Abstract

**Background:** Therapist validation in treatment is theorized to be related to positive outcomes (Linehan, 1993), including keeping patients in therapy longer. However, no research has directly examined the role of validation in premature dropout. **Aims:**  We sought to evaluate the role of therapist validation from both therapists’ and clients’ perspectives as a predictor of dropout from psychotherapy in three cognitive-behavioral training clinics. **Methods:** Clients in psychotherapy (*n* = 50; 80% female; 82% Caucasian) and their trainee therapists (*n* = 22; 68% female; 86% Caucasian) rated validation by the therapist at each of four early sessions of therapy. **Results:** After accounting for symptom severity, clients who reported greater therapist validation were less likely to drop out of treatment. Therapist-ratings of their own validating behaviors were unrelated to client dropout. Therapist experience moderated the relation between client-rated validation and dropout, such that validation was unrelated to dropout for more experienced therapists. **Conclusions:** Assessing and attending to client perceptions of validation by the therapist early in treatment, with brief self-report inventories, can alert therapists to clients at greater risk of dropout.

*Keywords*: dropout, validation, invalidation, psychotherapy training, cognitive behavior therapy

Validation Predicting Premature Dropout from Treatment Provided in Training Clinics

Dropout from psychotherapy is a significant concern for therapists and researchers alike. Clients who terminate psychotherapy early do not receive the recommended treatment dosage and, in many cases, do not meet the symptom reduction and personal goals which led them to initiate treatment (Fernandez, Salem, Swift, & Ramtahal, 2015). Dropout is defined as termination from therapy prior to receiving the full course of treatment or without mutual agreement between the client and therapist (Swift & Greenberg, 2012). Understanding dropout is important for several reasons. Most importantly, by dropping out of treatment early, clients may not have time to learn and practice the therapeutic strategies posited to promote successful outcomes. Though dropout rates can vary by treatment type, diagnosis, and across individual studies, a recent meta-analysis indicated the average dropout rate for Cognitive Behavior Therapy (CBT) is 26.2% (Fernandez et al., 2015). Similarly, the average dropout rate for Dialectical Behavior Therapy (DBT) in the treatment of Borderline Personality Disorder (BPD) is 27.3% (Kliem, Kröger, & Kosfelder, 2010). To better understand and ultimately reduce premature dropout, it is important to identify factors that can alert therapists to those at greater risk of dropout early in treatment.

There are many factors that are likely related to a client’s decision to drop out of treatment (e.g., initial symptom severity, rate of improvement, and events that occur outside of the therapy context). Identifying specific therapist factors that vary across therapy sessions and therapist-client dyads may help to gain a better understanding of dropout beyond less pliable factors. We were interested in one such factor in particular—validation. Validation communicates to clients the ways in which their behaviors, thoughts, and/or feelings make sense and are understandable given the current situation or their personal history (Linehan, 1993). In DBT, validation is considered a specific acceptance strategy but could be viewed as a non-specific factor common to all therapies. A therapeutic environment that communicates acceptance and understanding of the client’s experiences is likely to facilitate client retention (Linehan, 1997).

Invalidation, on the other hand, communicates that another’s responses are not understandable, do not make sense, or are even pathological and/or trivial (Linehan, 1997). Invalidation delegitimizes the other’s experience or conveys that it is simply unimportant or irrelevant. This can lead to negative emotional arousal, which may hinder learning and use of emotion regulation skills (Shenk & Fruzzetti, 2011). Greater negative emotional arousal and a reduction in emotion regulation learning and skillfulness will likely impede progress in treatment goals or, understandably, make it difficult to tolerate treatment, thus, increasing the likelihood of dropout. Though invalidation is likely unintentional in therapy sessions, this does not negate the impact it may have on treatment dropout.

Traditionally, validation and invalidation are theorized to be separable constructs (Fruzzetti, 2014; Linehan, 1993, 1997). However, in the context of therapy sessions, severe instances of invalidation may be unlikely, and clients may not be able to distinguish these constructs as separate. Therefore, we chose to focus on the continuum of validating behaviors, with high validation at one end of the continuum and high invalidation on the opposite end. Clients who believe they are understood and validated by their therapists may be more inclined to continue with treatment, even when sessions are difficult. Similarly, those who believe they are invalidated and misunderstood might be more likely to drop out. Further, there may be differences in clients’ and therapists’ perspectives of these factors.

Despite research demonstrating the potential negative effects of invalidation and positive effects of validation in experimental contexts (Herr, Jones, Cohn, & Weber, 2015; Shenk & Fruzzetti, 2011) and family environments (Buckholdt, Parra, & Jobe-Shields, 2014; Crowell et al., 2013; Shenk & Fruzzetti, 2014; Sturrock & Mellor, 2014; Whalen et al., 2014), there is scarce research on validation in psychotherapy. Additionally, an invalidating environment has been theorized to contribute to the development of chronic emotion dysregulation, particularly in those with already high emotional vulnerabilities (Crowell, Beauchaine, & Linehan, 2009; Fruzzetti, Shenk, & Hoffman., 2005; Linehan, 1993). Previous studies have demonstrated a relationship between invalidation in families and behavioral and psychological problems (Buckholdt et al., 2014; Crowell et al., 2013; Krause, Mendelson, & Lynch, 2003; Shenk & Fruzzetti, 2014; Sturrock & Mellor, 2014). Because those with greater emotional vulnerabilities may be particularly susceptible to invalidation, it is important to be alert to possible sources of invalidation in therapy sessions. However, there is currently no published research that examines invalidation in a therapeutic context. Carson-Wong, Hughes, and Rizvi (2018) conducted the only published study of the effects of validation on emotional experiences in therapy. They found that observer-rated therapist validation at higher levels (i.e., levels which function to normalize the client’s experience) were associated with increases in positive affect and decreases in negative affect in DBT sessions in a sample of clients with BPD.

Validation has only been studied in relation to dropout indirectly. Linehan et al. (2002) conducted a 12-month randomized controlled trial comparing DBT to comprehensive validation therapy plus a 12-step program for individuals with co-morbid opiate dependence and BPD. Though therapists in both conditions placed a strong emphasis on validation strategies, those in the comprehensive validation condition only utilized acceptance-based strategies without any behavioral change strategies. While both treatments were efficacious in reducing opiate use, the comprehensive validation condition had lower dropout rates than the DBT condition; specifically, none of the participants in the comprehensive validation condition dropped out compared to 27% in the DBT condition. Because validation use was not explicitly measured, this effect is only assumed to be related to validation due to the absence of any change based strategies; it is important to explicitly measure and delineate the link between dropout and validation when used in conjunction with change strategies in treatment (which have been shown to be important in other outcomes; Adler, Strunk, & Fazio, 2015; Neacsiu, Rizvi, & Linehan, 2010).

**Current Study**

With this study, we examined the role of therapist validation early in treatment as a predictor of dropout using data collected from three cognitive-behavioral graduate training clinics at a large Midwestern university: a general cognitive behavioral clinic (gCBT), an anxiety and stress disorders clinic (ASDC), and a DBT clinic (DBT). Client and therapist ratings of validation by the therapist were obtained from four early treatment sessions (between sessions 3 - 7). Early therapy sessions are important time points to examine, given this is where therapeutic gains are most likely to occur (Cooper et al., 2016), and more participants are still in treatment. These sessions were chosen to accommodate procedural and assessment differences in the first two sessions of treatment across clinics. Using a longitudinal design, we assessed the predictive value of client- and therapist-rated validation in treatment dropout.

We hypothesized that therapist validation in therapy would significantly predict dropout from treatment above and beyond client baseline symptom severity. Specifically, we hypothesized that more positive ratings of therapist validation would reduce the risk of dropout. Additionally, we hypothesized that client ratings would be better predictors than therapist ratings.

**Method**

**Participants**

**Clients.** The sample was composed of 55 client-therapist dyads from three graduate training clinics at a large Midwestern university. From this sample, 40% (*n* = 22) were identified as dropouts. However, three clients dropped out prior to their third therapy session when the first measures of validation were completed and, as such, are not included in these analyses. Additionally, two clients did not have measures of depressive or anxiety symptoms to include in analyses. Therefore, the final sample for all analyses was limited to 50 clients (gCBT: *n* =14; ASDC: *n* = 20; DBT: *n* = 16), with a dropout rate of 36%. Clients were primarily female (80.0%) and Caucasian (82.0%) with a mean age of 27.7 years (*SD* = 10.6). Other ethnicities included African American (4%), Asian (4%), Latino or Hispanic (2%), and multiracial (6%).

**Therapists.** Therapists (*n* = 22) were doctoral level trainees with a range of experience from 0 to 986 clinical hours (*M* = 291.5, *SD* = 317.7)[[1]](#footnote-1). Those in their first year of clinical training were all supervised in the gCBT clinic (*n* = 9), and trainees with one or more years of experience were supervised in the ASDC (*n* = 9) or DBT (*n* = 4) clinics. Therapists were also primarily female (68.2%) and Caucasian (86.4%; 13.6% Asian) with a mean age of 27.0 years (*SD* = 2.5). On average, each therapist treated 2.27 clients, with a mode of one client per therapist.

**Treatment clinics**

All three treatment clinics are located within the in-house psychological services center at a large Midwestern university and are intended to facilitate training in cognitive-behavioral treatment strategies. Therapists in all three clinics received supervision in both individual and group formats on a weekly basis by a licensed clinical psychologist, each with extensive experience supervising doctoral students. Clients in all three clinics were university students or members of the community. The primary problems targeted in each treatment differed slightly—mood and/or anxiety disorders in the gCBT clinic, anxiety or stress disorders in the ASDC clinic, and personality disorders or severe emotion dysregulation in the DBT clinic. Both the gCBT and ASDC clinics involved only individual therapy, whereas the DBT clinic consisted of all DBT modes, including individual therapy, group therapy, and phone coaching. Clients entering the DBT clinic committed to an initial six months of treatment. The gCBT and ASDC clinics had no required length of treatment.

**Measures**

**Depressive symptoms.** The 21-item self-report Beck Depression Inventory- 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996) was used to assess clients’ depressive symptoms, such as sadness, irritability, and loss of interest or pleasure. The BDI-II has been shown to have high internal consistency (α = .91; Beck, Steer, Ball, & Ranieri, 1996) and test-retest reliability over an average of 2 weeks ( *r* = .73 - .96; Wang & Gorenstein, 2013).[[2]](#footnote-2)

**Anxiety symptoms.** The 21-item self-report Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) was used to assess clients’ anxiety symptoms, including physiological symptoms such as racing heart and difficulty breathing, and emotional symptoms such as nervousness and inability to relax. The BAI has been shown to have high internal consistency (α = .92) and test-retest reliability over 1 week (*r* = .75; Beck et al., 1988).

**Borderline features.** The 24-item self-report Personality Assessment Inventory- Borderline Features Scale (PAI-BOR; Morey, 1991) was used to assess specific features of BPD, such as mood instability, anger, relationship difficulties, and impulsivity.The PAI-BOR has been shown to reliably distinguish those meeting criteria for BPD from those who do not (Southward & Cheavens, 2018). Internal consistency was high in this sample (α = .86).

**Therapist validation and invalidation.** The Self-Reported Validation and Invalidation Scale (SRVIS) is a 9-item scale designed to assess perceived levels of validation and invalidation. It was created by this research team for a series of studies on the role of validation in both experimental and clinical trial contexts. Subscales of the SRVIS (i.e., validation and invalidation) have demonstrated high internal consistency in studies in which validation and invalidation were experimentally induced (α = .89 and .86, respectively). In the clinical trial version, each item assesses different validating or invalidating behaviors by the therapist during a given session and is rated from 0 (never) to 4 (almost always/always). The SRVIS includes items such as the therapist’s level of attention toward the client, responsiveness to the client’s emotions, pathologizing the client’s responses, and fragilizing the client. High scores on the SRVIS represent greater levels of validation, while low scores represent less validation and greater invalidation. In this study, both clients and therapists reported on their perceptions of in-session validation by the therapist. We calculated between-person composite reliability estimates using multilevel confirmatory factor analysis (Geldhof, Preacher, & Zyphur, 2014) to account for the nesting of sessions within clients. Reliability was good for both client-rated (ω = .88) and therapist-rated validation (ω = .87).[[3]](#footnote-3)

**Procedure**

This naturalistic, longitudinal study was approved by the local Institutional Review Board. Clients and therapists completed baseline self-report questionnaires prior to the start of treatment (i.e., intake session) as well as at the end of each of four early therapy sessions (ranging from sessions 3 - 7). Client baseline measures included a demographics questionnaire and PAI-BOR. BAI and BDI-II session scores were taken from the first available time point for each client as a baseline measure of symptom severity. The majority of BAI and BDI-II scores were taken from the intake session, prior to initiating therapy (*n* = 47; *n* = 45, respectively). The rest were taken from the client’s first (BDI-II: *n* = 2), third (BAI: *n* = 1; BDI-II: *n* = 1), or fourth therapy session (BAI: *n* = 2; BDI-II: *n* = 2). Therapists also provided baseline data including information relevant to demographics and prior clinical experience. One therapist who saw three clients had missing data for therapist experience. This therapist was in their fifth year as a graduate trainee. We calculated the mean of experience hours for other fifth year trainee therapists (*M* = 973 hours) and used this value for the missing data.[[4]](#footnote-4) Clients and therapists completed the SRVIS after sessions three through seven.

Therapy completion was defined as clients who reached a mutually agreed upon termination in collaboration with their therapist or attended a full 6-month treatment course without any significant gaps (defined as four weeks or more). Therapy dropout was defined as clients who unilaterally discontinued treatment before the treatment protocol was completed/without therapist agreement or missed at least four consecutive weeks of treatment within the first six months. We chose missing four weeks of treatment as one definition of dropout based on the four-miss rule of DBT (Linehan, 1993). Clinics had different treatment course expectations, and only the DBT clinic required a minimum (i.e., 6 months) treatment duration commitment for all clients, which is why we included agreed upon termination as one definition of a completed course of therapy. All client charts were reviewed to assess dropout status.

**Analytic strategy**

Prior to the primary analyses, those who dropped out of (i.e., dropouts) and completed (i.e., completers) therapy were compared on client and therapist demographic characteristics and client symptom characteristics. Differences in dropout rates were also examined between clinics. We planned to enter any variables that distinguished dropouts and completers at the *p* < .10 level as a covariate in all analyses. We also planned to enter symptom measures (i.e., BAI, BDI-II, and PAI-BOR) as covariates due to their likely influence on dropout (e.g., Fernandez et al., 2015; Swift & Greenberg, 2012). To obtain one total score for both client- and therapist-rated validation, scores across the four therapy sessions were averaged. An average score was chosen to represent general patterns of validation. All covariates and predictor variables were mean centered to ease interpretability of the intercepts. All primary analyses predicting dropout were modeled with binary logistic regression. Individual models were run for both client- and therapist-rated validation. Because several therapists treated multiple clients in this sample, we attempted to account for within-therapist correlation in dropout using multilevel modeling. However, most therapists only treated one client and, as such, using these methods produced an uninterpretable model, such that the covariance matrix was not positive definite, and the within-therapist effects were estimated as 0. Therefore, all analyses were run without accounting for nesting within therapists.

Additionally, to help account for the variation in therapists’ hours of experience, we ran individual models examining the interaction between therapist experience and both client- and therapist-rated validation. Both models included all preplanned covariates. Moderation analyses were conducted with Hayes’ (2013) PROCESS macro. Significant interactions were probed at the mean and one standard deviation above and below the mean on therapist experience.

**Results**

On average, clients were in the moderate range for both depression (*M* = 22.2, *SD* = 11.5) and anxiety (*M* = 17.4, *SD* = 10.9) and were slightly under the proposed threshold for significant BPD features (*M* = 35.1, *SD* = 11.6). The overall rate of dropout across the three graduate training clinics was 36% (*n* = 18). The dropout rate was 35.7% (*n* = 5) from the gCBT clinic, 37.5% (*n* = 6) from the DBT clinic, and 35.0% (*n* = 7) from the ASDC clinic. Dropout rates did not differ between clinics, χ2(2) = .03, *p* = .99. Reasons for dropout as they were communicated to the therapists were extracted from client charts. Of those who dropped out, 61.1% (*n* = 11) did not provide any information and/or were unable to be contacted. Additional reasons included reporting a work or school conflict (*n* = 3), dissatisfaction with the therapist or therapy (*n* = 2), and moving out of town (*n* = 2). Time of dropout ranged from session 4 to 22, with clients, on average, dropping out before their 8th session (*SD* = 5.2). Clinics differed in the total number of sessions attended by all clients, *F*(2) = 4.76, *p* = .01 (gCBT: *M* = 17.1, *SD* = 9.6; ASDC: *M* = 14.2, *SD* = 7.4; DBT: *M* = 23.7, *SD* = 10.9). However, there were no differences in the number of sessions for clients that dropped out, *F*(2) = 2.61, *p* = .11 (gCBT: *M* = 6.8, *SD* = 2.7; ASDC: *M* = 6.7, *SD* = 3.9; DBT: *M* = 12.2, *SD* = 6.6). For treatment completers, only DBT had significantly more sessions than the other clinics, *F*(2) = 12.58, *p* < .001 (gCBT: *M* = 22.8, *SD* = 6.7; ASDC: *M* = 18.23, *SD* = 7.8; DBT: *M* = 30.6, *SD* = 5.8).

We then compared demographic and symptom characteristics between dropouts and completers to assess for any significant covariates. There were no significant differences between dropouts and completers in any client or therapist demographics variables (Table 1). There were also no significant differences in measures of symptom severity, including depression, anxiety, and borderline symptoms; however, these were entered as covariates into all models as planned.[[5]](#footnote-5)

Client - and therapist-rated validation were not significantly correlated (*r* = .25). Table 2 provides the correlations between client- and therapist-rated validation with client symptom severity. Therapist-rated validation was significantly correlated with depressive symptoms (*r* = -.41, *p* < .01).

Using binary logistic regression, we ran two models predicting dropout with client- and therapist-rated validation as independent predictor variables (Table 3). Both models included baseline depressive, anxiety, and borderline symptoms as covariates. Client-rated validation significantly predicted dropout. With each unit increase in therapist validation, as reported by clients on average across these four sessions, the likelihood of dropping out of treatment decreased by 22%, *B* = -.25, *SE* = .12, *OR* = .78, *p* = .03. Therapists’ perceptions of their own use of validation did not significantly predict treatment dropout, *p* = .76. Baseline client symptom measures (BAI, BDI-II, and PAI-BOR) were not significant predictors in either model, *p*s > .38. Additionally, because client and therapist ratings of validation were not correlated, we tested whether the discrepancy between these scores predicted dropout. The discrepancy between client and therapist ratings marginally predicted dropout, *B* = -.18, *SE* = .09, *OR* = .83, *p* = .05, such that when therapists rated themselves as more validating than their clients did, those clients were more likely to drop out.

We then conducted moderation analyses between either client- or therapist-rated validation and therapist experience (i.e., number of clinical hours). There was a significant interaction between client-rated validation and therapist experience, *B* = .001, *SE* = .0004, *p* = .04. We probed the interaction at the mean and one standard deviation above and below the mean on therapist experience (Figure 1). Greater client-rated validation significantly reduced the risk for dropout only for clients whose therapist had average, *B* = -.37, *SE* = .16, *p* = .02, or below average, *B* = -.63, *SE* = .23, *p* = .006, experience for this sample. However, client-rated validation was unrelated to dropout for clients who had a therapist with above average experience, *B* = -.08, *SE* = .18, *p* = .66. The interaction between therapist-rated validation and therapist experience was not significant, *p* = .13. Baseline client symptom measures (BAI, BDI-II, and PAI-BOR) were not significant predictors, *p*s > .40. We also examined these models controlling for clinic because therapists in the gCBT clinic had less experience. All patterns of results remained the same. Clinic was not a significant predictor in either model, *p*s > .48, nor did clinic moderate the relationship between client- or therapist-rated validation and dropout, *p*s > .22, suggesting that the interaction between client-rated validation and therapist experience in predicting dropout is unrelated to differences between clinics.

**Discussion**

Treatment dropout is an important clinical outcome to understand given the implications for mental health prognoses. With this study, we aimed to investigate the relationship between validation from clients’ and therapists’ perspectives and dropout in graduate training clinics. These results suggest that therapist validation, when rated from the perspective of the client in early sessions, predicted treatment dropout above and beyond symptom severity. Further, therapist experience moderated the relation between client-rated validation and dropout such that validation no longer predicted dropout for therapists with more experience. Attending to clients’ perceptions of validation may help identify clients at early risk for premature dropout.

The hypothesis that validation, particularly as rated by clients, would predict lower dropout was supported. A therapeutic environment characterized by understanding and acceptance of the client’s experience appears to be related to client retention but, as might be expected, only if the client views it as such. Finding ways to make clients feel more validated in therapy may help keep clients in treatment for the recommended length of time, which may have a positive impact on client outcomes. Moreover, it is important to find ways to increase clients’ perceptions of validation in therapy sessions. Future researchers should investigate whether validation is related to other client outcomes, such as symptom improvement or remission, and identify more malleable relational factors that may influence client dropout, such as use of change-based strategies.

Therapist ratings of validation were unrelated to treatment dropout. Considering the low correlations between client and therapist ratings, it appears that the client’s subjective experience of being validated is more important than the therapist’s perceptions of his or her own use of validation. Perhaps therapist trainees are not as adept at adequately recognizing how their behaviors relate to the experience of the client. Therapists attending only to their perceptions, without assessment of client views, may be unaware of clients at greater risk of dropout.

Therapist experience interacted with client-rated validation in predicting treatment dropout. For therapist trainees with an average amount of experience and for those just beginning therapy, greater client ratings of validation significantly reduced the risk of dropping out. However, for clients with more experienced therapists in this sample, client ratings of validation were unrelated to their risk of dropout. It is possible that validation is less important to dropout for more experienced therapists because they are providing higher quality therapy (e.g., providing more specific strategies to help clients ameliorate their problems or symptoms). This would be a question for future research. Another possibility is that as therapists gain more experience, they understand their clients’ perspective more but are not explicitly expressing this understanding. Perhaps these therapists move more quickly toward providing cognitive or behavioral skills to target the problem without sufficient reflection; thus, clients do not report feeling more validated.

It is somewhat surprising that client and therapist perceptions of validation were not significantly related to one another at all. Although the model cannot be interpreted, the discrepancy between perceptions was marginally significant, suggesting that the direction of therapists’ misreadings of clients’ experiences of validation may be important to dropout. Future research should examine this question further to confirm these findings. One possibility for this difference in therapist and client ratings may lie in the definition of validation. Validation, as defined by Linehan (1993, 1997), excludes validating the “invalid” components of another’s experience or behaviors that are in conflict with goals. For example, a therapist would likely not communicate complete acceptance of a clearly problematic or ineffective behavior, such as self-harm, but would potentially validate the strong emotions associated with the urge for this behavior (or even the urge itself). This distinction might be important therapeutically (and particularly in training clinics), yet a client might report that his or her experience was invalidated if parts of that experience were not fully accepted or normalized by the therapist. It is possible that therapists with more experience are better able to make this distinction. In regard to retaining clients in therapy, this may be a delicate balance to strike given these findings suggest that clients’ views were important in dropout and therapists’ perceptions were not. Additionally, this study was conducted in training clinics where all therapists were relatively inexperienced. Perhaps there would be a stronger correlation between client and therapist ratings of validation with more experienced therapists, who may be more attuned to the client’s experience and their own behaviors.

The correlations between validation and measures of personality and symptom severity are also informative. Understanding factors that relate to clients’ perspective would be valuable in efforts to reduce the risk of treatment dropout. Baseline depressive and anxiety symptoms were not correlated with client-rated validation. Similarly, BPD features were not related to clients’ perceptions even though BPD is hypothesized to be related to experiences of invalidating environments historically (Fruzzetti et al., 2005; Linehan, 1993). Future researchers should investigate possible predictors of clients’ views of validation. Although not a significant predictor of dropout in this study, the correlation between therapist ratings of validation with symptom measures are informative as well. It appears that therapists’ perceptions of their own validating behaviors in session are related to clients’ baseline depressive symptoms. This could have implications for training therapists, particularly for clients with greater symptom severity. For example, perhaps trainee therapists find it more difficult to validate clients with more severe symptoms or are more likely to unintentionally invalidate these clients.

There were several limitations to this study. First, the sample size was small. Replication in a larger sample would be important to substantiate these findings. Furthermore, because this was a naturalistic study, clients were not randomized to clinics or therapists. Although these were all cognitive-behavioral clinics housed in the same center, they vary in several non-random ways, including therapists, supervisors, treatment manuals, primary diagnoses, and severity of symptoms. Accruing large enough samples to determine if these relationships are present in each of these, and other, types of clinics would increase confidence in the commonality and generalizability of the findings. While validation occurs in all psychotherapies, our study only included cognitive-behavioral clinics, limiting generalizability to other types of treatment. Because this study was conducted in graduate training clinics, it would also be important to replicate with more experienced therapists to further increase external validity. Additionally, because validation measures were taken from sessions ranging from three through seven, analyses do not include clients who dropped out prior to a third session. Due to differences in clinics and assessment procedures, these sessions were chosen to examine early treatment sessions that would be most similar for all clients. Furthermore, while we believe that having measures of validation from both the clients’ and therapists’ perspectives was a strength of this study, these rely on self-reports. Future research may benefit from objective, observational ratings of validation. Finally, causal relations cannot be inferred because this is a naturalistic, not experimental, study. Thus, although there is temporal sequencing in which the predictors preceded the outcome, it could be that clients that are more likely to drop out are also more likely to view their therapists in particular ways for other, unmeasured, reasons. Although there could be other variables at play, we attempted to address this issue by examining several possible covariates.

These findings lead to many avenues for future research in addition to those previously mentioned. One lingering question involves investigating the mechanism driving the relation between client-rated validation and dropout. Possible mechanisms that could be examined are changes in positive or negative affect or changes in symptom severity. A client who leaves a session with more positive affect or, perhaps more importantly, reduced negative affect or symptoms might be more likely to return to the next session. It would be important to understand if changes in symptoms or affect mediate the relation between validation and dropout. Additionally, perhaps a more validating and accepting therapeutic environment facilitates learning the skills and techniques taught in treatment. Clients who feel they are gaining new, adaptive skills in treatment may be more likely to return. Understanding the mechanisms might help to elucidate other ways therapists can address these issues and hopefully increase the chances that clients will stay for the recommended duration of treatment.

**Conclusion**

In summary, in a sample from three graduate training clinics, clients were less likely to drop out when they viewed their therapists as more validating early in treatment. However, client-rated validation was only related to dropout when therapists had average or below average experience for this sample. In this study, clients with more severe symptom presentations were no more likely to drop out than those with less severe symptom presentations; rather, it was validation, as assessed by the client, that predicted dropout, which may have important implications for other clinical outcomes. Client ratings of therapist validation can be a simple method for alerting therapists early in treatment to risk of premature or unilateral dropout. Replicating these findings and understanding ways to improve clients’ perceptions of validation would be important areas of future study.

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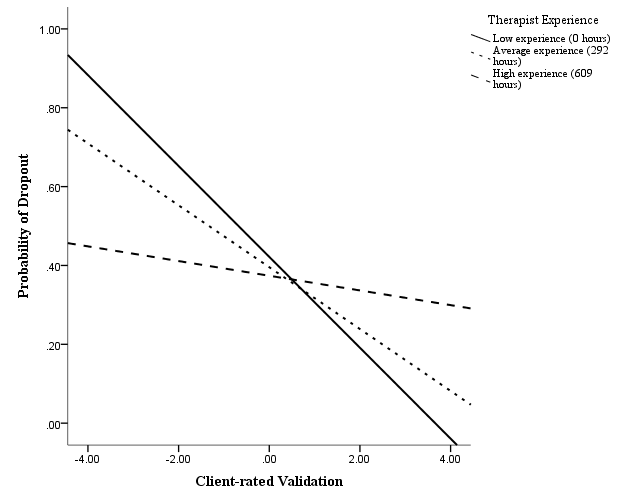
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| Table 1 |  |  |  | |  |
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| *Client and therapist characteristics by dropout* | | | |
|  | Dropouts | Completers | Effect Size | |  |
| Client | M (SD) or % | M (SD) or % | *d* or ϕ | |  |
| Age | 29.0 (10.6) | 26.9 (10.0) | .19 | |  |
| Female (%) | 77.8 | 81.3 | .04 | |  |
| Caucasian (%) | 77.8 | 84.4 | .08 | |  |
| Single (%) | 55.16 | 45.2 | .36 | |  |
| Previous psychotherapists | 2.6 (2.1) | 2.7 (2.4) | .02 | |  |
| Previous hospitalizations | .7 (1.9) | .5 (1.3) | .12 | |  |
| PAI-BOR | 37.3 (13.2) | 33.8 (10.5) | .30 | |  |
| BDI-II | 24.2 (12.4) | 21.1 (11.1) | .27 | |  |
| BAI | 18.8 (11.2) | 16.5 (10.9) | .21 | |  |
|  |  |  |  | |  |
| Therapist |  |  |  | |  |
| Age | 27.4 (2.6) | 27.4 (2.7) | .03 | |  |
| Female (%) | 72.2 | 65.6 | .07 | |  |
| Caucasian (%) | 88.9 | 96.9 | .16 | |  |
| Experience (hours) | 282.1 (303.3) | 296.8 (330.1) | -.04 | |  |
| *Note. PAI-BOR = Personality Assessment Inventory - Borderline Features Scale, BDI-II = Beck Depression Inventory, 2nd Ed., BAI = Beck Anxiety Inventory. Significance tests reflect whether dropouts and completers differ in mean value or percentage. Effect sizes reflect Cohen's d for mean differences and Cramer's* ϕ *for proportion differences. One SD below the mean on therapist experience is out of range for both groups.* | | | |

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| Table 3 |  |  |  |  |  |
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| *Predictors of dropout* | | | | | |
| Model | Estimate | *SE* | *p* | Odds Ratio | 95% CI |
| **Client-rated Validation** |  |  |  |  |  |
| Intercept | -.63 | .32 | .05 | .53 | [.28, 1.00] |
| SRVIS-C\* | -.25 | .12 | .03 | .78 | [.61, .98] |
| PAI-BOR | .03 | .03 | .38 | 1.03 | [.97, 1.09] |
| BDI-II | .01 | .03 | .80 | 1.01 | [.95, 1.07] |
| BAI | -.00 | .03 | .99 | 1.00 | [.94, 1.05] |
| **Therapist-rated Validation** |  |  |  |  |  |
| Intercept | -.60 | .30 | .05 | .55 | [.31, 1.00] |
| SRVIS-T | -.04 | .14 | .76 | .96 | [.73, 1.07] |
| PAI-BOR | .02 | .03 | .41 | 1.02 | [.97, 1.08] |
| BDI-II | .01 | .03 | .72 | 1.01 | [.95, 1.07] |
| BAI | .01 | .03 | .67 | 1.01 | [.96, 1.07] |
| *Note. SRVIS = Self-Reported Validation and Invalidation Scale (Client or Therapist version), PAI-BOR = Personality Assessment Inventory - Borderline Features Scale, BDI-II = Beck Depression Inventory, 2nd Ed., BAI = Beck Anxiety Inventory. Outcome coded: 0 = complete, 1 = dropout.* | | | | | |
| \*p < .05 |  |  |  |  |  |



*Figure 1.* Moderation analysis between client-rated validation and therapist experience in hours predicting risk of dropout.

1. For therapists with 0 clinical hours, the study participant was their first client. [↑](#footnote-ref-1)
2. Total scores for the BDI-II and BAI were taken from client charts. As such, we were unable to calculate internal consistency. [↑](#footnote-ref-2)
3. We constrained the variance of two items to zero for therapist-rated validation due to estimated negative variances in the unconstrained model. [↑](#footnote-ref-3)
4. When excluding the three participants with missing data for therapist experience, patterns of results from all analyses remain the same. Similarly, when excluding the four participants with BDI-II or BAI scores only from the third or fourth therapy session (when validation was measured), patterns of results from all analyses remain the same. [↑](#footnote-ref-4)
5. Results did not differ when excluding these covariates, in either analyses with or without the two clients without BDI-II or BAI scores. [↑](#footnote-ref-5)