RELIABILITY AND VALIDITY OF THE DBT-VLCS: A MEASURE TO CODE DBT VALIDATION LEVELS WITHIN AN INDIVIDUAL THERAPY SESSION

by

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ABSTRACT OF THE THESIS

Reliability and Validity of the DBT-VLCS: A Measure to Code DBT Validation Levels within an Individual Therapy Session

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Dialectical behavior therapy (DBT) is a treatment for Borderline Personality Disorder (BPD) that includes specific strategies a therapist can use to direct treatment. Of these strategies, validation is considered to be the most direct method for communicating acceptance, is proposed to lead to a down-regulation of a problematic emotional response, and is important to consider in treating population characterized by emotional dysregulation. While validation is implicit in many therapies, DBT is one of few treatments to explicitly include six validation strategies. Little research has been conducted to examine how validation is used in therapy and no studies have examined the six levels of validation in DBT. One major limiting factor is the lack of measures designed to assess validation strategies. The DBT-Validation Level Coding Scale (DBT-VLCS) was designed bridge this gap and code for the use of the six validation levels (VL). Two studies were conducted to determine the preliminary psychometric properties of the DBT-VLCS. Results demonstrated that reliability was good for the complete measure (ICC= .905), VL 1 (ICC= .771), VL 2 (ICC= .738), VL 3 (ICC=.623), VL 4 (ICC= .914), VL 5 (ICC= .836), VL 6 (ICC= .831), and an item coding perceived client

response (ICC= .900) for all raters. Content validity of the DBT-VLCS was examined through a survey distributed to expert DBT clinicians. The measure achieved good content validity for VLs 1 through 4, VL 6, and the item coding perceived client response. The item coding VL 5 did not achieve good content validity. Overall, the DBT-VLCS appears to be a reliable and valid measure to code the presence of therapist use of validation within an individual DBT treatment session. This measure opens up the opportunity for research on validation that has not previously been possible, including how to increase the effectiveness of DBT for clients with significant emotional dysregulation through the strategic use of therapeutic strategies.

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I. Introduction

Borderline personality disorder (BPD) is an Axis II disorder characterized by pervasive emotional, behavioral, and cognitive dyscontrol. Until fairly recently, BPD was largely considered to be untreatable. However, in recent years, a number of psychotherapies have been developed for BPD. A few of these therapies, such as Transference Focused Psychotherapy (Kernberg, Selzer, Koenigsberg, Carr & Appelbaum, 1989), Mentalization Based Therapy (Bateman & Fonagy, 2004), Schema Focused Therapy (Young, 1990), Systems Training for Emotional Predictability and Problem Solving (Blum, Pfohl, John, Monahan & Black, 2002) and Dialectical Behavior Therapy (DBT; Linehan, 1993), have been shown to be effective in reducing suicidal behaviors, decreasing use of psychiatric medication, increasing overall global functioning, and decreasing hospitalizations in BPD populations. Of these psychotherapies, DBT has been the most studied and widely practiced.

Overview of DBT

DBT is a psychosocial treatment developed by Linehan originally as an outpatient treatment for women who met criteria for BPD and who had a history of suicidal or non-suicidal self-injurious behaviors (Linehan, 1993). Standard DBT consists of four treatment modes (weekly individual therapy, weekly group skills training, as-needed phone coaching, and therapist consultation team meetings), and is guided by three theories (biosocial theory, behavioral theory, and dialectical philosophy). These three theories guide all aspects of DBT, but are most apparent within individual therapy. The biosocial theory posits that the core feature in BPD is a pervasive emotional

dysregulation that transacts with a pervasive invalidating environment. Emotional dysregulation is defined as a heightened emotional sensitivity, increased emotional reactivity, and a slower return to baseline (Crowell, Beauchaine & Linehan, 2009; Linehan, 1993). An invalidating environment is considered to be an environment that chronically invalidates an individual's communication of internal experiences, including emotions. An environment may be invalidating to an individual in a variety of ways including: 1) the individual's emotional experiences are not tolerated by significant people in the individual's environment, 2) emotions expressed by the individual are ignored until the individual increases his/her emotions to a level high enough that someone in the environment attends to the emotions, resulting in intermittent reinforcement of the individual's emotions, and 3) sufficient skills for regulating emotions are not modeled or taught so the individual does not learn how to label, tolerate, or regulate his/her emotional experience. The development of BPD is proposed to be a transaction between the biological dysfunction and invalidating environment, in which each factor affects the other, resulting in significant emotional dysregulation.

The remaining guiding theories that influence DBT are behavioral theory and dialectical philosophy. The behavioral theory shapes treatment in terms of how problem behaviors are defined, assessed, and treated. Dialectical philosophy posits that reality is interrelated and consists of opposing ideas. DBT is influenced by the dialectical philosophy as both a worldview that therapists and clients are encouraged to adopt in their thinking about the nature of reality and what is "truth," and as a set of treatment strategies to be utilized when the client and therapist reach an impasse.

Within DBT, there are four sets of strategies a therapist can use to direct treatment: 1) dialectical strategies, 2) core strategies, 3) stylistic strategies, and 4) case management strategies (Linehan, 1993). While all strategies are considered important to use throughout treatment, the core strategies, consisting of validation (acceptance) and problem solving (change), comprise the heart of the treatment. All other strategies are built around the core strategies (Linehan, 1997). Validation is considered to be the most direct method for communicating acceptance, and problem solving is considered to be the most direct of the change strategies. Dialectical strategies are then used to balance both change and acceptance and to strive for a synthesis when polarization between the therapist and client occurs.

Use of core strategies (change and acceptance) as a treatment technique was developed through observations made by Linehan during her work with women who met criteria for BPD and who had a history of suicidal or non-suicidal self-injurious behaviors, prior to the creation of DBT. Through trial and error, Linehan observed that with this population, focusing solely on either change strategies or solely on validation strategies resulted in clients' report that the therapist did not understand or were not acknowledging the severity of her experience. Clients felt that when a therapist focused solely on change strategies, that the therapist oversimplified the problem and that the therapist did not understand how difficult it was for the client to live her life. Additionally, Linehan observed that when the client experienced extreme emotional distress, the use (or over-use) of change strategies, such as problem solving, led to client non-compliance, an escalation of anger, aggressive attacks, or even drop-out from treatment (Linehan, 1997). Alternatively, when the therapist focused solely on validation

strategies, Linehan observed that the clients also experienced feeling a lack of understanding. Clients felt that the therapist did not recognize her emotional distress and the need for change. These clinical observations suggested that neither change strategies nor validation strategies alone are sufficient, leading Linehan to propose a therapy that strived for a dialectical balance between both change and acceptance.

Function of Validation

Validation has been proposed to help soothe escalating negative emotion, increase effective communication, slow negative reactivity, build a trusted relationship between a therapist and client, and increase the client's own self-respect (for a review, see Fruzzetti, 2006). When a client feels invalidated, a sense of increased arousal may lead to an escalation of a problematic emotion. The strategic use of validation is proposed to lead to a down-regulation of a problematic emotional response (Shenk & Fruzzetti, 2011). For this reason, it is likely that the use of validation is especially important to consider in the treatment of a population characterized by severe emotional dysregulation.

The self-verification theory (Swann, 1983) also supports the use of validation in treatment. The self-verification theory posits that stable self-views, rather than disconfirmation of self-views, help people to define and organize their experiences in order to help plan for the future and help them to interact socially (Swann, 1983). Swann (1997) found that once self-views are established, people seek out verification for their self-view, regardless of whether the self-view is positive or negative. For example, if a client held the belief that they are unlovable, the client might actively seek relationships in which the client's partner frequently verbalizes that the client is a bad partner or that

the client is not worthy of affection. Therefore, the client's belief that he or she is unlovable is confirmed. A study examining participants who were randomly selected from a college counseling center's waiting list found that those who received feedback that was congruent with their beliefs about themselves from a therapist (even if the feedback was negative) returned the following week with increased self-esteem when compared to those who received incongruent feedback (Finn & Tonsager, 1992). Based on this theory, even if a client feels negatively about him/herself, he or she still prefers to have his or her self-view verified by their therapist, rather than receive positive feedback he or she does not feel to be true. Verification of one's self-view, or validation of the client's thoughts, feelings, or behaviors, is believed to lead to a feeling of competence and mastery (Swann, 1997). It is this social psychological construct that informs the use of validation in DBT.

While validation is implicit in many therapies, DBT is one of the few to explicitly include validation as a treatment strategy and outline how to validate and what to validate. Validation is defined by Linehan as "communication to the client that their responses make sense and are understandable within the current context" (Linehan, 1993, p.222). In DBT, the use of strategies that validate the client's self-view and his or her own thoughts or feelings may be especially powerful. It is for this reason that after the publication of the DBT manual in 1993, Linehan felt that a greater focus on validation strategies was necessary for the treatment of severely emotionally dysregulated individuals. Linehan thus published a subsequent chapter detailing therapeutic techniques that explicitly describe how and what to validate within an individual DBT treatment session (Linehan, 1997).

Levels of validation in DBT

Linehan (1997) defines six explicit strategies, which she labeled "levels of validation." Each validation level (VL) is considered to be vital in DBT treatment. However, to-date, the use of these specific levels and the impact each level may have on a client in individual therapy has not yet been empirically validated. Each level, as defined by Linehan, is summarized here.

VL 1 is characterized as the therapist listening with complete awareness and being awake. In this level, the therapist makes an active effort to listen to the client and observe nonjudgmentally what is being said by the client. The therapist actively seeks an empathetic understanding of the client and the context in which the client exists. The therapist may do this by referencing what the client has previously said or done. Examples of VL 1 would be the therapist being fully focused on the client, attentive to what the client is communicating verbally and nonverbally, and making eye-contact throughout the session.

VL 2 is characterized as the therapist accurately reflecting what the client is communicating. In this level, the therapist communicates to the client that he or she understands the client by reflecting back, using words similar to what the client has used, what the client has just stated. In VL 2, if the client were to state, "Seeing my ex-boyfriend with his new girlfriend was really difficult," the therapist may respond with, "So, I understand that seeing someone that you were once close with in that situation was tough for you." At this level, the therapist simply acknowledges what the client has said, and the therapist does not add any of his or her own interpretations.

In VL 3, the therapist conveys to the client what the client is thinking or feeling but has not yet verbalized. In the previous example, the therapist may respond to the client by using VL 3 by stating "it sounds like seeing your ex-boyfriend with a new girlfriend led you to doubt your self-worth." This level can be particularly validating to the client when the therapist is accurate as this can convey to a client who frequently experienced invalidation that his or her thoughts, feelings, or behaviors can be understood within the current context. This level illustrates to the client that the therapist understands the client without the client needing to always explain him or herself.

VL 4 refers to when the therapist explains how the client's behavior, thoughts, or emotions make sense in terms of the client's *past* learning experience or biology. Relatedly, VL 5 refers to the therapist explaining how the client's behaviors, thoughts, or emotions make sense given the *current* situation. For either of these levels, the therapist searches to find what is effective, adaptive, or relevant about the client's response in the current situation. If the client had a history of being physically attacked by an unknown male, a therapist may validate using VL 4 by stating "based on your traumatic history, I can understand why you are fearful of men you don't know." In this instance the therapist could also use validation VL 5 by stating "I can understand your fear of unknown men. Any woman walking home alone at night would be afraid of a man approaching her in that situation." If it is possible to use either a VL 4 or a VL 5, Linehan (1997) suggests that VL5 should be used as it is temporally more relevant and may be more likely to be non-pathologizing of the client.

In the highest level, VL 6, the therapist demonstrates "radical genuineness." In order to display this level, the therapist acts in a way towards the client similar to how

they would towards a respected friend. It communicates to the client that the therapist views the client as a person of equal status and worthy of equal respect rather than as just a client or as someone with a mental disorder. VL 6 validation is one in which the therapist shares in the client's experience as an equal. If client told the story of seeing her ex-boyfriend with a new girlfriend, an example of VL 6 validation could be the therapist self-disclosing his or her own example by stating "that really stinks. I know I felt awful after seeing my ex-boyfriend with his new girlfriend, too."

Research on validation

Much of what we know about validation and DBT has been determined through clinical observations made by Linehan and others. Little research has been conducted to examine how validation is used in therapy or how validation may help the therapeutic process. To date, no studies have been conducted examining the levels of validation and how the use of different VLs may affect a client's experience or progress in therapy. For example, statements have been made that higher levels of validation have a greater therapeutic impact (Linehan, 1993; 1997); however, no studies have empirically validated this statement. It has been hypothesized that validation in a treatment session can be used to decrease a client's emotional response to allow effective communication with a therapist (Fruzzetti, 2006; Koerner, 2012; Linehan, 1993), however, no studies have been conducted to confirm this hypothesis.

Few studies have examined the impact of overall validation on treatment outcomes and emotion regulation. One such study, by Shearin and Linehan (1992), examined therapist-client dyads for female clients enrolled in a year-long DBT program

with a diagnosis of BPD and a history of self-injury. Therapist and client relationship ratings and client self-injury behaviors were assessed weekly for a seven month period. High ratings of both therapist instruction (similar to DBT change strategies) and the therapist treating the client as autonomous (similar to DBT validation strategies) within a treatment session were associated with a decrease in suicidal behaviors over the following week. Based on these results, researchers concluded that the therapist's dialectical focus on both acceptance and change strategies in an individual treatment session were more effective than change strategies alone or acceptance strategies alone.

In another study, DBT was compared to comprehensive validation treatment and a twelve step program (CVT+12S) for women diagnosed with BPD and opiate dependence (Linehan et al., 2002). In the CVT+12S condition, clients received all acceptance-based strategies typically used in DBT, including validation, reciprocal communication, and case management, without any of the problem-solving or change strategies. This study found that DBT and CVT+12S were both effective in reducing and maintaining the reduction of opiate use in the first four months of treatment. However, those in CVT+12S increased opiate use significantly during the last four months of treatment while those in the DBT condition did not. This suggests that while validation may be effective for a short period of time, change strategies are necessary to create a more lasting change in the client's behavior. Validation in this study, while not effective for causing a lasting change in behavior, was still associated with a short term decrease in opiate use.

A third study, concerning the use of validation on emotional reactivity, by Shenk and Fruzzetti (2011), examined the use of validating versus invalidating responses, modeled after DBT levels of validation, to a sample of undergraduate students after the

students expressed an emotional reaction to a mental arithmetic task. This laboratory study found that students who received invalidating responses experienced higher levels of negative affect and heart rate when compared to students who received validating responses. While these studies have all suggested the positive impact of validation on treatment outcomes and emotional regulation, no studies have examined the six DBT VLs and their potential differential effects.

One major factor limiting research regarding the impact of the different VLs is the lack of measures designed to assess for the presence of these therapeutic strategies. The study conducted by Shearin and Linehan (1992) operationalized validation and invalidation using a Structural Analysis of Social Behavior (SASB) INTREX, which is a measure used for classifying interpersonal behavior (Benjamin, 1974). While the SASB does measure behaviors such as “affirmation and understanding,” this measure is limited in its ability to code for the specific validation strategies as defined by Linehan. In response to the lack of adequate measures to code for DBT validation, Fruzzetti (2001) developed a measure, the Validating and Invalidating Behaviors Coding Scale (VIBCS). This measure is designed to code for validating and invalidating responses between dyads. This scale includes a Likert-based scale ranging from 1 to 7 that codes for both validation and invalidation, with higher ratings indicative of a more validating or invalidating response. The study by Shenk and Fruzzetti (2011) used the VIBCS to code for and operationalize the validating and invalidating responses made to the participants. While this scale is the first published scale that also demonstrated good inter-rater reliability designed to code for overall validation and invalidation, this scale is limited in that it does not code for the use of the six specific DBT VLs.

It is with these existing limitations in mind that the DBT-Validation Level Coding Scale (DBT-VLCS) was developed. Following an iterative process of development, the final measure consists of seven items, six items that code for the presence of each of the individual VLs as well as one item designed to code for the perceived client response to therapist use of validation. To use this measure, raters are instructed to observe an individual DBT therapy session in its entirety (approximately 60 minutes) and code for the presence of each level, using a 0-3 Likert-based scale (see Appendix for complete measure).

The purpose of the two studies described below was to begin to assess the psychometric properties of the DBT-VLCS. In the first study, inter-rater reliability was examined. In order to do so, raters were trained to use the DBT-VLCS and independently coded therapy sessions. The second study examined the scale's validity. As there are no alternative measures designed to code for VLs, this study examined content validity only. Experts in the field of DBT were surveyed to determine the degree to which they either agreed or disagreed with the items in the DBT-VLCS. A reliable and valid instrument designed to code for the individual VLs in DBT would open the opportunity for research on validation that has not previously been possible, including how to increase the effectiveness of DBT for clients with significant emotional dysregulation through the strategic use of therapeutic strategies.

II. Study 1

Method

Client participants

Participants were drawn from clients who enrolled in the Dialectical Behavior Therapy program at Rutgers University (DBT-RU) between September 2010 and February 2012. The inclusion criteria for participation in DBT-RU were: a DSM-IV-TR diagnosis of BPD (First, Gibbon, Spitzer, Williams & Benjamin, 1997), age 18 years or older, agreement to take part in assessments, videotaping/audiotaping and coding of their sessions by a research team, and an agreement to discontinue all other forms of psychotherapy. Exclusion criteria were: mental health problems that required services that could not be provided by the DBT-RU (e.g., schizophrenia, life-threatening anorexia), non-English speaking, an indication that the client had an IQ of 70 or below, and inability to understand or sign the research consent forms. Eligibility for DBT-RU was determined through an intake assessment that was conducted by clinical psychology doctoral students. Once a client was considered eligible for treatment, he or she was assigned to a graduate student therapist and received six months of standard DBT which included weekly individual therapy, a weekly skills group, and phone coaching as needed. Both the individual therapy sessions and weekly skills group were videotaped for purposes of supervision, training, and adherence coding.

Participants included 15 adults (M_{age}= 33.2, *SD*=13.06) with a diagnosis of BPD. Eleven (73.3%) were female; 10 (66.7%) were Caucasian, 1 (6.67%) was Hispanic, 2 (13.3%) were Asian, and 2 (13.3%) were other ethnicities. Two (13.3%) participants maintained full-time employment, 2 (13.3%) maintained part-time employment, 2

(13.3%) were students, and 9 (60%) were unemployed. At the time of intake, 10 (66.7%) met criteria for comorbid major depressive disorder, 1 (6.67%) met criteria for bipolar disorder, 3 (20.0 %) met criteria for dysthymia, 10 (66.7%) met criteria for an anxiety disorder (i.e., generalized anxiety disorder, post-traumatic stress disorder, specific phobia, social phobia, panic disorder and anxiety disorder not otherwise specified), 3 (20.0%) met criteria for alcohol dependence, 2 (13.3%), met criteria for alcohol abuse, and 4 (26.7%) met criteria for substance dependence. The study was approved by the Rutgers Institutional Review Board and all participants provided written informed consent.

Independent Raters

The raters in this study consisted of six graduate students in clinical psychology and two undergraduate students majoring in psychology (M_{age}= 25.25, *SD*= 3.33). Six (75.0%) were female; 4 (50.0%) were Caucasian, 2 (25.0%) were Hispanic, 1 (12.5%) was Asian, and 1 (12.5%) was other ethnicity. Each rater received six months of training, including didactic instructions about the theory of DBT and levels of validation in the acceptance strategies utilized throughout treatment, online training in validation provided by Behavioral Tech, LLC, and instruction on the DBT-VLCS. In addition, five of the graduate student participants attended a DBT intensive training and had clinical experience.

Development of the DBT-VLCS

The DBT-Validation Level Coding Scale (DBT-VLCS) measure (see Appendix) is a seven item measure developed to code for DBT validation strategies used in individual treatment sessions. This measure was designed based on the description of VLs by Linehan (Linehan 1993; Linehan 1997) and was developed in three stages.

In the first stage, anchors were developed for each VL using a 3-point Likert based scale ranging from 0 to 2 (0 indicating no use of the level to 2 indicating use of the level throughout the session). The measure also included a rating for client response to the therapist use of validation on a 3-point scale that ranged from 0 to 2. Raters independently watched three treatment session videos and coded the video using the measure. Raters met weekly and any discrepancies between ratings were discussed. During this stage, feedback and observations provided by the raters were taken into account to refine the items.

In the second stage, the scale range was increased to a Likert-based scale ranging from 0 to 3 (0 indicating no use of the level to 3 indicating frequent use of level throughout the session) in order to more accurately measure the range in use of VLs within sessions. In addition, for VL 2 through 5, anchors were modified to account for the number of times each VL was used in the session. For example, five or more instances of VL 2 (i.e., statements made by the therapist in which the therapist communicates to the client that he or she understands the client by reflecting back, using words similar to what the client has used, what the client has just stated) were necessary for the video to receive a rating of 3. After training each rater on the new version of the measure, raters independently watched four video sessions. Ratings for each of these videos were discussed during the weekly meetings. Raters achieved excellent overall inter-rater

reliability on this measure from the second stage (ICC = .83). Feedback and observations provided by the raters and analysis of inter-rater reliability were taken into account and the DBT-VLCS was modified to its current form.

In the third and final stage, the anchors were modified and based on rater judgment for the presence of each level (e.g., few instances, several instances, or frequent instances) rather than counting the instances of each level during the treatment session. Following this change, raters were trained on the new and final version of the DBT-VLCS.

Procedure

To test of the reliability of the final version of DBT-VLCS, 20 therapy sessions were randomly selected from participants who enrolled in the DBT-RU between September 2010 and February 2012. Each video was watched in its entirety (approximately 60 minutes) and coded independently by the eight trained raters. Raters were instructed to not discuss their independent ratings with each other.

Statistical Analysis

Inter-rater reliability was determined for the DBT-VLCS using a two-way mixed Intraclass Correlation Coefficient (ICC; Shrout & Fleiss, 1979) and based on the coding of full individual treatment session videotapes. ICCs give a ratio of the true score variance to the total variance, providing a reliability estimate for the mean scores. ICCs were analyzed for the overall measure as well as each individual item in the measure. ICCs for the overall measure and individual items were analyzed for the eight raters as

well as for the more clinically experienced five raters in order to determine if clinical experience is necessary to reliably code for the presence of validation levels. An ICC value of .40-.59 was considered fair, .60-.74 was considered good, and .75-1.00 was considered excellent (Cicchetti & Sparrow, 1981).

Results

For the eight raters, the complete measure achieved excellent inter-rater reliability (ICC=.905). Inter-rater reliability was excellent for the measure item coding VL 1 (ICC=.771, *M*=2.43, *SD*=.62; range= 0-3), VL 4 (ICC=.914, *M*=.75, *SD*=.74; range= 0-3), VL 5 (ICC=.836, *M*=1.06, *SD*=.91; range= 0-3), and VL 6 (ICC=.831, *M*=1.99, *SD*=.69; range= 0-3). In addition, the item coding perceived client response to therapist validation had excellent reliability (ICC=.900, *M*=2.06, *SD*=.77; range= 0-3). The items coding VL 2 and VL 3 achieved good inter-rater reliability (ICC=.738, *M*=2.33, *SD*=.76; range= 1-3 and ICC=.623, *M*=1.97, *SD*=.86; range= 0-3, respectively).

Inter-rater reliability for the five more clinically experienced raters achieved similar results. Using the scores from just these raters, the overall measure had excellent inter-rater reliability (ICC=.900). Inter-rater reliability was excellent for the measure items coding validation VL 1 (ICC=.779, *M*=2.46, *SD*=.62; range= 0-3), VL 4 (ICC=.896, *M*=.68, *SD*=.69; range= 0-3), VL 5 (ICC=.824, *M*=.91, *SD*=.87; range= 0-3), and VL 6 (ICC=.777, *M*=1.95, *SD*=.67; range= 1-3). The item coding perceived client response to therapist validation also had excellent reliability (ICC=.893, *M*=2.07, *SD*=.77; range= 0-3). The measure item coding validation VL 2 achieved good inter-rater reliability (ICC=.708, *M*=2.36, *SD*=.74; range= 1-3) and the item coding VL 3 achieved fair inter-rater reliability (ICC=.534, *M*=2.10, *SD*=.85; range= 0-3)

III. Study 2

Method

Participants

The participants in this study were 61 expert DBT clinicians who were identified through the list of trainers and consultants at several DBT training companies, including Behavioral Tech, Evidence Based Practice Institute, and Treatment Implementation Collaborative. These participants were chosen due to their experience and presumed understanding of specific DBT strategies.

Of the 61 participants contacted, 46 agreed to participate in the study as evidenced by providing their informed assessment prior to initiating the online survey. Of these 46, 37 participants began the survey and 34 completed the survey. All data gathered, even if a participant did not complete the entire survey, was included in the analysis. Since demographics were collected at the end of the survey, only demographic information for the 34 completers is included. Of these 34 participants (M_{age}= 47.13, *SD*=9.13), 19 (56%) were female; 28 (82%) had a Doctorate degree (Ph.D., Psy.D, MD); 3 (8%) had a degree in social work (MSW, LSW); 2 (6%) had a Masters degree (MA, MS); and 1 (3%) had a Bachelors degree. The mean number of years since the participants received initial training in DBT was 15.94 (*SD*=5.04) and the mean number of years participants were engaged in teaching DBT to other clinicians was 12.62 (*SD*=6.14). The study was approved by the Rutgers Institutional Review Board and all participants provided informed assent.

Procedure

Potential participants received an e-mail requesting their participation in a brief online survey. The participants were informed of the purpose of the study and that their participation was voluntary. The survey could be accessed through a URL included as a hotlink within the email. Once the participant clicked the link, the participant was given access to the online survey and a statement of assent preceded the survey questions. The survey contained six questions asking the participant how much they agreed that the measure items captured their understanding of the VLs and one question asking the participant how much they agreed that question concerning perceived client validation captured the range of possible perceived client response. Participants were asked to indicate their agreement with each item using a 5-item Likert based scale with response options ranging from strongly disagree to strongly agree. The survey took approximately ten to fifteen minutes to complete. All data was collected through the online survey provider, Qualtrics, and the data was recorded in a manner in which the participants could not be identified and the data could not be connected to specific participants (Qualtrics, 2013).

Results

The purpose of this study was to examine the content validity, or the extent to which the DBT-VLCS captures the essence of the VLs, as defined by Linehan. For the purpose of this study, more than75% participant agreement on an item (a response of either "agree" or "strongly agree") was considered to demonstrate good content validity. The descriptive statistics of participant responses to the individual items on the DBT-VLCS are displayed in Table 1. Using our metric, the measure appears to have good content validity. Validity was good for the measure items coding VL 1 (92% agreement by experts); VL 2 (92% agreement by experts); VL 3 (81% agreement by experts); VL 4 (79% agreement by experts); and VL 6 (76% agreement by experts). In addition, the item measuring perceived client response to therapist validation also had good content validity (85% agreement by experts). The item coding VL 5 did not achieve good content validity (64% agreement by experts).

IV. Discussion

The two studies presented here provide preliminary evidence that the DBT-VLCS is a psychometrically sound measure that may be used to code the presence or absence of therapist use of validation within an individual DBT treatment session. This measure is the first measure to attempt to code for the six individual VLs, as defined by Linehan (1997), and perceived client response to the therapists' use of validation. With some exceptions, the items coding for individual VLs on the DBT-VLCS show good inter-rater reliability and content validity, suggesting that this measure is a good first step at attempting to code for the specific therapeutic validation strategies.

It is important to note that the overall inter-rater reliability for the measure was considered excellent for both the groups of eight and five raters. The eight raters included three clinically inexperienced raters as well as the five more clinically experienced raters. The lack of difference in reliability between the group of only clinically experienced raters versus the group of clinically experienced and inexperienced raters, highlights the potential broad usability of this measure. The standard training received by each rater, six months of training which included didactic instructions about the theory of DBT and the VLs in the acceptance strategies, online training in validation, and overall instruction on the DBT-VLCS, was shown to be sufficient in training a rater to reliably identify the VLs in a treatment session. Additional clinical experience did not appear to increase rater reliability. In fact, additional clinical experience may actually detract from a rater's ability to identify specific validation strategies, as suggested by the consistently lower ICC values of the five raters compared to the group of eight raters. However, more assessment is needed to confirm this trend. These results suggest that this measure has

broad usability in a wide range of research settings. Researchers interested in studying the relationship between therapist use of validation within a treatment session and a particular treatment outcome may now have an appropriate measurement tool to consistently measure the presence of these VLs that does not require raters with a high level of clinical experience. As with any coding scheme, coding for the presence of therapeutic techniques within a treatment session is costly and time consuming. By being able to use adequately trained research assistants, rather than clinically experienced raters, researchers are able to avoid using clinicians whose abilities and time may be more useful elsewhere (e.g., treating clients). This allows for wider use of this measure in a variety of research contexts for researchers interested in studying validation.

While the measure showed excellent overall inter-rater reliability, the importance of this new measure comes from the fact that it is the first measure to attempt to code for the presence of each of the individual VLs. Raters achieved excellent reliability when coding items VL 1 (i.e., therapist listening with full awareness), VL 4 (i.e., "communication from the therapist that all behaviors are caused by certain events, including past learning or biological dysfunction"), VL 5 (i.e., "communication from the therapist that all behavior is justifiable, reasonable, or meaningful in terms of the present context and normative biological functioning"), and VL 6 (i.e., therapist displays radical genuineness). In addition, raters reliably coded the perceived client response to therapist use of validation. It is significant that all raters were able to produce excellent inter-rater reliability for five of the seven items on the DBT-VLCS. It is possible that these particular items on the measure were phrased in a way that gave clear behavioral definitions that increased reliability. For example, VL 1 gave explicit examples of how a

therapist may appear distracted (e.g., looking at papers or the clock, asking the client to repeat him/herself) or engaged in the session (e.g., therapist makes eye contact, therapist makes connections between the client's current situation and past conversations the therapist and client have had). In addition, it is also possible that these particular items are easy to differentiate from one another, making the coding of these items more clear. For example, the wording for a therapist using VL 4 will be clearly different from a VL 5. In VL 4, the therapist uses statements such as "based on your history/biology, it makes sense you felt those emotions" while VL 5 uses statements such as "anyone in that situation would have felt that those emotions." Determining what behaviors capture the essence of the level as defined by Linehan was the most significant factor in developing these items on the DBT-VLCS. Once this definition was developed, training of the raters to identify these behaviors was achieved by observing portions of the treatment session together and discussing the presence of the therapist behaviors within the video segment.

Despite the high inter-rater reliability for five of the seven items, raters were only able to independently code therapist use of VL 2 or VL 3 to a fair or good level of reliability. It is notable that reliability for VL 2 and 3 is lower than VL 1, VL 4, VL 5, and VL 6. Though the definition may be clear for VL 2 (i.e., "accurate reflection of the client's feelings, thoughts, and assumptions") and VL 3 (i.e., "communication to the client that the therapist understands the client's experience and the client's emotions, thoughts and behaviors in response to the event that have not been verbalized"), it is likely that the appearance of these validating statements within an treatment session may differ and may be difficult to determine due to therapeutic style as well as rater perception. In addition, in both VL 2 and VL 3, minor changes in wording change

whether or not the therapist statement is considered a specific validation strategy. The difference between a VL 2 and a VL 3 is if the therapist is simply repeating back a statement made by the client or if the therapist is repeating back a statement while adding on an unverbalized thought, feeling, or behavior. It is the job of the rater to determine if the different word choice made by the therapist is simply an accurate reflection or if the word choice implies something that has not been verbalized by the client. For example, if the therapist and client are discussing the client's fears about the end of treatment and the client states "you know things will not go well after our last appointment," the therapist has a variety of responses that he or she can make. The therapist may state "you know, I'm hearing that you are really worried about what will happen when we end." The rater must then decide if the word "worried" was implied by the client and thus just reiterated by the therapist (VL 2) or if this is now an interpretation and something that has not been verbalized (VL 3). Here, rater perception may play a large role in how the rater codes the statement. The lower level of inter-rater reliability for VL 2 and VL 3 suggest that coding for VL 2 and VL 3 is an area that that needs to be addressed in further measure development in order to enhance the psychometric properties of the DBT-VLCS further.

A separate aim of the study was to determine the content validity of the measure. In order to do so, 61 experts in the DBT community were polled. Of these 61, 34 completed the study (a 56% response rate). For the purpose of this study, good content validity was defined as greater than 75% agreement. Based on expert responses, the DBT-VLCS demonstrated good overall content validity. The definition and the anchors coding for VL 1, VL 2, VL 3, VL 4, VL 6, and the item coding for perceived client response to therapist use of validation also exhibited good content validity. It is

significant that six of the seven items on the DBT-VLCS demonstrated content validity. In defining each VL, Linehan is clear in explaining the essence of each level. Each level in the DBT-VLCS was created through careful reading of the definitions given by Linehan and watching of several therapy sessions to observe what therapist behaviors may and may not be considered validation. Through this information, behavioral definitions for each level were created. The fact that six of the seven items in the DBT-VLCS demonstrate content validity, show that it is possible to capture the essence of a VL using a behavioral definition.

However, one item, VL 5, did not meet our definition of good content validity. In VL 5, the therapist makes a statement that normalizes the client's behavior and clarifies how the client's behaviors, thoughts, or emotions make sense given the current situation. For this item, 64% of experts agreed, 21% neither agreed nor disagreed, and 15% disagreed with the definition and anchors. It is important to note that despite not meeting our criterion for good content validity, nearly two-thirds of the polled experts still agreed with the definition. Despite this, unsolicited commentary from experts regarding individual items on the DBT-VLCS suggest that the greatest disagreements experts had in regards to items in the measure were not with item definitions, but with the anchors offered in the measure. This may be of particular concern for the anchors provided for VL 5. The essence of VL 5 is to normalize the client's thoughts, emotions, or behaviors. For this item, it is clinically important that the therapist validate the valid and not validate the invalid. For example, during the therapy session the client tells the therapist about becoming so sad and anxious after dropping his daughter off at school for the first time that the client went home and cut his wrist. After disclosing this information, the therapist

may validate the sadness and anxiety (emotion) but it is important that the therapist not validate the cutting (behavior). The therapist must be careful to only validate what is "normal," understandable, and effective, and not validate the ineffective response. For this reason, it is possible that the experts expressed disagreement with this item because the item focused solely on validation. For example, anchor "0" states "the therapist does not use this level OR throughout the treatment session the therapist implies or states what the client does is not normal." However, there may be instances in which it is clinically indicated to state that the client's behavior is not normal (e.g., cutting in response to significant emotional dysregulation). One expert in particular suggested that the "0" anchor coding for VL 5 in a session be modified to state that "the therapist does not use this level OR throughout the treatment session the therapist implies or states what the client does is not normal --- when there is evidence that the client's behavior is actually normative" because it is important for a therapist to "say that a [client's] [thoughts, behaviors, or emotion] is not normative, when it in fact is not normative." Based on expert responses, it is clear that anchors for VL 5 need further clarification on future iterations.

While the DBT-VLCS was shown to have good psychometric properties, it is of interest to compare and contrast the results across both studies. Items such as VL 1, VL 4, VL 6, and the item coding for perceived client response to therapist use of validation show both good inter-rater reliability and content validity. However, VL 2 and VL 3 demonstrate good content validity but a lower level of inter-rater reliability. VL 5 shows excellent inter-rater reliability but lacks content validity. The discrepancy between reliability and validity on these items suggests possible differences between research and

clinical practice. While the definition for VL 2 and VL 3 is sound, the lower level of reliability highlights a potential difficulty for this item to be identified in clinical practice. The definition for these items captures the essence of the item as defined by Linehan, but this essence is hard to identify within a dialogue during an individual treatment session. Alternatively, VL 5 showed good inter-rater reliability yet did not display good content validity. In this instance, adequate training of the raters enables raters to reliably identify VL 5 as defined in the DBT-VLCS, but experts feel more clarification is necessary in order for this item to adequately capture the essence of VL 5 in clinical practice.

There are a few limitations that are important to note and should be addressed in future research on validation strategies in DBT. One limitation of this study is the range of experience of the raters. While the raters for this study included clinically experienced graduate students and clinically inexperienced undergraduate students, each rater was a student. Due to this, the number of years the clinically experienced graduate students have spent engaging in clinical work is minimal when compared to the number of years practicing clinicians have spent engaging in clinical work. Further research is needed to examine if the reliability results found with this study could be replicated with more clinically experienced individuals or with even less experienced individuals. This is an important factor in considering the generalizability of the results. The inter-rater reliability results from this study suggest that additional clinical experience may actually detract from a rater's ability to identify specific validation strategies. Gaining further information about this may significantly impact who may and may not be able to reliably code for individual validation strategies in a DBT session.

Another limitation to this study was the relatively few sessions recorded in order to determine the reliability for the DBT-VLCS. In determining inter-rater reliability, raters were instructed to observe and code twenty videotapes independently. It is possible that this small sample of independently coded videos decreases this studies external validity and that these results may not generalize to other samples. It is important that future studies replicate this study with a larger sample size and with different populations.

Another aspect of these studies that is important to consider is that this is the first measure to attempt to code for individual levels of validation within a treatment session. While this is not a limitation, the lack of alternate forms for coding VLs meant that we were not able to assess other aspects of validity, such as convergent validity. However, we attempted to mitigate this lack of alternative measures by contacting experts within the field. In addition, it is important to highlight that the main purpose for this study was to determine if it is possible to create a measure that captures the essence of the levels as defined by Linehan. Validation is an aspect of DBT that is clinically significant but has large gaps in research in this area. For this reason, this measure is a good first step at attempting to fill the gaps in this area, but future research is to further assess the validity of the DBT-VLCS.

Despite these limitations, the DBT-VLCS appears to be a reliable and valid measure to code the presence of therapist use of validation within an individual DBT treatment session. Further research is needed to refine the items to increase reliability on VL 2 and VL 3, and further clarification may be necessary to increase expert agreement. However, the overall good reliability and validity of this initial measure opens up the possibility of a large body of research that has not been possible previously, such as

examining the relationship between therapist use of validation and change in client emotion throughout a session. Clinical observation has suggested such a relationship, but without a measurement tool, statistically examining this relationship has not previously been possible.

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Table 1

Descriptive statistics of participant agreement with individual items on the DBT-VLCS

		n	%	M	SD
Validation Level 1 (n=37)				4.14	.82
	Strongly Disagree	1	3		
	Disagree	1	3		
	Neither Disagree or Agree	1	3		
	Agree	23	62		
	Strongly Agree	11	30		
Validation Level 2 (n=37)				4.30	.70
	Strongly Disagree	0	0		
	Disagree	1	3		
	Neither Disagree or Agree	2	5		
	Agree	19	51		
	Strongly Agree	15	41		
Validation Level 3 (n=37)				4.05	.94
	Strongly Disagree	0	0		
	Disagree	4	11		
	Neither Disagree or Agree	3	8		
	Agree	17	46		
	Strongly Agree	13	35		
Validation Level 4 (n=34)				4.06	.85
	Strongly Disagree	0	0		
	Disagree	2	6		
	Neither Disagree or Agree	5	15		
	Agree	16	47		
	Strongly Agree	11	32		
Validation Level 5 (n=34)				3.74	1.08
	Strongly Disagree	1	3		
	Disagree	4	12		
	Neither Disagree or Agree	7	21		
	Agree	13	38		
	Strongly Agree	9	26		

Validation Level 6 (n=34)				4.12	.84
	Strongly Disagree	0	0		
	Disagree	1	3		
	Neither Disagree or Agree	7	21		
	Agree	13	38		
	Strongly Agree	13	38		
Perceive Client Response (n=34)				4.21	.77
	Strongly Disagree	0	0		
	Disagree	1	3		
	Neither Disagree or Agree	4	12		
	Agree	16	47		
	Strongly Agree	13	38		

Appendix

Dialectical Behavior Therapy- Validation Level Coding Scale (DBT-VLCS)

Therapist use of validation levels (code based on therapist behavior):

Level 1: listening to and observing the client's statements, feelings, and behaviors, as well as demonstrating an active effort to understand the client	
0	Throughout the session the therapist does not appear to be fully engaged with the client (ex. therapist asks the client to repeat his/herself multiple times, does not answer the client's question, or appears to misunderstand the client), therapist repeatedly does not make eye contact with the client and instead appears frequently distracted (ex. looks at papers or the clock). If therapist is not clear on the video, code based on verbal cues given by therapist (ex. "can you say that again?").
1	Throughout the session, the therapist appears to be engaged with the client, but there are a few instances that the therapist appears to be inattentive, and the rater feels that these instances are significant (ex. therapist appears to be significantly distracted for a moment) OR the therapist behaves in a way throughout the session that is inconsistent with the therapist alternating between being inattentive and fully engaging with the client.
2	Throughout the session the therapist appears to be engaged with the client, but there are there are a few instances that the therapist appears to be inattentive, and the rater feels that these instances are minor (ex. therapist forgets a statement made by the client earlier in the session, the therapist appears to miss what the client has stated).
3	Throughout the session the therapist appears to be fully engaged with the client (ex. therapist did not ask client to repeat his/herself and correctly responds to a client's comments or question) and is not inattentive at any point. The therapist responds verbally to the client indicating that they are following the client's statements (ex. "hmmmm", "What happened next?", "ok"), therapist makes connections between the client's current situation and past conversations the therapist and client have had. The therapist is nonverbally engaged with the client (ex. therapist makes eye contact with the client, affirmative head nods).

2) Level 2: accurate reflection of the client's feelings, thoughts, and assumptions	
0	The therapist does not use this level OR each time the therapist attempts this level, the rater thinks the therapist is incorrect (ex. the therapist parrots back to the client exactly what the client has just stated, the therapist inaccurately summarizes the clients statements or behavior).
1	Throughout the treatment session there are a few instances in which the therapist reflects back the client's thoughts, feelings, or behaviors in a way that does not add interpretations OR throughout the treatment session the therapist attempts this level several times and the rater believes some instances are correct but there are a many instances in which the rater thinks the therapist is incorrect.

2	Throughout the treatment session there are several instances in which the therapist reflects back the client's thoughts, feelings, or behaviors in a way that does not add interpretations OR the therapist attempts this level several times, but there are a few instances in which the rater thinks the therapist is incorrect.
3	Throughout the treatment session there are frequent instances in which the therapist reflects back the client's thoughts, feelings, or behaviors in a way that does not add interpretations. The reflection adds a sense of organization to what the client says or is feeling. Therapist labels the client's thoughts, feelings or behavior (ex. client states "I am such a horrible person for feeling this way" the therapist responds "so, you are having judgments about yourself") in a way that the rater thinks is correct.

3) Level 3: communication to the client that the therapist understands the client's experience and the client's emotions, thoughts and behaviors in response to the event that have not been verbalized	
0	The therapist does not use this level OR each time the therapist attempts this level, the rater thinks the therapist is incorrect (ex. the therapist incorrectly interprets the clients verbal or non-verbal cues).
1	Throughout the treatment session there are a few instances in which the therapist accurately articulates the client's unspoken thoughts, feelings, or behaviors OR throughout the treatment session the therapist attempts this level several times and the rater thinks some instances are correct, but there are many instances in which the rater thinks the therapist is incorrect.
2	Throughout the treatment session there are several instances in which the therapist accurately articulates the client's unspoken thoughts, feelings, or behaviors OR the therapist attempts this level several times and there are few instances in which the rater thinks the therapist is incorrect.
3	Throughout the treatment session there are frequent instances in which the therapist accurately articulates the client's unspoken thoughts, feelings, or behaviors (ex. if the client begins to cry in a session, the therapist responds in a way that verbalizes what the client has not verbalized, such as "so, it seems that seeing your ex with a new girlfriend led you to feel lonely and hopeless") in a way that the rater thinks is correct.

4) Level 4: communication from the therapist that all behaviors are caused by certain events, including past learning or biological dysfunction	
0	The therapist does not use this level OR throughout the treatment session the therapist implies that the problem the client is experiencing is a result of him/her not trying hard enough or pathologizes client's biology or disorder.
1	Throughout the treatment session the therapist attempts this level a few times OR the therapist attempts this level several times and rater believes some instances are correct but a majority of attempts are incorrect.

2	Throughout the treatment session there are several instances in which the therapist states that the client's thoughts, feelings, or behaviors are understandable based on the client's learning history, biology, or disorder OR the therapist attempts this level several times and there are few instances in which the therapist implies that the problem the client is experiencing is a result of him/her not trying hard enough.
3	Throughout the treatment session there are frequent instances in which the therapist states that the client's thoughts, feelings, or behaviors could not have been otherwise and are understandable based on the client's learning history, biology, or disorder AND there are no instances in which the therapist implies that the problem the client is experiencing is a result of him/her not trying hard enough.

5) Level 5: communication from the therapist that all behavior is justifiable, reasonable, or meaningful in terms of the present context and normative biological functioning.	
0	The therapist does not use this level OR throughout the treatment session the therapist implies or states what the client does is not normal.
1	Throughout the treatment session the therapist attempts this level a few times OR the therapist attempts this level several times and rater believes some instances are correct but a majority of attempts are incorrect.
2	Throughout the treatment session there are several instances in which the therapist behaves in a way that communicates to the client how the client's thoughts, feelings, or behaviors make sense, are justifiable, and reasonable in terms of the current context, normative biological functioning OR the therapist attempts this level several times and there are few instances in which the therapist implies or states what the client does is not normal.
3	Throughout the treatment session there are frequent instances in which the therapist communicates to the client how the client's thoughts, feelings, or behaviors make sense, are justifiable, and are reasonable in terms of the current context, normative biological functioning, and behaviors are directed towards achieving the client's goals (ex. "anyone in your position would feel that way", "it makes sense").

6) Level 6: therapist sees and responds to the strengths and capacity of the client while maintaining a firm empathic understanding of the client as he/she is.	
0	Throughout the session, there are instances in which the therapist treats the client as fragile and the rater feels that these instances are significant (ex. therapist does not address a problem that may significantly impact the client). The therapist over-apologizes or treats the client as if they are incapable.
1	The therapist maintains the inherent therapist-client hierarchy in the session and does nothing to break the status quo.

2	Throughout the session, there are a few instances in which the therapist goes beyond the therapist-client hierarchy and the therapist responds to the client in a genuine manner or in a way one would expect the therapist to talk to a friend/peer/equal (ex. the therapist uses appropriate self-disclosure, humor, natural reactions). The rater feels that these instances are minor.
3	Generally, throughout the session the therapist responds to the client in a genuine manner or in a way one would expect the therapist to talk to a friend/peer/equal (ex. the therapist uses appropriate self-disclosure, humor, natural reactions). The rater feels that these instances are significant. There are no instances in which the therapist treats the client as fragile. The therapist specifically validates the client as an individual rather than validating just the behavior. The therapist does not treat the client as a person with a disorder.

Client response in session (code based on client behavior):

7) How validated did the client appear in session?	
0	The client frequently denies statements made by the therapist verbally (ex. “you’re wrong”, “that’s not right”, “you’re not understanding what I’m saying”) and/or nonverbally (ex. shaking his/her head no, increase in agitation).
1	Client neither confirms nor denies validation statements made by the therapist OR the therapist uses several validation strategies in session, but the client responds positively to some and negatively to other statements. In general, client responds more negatively than positively (behaviors noted in 0)
2	Therapist uses several validation strategies in session, but the client responds both positively to some and negatively to other statements. In general, client responds more positively than negatively (behaviors noted in 3)
3	Client frequently confirms validation strategies made by therapist verbally (ex. “yea, you’re right”, “that was tough for me”), nonverbally (ex. nodding his/her head yes), or displays a decrease in emotional dysregulation (ex. becoming visibly less agitated, decrease in tone of voice).

DBT-VLCS Score Sheet

Therapist use of validation levels
Level 1 Score: ____
Level 2 Score: ____
Level 3 Score: ____
Level 4 Score: ____
Level 5 Score: ____
Level 6 Score: ____
Total Validation Score: ____
Client response in session
Question 7: ____