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THE ROLE OF VALIDATION IN PSYCHOTHERAPY OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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Summary

The article presents the importance of validation in the psychotherapy of patients with borderline personality disorder (BPD). The author emphasizes the specific epistemic position in which the psychotherapist, adopting an open, dialectical stance toward multiple perspectives, combines an understanding of the biological and psychosocial factors influencing the patient's functioning with respect for the subjective dimension of their experiences. This is a crucial condition for the effectiveness of validation. Validation is presented as a therapeutic strategy applicable regardless of the psychotherapeutic modality used; it supports the establishment of a therapeutic alliance, facilitates emotion regulation, and creates a relational space that allows reflection and self-discovery. The paper cites experimental research findings indicating a significant effect of invalidation on the level of physiological arousal and on participants' self-reported negative affect, which further highlights the importance of validation in the therapeutic process. It is also emphasized that the effectiveness of validation ultimately depends on whether the patient truly feels understood and supported by the therapist. In conclusion, the author points to the need for further research into the mechanisms and long-term effectiveness of this strategy in psychotherapy.

Introduction

Conducting psychotherapy with patients diagnosed with Borderline Personality Disorder (BPD) is particularly challenging due to the complex and multidimensional nature of their difficulties in the areas of emotional regulation, interpersonal relationships, and motivation to engage in and sustain therapeutic efforts. Their emotional functioning is characterized by instability, high intensity of affect, and a particular sensitivity to stimuli that trigger emotional reactions. The establishment of a therapeutic relationship based on mutual trust and collaboration is hindered, among other factors, by intense transference phenomena,

rapidly shifting perceptions of the therapist (ranging from idealization to devaluation), and the clinician's fear of patient's potential self-destructive acting-out behaviors. An additional challenge is the ambiguous and fluctuating motivation for therapy: patients with BPD, on the one hand, seek relief from suffering and understanding of their experiences, while on the other hand, may quickly withdraw from the therapeutic process, question its value, or challenge the competence and professionalism of the therapist. Given the differing conceptualizations of BPD across therapeutic approaches, it is important to emphasize that the clinical picture presented here aligns with currently accepted diagnostic criteria. The content of this article thus refers to those understandings of BPD that are consistent with the DSM-5 [1] and ICD-10 [2].

The specific characteristics of patients with BPD require the therapist to develop a therapeutic repertoire tailored to the complexity of this clinical presentation. In doing so, the therapist can draw upon the achievements of various clinician-researchers, as recent decades have seen significant advancements in the psychotherapy of this patient group. Several therapeutic approaches have been developed specifically to address the multifaceted difficulties experienced by individuals with BPD. Among empirically validated treatment methods are Dialectical Behavior Therapy (DBT) [3, 4], Mentalization-Based Treatment (MBT) [5, 6], Transference-Focused Psychotherapy (TFP) [7], Schema-Focused Therapy (SFT) [8, 9], Cognitive Behavior Therapy (CBT) [10, 11], as well as approaches not yet widely implemented in Poland, such as Good Psychiatric Management (GPM) [12] and Systems Training for Emotional Predictability and Problem Solving (STEPPS) [13]. Each of these approaches is grounded in a theoretical model that serves as a framework for understanding the patient's observed difficulties. Despite their diversity, these therapeutic modalities share more similarities than differences. Common features include clearly defined and structured treatment frameworks, increased therapist activity, therapeutic interventions focused on the therapeutic relationship, and interventions aimed at emotional processing [14].

One of the therapeutic interventions that, to varying degrees and in different forms, characterizes the majority of psychotherapy approaches is validation. It has played a role in numerous modalities, including client-centered therapy [15], existential therapy [16], CBT [17], behavioral therapy [18], MBT [6], and DBT [3, 4]. It is within the framework of DBT that validation has been particularly emphasized and operationalized — a fact that forms the foundation of this paper, which draws primarily on the concepts and clinical experience derived from DBT practice. At the same time, validation remains a universal therapeutic skill that enriches the clinician's work across all modalities — from cognitive-behavioral and psychodynamic therapy to systemic and humanistic approaches.

Validation — toward a definition

Validation is a term popularized in the field of psychotherapy by Marsha Linehan, the creator of DBT, who describes validation in the following way: "The essence of validation is this: The therapist communicates to the patient that her responses make sense and are

understandable within her current life context or situation. The therapist actively accepts the patient and communicates this acceptance to the patient. The therapist takes the patient's responses seriously and does not discount or trivialize them. Validation strategies require the therapist to search for, recognize, and reflect to the patient the validity inherent in her responses to events. With unruly children, parents have to catch them while they're good in order to reinforce their behavior; similarly, the therapist has to uncover the validity within the patient's response, sometimes amplify it, and then reinforce it." [3, p. 222].

In another context, Linehan defines validation as a set of acceptance strategies and identifies six levels of validation: (1) listening and observing, (2) accurate reflection, (3) articulating what is unspoken, (4) validating in terms of (not necessarily valid) causes, (5) validating something as understandable in the present moment, and (6) radical genuineness [19]. In this framework, validation encompasses numerous forms of expressing acceptance and support — from compliments, maintaining eye contact, or touch (a discussion of the positions held by various therapeutic approaches regarding touch in psychotherapy exceeds the scope of this paper and leads to broader reflections on the boundaries and ethics of the psychotherapist's profession; an interesting example of a mindfulness exercise used in DBT, which the author learned during a DBT training workshop with Professor Alan Fruzzetti, is "E.T. mindfulness," named after the Steven Spielberg film, which involves the patient and therapist touching the tips of their index fingers and attentively observing the resulting sensory impressions), to all manifestations of empathy that can foster a sense of being understood, appreciated, or noticed. From this perspective, nearly any positive interaction may be perceived as validating.

Given such a broad definition, some authors propose narrowing it to the conscious, intentional, verbal or nonverbal communication to the patient that their way of thinking, feeling, or behaving is understandable in the context of their personal history and current situation — which corresponds to the fourth and fifth levels of validation as described by Linehan [20]. Limiting the definition of validation to the message "this makes sense" allows this technique to be distinguished as a specific clinical tool and facilitates both its systematic teaching and the reliable study of its effects in therapeutic practice [21].

Validation is a key component in building and maintaining a therapeutic relationship based on trust and a sense of safety. It effectively reduces the patient's emotional arousal, particularly in the face of feelings such as shame or fear [22]. With a validating therapist, the patient does not have to defend against criticism or attempt to "prove" the legitimacy of their experiences; instead, they receive understanding that supports their capacity for self-regulation. In cases of misunderstandings or disruptions in the therapeutic alliance, validation facilitates effective relationship repair.

It is important to distinguish that validation does not imply agreement with or approval of the patient's behaviors or beliefs. Rather, it signifies the recognition of the subjective importance and meaningfulness of their experiences in a given moment or life context. A therapist can fully validate a patient's emotions and thoughts while simultaneously making it clear that not all actions stemming from those emotions are appropriate or beneficial. Moreover, validation that is not complemented by strategies aimed at improving

the patient's life is, in itself, invalidating. Shireen L. Rizvi compares validation to lubricant that keeps the "change machine" running. Too little validation can cause the mechanism to stall, while too much can result in the gears slipping past one another [23].

A validation-promoting epistemic stance

Recognizing the patient's experiences as meaningful requires, on the one hand, adopting a deterministic perspective — one that assumes reality operates according to a cause-and-effect logic, where every state of affairs results from what preceded it. In practice, this means accepting that everything the patient experiences and describes — regardless of how bizarre, incomprehensible, or seemingly senseless it may appear — is, in some way, determined by underlying conditions.

A similar idea can be found in the Buddhist tradition, where it is referred to as "interdependent co-arising" (Sanskrit: *pratītyasamutpāda*). According to this doctrine, all phenomena arise and cease as a result of the interdependence of causes and conditions — they are mutually connected and inevitably emerge from preceding states [24]. The reference to Buddhism is not incidental, as Buddhist philosophy served as a significant inspiration for Linehan in formulating her dialectical view of psychotherapy. Nevertheless, a comparable perspective is present, to some extent, in most therapeutic approaches, beginning with Freud's psychoanalytic theories [25]. For example, Agnieszka Leźnicka-Łoś, in her textbook *Podstawy terapii psychoanalitycznej* (*Fundamentals of Psychoanalytic Therapy)*, writes about determinism as follows: "Determinism assumes that everything has a cause. If we apply this assumption to mental functioning, it means that nothing in our mind happens by accident. Every thought, fantasy, and action is a link in a chain of cause and effect. For instance, a dream that upon waking seems unrelated to our thoughts and feelings is, upon closer examination, rooted in our deeply hidden desires and the events of the previous day. The feeling of anxiety that accompanies us in the morning, seemingly without reason, also has a cause" [26, p. 16]. In the context of conceptualizing underlying conditions, differences between therapeutic schools are reflected in which aspect of a "preceding state of affairs" is understood to influence the "current state of affairs" — whether it is unconscious processes, systemic influences, learning processes, cognitive schemas, biological factors, or others — and in how freedom is conceived: as arising primarily from gaining insight into one's conditioning, or from learning new behaviors and thought patterns.

Patients with BPD often struggle to recognize and understand their own emotional states and to link them to specific triggering stimuli. The intensity and rapid fluctuation of these emotions can make it difficult for them to perceive or grasp clear cause-and-effect relationships. As a result, an overly deterministic perspective — one that emphasizes that "everything happens for a reason" — may be difficult for them to accept and may even feel invalidating, as it does not account for the chaos and subjectivity characteristic of their inner experience. When a therapist places too much emphasis on mechanistic explanations and causality, the patient may feel that their complex, often elusive emotional experiences

are being oversimplified or diminished. This, in turn, can heighten the sense of being misunderstood and may further strain the therapeutic relationship.

On the other hand, many contemporary therapeutic approaches — particularly those described as postmodern — tend to adopt a pluralistic, constructivist epistemic stance. For constructivist therapists, key principles include not-knowing, contextuality, and multiperspectivity. A significant contribution to the development of these perspectives was made by Harlene Anderson and Harry Goolishian, who placed not-knowing at the center of their therapeutic practice [27].

The stance of not-knowing and embracing multiple versions of reality, while often described as fostering openness and supporting the therapeutic relationship, may in certain situations be experienced by patients with BPD as invalidating. This is particularly true when there is a lack of appropriate sensitivity and attunement to the specific needs of this group. Not-knowing — which assumes that the therapist does not have all the answers — can be interpreted by patients as a sign of incompetence or lack of engagement, thereby intensifying their sense of chaos and fear. Such experiences may reinforce feelings of being misunderstood, which are particularly painful for individuals with BPD. These patients often struggle to construct a coherent narrative about themselves, and the emphasis on multiple versions of reality may feel disorienting and undermine their subjective experience. Due to their heightened sensitivity to signals of rejection and invalidation, a perspective that openly acknowledges diverse interpretations may, rather than alleviating distress, intensify emotional pain.

In reflecting on epistemic stance, it is valuable to consider the perspective emerging from the assumptions of Hegelian dialectical philosophy, which posits that reality evolves through the clash of opposites (thesis and antithesis), leading to the emergence of a synthesis — a "new state of affairs" that is qualitatively distinct from the preceding tensions [28, 29]. From this viewpoint, reality, although shaped by deterministic conditions, is in a constant state of flux and transformation, which ultimately makes it impossible to fully grasp it. The process of change is not a straightforward, linear chain of cause and effect, but rather a dynamic and unpredictable unfolding, in which new qualities emerge — highlighting the emergent nature of phenomena in the world around us.

In the face of such a complex, multidimensional, and elusive process of change, dialectical philosophy inspires psychotherapists to adopt a specific epistemic position — one that acknowledges the impossibility of fully understanding all the determinants shaping the patient's functioning. In the process of "seeking the truth," the goal is therefore not to exclude or reject any particular perspective, but rather to creatively integrate diverse viewpoints and continuously strive for their development. This allows the dialectical approach to remain open to new interpretive possibilities, to expand through the inclusion of emerging perspectives, and to deepen understanding without resorting to extreme or one-sided conclusions.

Such an epistemic stance — "I know and understand a little, I don't know and don't understand a lot, I strive for knowledge and understanding, but humbly acknowledge that things may be too complex to fully grasp" — appears to offer a skillful synthesis of univer-

salism ("the world is single-versioned, exists objectively and independently of perception, and everything in it is determined") and pluralism ("the world is multi-versioned, and various subjective versions of reality are possible"). It enables a simultaneous pursuit of understanding the world in a systematic and objective manner, while also accepting that our knowledge is always partial and context-bound. This stance supports the accumulation and organization of knowledge about human functioning, while acknowledging the complexity of reality and maintaining humility in the face of the limits of human cognition. It avoids the pitfalls of reductionism (over-simplifying the world into a single-version narrative) and relativism (abandoning the search for universal patterns altogether), offering instead a dynamic and balanced approach to exploring and understanding reality. The subjective experiences of the patient, the subjective experiences of the therapist, and the therapist's accumulated knowledge and clinical expertise all take part in an ongoing dance of knowing and "truth-seeking."

It is precisely this view of reality that appears most conducive to validating the experiences of a patient who is highly sensitive to signs of misunderstanding or lack of acceptance from the therapist. Such a therapist acknowledges that the patient's behaviors or emotional states do not arise "out of nowhere," but result from a chain of interconnected biological, social, and psychological factors. At the same time, the therapist refrains from claiming ultimate or unquestionable explanations, remaining open to multiple interpretations and the subjectivity of lived experience.

Validation — empirical findings

The role of validation in building interpersonal relationships and reducing emotional reactivity is not only a claim rooted in clinical practice but also an empirically documented phenomenon. In a study involving 90 participants, it was observed that receiving invalidating messages was associated with a marked increase in both physiological and psychological arousal, as well as a decrease in social engagement [30]. Another study found that individuals with difficulties in emotion regulation were more likely to behave aggressively in response to invalidation than those who generally manage arousal well [31]. The same research group demonstrated in a separate experiment that individuals with lower levels of agreeableness and conscientiousness — especially those with elevated neuroticism — became more aggressive after experiencing invalidation. This suggests that certain personality traits associated with aggression may become more pronounced in the context of invalidating interactions [32].

Particularly noteworthy in this context are the findings of a study conducted by Chad Shenk and Alan Fruzzetti [33], who investigated how emotional experiences and sympathetic nervous system activity change depending on whether a person, while under stress, experiences validation or invalidation. After being randomly assigned to one of two groups (one receiving validation, the other invalidation), sixty participants were asked to solve arithmetic tasks in their heads, used as a cognitive stressor. During the task, participants were asked three times to describe their emotional state. In response, the experimenter

provided comments: in the validating group, the comments normalized and acknowledged the participants' emotions (e.g., "Completing math problems without a pencil or paper is frustrating," "Most other participants have expressed the exact same feeling" or "I too would feel upset if I were the one completing the task"); in the invalidating group, the comments questioned the legitimacy or intensity of the participants' emotional responses (e.g., "I don't understand why you would feel that way," "There's no need to get upset," or "People were frustrated but not as much as you seem to be.")

Self-reported levels of negative emotion, along with heart rate and skin conductance measurements, indicated that participants exposed to invalidation experienced significantly higher arousal than those who were validated. It is worth noting that at the beginning of the study, no significant differences between the groups were observed in the monitored variables. As the experiment progressed, the arousal level in the invalidated group increased significantly, while in the validated group, no significant changes were observed. Slope analyses confirmed a marked increase in negative affect in the invalidated group, providing strong evidence of the emotional impact of invalidating interactions. The authors summarized their findings as follows: "(…) results from this study suggest that in addition to understanding the role of individual factors in emotion regulation, social factors also appear important in understanding how individual emotional reactivity and regulation is influenced and how interventions might be shaped to improve psychological outcomes" [33, pp. 180–181].

Why is validation so important in the psychotherapy of patients with BPD?

The importance of validation as a therapeutic strategy in the treatment of patients with BPD is highlighted by the theoretical model proposed to explain the development of chronic emotion dysregulation in this group. This model, known as the biosocial or transactional model, emphasizes the central role of so-called invalidating environmental responses in the individual's developmental context. An invalidating environment is one that ignores, dismisses, minimizes, negates, or even punishes a person's feelings, thoughts, needs, and experiences. Persistent difficulties in emotion regulation — along with related behavioral, cognitive, and interpersonal challenges — are thus understood as the cumulative result of complex interactions between the child and their environment, which (intentionally or not) invalidates their emotional responses, ultimately contributing to progressive dysregulation.

It has been suggested that individuals with certain innate temperamental traits are particularly vulnerable to developing difficulties with emotion regulation. Three key temperamental features have been identified as contributing to increased susceptibility to emotional dysregulation: (1) emotional sensitivity, (2) emotional reactivity, and (3) a slow return to emotional baseline. A person who is emotionally sensitive tends to react to stimuli or signals that others might consider trivial or insignificant. They may become easily frustrated, anxious, or tearful. An emotionally reactive individual experiences intense emotions that, from an outside observer's perspective, may appear disproportionate to the situation. Instead of sadness, they may feel despair; instead

of anger — rage; instead of fear — terror. For such individuals, most emotional experiences are deeply distressing and painful. People who take a long time to return to emotional baseline struggle significantly to recover from heightened emotional arousal. The emotional activation lingers in their body and mind long after the triggering event. These lingering emotions may manifest as intrusive memories, rumination, or recurring nightmares. If a person exhibiting one or more of these temperamental traits is raised in an invalidating or otherwise non-supportive family or social environment, their ability to regulate emotions tends to diminish. Consequently, episodes of emotional dysregulation become more frequent and more severe [3, 34].

According to the biosocial theory, individuals with BPD often experienced intense emotions during their developmental years and frequently did not receive appropriate responses to their emotional expressions. This lack of attunement contributed to the formation of dysfunctional emotion regulation patterns. In this context, validation serves as a specific form of "repair" for earlier experiences of misunderstanding or emotional neglect. It also acts as a foundation for developing the patient's capacity for self-validation. Through consistent, empathetic, and accepting reflection of the patient's emotions and experiences, the individual gradually learns to recognize their own needs, thoughts, and feelings, and to see them as valid and meaningful within the context of their life story. This growing awareness — that one's emotional states can be both understandable and legitimate — directly supports the development of self-validation in daily life. By regularly experiencing being heard and understood in therapy, the patient begins to evaluate the reality and validity of their emotions, thoughts, and needs independently. This process reduces their vulnerability to self-doubt and external criticism, enhancing emotional stability and self-trust.

Validation in the patient's experience — the key role of subjective perspective

Validation as a clinical strategy is a relational act, situated within the context of emotional exchange between the patient and the psychotherapist. Its effectiveness depends on conditions present on both the sender's and the receiver's side. Just as beauty does not exist solely as an objective quality but is revealed in the subjective perception of the observer, validation cannot be reduced to a simple message such as "Your emotions are important." In essence, validation is a cognitive-emotional-relational process in which the patient truly feels that their experiences and needs have been acknowledged as meaningful and legitimate. Empathically worded statements or gestures from the therapist may be objectively appropriate, yet still not perceived as validating if they fail to resonate with the patient's individual emotional experience. For some patients, even the therapist's best efforts to convey the legitimacy of their reactions may not result in a felt sense of being validated. Ultimately, the effectiveness of validation hinges on whether the patient internally experiences a genuine acknowledgment of their experience. Without this subjective sense of being understood, even the therapist's best intentions remain ineffective.

Different individuals may respond differently to similar therapeutic interventions — for some, verbal affirmations will be essential, while for others, the value may lie in the

therapist's restraint from commenting, paired with attentive and mindful presence. In every therapeutic relationship, validation should therefore take a form tailored to the patient's unique needs. Just as a work of art can evoke a range of emotions in different viewers, what holds the greatest significance in psychotherapy is what the patient perceives as genuinely supportive and accepting.

The therapeutic relationship is also of critical importance and cannot be overstated. It is shaped by factors such as the patient's personal history, the therapist's working style, the current phase of the therapeutic process, and others. Therefore, the experience of validation is not a single act, but rather something that matures within the specific context of the patient–therapist encounter. It is often not enough to express acceptance just once — its genuine emergence is the result of a process of co-creating a relational space in which the patient can authentically feel seen and understood. True validation arises within this shared relational field, where the therapist responds with empathy and attunes to the patient's needs, and the patient begins to experience their emotions as meaningful and justified.

Conclusion

The ability to validate allows the therapist to establish a deeper connection with the patient and to build an atmosphere of trust, which forms the foundation of effective therapy. When patients feel understood and accepted, they are more likely to open up to exploring difficult topics, consider new perspectives, and face therapeutic challenges. Validation is also a powerful tool for supporting emotion regulation. Within the therapeutic relationship, the therapist can model this process, demonstrating how the patient can begin to manage difficult emotions more effectively. However, validation does not mean that the therapist agrees with everything the patient says or does. Rather, it involves recognizing that the patient thinks, feels, and acts in ways that follow an internal logic — even if those patterns lead to destructive outcomes.

A key therapeutic skill is the strategic use of validation, which means that the therapist should continuously assess the appropriateness of validation at a given moment in the therapeutic dialogue and monitor its effects.

Validation typically leads to a de-escalation of emotional arousal and a reduction in tension within the therapeutic relationship. It can also enhance the patient's trust in the therapist and strengthen their sense of safety in the therapeutic process. At the same time, in line with behavioral theories, validation functions as a form of reinforcement that increases the likelihood of the behavior it follows or refers to. When used accurately and strategically, it can therefore reinforce, for example, the patient's appropriate expression of internal states.

It is also important to note that validation is not a strategy to be used universally or indiscriminately. If it is not accompanied by therapeutic interventions aimed at facilitating change, the therapy may stagnate and lack progress. Additionally, the therapist must remain attentive to the risk of validating what is, in fact, invalid — thereby unintentionally reinforcing dysfunctional behaviors. For example, in interactions with a patient who

engages in self-injury, it is possible to validate the underlying desire to reduce emotional tension (if present), without validating — and in some cases, explicitly invalidating — the act of harming oneself.

Although existing research and clinical observations highlight the significant role of validation in the therapeutic process and the development of healthy emotion regulation, this area still requires further in-depth analysis. Studies based on raw qualitative data may be particularly valuable, as they can provide deeper insight into the complex and interdependent mechanics of psychotherapeutic interactions. A better understanding of how validation works could contribute to the refinement of theoretical models and the improvement of treatment protocols across various psychotherapeutic modalities. Further well-designed studies — especially longitudinal ones — would allow for a more accurate assessment of the effectiveness of different forms of validation and help identify the factors that support the consolidation of positive change in patients. Moreover, building a robust body of scientific evidence may support the broader application of validation beyond traditional therapy settings — for example, in education, counselling, or psychosocial support — thereby enhancing the effectiveness of interventions and contributing to the improvement of quality of life for many individuals.

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