced invalidation, perhaps to avoid casting a negative light upon their student therapists.

Lastly, the very high correlation between the invalidation subscale of the SRVIS and the alliance measure that was utilized (CALPAS) suggests that there is a long way to go before the measure can be confidently utilized as a measure of a distinct construct pertaining to invalidation. It is likely that clients’ responses to the current version of the invalidation subscale are being influenced by their general perception of the current
strength or weakness of the alliance; in other words, clients who view their therapist positively may not be reporting much invalidation, whereas clients reporting lower satisfaction are much more likely to also report higher levels of invalidation. Further work is required to expand and refine the SRVIS subscales, to improve internal consistency, but more critically, to ensure that the scale does not function simply as another measure of the strength of the alliance, but instead to improve the invalidation subscale so that it more precisely assesses only the construct of invalidation.

**Future Directions**

One area for future research would be to examine the impact of invalidating experiences on clients’ expectancies for treatment over time. Given the consistent finding that clients’ expectancies are influential on treatment outcomes (e.g., Constantino et al., 2007; Price & Anderson, 2012), and further given that there is some evidence of an association between expectations and alliance (e.g., Constantino, Arnow, Blasey, & Agras, 2005), it seems that further research on how these constructs interact would significantly inform the treatment process literature.

More specifically, it would be important to learn more about how invalidation from one’s therapist (or validation, for that matter), might interact with that clients’ role expectations for how a therapist should behave. These could be assessed right at the start of treatment, and again in an ongoing fashion, to track how the levels of self-reported invalidation and validation contribute to changes in both role and outcome expectancies. Future research should continue to identify other relationship factors (interpersonal, temporal, and otherwise) that may increase or decrease the magnitude of a person’s emotional and cognitive responses to invalidation.
Another important future direction would be to assess these same constructs starting earlier and extending further into the therapy course, to speak to any differences in these associations that may be observed based upon when they occur in therapy (i.e., does invalidation at session 1 differ from session 10, or from session 20, in terms of its associations with affect or session attendance?). A longer time window for these comparisons would also allow for a better sample of the outcome data (few differences were observed in the present study when comparing session 3 responses with session 6, so it is likely that these sessions are not far enough apart to reliably assess for this type of change).

Alternatively, it may be the case that the associations with validation and invalidation take place on a more moment-to-moment basis, and thus assessing an entire session may miss these relationships (e.g., an invalidating comment at minute 12 of psychotherapy linking to whether or not a client chooses to self-disclose at minute 13). Further research examining minute-by-minute coding of psychotherapy sessions holds the potential to shed light on any shorter-term associations that may be present. Interactions between related variables which are also likely to change over the course of treatment (i.e., the strength of the therapy alliance) could also be included in the models to assess how these relationships are associated with one another, as well as examine their eventual link to the outcomes of the therapy course.

It would also be interesting to know more about therapists’ perceptions of what they said or did which they believed would be perceived as invalidating by their clients, perhaps by including a blank space on the therapist form and asking for descriptions of potentially invalidating interactions. Similarly, an open-ended answer format for clients
would allow them to provide a description of the interaction(s) which they found to be most invalidating. Such rich qualitative data could then be used in conjunction with the quantitative data already being gathered, and would also inform ongoing research questions to uncover more information about the complicated and interactive nature of validating and invalidating responses within the process of psychotherapy.

Conclusions

This project is the first known empirical study to examine associations between validation, invalidation, and three relevant therapy variables: positive affect, negative affect, and session attendance failures. We found significant association between invalidation and both positive and negative affect post-session, even after controlling for pre-session affect. These results suggest that invalidation associates uniquely with clients’ affective experiences in session, and may be worth tracking throughout the therapy course. Tracking the level of experienced invalidation at several points throughout therapy could provide useful feedback to the therapist, particularly if their clients are perceiving the therapy interactions as particularly invalidating or are perceiving a lack of validation. It may be the case that a focus on preventing inadvertent invalidation (versus on being more validating) would be most important for maintaining positive affect (and, perhaps, treatment engagement and participation), and using the SRVIS as a periodic check-in measure would allow for a closer look at these perceptions.

Validation, contrary to expectations, did not significantly associate with any of the three outcome variables tested. It may be the case that, because validation is expected in the therapy setting, its mere presence does not in fact associate with differences in positive affective responses, although its absence may certainly be related to negative
ones. Alternatively, it is possible that validating life’s traumas and frustrations serves to increase negative affect in some, and reduce it in others, thereby yielding null results when examining the overall sample as a whole.

Regarding session attendance, our results were largely non-significant. Neither the overall model, nor the three session pairs tested to look for immediate session-to-session effects, showed a significant relationship between validation or invalidation and next-session or overall session attendance failures. It may be the case that there is an underlying relationship which was not detected by some of these analyses (which rely upon a smaller number of observations) due to low power, limited by sample size, as well as a likely ceiling effect for validation, which restricts the range and limits the amount of variance in the collected data.

These results provide a first look at the associations between invalidation and post-session affective responses, substantiating the current theory pertaining to invalidating responses from one’s therapist during the therapeutic process and their link to increased negative affect (and decreased positive affect). The present study informs current clinical practice by describing the degree and nature of real-world invalidating and validating experiences from the perspective of the client, and shedding light on the discrepancy between therapists’ perceptions of their own potentially invalidating behaviors and those reported by their own clients. While it is clear that the SRVIS scale is still in need of additional refinement to increase its precision at measuring only the construct of invalidation (and not the strength of the overall alliance as a whole), these results nonetheless provide a valuable first look at how validation and invalidation are experienced by clients during real-world psychotherapy sessions, and begin to make
empirical sense of the associations these experiences may have with important theoretically related (but as yet largely untested) psychotherapy variables.
References


APPENDIX A: TABLES
Table 1

Schedule of Selected Client Questionnaires

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>Corresponding Session</th>
<th>PAI-BOR</th>
<th>PRE PANAS</th>
<th>POST PANAS</th>
<th>SRVIS-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Session 2 or before</td>
<td>X</td>
<td></td>
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<tr>
<td>2</td>
<td>Session 3</td>
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<tr>
<td>3</td>
<td>Session 4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Session 5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Session 6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>8 weeks after S6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Note. S6 = session 6*
Table 2
Means and Standard Deviations for Demographic Data and Dependent Variables, By Clinic

<table>
<thead>
<tr>
<th></th>
<th>DBT</th>
<th>ASDC</th>
<th>Gen</th>
<th>Total Sample</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender ( % female)</td>
<td>95</td>
<td>65</td>
<td>75</td>
<td>79</td>
<td>.08</td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td>31.47 (13.07)</td>
<td>25.82 (8.76)</td>
<td>24.25 (7.10)</td>
<td>27.40 (10.46)</td>
<td>.09</td>
</tr>
<tr>
<td>Previous Therapists</td>
<td>3.58 (2.12)</td>
<td>2.25 (2.21)</td>
<td>1.81 (2.23)</td>
<td>2.61 (2.27)</td>
<td>.05</td>
</tr>
<tr>
<td>Previous Psychiatrists</td>
<td>1.68 (1.67)</td>
<td>0.56 (1.03)</td>
<td>0.88 (1.67)</td>
<td>1.08 (1.55)</td>
<td>.08</td>
</tr>
<tr>
<td>Previous Hosp</td>
<td>1.32 (2.16)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.24 (0.97)&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>0.13 (0.34)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.60 (1.51)</td>
<td>.03*</td>
</tr>
<tr>
<td>SRVIS-C-V</td>
<td>14.64 (0.77)</td>
<td>14.50 (1.69)</td>
<td>14.74 (0.86)</td>
<td>14.63 (1.15)</td>
<td>.84</td>
</tr>
<tr>
<td>SRVIS-C-I</td>
<td>3.03 (2.72)</td>
<td>3.28 (3.03)</td>
<td>2.99 (2.24)</td>
<td>3.10 (2.64)</td>
<td>.94</td>
</tr>
<tr>
<td>Post-PANAS PA</td>
<td>22.88 (7.16)</td>
<td>23.50 (9.23)</td>
<td>24.95 (6.29)</td>
<td>23.73 (7.57)</td>
<td>.73</td>
</tr>
<tr>
<td>Post-PANAS NA</td>
<td>17.71 (5.90)</td>
<td>14.58 (4.69)</td>
<td>14.03 (4.42)</td>
<td>15.55 (5.26)</td>
<td>.08</td>
</tr>
<tr>
<td>Session Attendance Failures</td>
<td>0.79 (0.92)</td>
<td>1.13 (1.03)</td>
<td>0.67 (0.98)</td>
<td>0.86 (0.97)</td>
<td>.40</td>
</tr>
</tbody>
</table>

Notes: Measures: Hosp= Hospitalizations, SRVIS-C-V= Self-Reported Validation and Invalidation Scale, client version, validation subscale, SRVIS-C-I=invalidation subscale, Post-PANAS PA= post-session Positive & Negative Affectivity Schedule, positive affect, Session Attendance Failures = raw number of missed sessions; higher numbers mean a greater number of absences

*p < .05; Means with different superscripts are significantly different (based on results from Tukey tests) at the p < .05 level.
Table 3

*Pearson's Correlations among Validation, Invalidation, and Baseline Measures*

<table>
<thead>
<tr>
<th></th>
<th>SRVIS-C-V</th>
<th></th>
<th>SRVIS-C-I</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>p</td>
<td>r</td>
<td>p</td>
</tr>
<tr>
<td>Age</td>
<td>.007</td>
<td>.96</td>
<td>-.12</td>
<td>.41</td>
</tr>
<tr>
<td>Gender</td>
<td>.007</td>
<td>.96</td>
<td>.12</td>
<td>.40</td>
</tr>
<tr>
<td>Previous Therapists</td>
<td>.07</td>
<td>.63</td>
<td>-.05</td>
<td>.73</td>
</tr>
<tr>
<td>Previous Psychiatrists</td>
<td>-.11</td>
<td>.45</td>
<td>-.15</td>
<td>.32</td>
</tr>
<tr>
<td>Previous Hospitalizations</td>
<td>-.07</td>
<td>.61</td>
<td>-.04</td>
<td>.79</td>
</tr>
<tr>
<td>AIM</td>
<td>-.08</td>
<td>.56</td>
<td>-.20</td>
<td>.17</td>
</tr>
<tr>
<td>DERS</td>
<td>-.03</td>
<td>.85</td>
<td>.02</td>
<td>.89</td>
</tr>
<tr>
<td>IIP</td>
<td>-.001</td>
<td>.99</td>
<td>.09</td>
<td>.52</td>
</tr>
<tr>
<td>PAI-BOR</td>
<td>-.02</td>
<td>.88</td>
<td>.003</td>
<td>.98</td>
</tr>
</tbody>
</table>

*Notes. Measures: AIM= Affect Intensity Measure, DERS= Difficulties in Emotion Regulation Scale, IIP= Inventory of Interpersonal Problems, PAI-BOR= Personality Assessment Inventory, Borderline Scale. For Gender, higher values indicate a greater likelihood of female gender.*

* = $p < .05$
Table 4

*Pearson's Correlations among Therapy Variable Means*

<table>
<thead>
<tr>
<th></th>
<th>Post PA</th>
<th>Pre NA</th>
<th>Post NA</th>
<th>Non attend</th>
<th>SRVIS-C-V</th>
<th>SRVIS-C-I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre PA</td>
<td>.81**</td>
<td>.05</td>
<td>.03</td>
<td>.01</td>
<td>.08</td>
<td>-.21</td>
</tr>
<tr>
<td>Post PA</td>
<td>.08</td>
<td>-.09</td>
<td>-.09</td>
<td>.17</td>
<td>-.36*</td>
<td></td>
</tr>
<tr>
<td>Pre NA</td>
<td></td>
<td></td>
<td>.77**</td>
<td>.14</td>
<td>-.20</td>
<td>.24</td>
</tr>
<tr>
<td>Post NA</td>
<td></td>
<td></td>
<td></td>
<td>.26</td>
<td>-.40**</td>
<td>.47**</td>
</tr>
<tr>
<td>Nonattend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.05</td>
<td>.30*</td>
</tr>
<tr>
<td>Val</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.67**</td>
</tr>
</tbody>
</table>

*Notes.* Pre PA= pre-session positive affect, Post PA= post-session positive affect, Pre NA= pre-session negative affect, Post NA= post-session negative affect, Nonattend= number of missed or rescheduled sessions, SRVIS-C-V = Self-Reported Validation and Invalidation Scale, Client Version, Validation subscale, SRVIS-C-I = Self-Reported Validation and Invalidation Scale, Client Version, Invalidation subscale

*= p < .05; **= p < .01
Table 5
Hierarchical Regression Analyses for Mean Invalidation and Validation as Predictors of Mean Post-Session Negative and Positive Affect (N = 52)

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Predictors</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1</td>
<td>Step 1 adj. R²</td>
<td>Step 2</td>
<td>Step 2 Δ R²</td>
</tr>
<tr>
<td>Post-PANAS-PA</td>
<td>Pre-PANAS-PA</td>
<td>.81**</td>
<td>.64</td>
<td>Pre-PANAS-PA</td>
</tr>
<tr>
<td></td>
<td>SRVIS-C-I</td>
<td>-.21*</td>
<td></td>
<td>SRVIS-C-V</td>
</tr>
<tr>
<td></td>
<td>SRVIS-C-V</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-PANAS-NA</td>
<td>Pre-PANAS-NA</td>
<td>.69**</td>
<td>.47</td>
<td>Pre-PANAS-NA</td>
</tr>
<tr>
<td></td>
<td>SRVIS-C-I</td>
<td>.22*</td>
<td></td>
<td>SRVIS-C-V</td>
</tr>
<tr>
<td></td>
<td>SRVIS-C-V</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes. SRVIS-C-I = Self-Reported Validation and Invalidation Scale, Client Version, Invalidation Subscale, SRVIS-C-I = Self-Reported Validation and Invalidation Scale, Client Version, Validation Subscale
* = p < .05; ** = p < .01
APPENDIX B: FIGURES
Figure 1: Comparison of baseline treatment history variables, divided by clinic.

Note: Clinics differed significantly on Previous Hospitalizations ($p = .03$), and differed at a trend/nearly significant level on Previous Therapists ($p = .05$); see Table 2 for details on these differences.
Figure 2: Mean SRVIS-C validation and invalidation subscale scores, divided by clinic.

Notes: SRVIS-C = Self-Reported Validation and Invalidation Scale, Client Version, DBT = Dialectical Behavior Therapy, ASDC = Anxiety and Stress Disorders Clinic.

There were no significant differences by clinic on mean validation or invalidation.
Figure 3: Mean pre- to post-session change in PANAS positive and negative affect, divided by clinic.

Note: PANAS = Positive and Negative Affectivity Schedule, PA = positive affect, NA = negative affect, DBT = Dialectical Behavior Therapy, ASDC = Anxiety and Stress Disorders Clinic.
APPENDIX C: STUDY FORMS
Self-Reported Invalidation Scale- Client Version (SRVIS-C)

Please rate the following ten statements using the scale below:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>Rarely</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes</td>
</tr>
<tr>
<td>3</td>
<td>Often</td>
</tr>
<tr>
<td>4</td>
<td>Almost Always/Always</td>
</tr>
</tbody>
</table>

_____ 1) Was your therapist paying attention to you? (V)
_____ 2) Did your therapist increase your negative feelings? (I)
_____ 3) Did your therapist see your responses as abnormal or inaccurate? (I)
_____ 4) Did your therapist tell you what you should think or feel? (I)
_____ 5) Was your therapist interested in what you had to say? (V)
_____ 6) Did your therapist take your responses seriously? (V)
_____ 7) Was your therapist condescending or contemptuous toward you? (I)
_____ 8) How much of the time did you feel understood by your therapist? (I)
_____ 9) Was your therapist responsive to your emotions? (V)
_____ 10) Did your therapist see you as more fragile than you really are? (I)

_____ / ____
Self-Reported Invalidation Scale- Therapist Version (SRVIS-T)

Please rate the following ten statements using the scale below, regarding your most recent therapy session with this client.

<table>
<thead>
<tr>
<th>0 – Never</th>
<th>1 – Rarely</th>
<th>2 – Sometimes</th>
<th>3 – Often</th>
<th>4 – Almost Always/Always</th>
</tr>
</thead>
</table>

_____ 1) Were you paying attention to your client? (V)
_____ 2) Did you increase your client’s negative feelings? (I)
_____ 3) Did you see your client’s responses as abnormal or inaccurate? (I)
_____ 4) Did you tell your client what they should think or feel? (I)
_____ 5) Were you interested in what your client had to say? (V)
_____ 6) Did you take your client’s responses seriously? (V)
_____ 7) Were you condescending or contemptuous toward your client? (I)
_____ 8) How much of the time did you understand your client? (V)
_____ 9) Were you responsive to your client’s emotions? (V)
_____ 10) Did you see your client as more fragile than they really are? (I)

_____ / ____