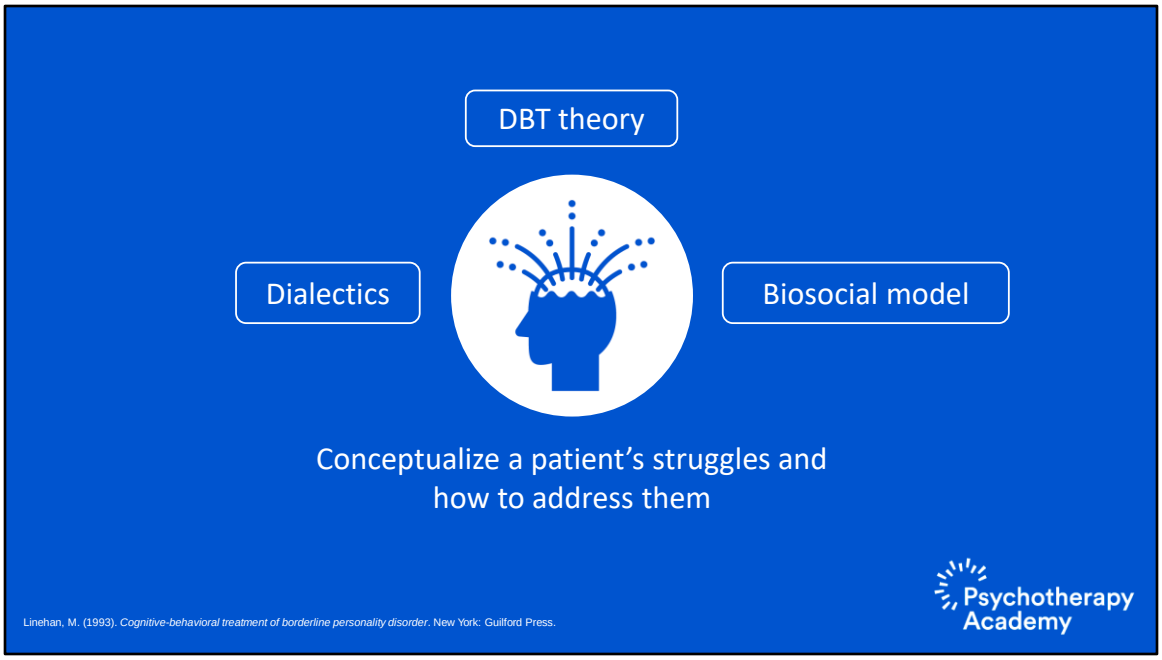
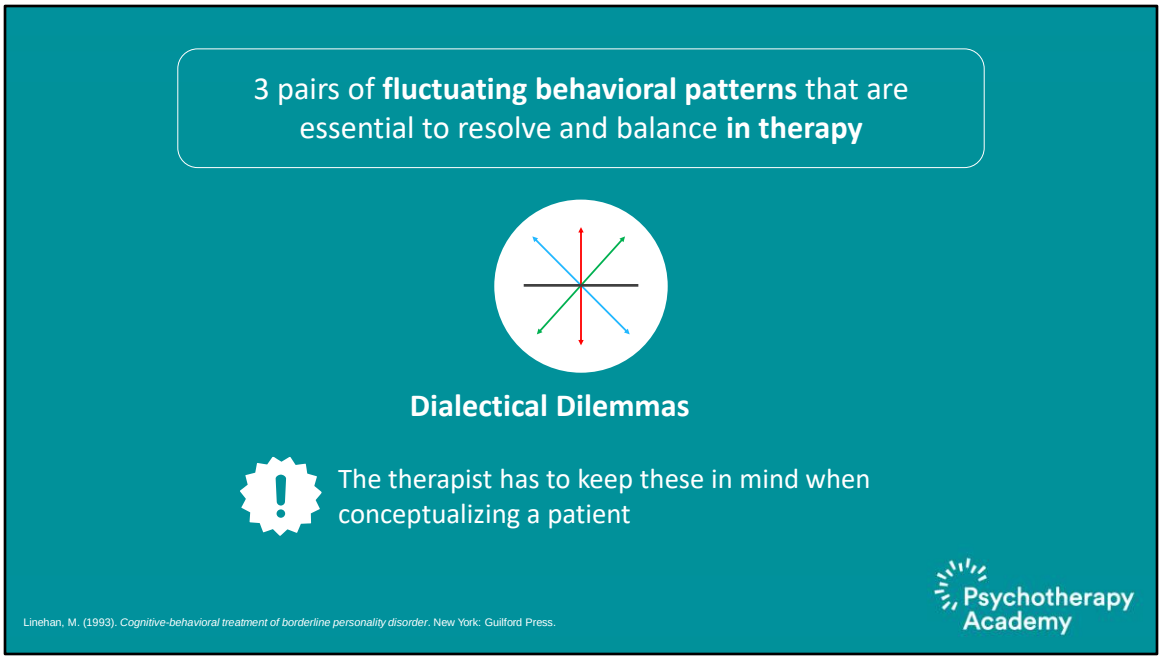
Psychotherapy Academy

Dialectical Dilemmas Overview

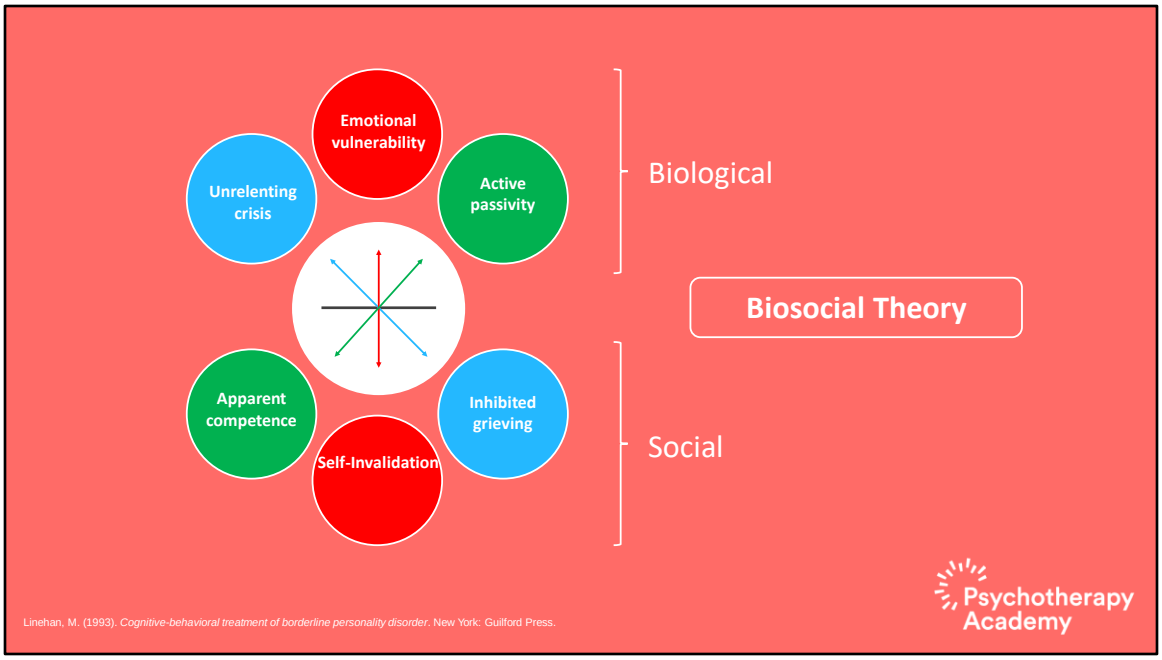
Stephanie Vaughn, PsyD



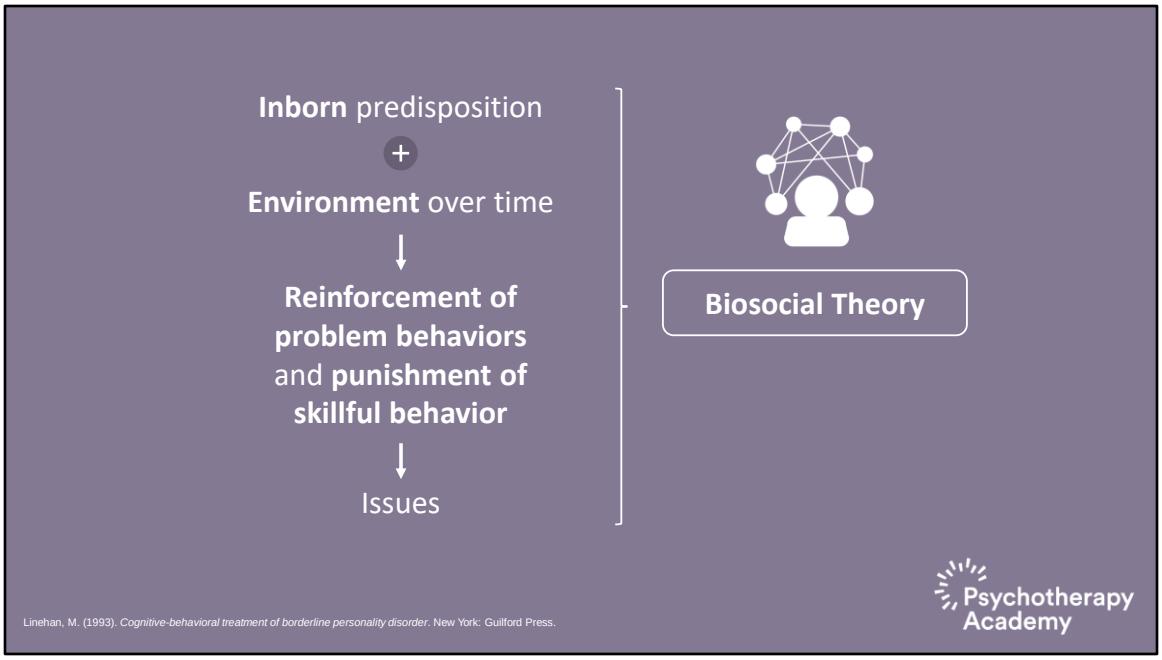
Although there are plenty of skills and strategies to learn, it is essential to keep DBT theory in mind in order to effectively conceptualize a patient's struggles and how to address them. Thinking dialectically can be challenging and understanding and applying the idea of dialectical dilemmas takes time. The concept of dialectics in the biosocial model has been explained in earlier discussions. So for our purposes, we will assume a basic understanding of both of these concepts.



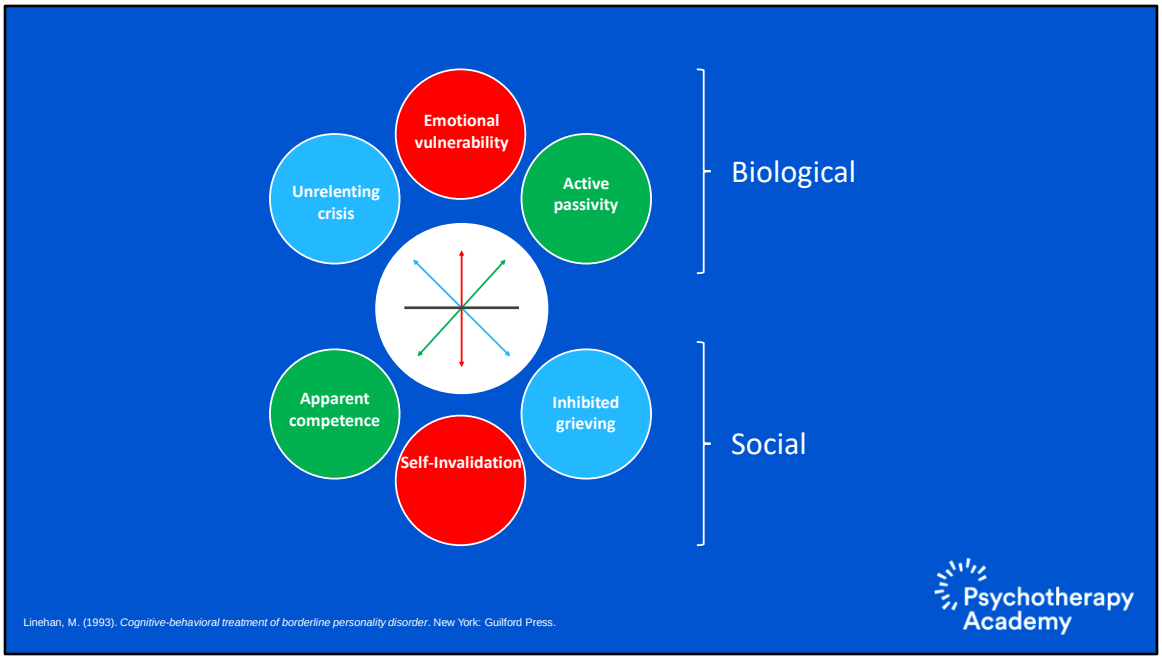
What are dialectical dilemmas? Dialectical dilemmas are three pairs of fluctuating behavioral patterns that Linehan identified as essential to resolve and balance in therapy. It is the task of the therapist to keep these in mind when conceptualizing a patient.



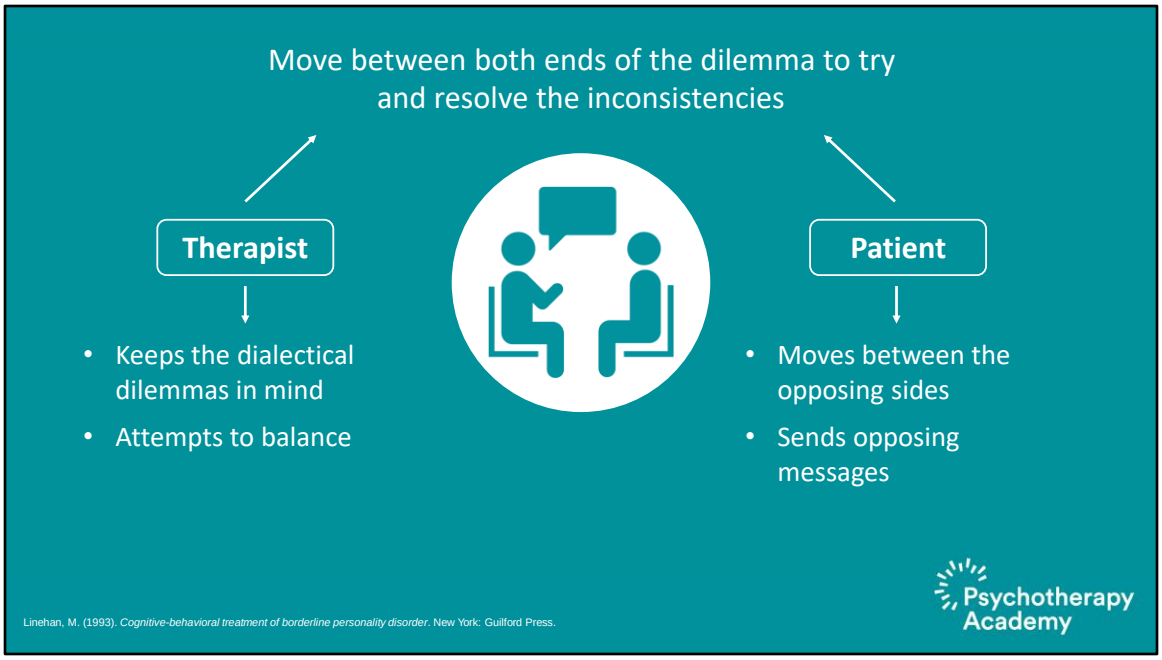
As a visual, imagine a vertical line with a point at each end. At one end is emotional vulnerability and at the other is self-invalidation. This is one pair of behavioral patterns as described in DBT. As the behavioral patterns of each dilemma are presented at opposite ends, there are a total of six problematic patterns or three dialectical dilemmas. The remaining two are unrelenting crisis versus inhibited grieving, active passivity versus apparent competence.
To understand the dialectical dilemma diagram, at each of the pairs, one is the behavioral patterns which are more biologically based and on the other end are those which are more socially influenced.



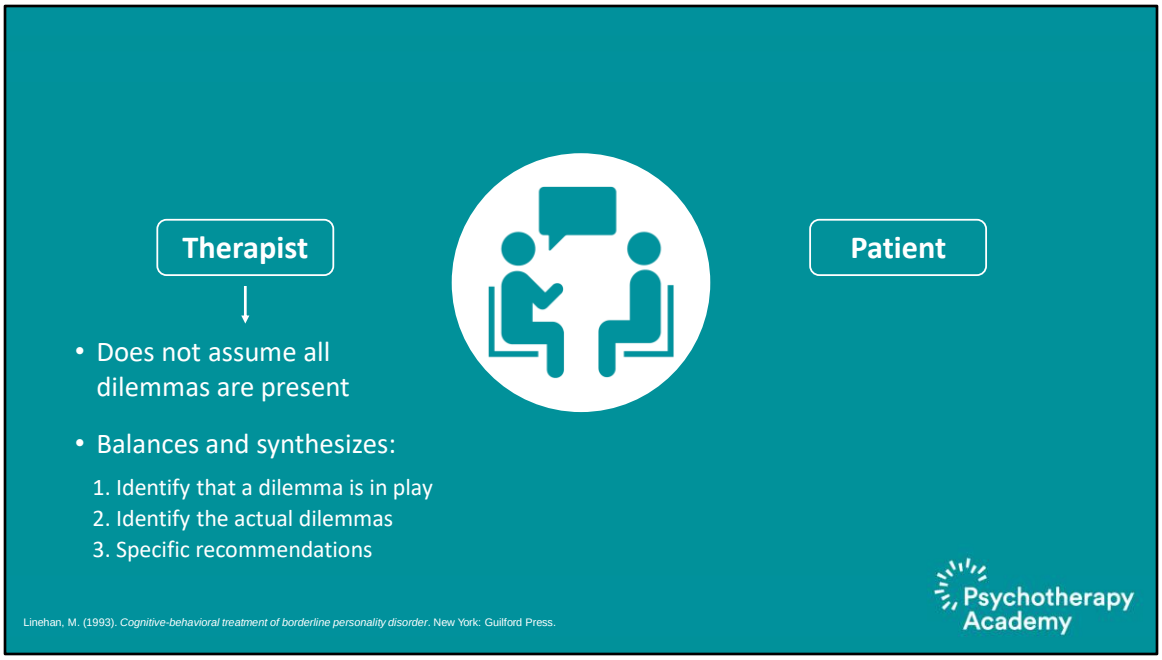
This is consistent with the underlying DBT biosocial theory that posits it is a combination of inborn genetically predisposition temperaments and the way that the environment interacts with the individual over time that lead to issues. This is due to the inadvertent reinforcement of some problem behaviors and simultaneous punishment of more skillful behavior.



So the inborn biologically determined emotional vulnerability lies on one end of the line while the tendency to engage in self-invalidation is socially influenced and lies on the other end. For the remaining dilemmas, unrelenting crisis at one end is biological while at the other end, inhibited grieving is socially influenced. Active passivity at one end is considered biological while at the other end, apparent competence is considered to be socially influenced.
As you can see, if we draw a horizontal line across the midpoint where these lines intersect, those behavioral patterns above the midline represent all three of those which are biologically influenced while those below the midline are more socially influenced.



DBT therapists keep the dialectical dilemmas in mind within the session and across sessions as it helps to conceptualize the patient's behavior and drive treatment. The therapist and the client move between both ends of the dilemma to try and resolve the inconsistencies.
The whole idea is clients tend to move back and forth between the opposing sides of these dilemmas like moving on a seesaw. They seem to send opposing messages at times and this can be confusing for others in their environment including therapists. Rapid attempts to balance for a therapist can turn out like that time an eighth grader plopped himself down on the other end of your first grade teeter-totter time. The goal on a seesaw and in DBT therapy is to move back and forth at a reasonable yet effortful pace not holding anyone hostage in the air or jumping off so quickly that the other party plunges to an uncomfortable stop in the dirt and instead maintaining a general balance between two ends.



Therapists should not assume that all three of the dilemmas are present for the patient. But once one or more are assessed and identified, the therapist should work toward balancing and synthesizing them. How does this balancing and synthesizing occur? The first step is to identify that a dilemma is in play. This may present in many different ways depending on which dilemma is active and I will highlight some specific examples for each of the dilemmas that my team and I have observed in doing therapy. Next, identify the actual dilemmas for the patient and for the therapist in each dyad. While there is no formula or equation on exactly what to do in therapy once this has been identified, there are some specific recommendations to keep in mind for each of the three pairs of dilemmas as we will go into individually in further discussions.

Key Points

- There are **six problematic behavioral patterns** paired together:
  1. Emotional vulnerability vs self-invalidation
  2. Unrelenting crisis vs inhibited grieving
  3. Active passivity vs apparent competence
- For each of the three dilemmas, there is a **biological** component and a **social** component.
- **Identifying, balancing, and synthesizing** dialectical dilemmas is a goal of the DBT **therapist**.

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

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Key Points
There are six problematic behavioral patterns which are paired together in dyads representing the three dialectical dilemmas as follows: Emotional vulnerability versus self-invalidation, unrelenting crisis versus inhibited grieving, and active passivity versus apparent competence.
For each of the three dilemmas, there is a biological component and a social component.
Identifying, balancing and synthesizing dialectical dilemmas is a goal of the DBT therapist.


Next Presentation:
Emotional Vulnerability
vs. Self-Invalidation
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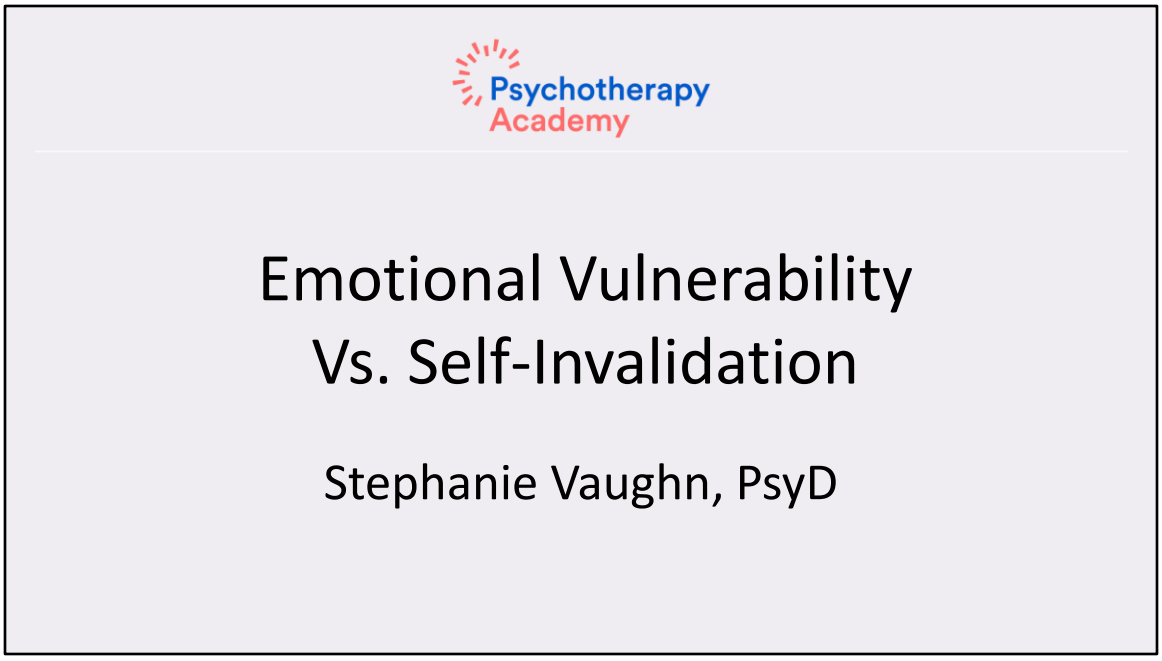
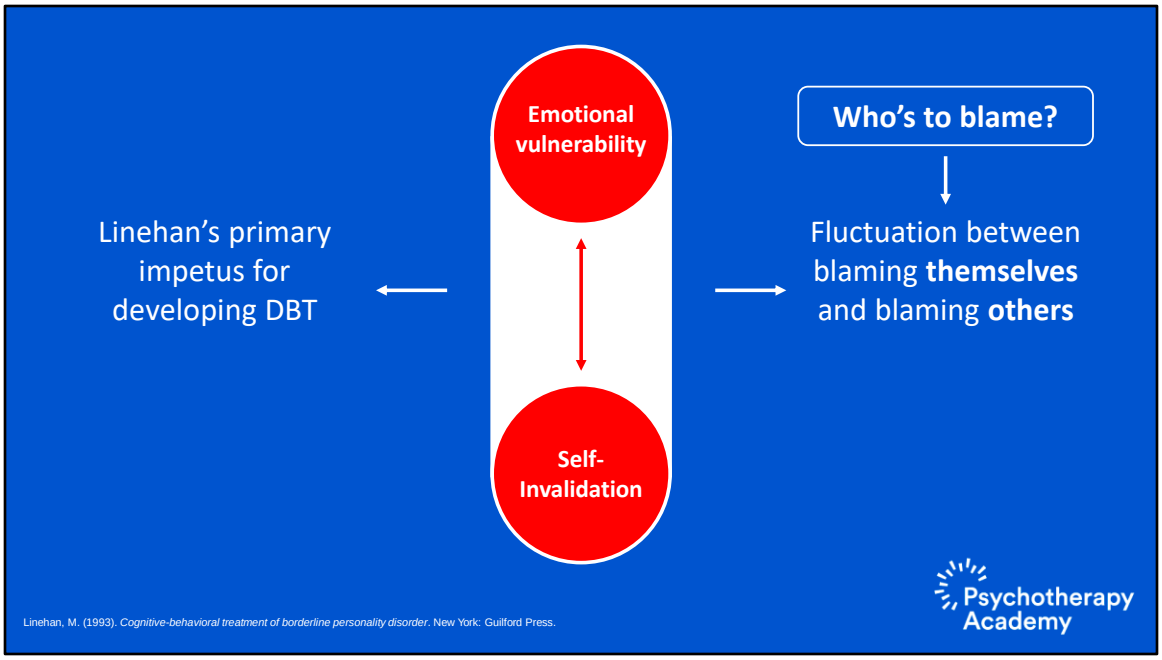
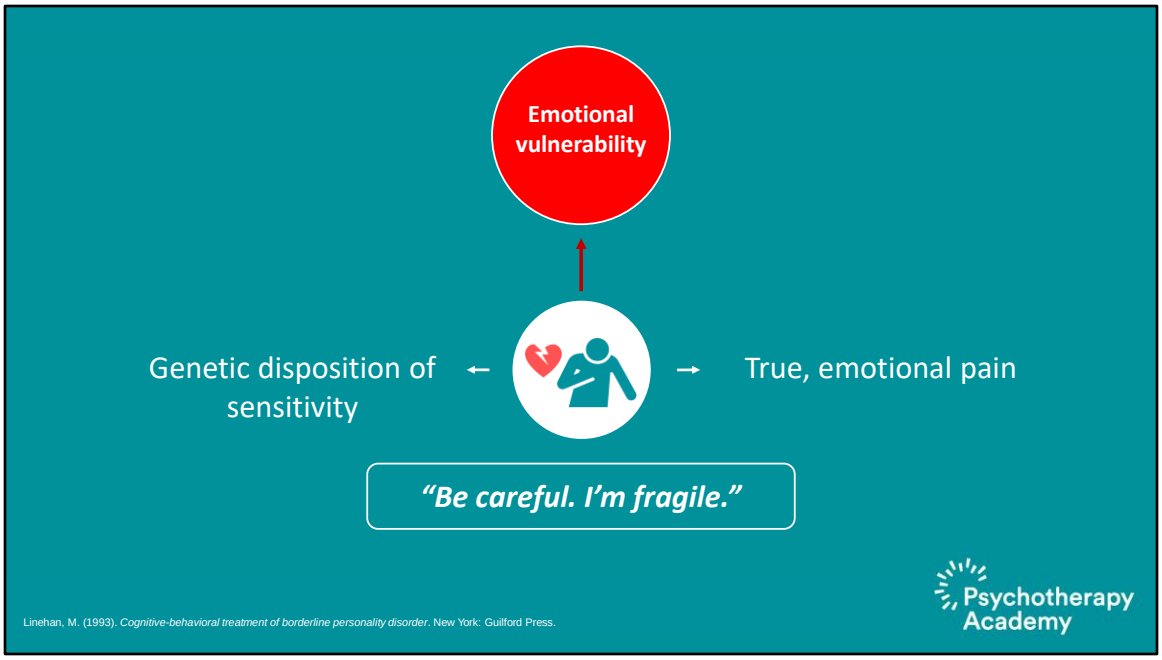


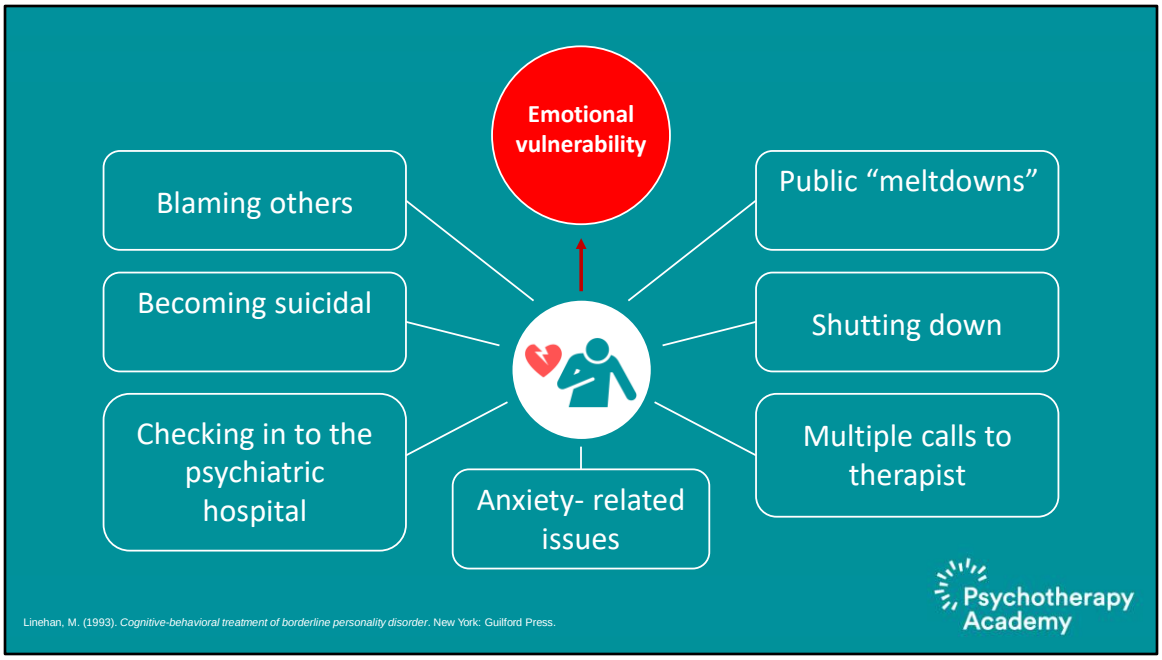
Emotional Vulnerability vs Self-Invalidation.



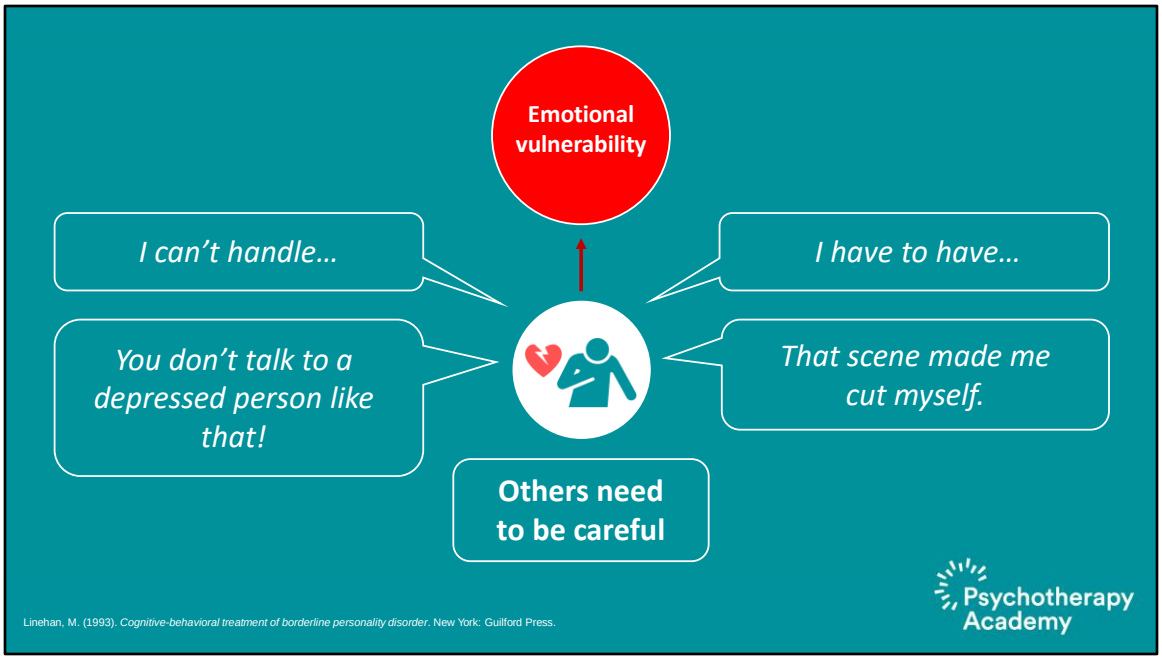
The experience of this dilemma was reported by Linehan to be the primary impetus for developing DBT. The theme centers around who's to blame and the patient may fluctuate rapidly between blaming themselves and blaming others. You may recall how Linehan began working with chronically suicidal people using behavioral therapy and that it was not particularly effective on its own because the true biologically inborn emotional vulnerability of the patient was not taken into account. Thus, the patient was highly invalidated rather than helped.



On the one side of the dialectical dilemma, emotional vulnerability, we have an individual with a genetically inherited disposition of sensitivity. There is true emotional pain. When the patient is on this side of the dilemma, the message either explicit or implicit is be careful, I'm fragile.



This may manifest in a variety of ways including but not limited to blaming others, insisting or implying that they need to be treated more carefully, public meltdowns or tantrums, becoming suicidal, shutting down, checking in to psychiatric hospitals, multiple calls to the therapist or others, avoidance of anxiety, threatening legal action, crying, bringing emotional support animals, using as-needed anxiety medication, appearing to be highly anxious, panic attacks and pseudoseizures and isolating.



Some statement examples that we have heard in therapy when this emotional vulnerability is the active issue include: I can't handle fill in the blank. I have to sit by the door or I have to have a blanket or I have to have. I have to. Another example is you don't talk to a depressed person like that. And finally, that scene in the movie made me cut myself. The bottom line with these statements and behaviors is the idea that the therapist and others need to walk on eggshells or be careful with the patient.

Therapist's Dilemmas/Risks

- Treating them as fragile
- Blaming them
- Believing they are seeking attention
- Reinforcing:
  - Avoidance
  - Hostility toward the therapist

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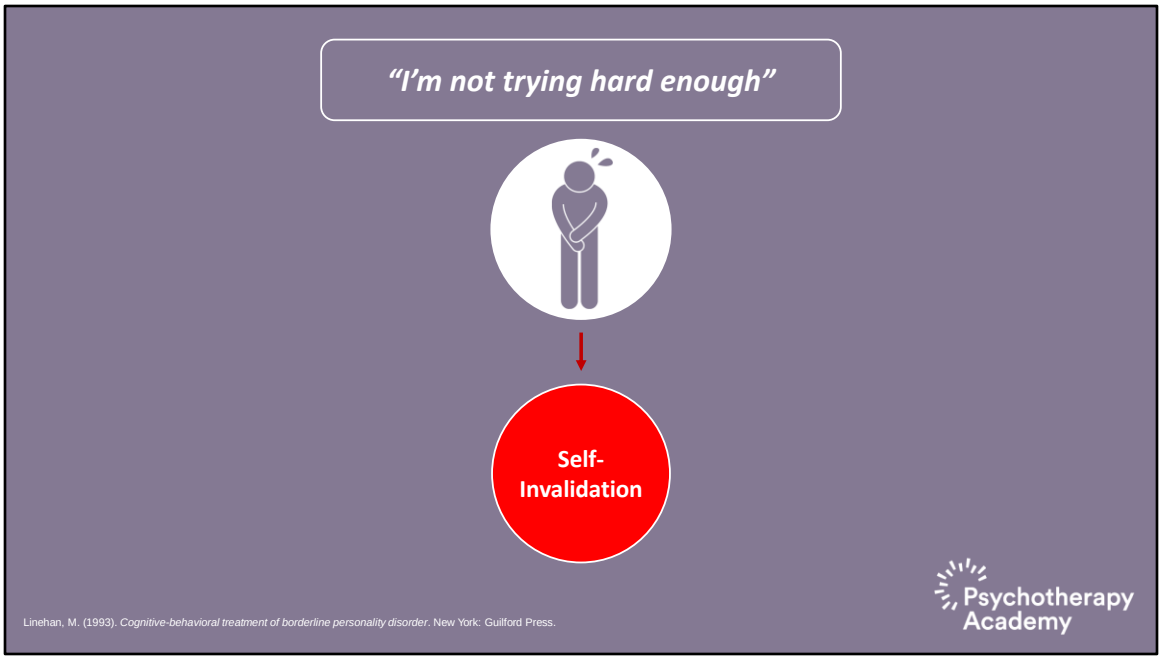
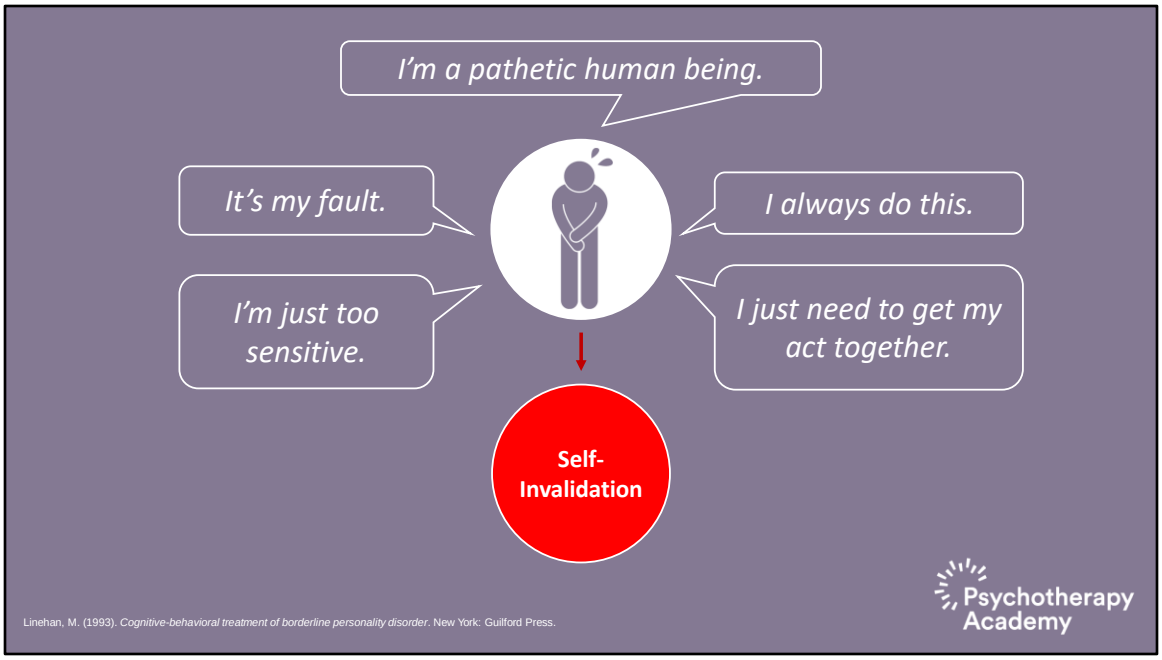
The dilemmas for the therapist or the risks involved in treating a person when they are in this extreme along the dialectical continuum are as follows: Treating the patient like she is fragile. Blaming the patient. Believing that the patient is purposefully seeking attention regardless of their actual intention. Reinforcing avoidance. Reinforcing hostility toward the therapist.

Invalidating the patient's suffering. The therapist may feel exasperated. The therapist may be reinforced for iatrogenic therapy. Therapist burnout is high.

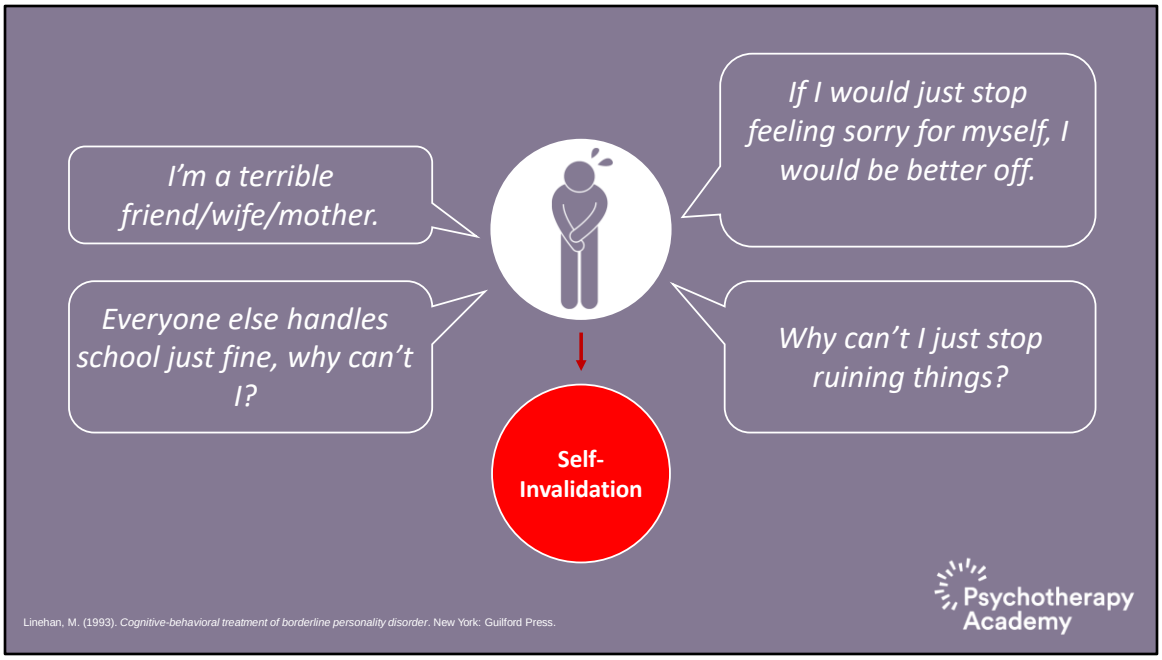
Not believing the patient. Escalation of the behavior due to not being taken seriously. And the therapist may drop the DBT protocol all together in favor of heart-to-heart discussions or other non-DBT therapy.



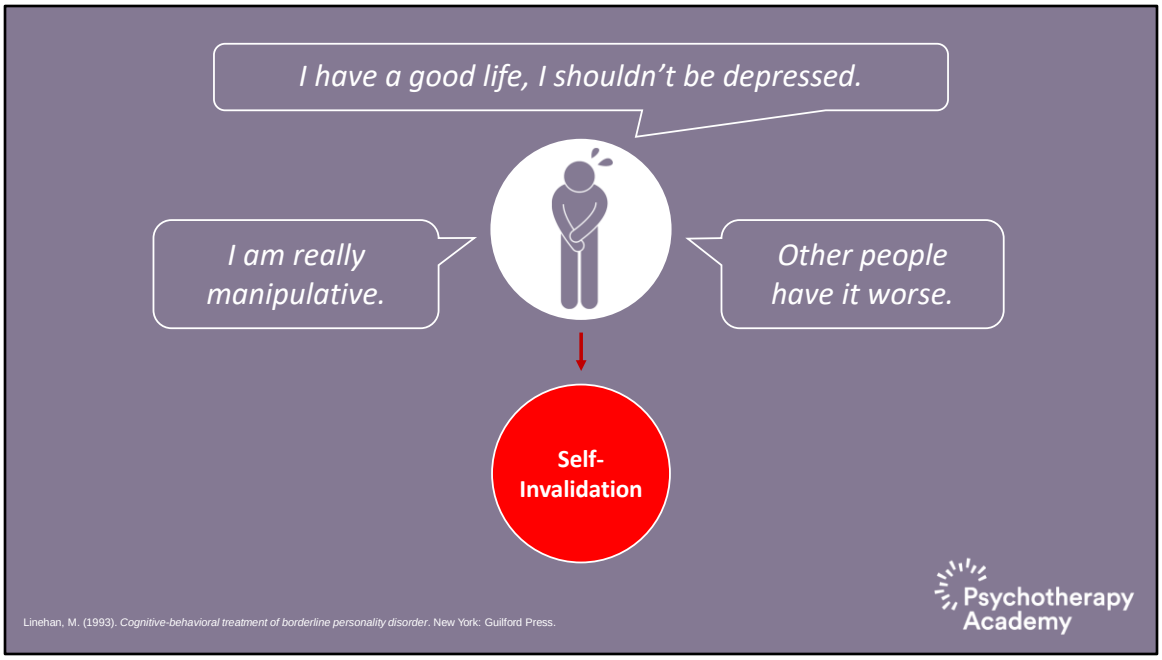
On the other side of this dilemma that of self-invalidation, the implicit or explicit message from the patient is I'm not trying hard enough.



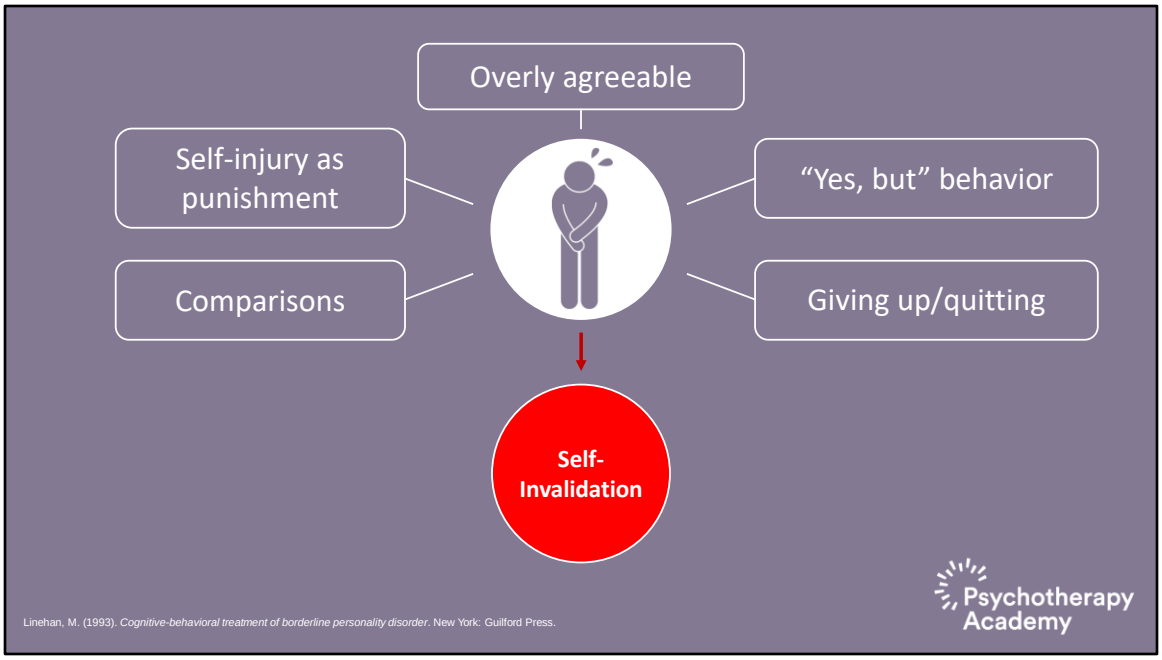
This may manifest by overt statements to that very effect or similar ones such as: It's my fault. I'm a pathetic human being. I always do this. I'm just too sensitive. I just need to get my act together.



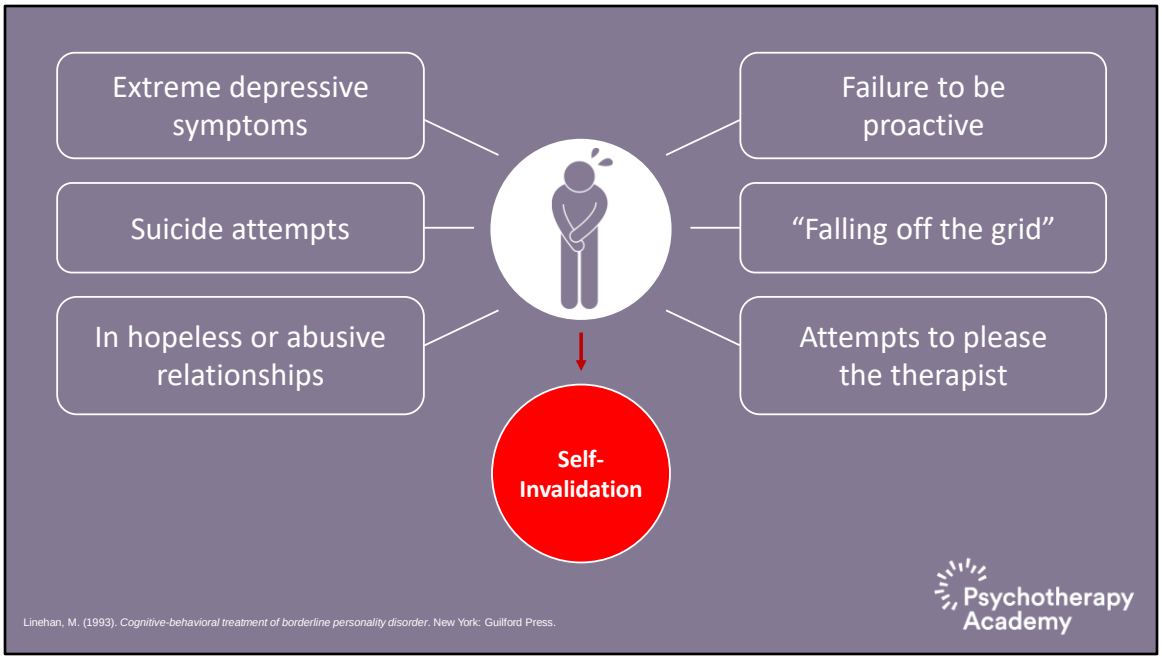
I'm a terrible friend, wife or mother. If I would just stop feeling sorry for myself, I would be better off. Everyone else handles school just fine, why can't I? Why can't I just stop ruining things?



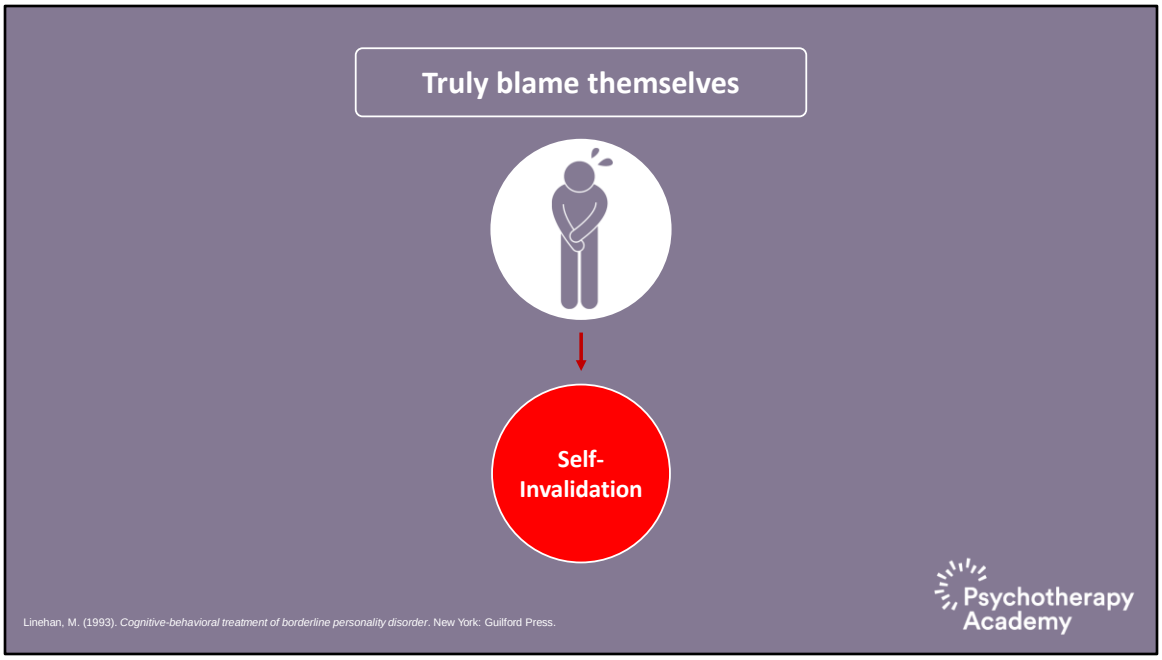
I'm really manipulative. I have a good life; I shouldn't be depressed. Other people have it worse. So these are statements that a patient might make if they are stuck in the self-invalidation end of the dialectical dilemma of emotional vulnerability versus self-invalidation.



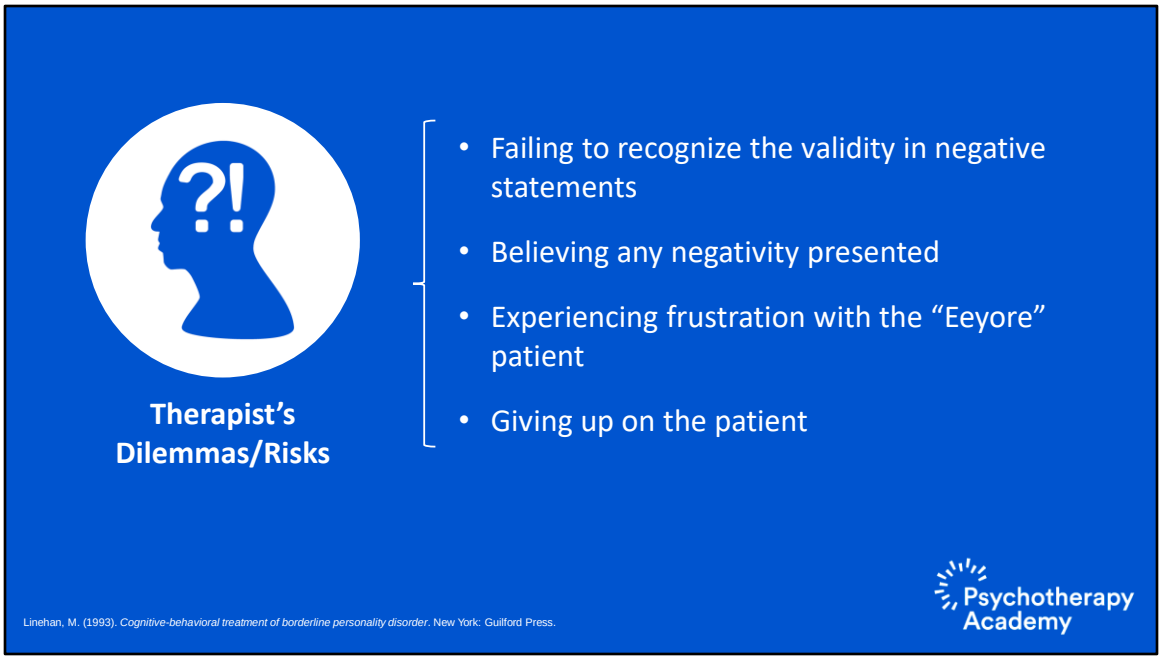
They might exhibit behaviors if they are in the self-invalidation point such as self-injury as self-punishment, being overly agreeable with the therapist, yes but-ing behavior in session when the patient says yes but after multiple things that a therapist will suggest, comparing themselves to others or another time period when they were doing better, avoiding confrontation, giving up or quitting.



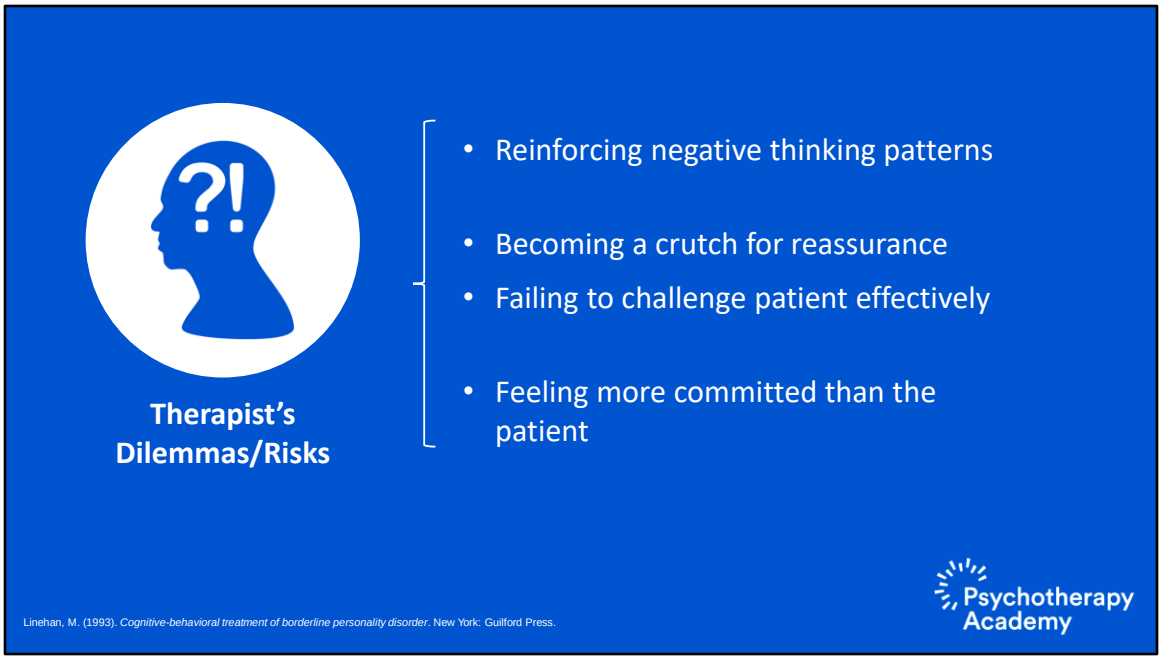
Extreme depressive symptoms, failure to be proactive or to problem solve, suicide attempts, falling off the grid or not coming to session, not being able to be located, remaining in hopeless or abusive relationships and attempts to please the therapist.



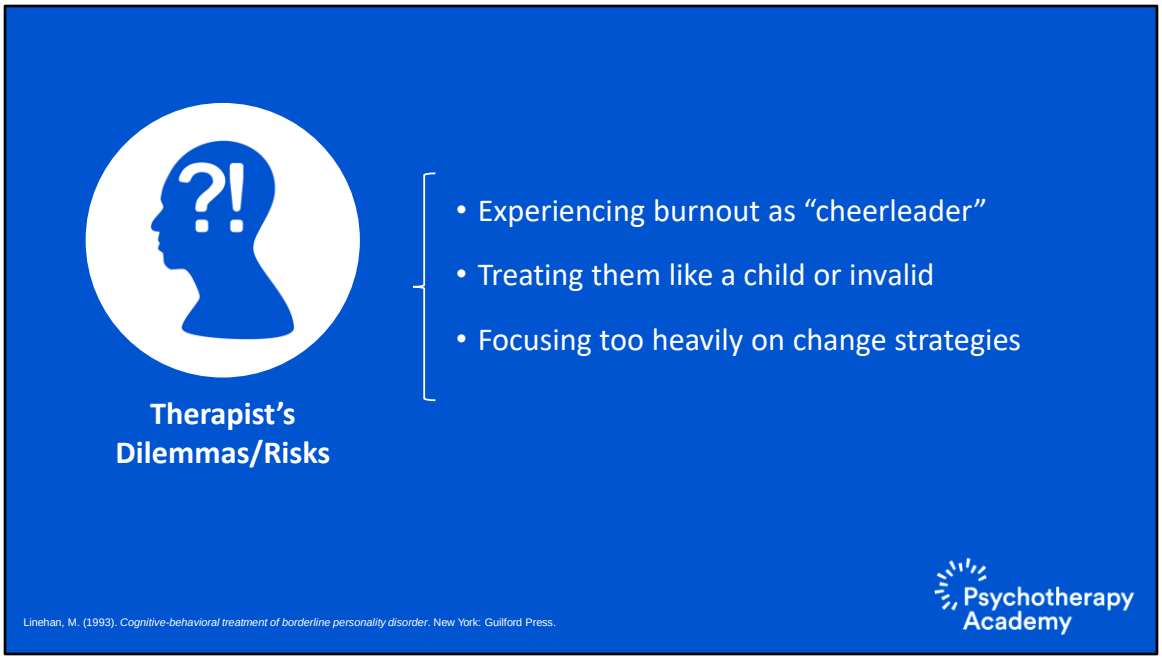
So the theme here when they are in self-invalidation mode is they truly blame themselves despite this true emotional vulnerability that they have which is biologically predisposition. So they may engage in behaviors such as self-harm, being overly agreeable with the therapist.



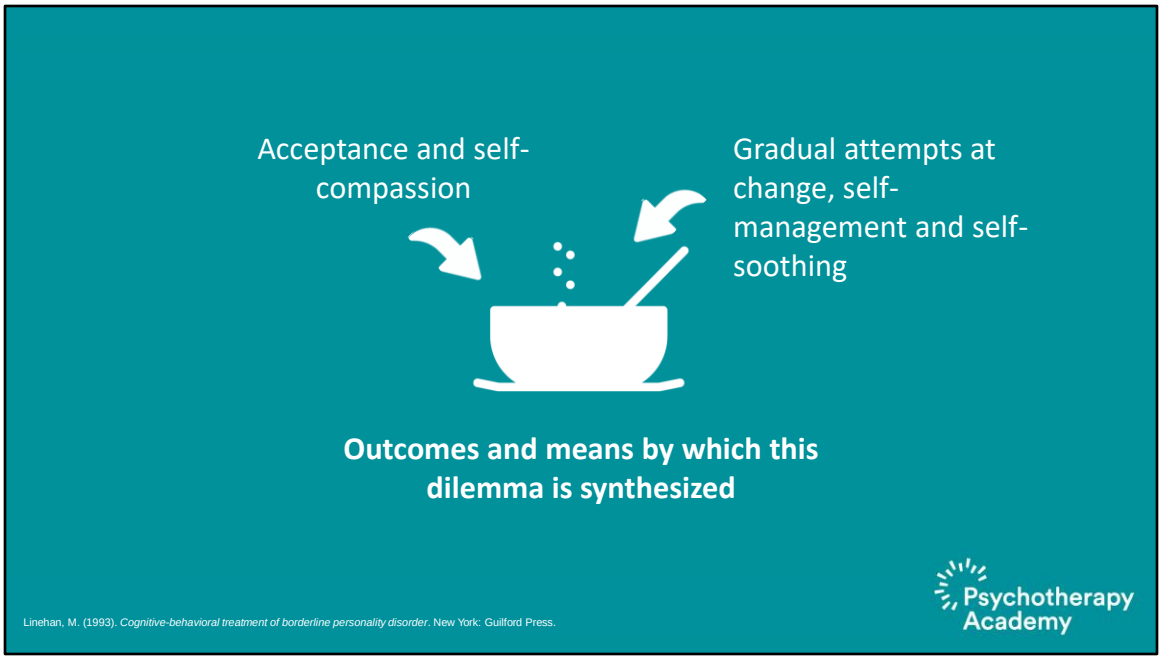
The dilemma for the therapist when the patient is at this point along the dialectical dilemma is that the therapist may fail to recognize the validity in their negative statements and alternatively they may 100% believe any negativity presented. So there is a risk of both of these. There's also the risk that the therapist becomes frustrated with the patient who they see as being an Eeyore or highly negative intransigent case. They may give up on the patient.



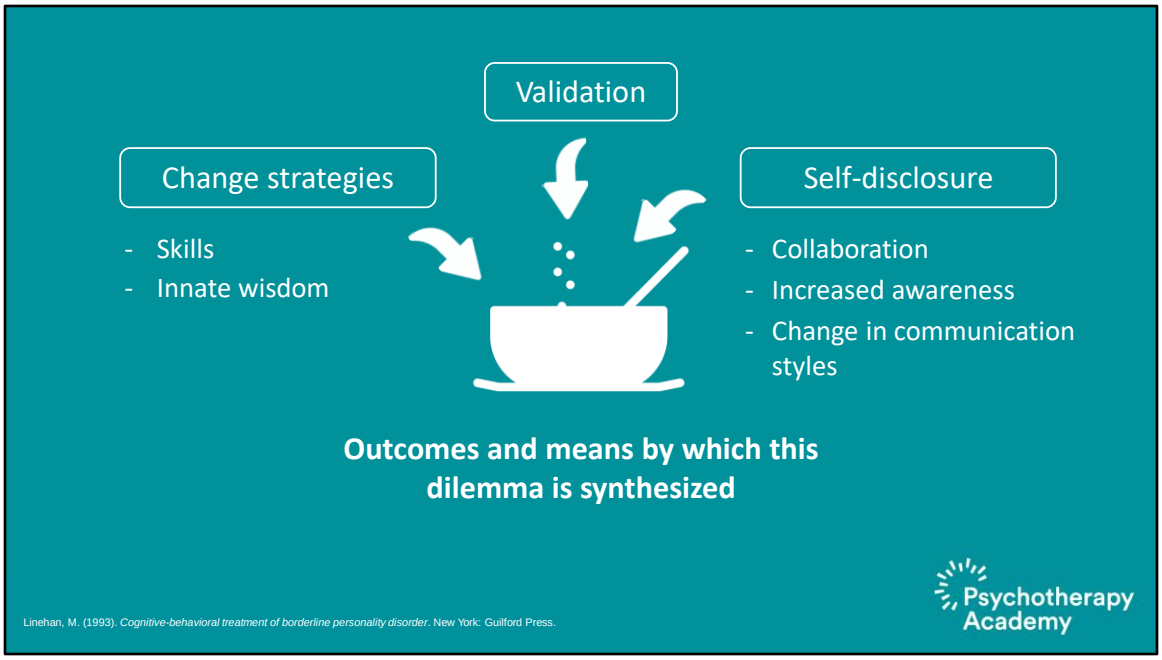
They may inadvertently reinforce the patient's negative thinking patterns. The therapist may become a crutch for reassurance, constantly relying on the therapist to prop them up. The therapist may fail to challenge the patient effectively at this point. They may feel more committed than the patient.



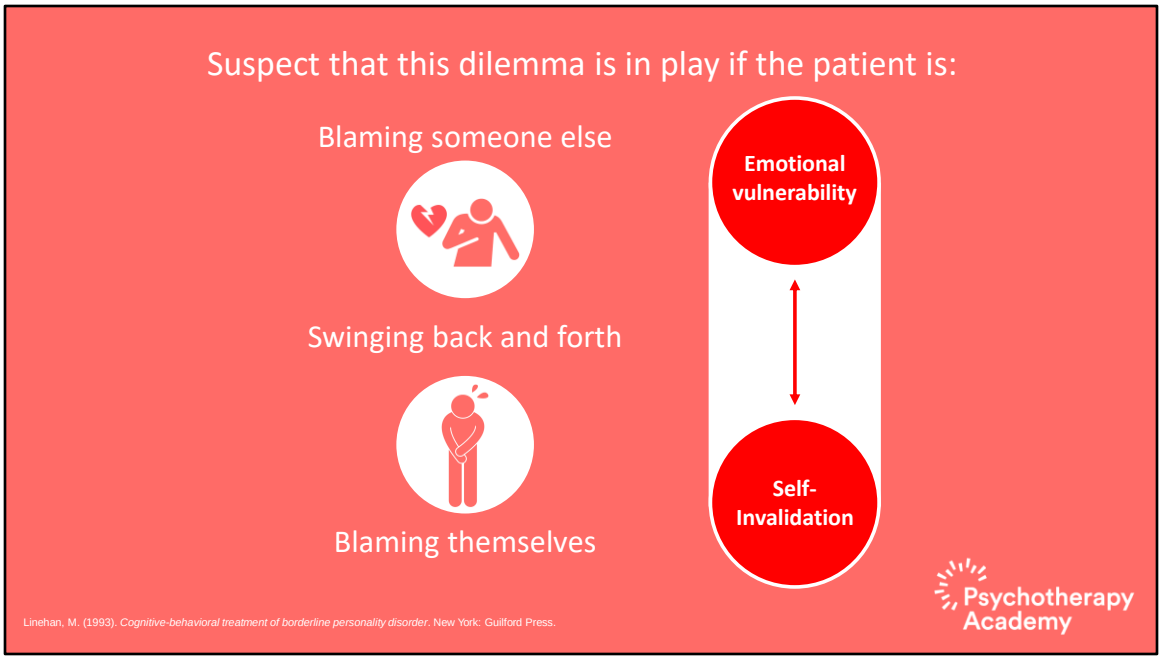
And feel a sense of burnout being that they're the patient's cheerleader. They may treat the patient like a child or an invalid and they may focus too heavily on change strategies.



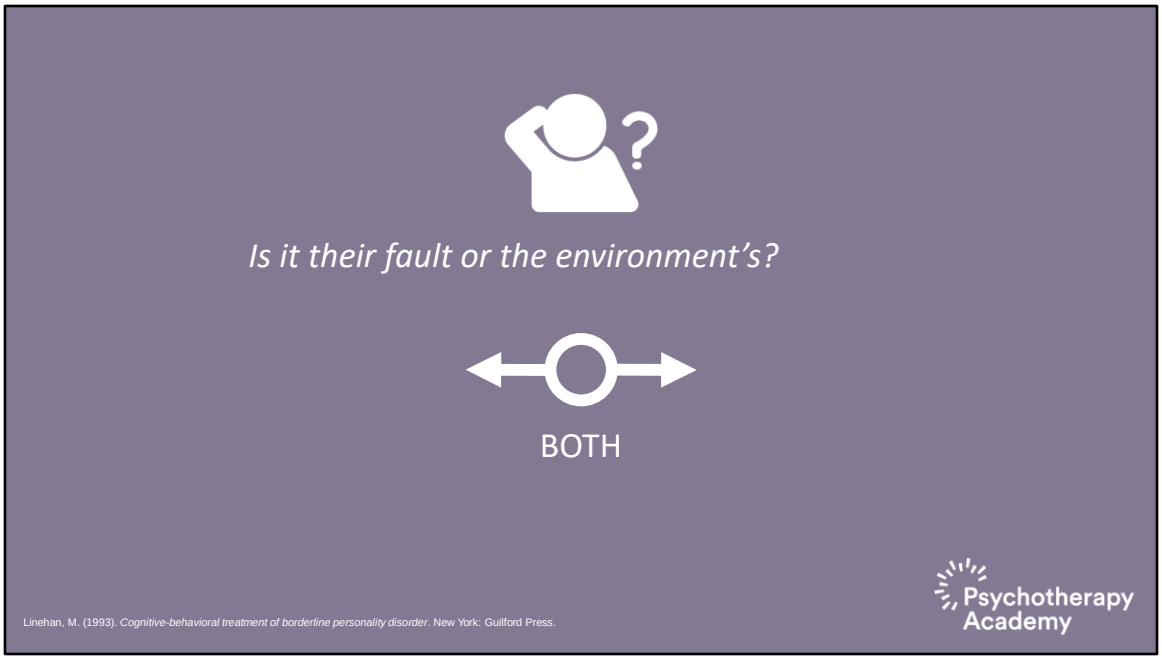
So at this dilemma, patient's acceptance and self-compassion combined with gradual attempts at change, self-management and self-soothing are stated by Linehan to be both the outcomes and the means by which this dilemma is synthesized for the patient.



To do so, the therapist combines validation with change strategies such as skills training paying particular mind to the innate wisdom in the patient's experience. In addition, I found that self-disclosure from the therapist in the form of how the therapist is experiencing the patient can be helpful. For example, if the therapist were to say, when you tense your body like that, you don't say anything but on my end, I receive a message from you that says stop talking about that. Is this what I'm supposed to receive? Discussions like these can lead to more fruitful ones about collaboration on goals. They can increase the patient's awareness of their non-verbal influences on others and lead to change in communication styles. This kind of feedback allows for corrective information in the case that the therapist is wrong.



You want to suspect that this dilemma is in play if the patient is either blaming themselves, that's the self-invalidation portion, blaming someone else, that's the emotional vulnerability side, or swinging back and forth rapidly between the two.



So which is it, therapist? Is it their fault or the environment's? Of course, it's both.

Key Points

- **Emotional vulnerability vs. self-invalidation** dilemma was the primary impetus for developing DBT.
- It accounts for the struggles of the patient in attempting to reconcile whether it is the **environment** or **themselves** which is **to blame** for their circumstances.
- In order to synthesize the two opposing sides, the therapist must effectively **validate** without reinforcing problem behaviors and listen for the **innate wisdom** of the patient's current experience.

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

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The key points are:
The dialectical dilemma of emotional vulnerability versus self-invalidation was the primary impetus for Linehan developing DBT as it accounts for the struggles that the patient experiences in attempting to reconcile whether it is the environment or themselves which is to blame for their circumstances.
In order to synthesize the two opposing sides of emotional vulnerability versus self-invalidation, the therapist must effectively validate without reinforcing problem behaviors and listen for the innate wisdom of the patient's current experience.


Next Presentation:
Unrelenting Crisis vs. Inhibited Grieving
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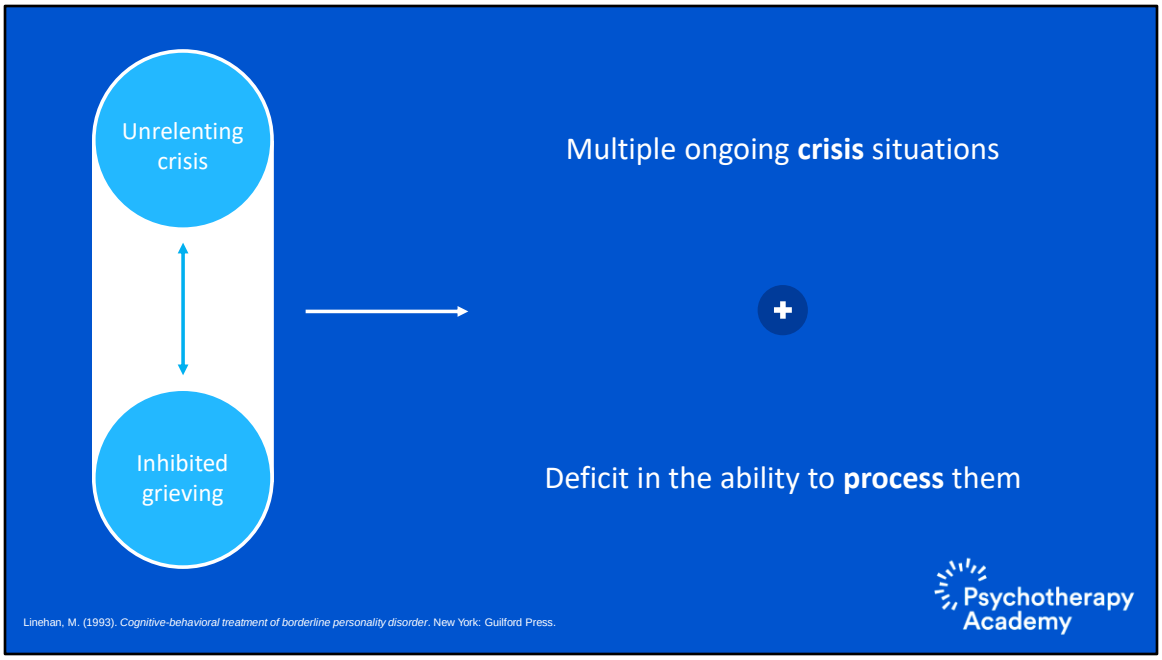
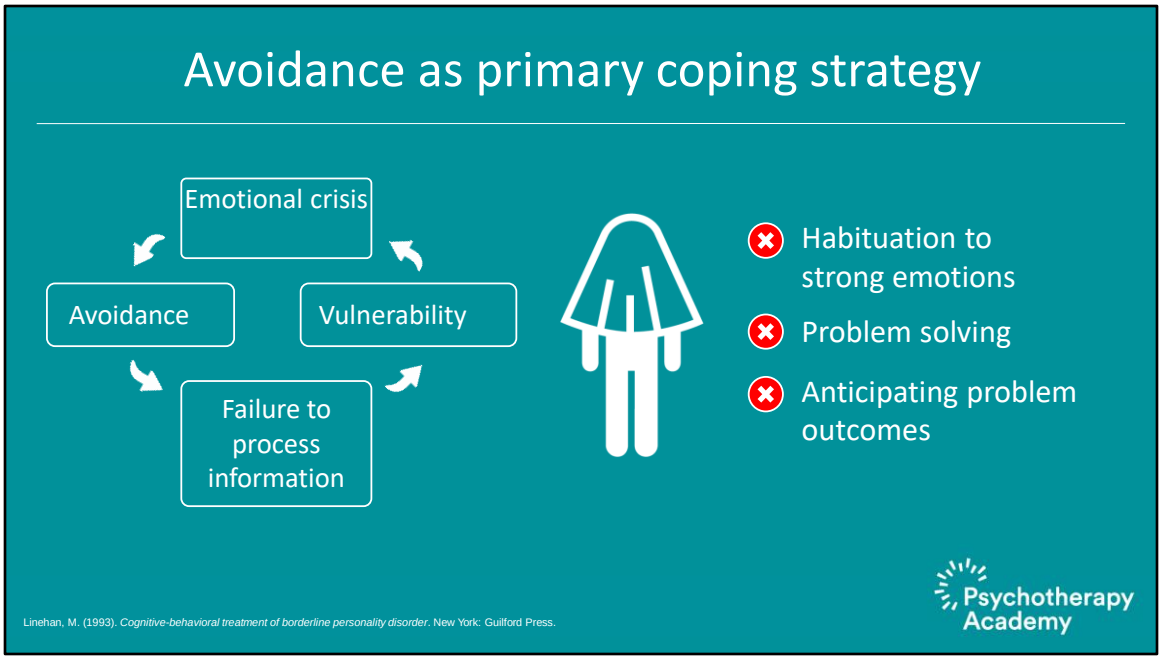
Unrelenting Crisis vs. Inhibited Grieving

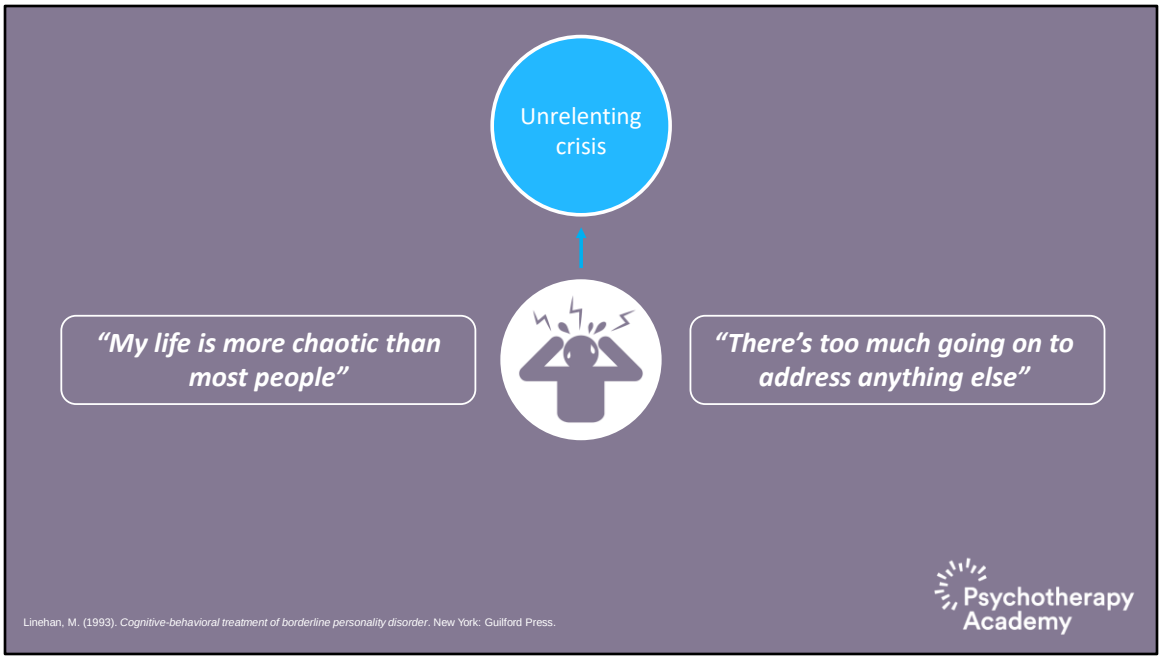
Stephanie Vaughn, PsyD



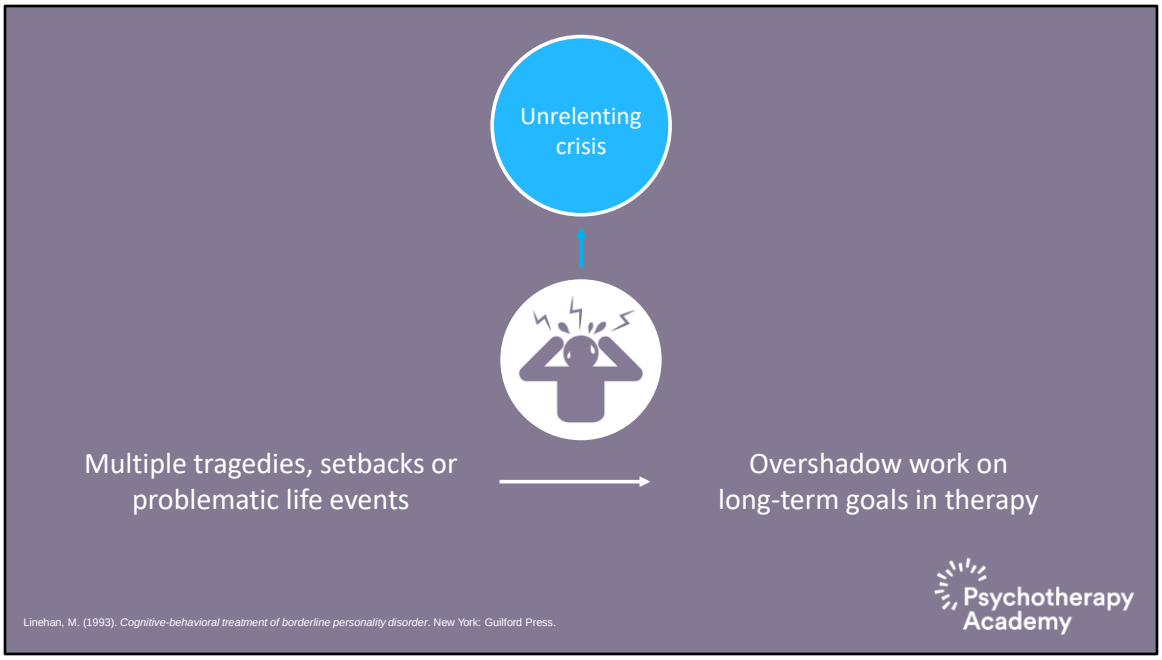
This dilemma refers to the tendency of some patients to have multiple ongoing crisis situations coupled with an unfortunate deficit in the ability to process them. Think of it this way. If you eat a ton of food, you better have a great digestive system. The patient may seem to present in an inconsistent way as highly dysregulated about an event in one session and then seeming to dismiss it as no big deal in the next.



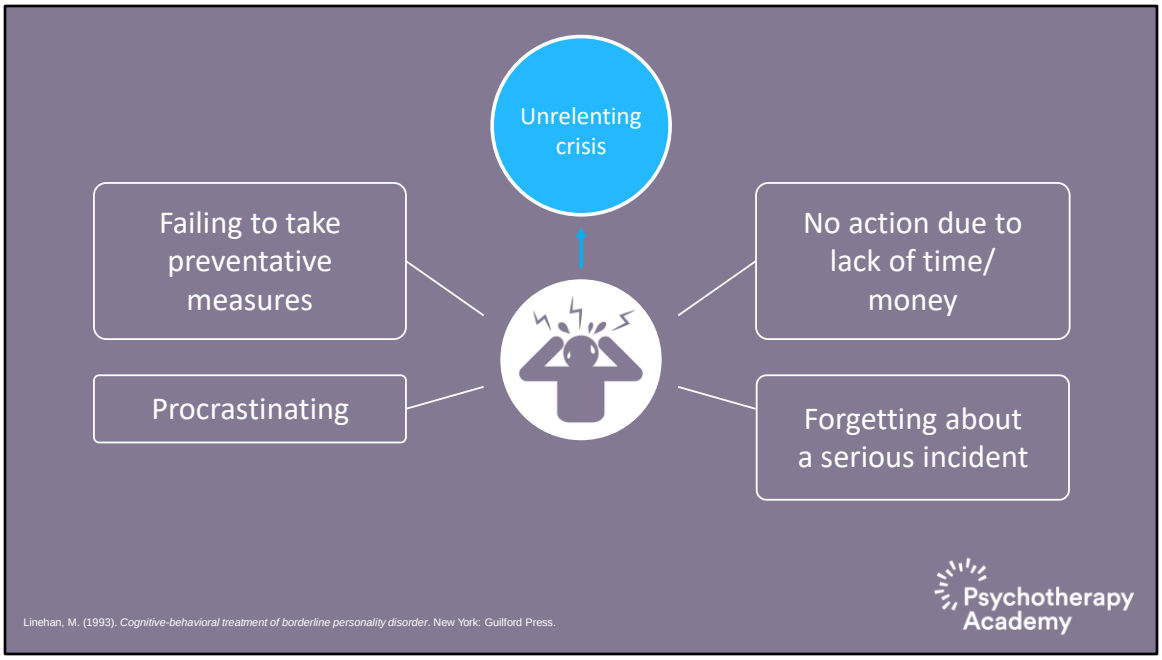
This fluctuation is thought to arise from the problematic way that they avoid processing emotionally charged material and instead use avoidance as their primary coping strategy. This cognitive avoidance is not sustainable and leaves them more vulnerable to future dysregulation and behavioral issues due to their failure to process the information properly. This then leads to a vicious cycle of emotional crisis and avoidance. Because it is relieving in the short term, avoidance perpetuates further avoidance and not only gets in the way of habituation to strong emotions but also creates a setup for future crises due to a lack of problem solving and anticipating problem outcomes.



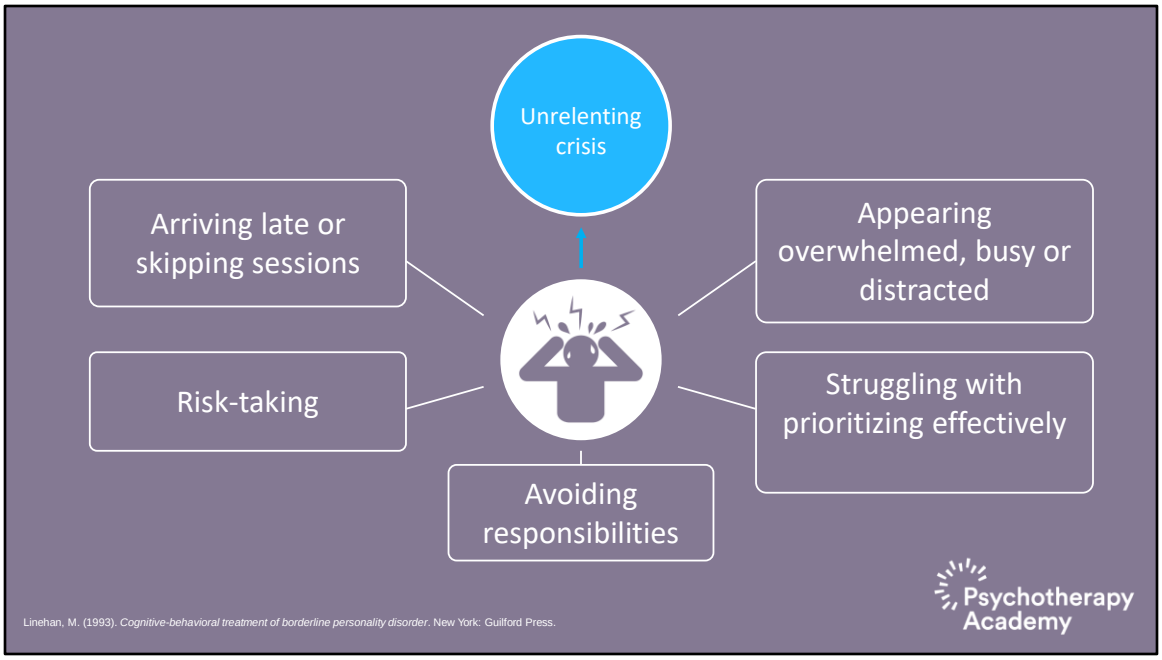
When a patient is on the side of unrelenting crisis, the message is my life is more chaotic than most people or there's too much going on to address anything other than this. Therapists may think of this as the crisis of the weak type of situation.



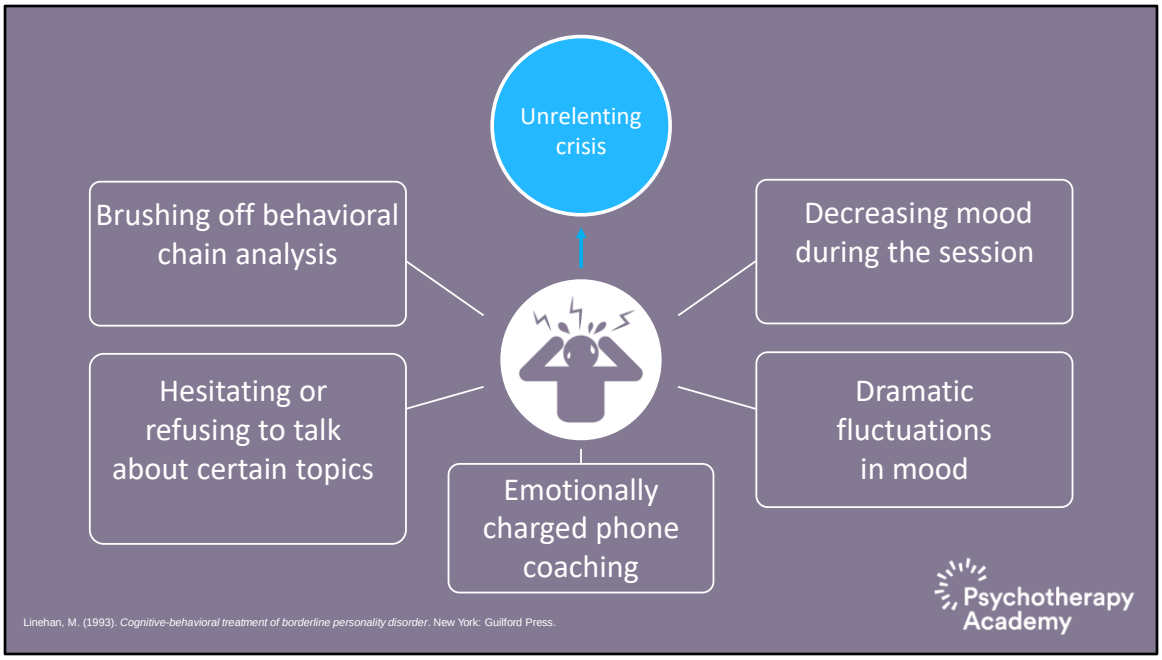
The patient may present multiple tragedies, setbacks or problematic life events which tend to overshadow work on more long-term goals in therapy.



Along with these environmental events, the patient may do any of the following: Fail to take preventative measures such as locking doors, paying bills, checking tires, etc. Fail to take action to solve a problem due to lack of time, money, etc. Procrastinate. Forget about a serious incident.



Arrive late or skip sessions due to crises. Appearing overwhelmed or busy or distracted during session. Engaging in risk-taking behavior. Struggles with prioritizing effectively. Avoiding responsibilities.



Brushing off behavioral chain analysis because “it’s over now.” Their mood may decrease during the session from beginning to end. Hesitation or refusal to talk about certain topics. Dramatic fluctuations in mood presentation which is crisis dependent. And emotionally charged phone coaching.

Therapist's Dilemmas/Risks

- Difficulty believing the patient or considering them as dramatic
- Blaming and thus dismissing the patient
- Not holding the patient accountable for progress toward goals because of crises

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

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The risks for the therapist are that these continued crises lead to difficulty believing the patient or considering them as being dramatic or exaggerating, blaming and thus dismissing the patient, not holding the patient accountable for homework or progress toward goals because of the crises.

Therapist's Dilemmas/Risks

- Failure to help a patient who's experiencing a true crisis
- Confusion and burnout
- Waiting to address life-threatening behavior

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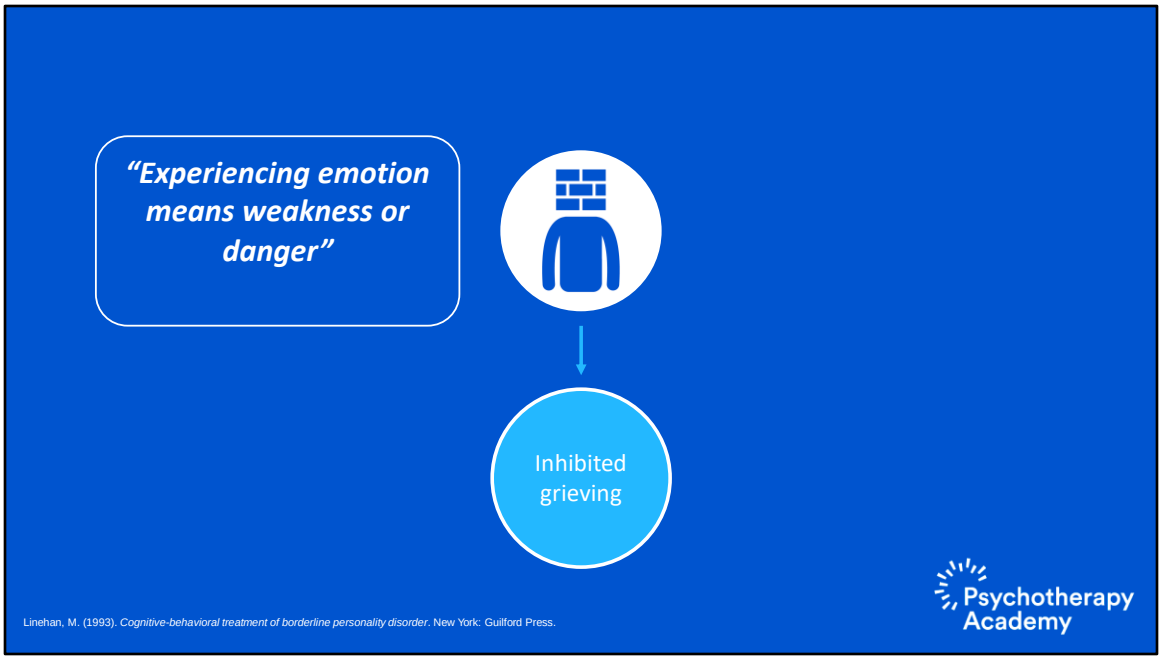
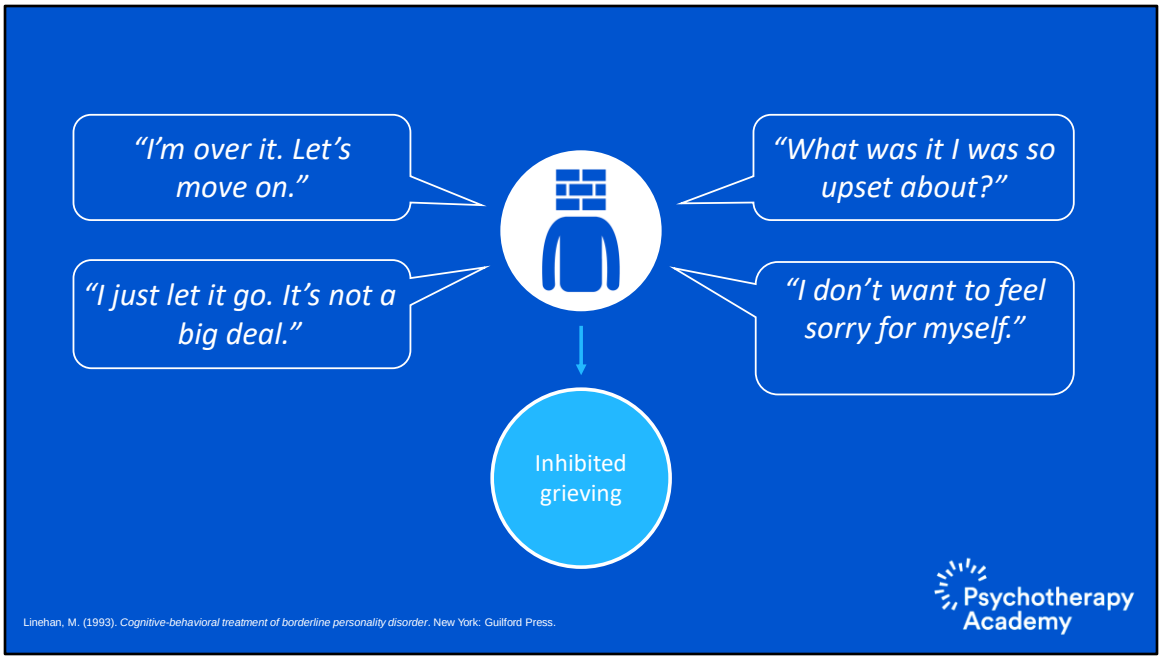
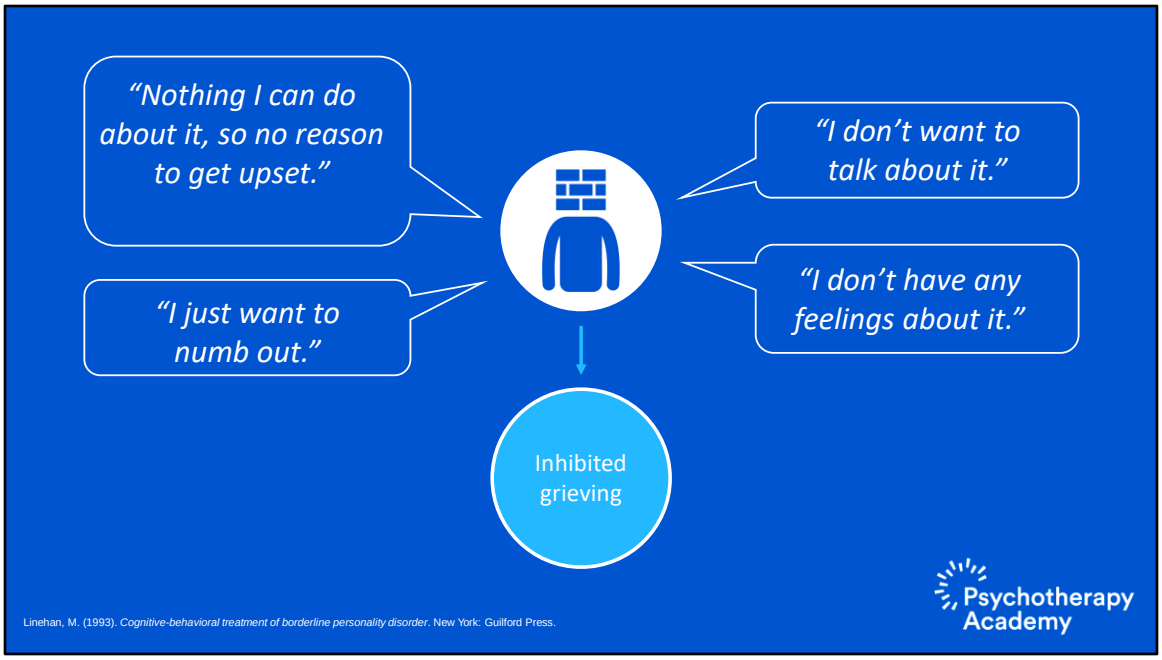
Failure to help a patient who's experiencing a true crisis, therapist confusion and burnout and waiting to address life-threatening behavior due to multiple quality of life-interfering behaviors which is against DBT protocol.



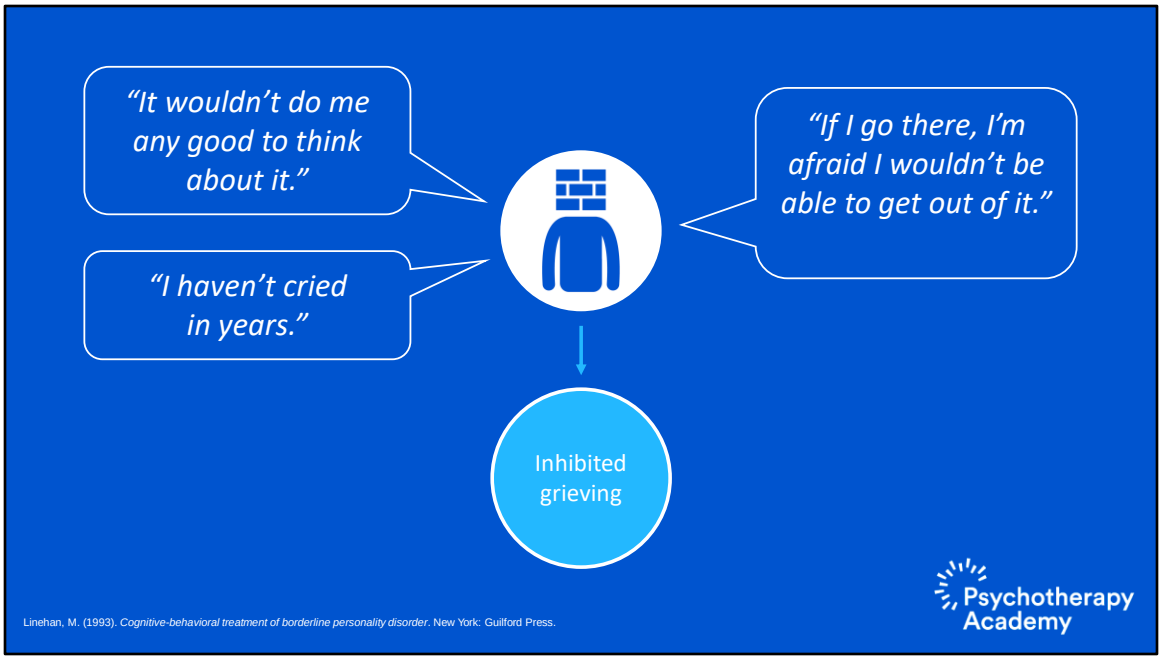
When the patient is on the side of inhibited grieving in this dialectical dilemma, the implicit message is that experiencing emotion means weakness or danger.



Patients may say things like: I'm over it. Let's move on. What was it I was so upset about? I just let it go. It's not a big deal. I don't want to feel sorry for myself.

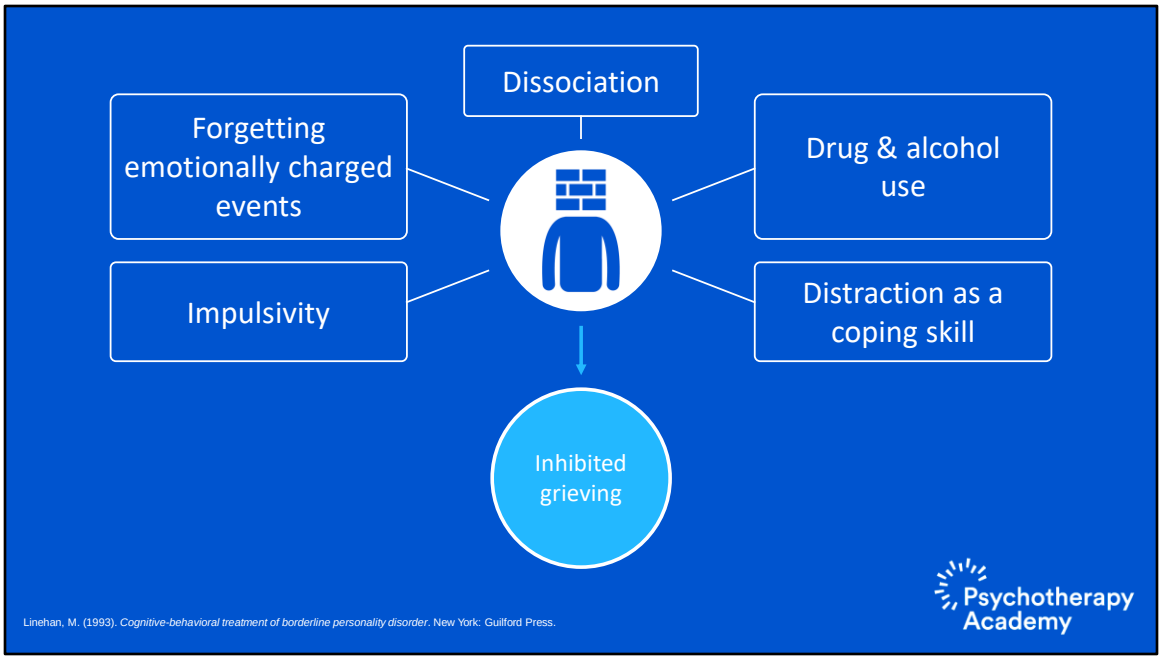


There's nothing I can do about it so there's no reason to get upset. I don't want to talk about it. I just want to numb out. I don't have any feelings about it.

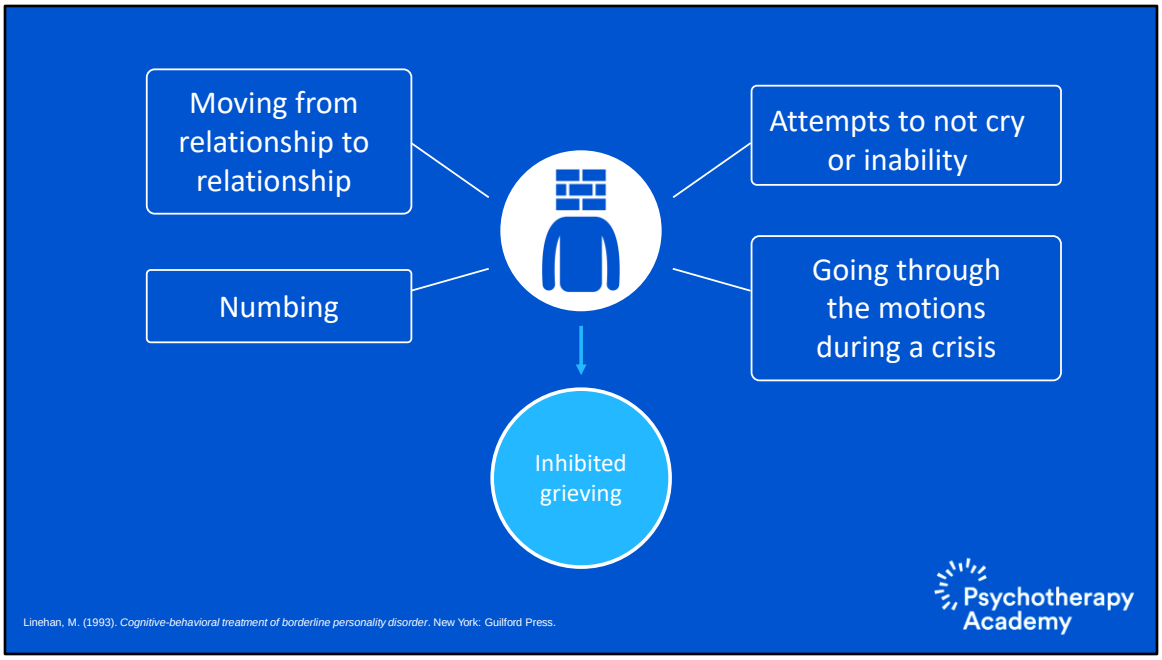


It wouldn't do me any good to think about it. If I go there, I'm afraid I wouldn't be able to get out of it. I haven't cried in years.

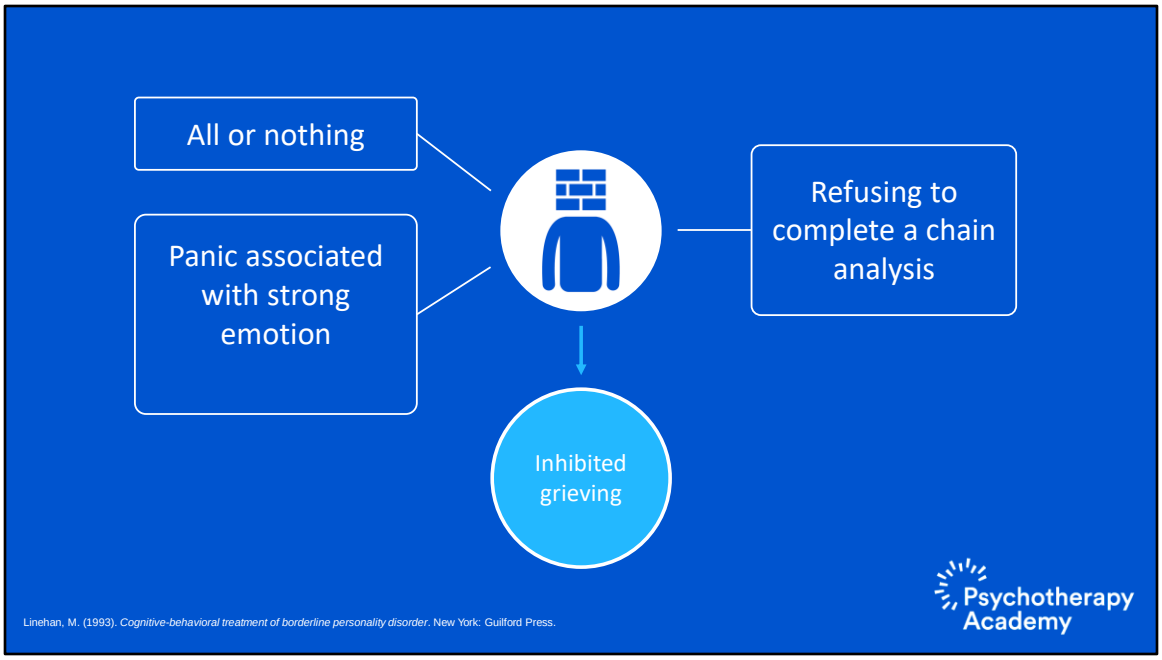
Just give me something so I don't have to feel it. I don't know how I feel. I never really thought about it. I can't handle that today.



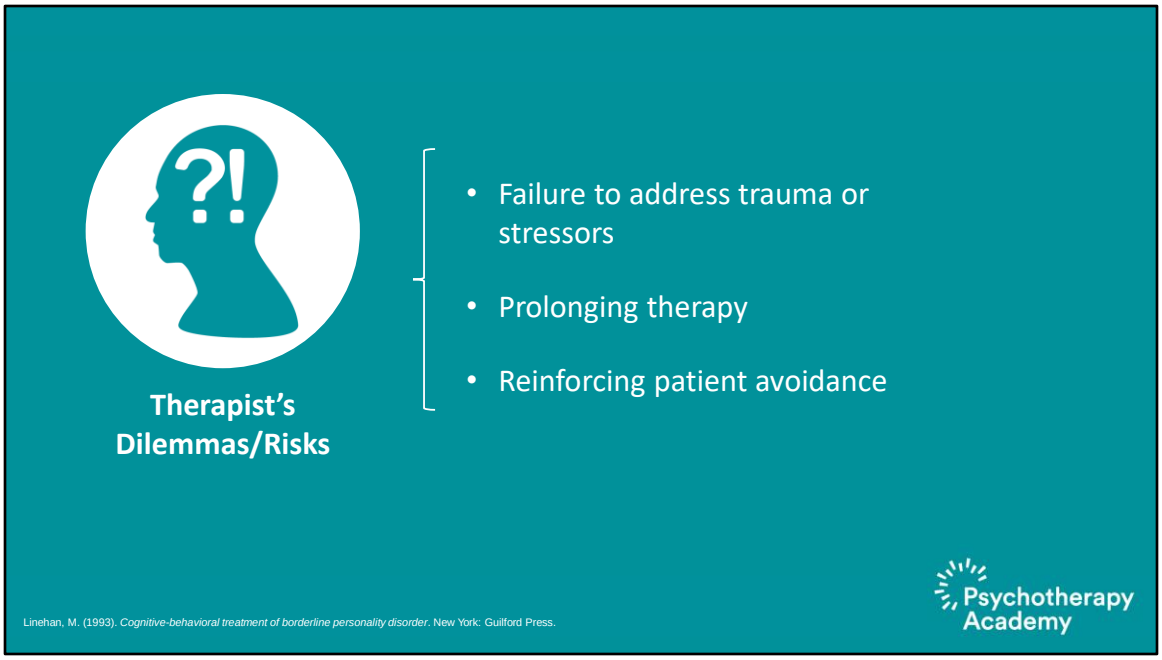
The behaviors they might display when on the side of inhibited grieving include dissociation, forgetting or distracting from emotionally charged events, drug and alcohol use, primarily relying on distraction as their coping skill, engaging in impulsivity



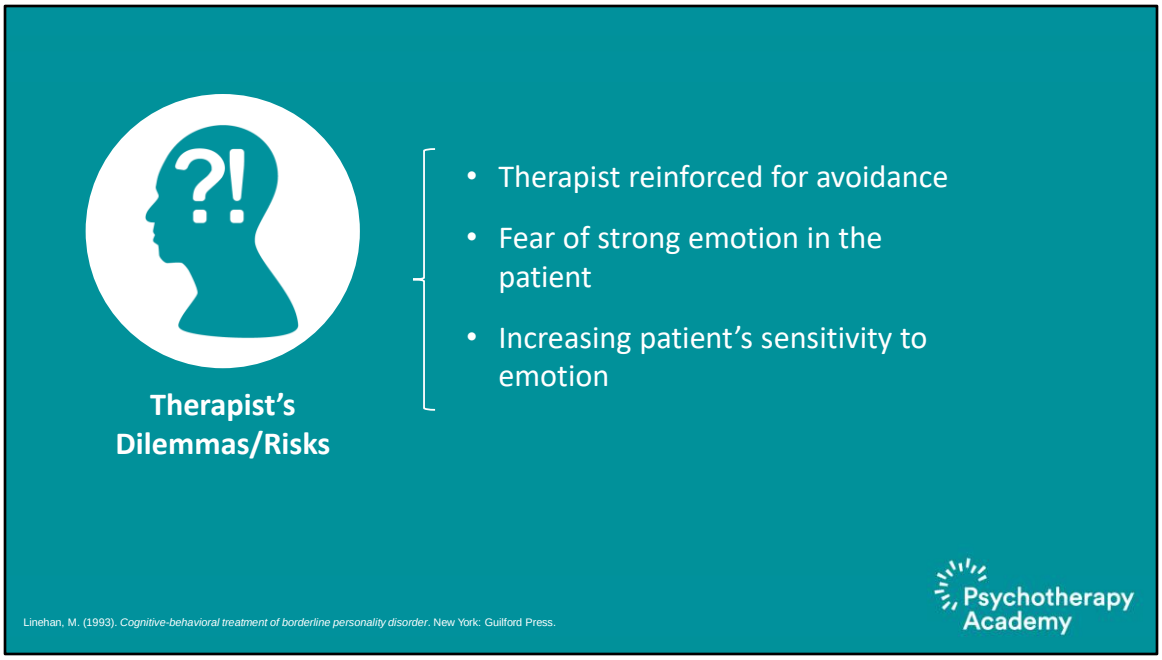
Moving quickly from relationship to relationship, purposeful attempts to keep from crying or an inability to cry, numbing, going through the motions during a crisis.



All or nothing mood presentation, refusing to complete a chain analysis, panic associated with strong emotion and avoidance of crying.



The risks when the patient is on the side of inhibited grieving are that the therapist may fail to address the trauma or stressors properly, prolonging therapy, reinforcing patient avoidance of emotion.



The therapist may be reinforced for avoidance. The therapist may become fearful of strong emotion in the patient. And they may inadvertently increase a patient's sensitivity to emotion due to having reinforced their avoidance during session.

So the task for the therapist is to manage their own reactions to the patient's changing levels of distress, to teach grieving skills and to help them learn to grieve as well as how to end the grieving process. Normalizing emotion in grieving is essential in getting past this dialectical dilemma.

Key Points

- The dilemma of **unrelenting crisis vs. inhibited grieving** occurs due to the patient using **avoidance** as a primary coping skill.
- Avoidance of unpleasant emotion is reinforced by the **environment** and **short-term relief**.
- This creates a **vicious cycle** in which avoidance sensitizes the patient to future life stressors and leads to more actual crises.

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

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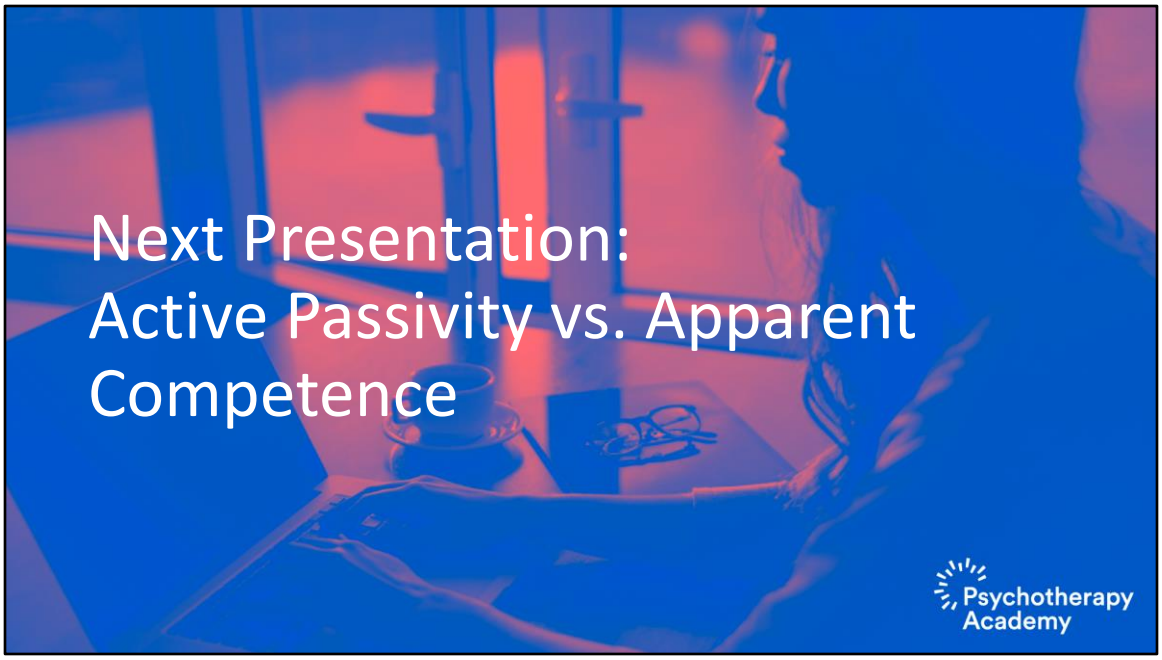
The dilemma of unrelenting crisis versus inhibited grieving occurs due to the patient using avoidance as a primary coping skill rather than emotional processing to deal with stressors and traumatic events.
Avoidance of unpleasant emotion is reinforced both by the environment and by the relief obtained in the short term but this creates a vicious cycle in which avoidance both sensitizes the patient to future life stressors and avoidance of problem solving leads to more actual crises.


Next Presentation:
Active Passivity vs. Apparent Competence
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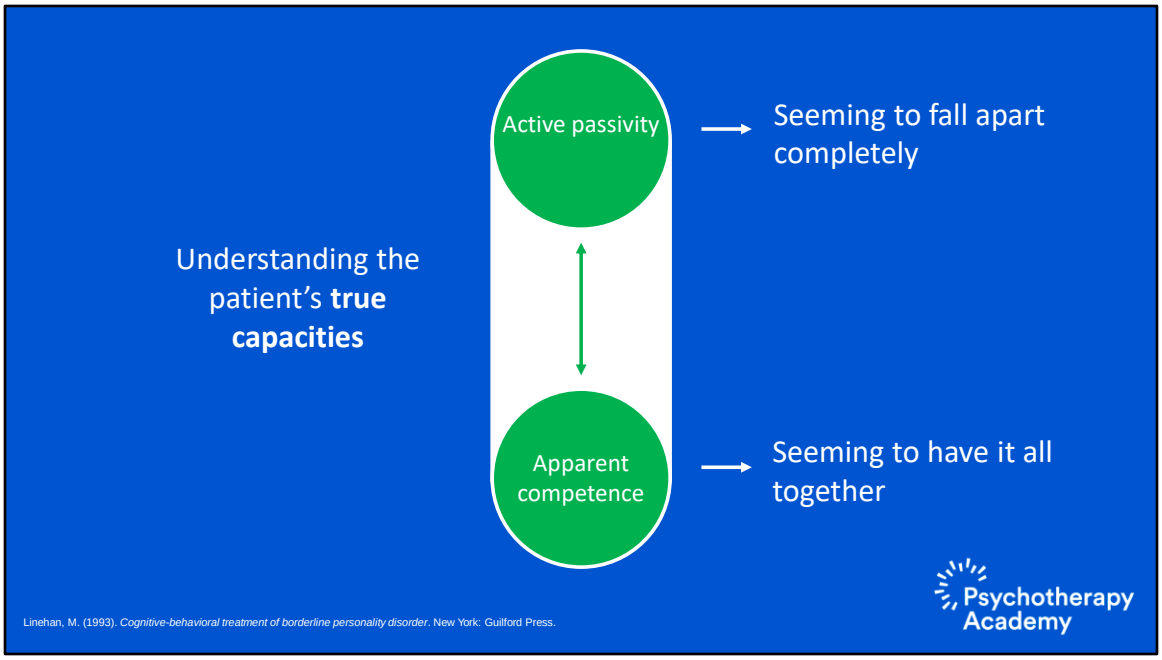
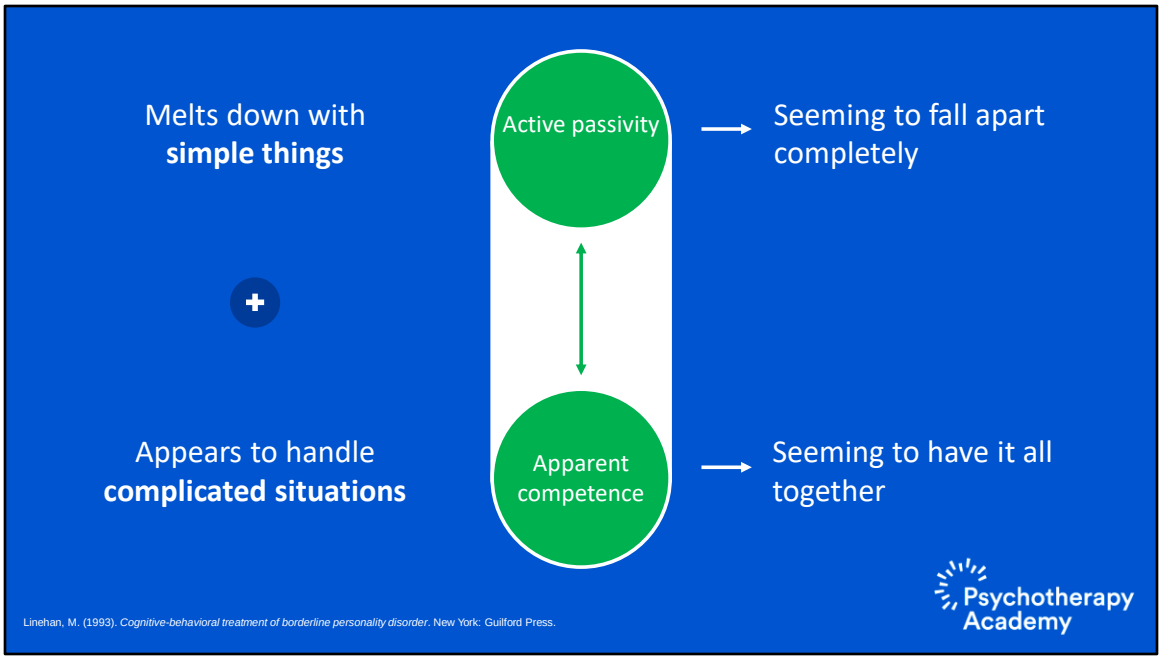
Active passivity versus apparent competence.

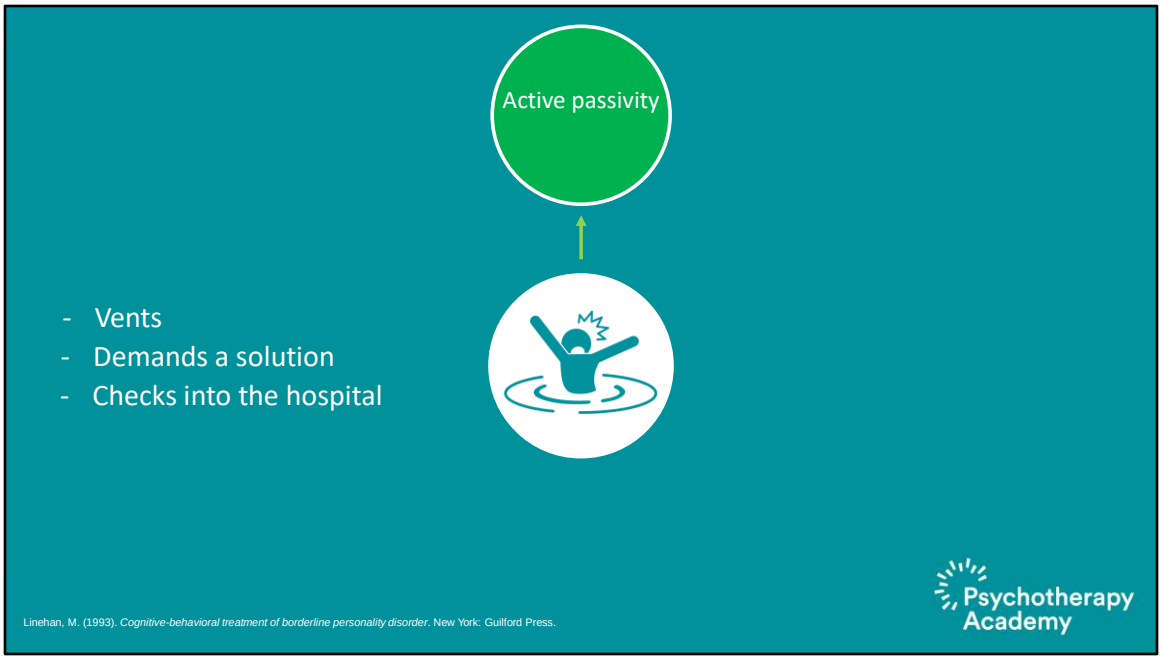


When the dialectical dilemma of active passivity versus apparent competence is in play, the patient and the therapist may have difficulty understanding what the patient's true capacities are because their behavior fluctuates dramatically between seeming to have it all together and seeming to fall apart completely.



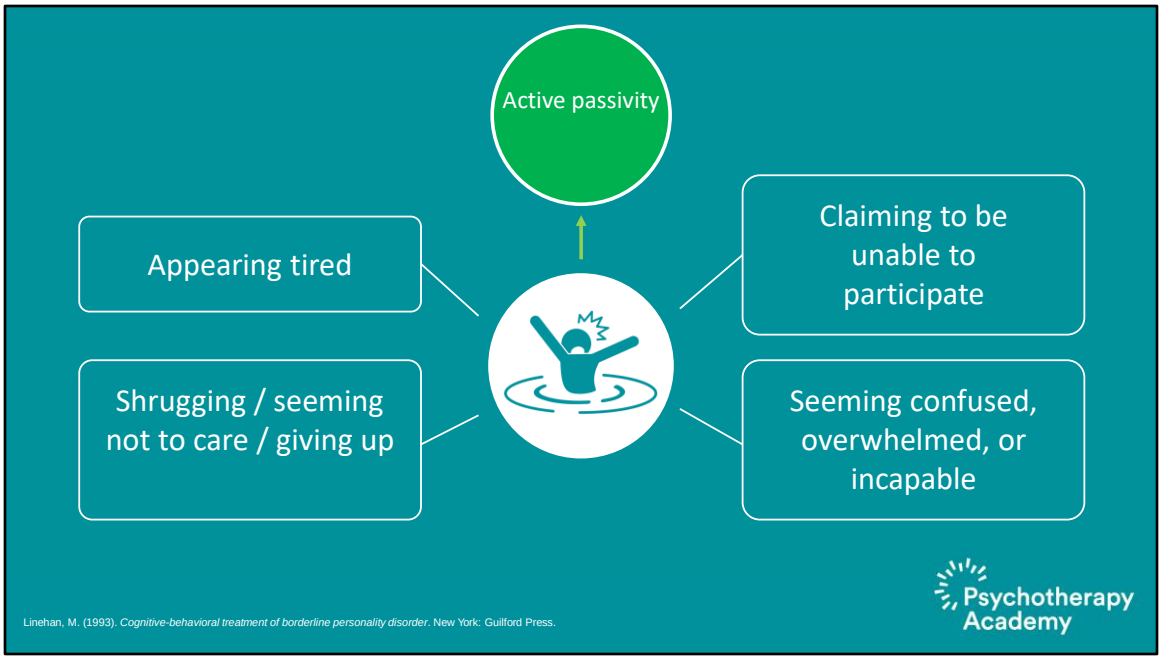
The patient may appear on the surface to be able to handle even complicated situations with ease such as successfully working as a nurse in a neonatal intensive care unit but then paradoxically melts down when deciding on simple things such as choosing a paint color.

When on the side of active passivity, the underlying message is if you don't help me, I may die. Problems are approached in a manner which appears more helpless and emotion focused rather than engaged and active in working to find a solution.

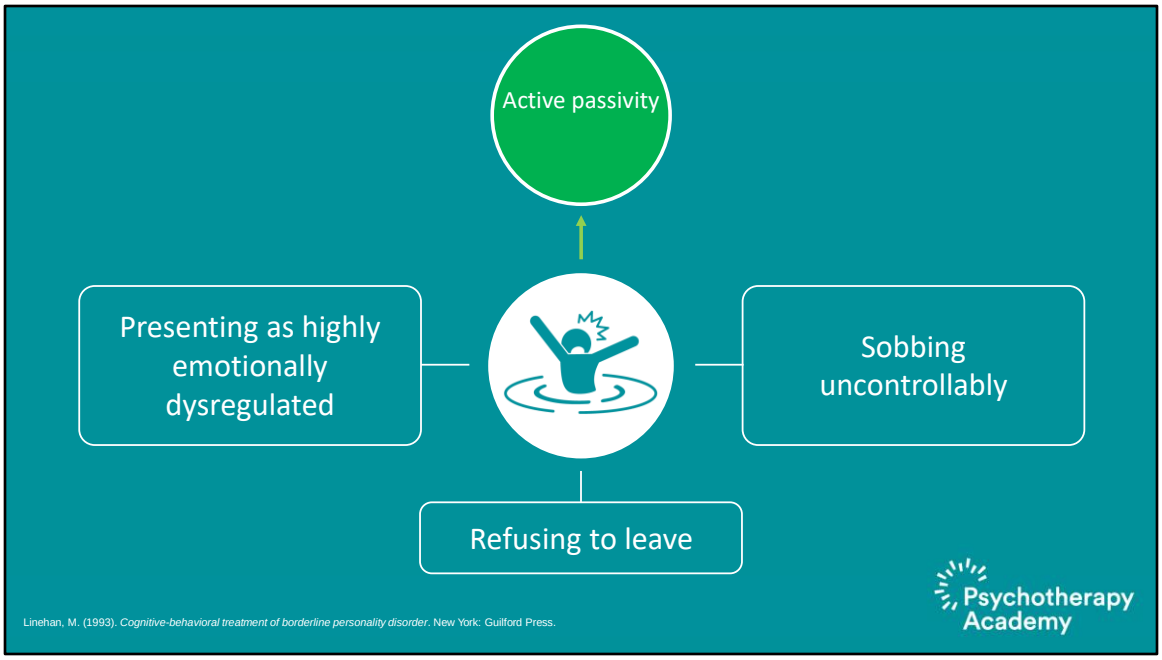


They may vent about the problem, demand a solution from the therapist or check themselves into the hospital.

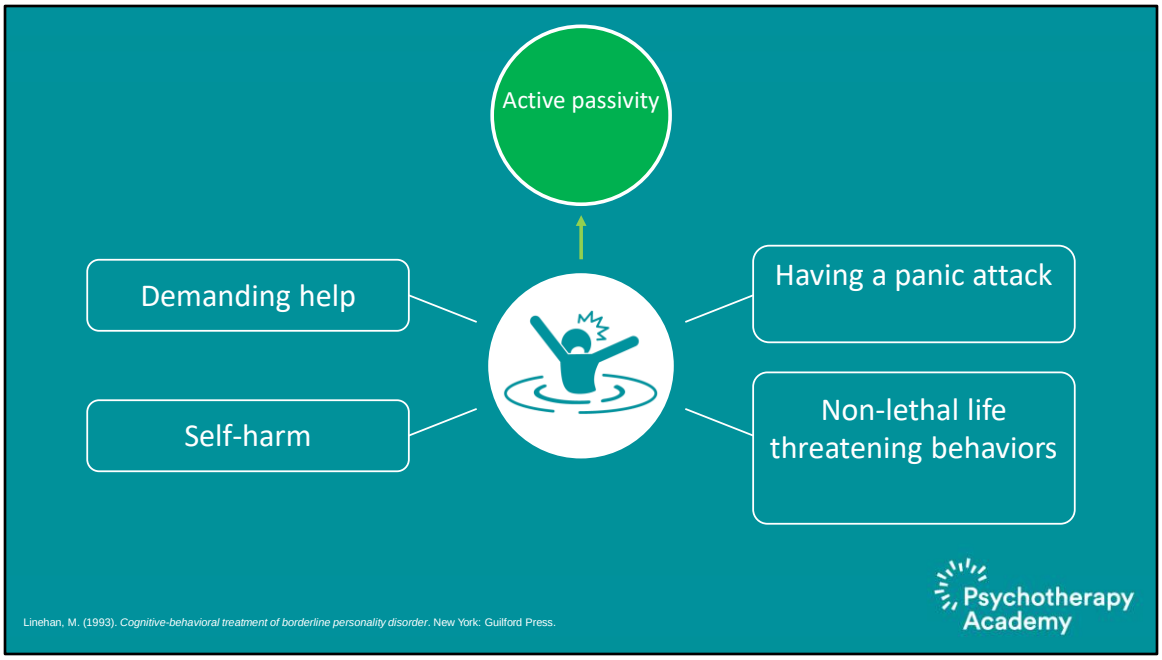
This approach differs from learned helplessness in that in learned helplessness, the person truly gives up without expecting a changed outcome while in active passivity, the function of the helpless behavior is to invoke others to engage in problem solving on their behalf.



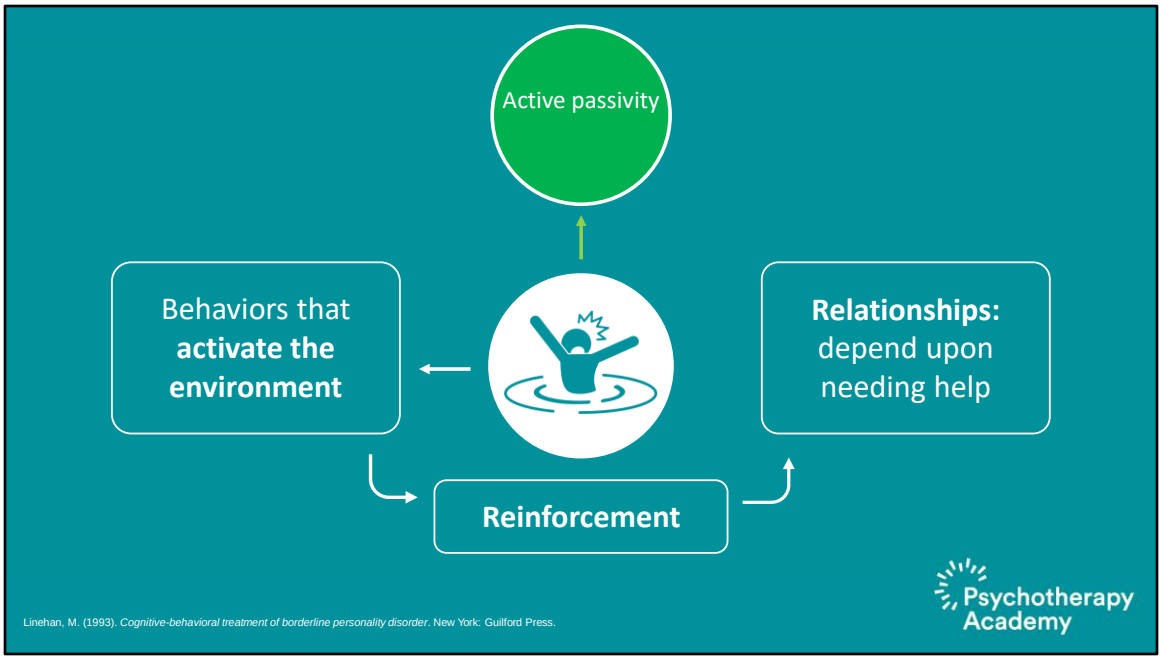
Other associated behaviors include yawning, appearing tired or claiming to be unable to participate, shrugging, seeming not to care and giving up in the face of a large problem, seeming confused, overwhelmed or incapable.



Presenting as highly emotionally dyregulated or out of control, sobbing uncontrollably, refusing to leave the therapist's office.

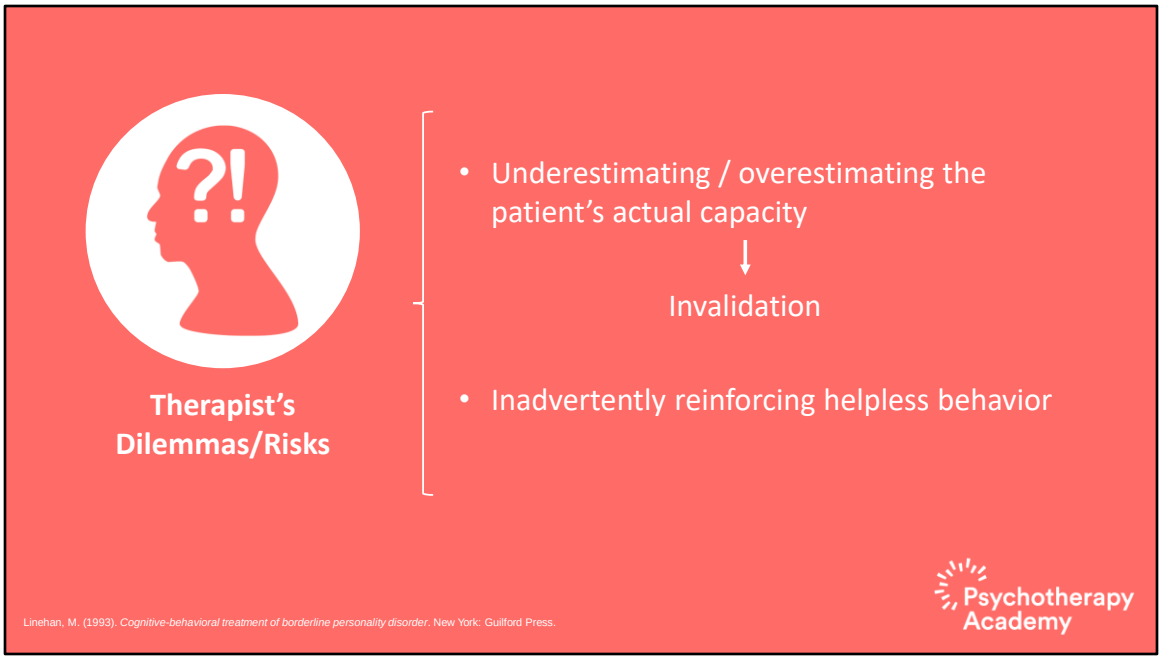


Demanding help, having a panic attack, engaging in self-harm and other non-lethal life-threatening behaviors.

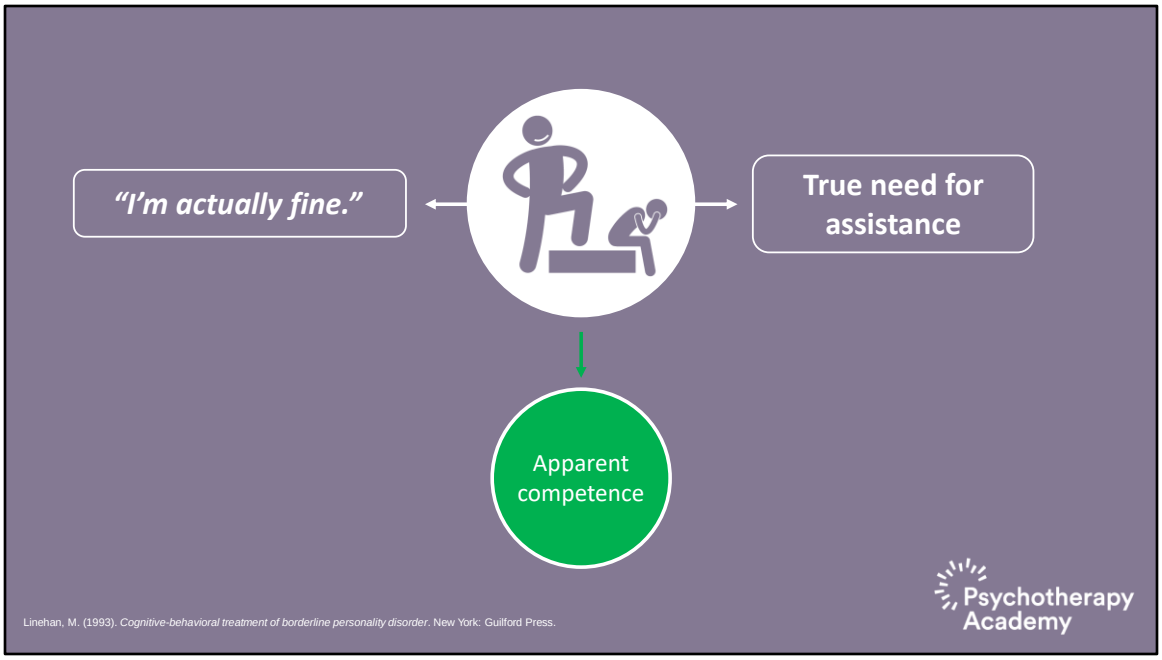


These behaviors serve to activate the environment and thus the individual is highly reinforced for exhibiting them. In addition, some or all of the patient's relationships may depend upon the degree to which the patient needs help such as in a treatment setting.

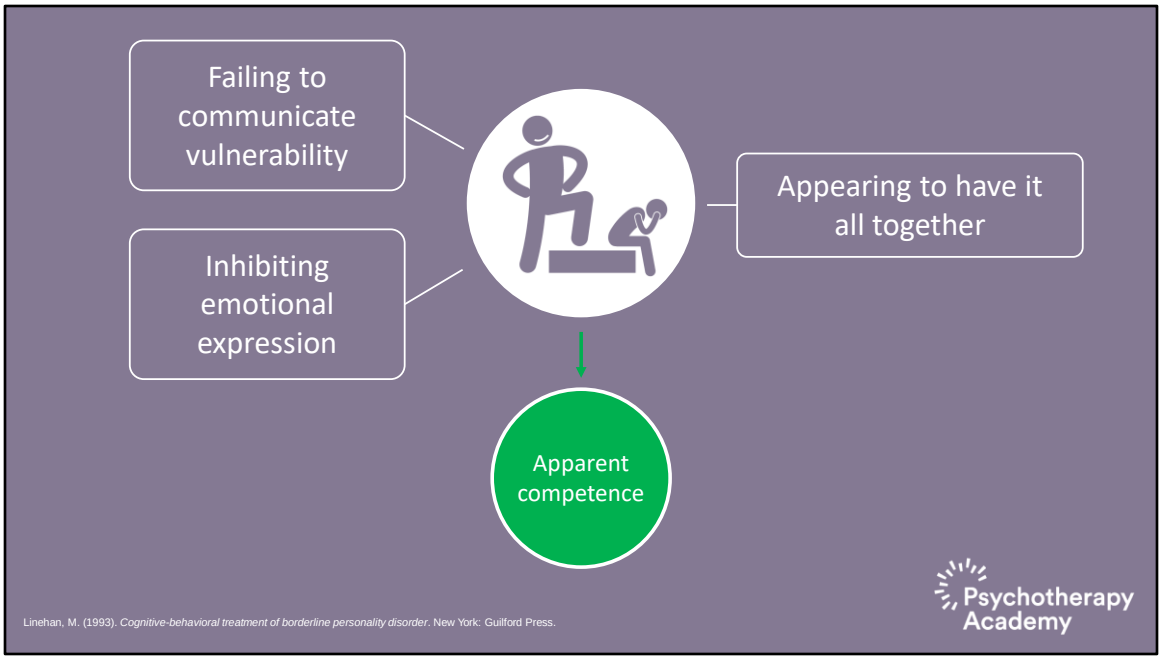
So helpless behavior may be reinforced because it sustains relationships the patient desperately desires.



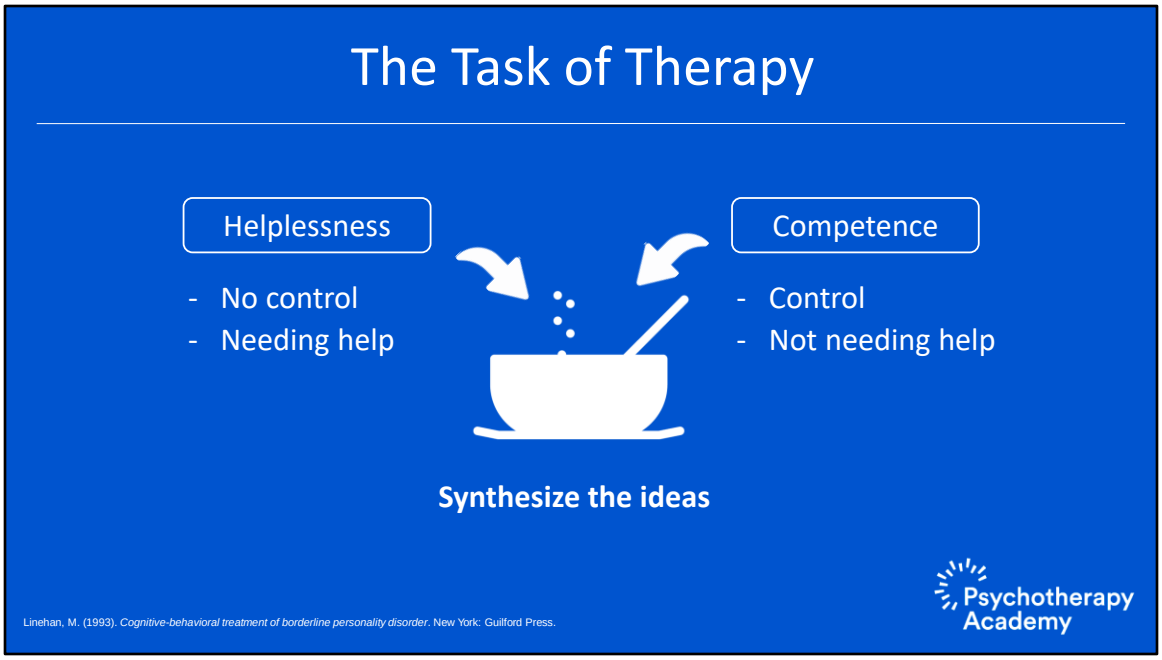
The risks in therapy include underestimating or overestimating the patient's actual capacity which can lead to invalidation. Another risk is inadvertently reinforcing helpless behavior.



By contrast, when on the side of apparent competence, the message is I'm actually fine while the underlying issue is a true need for assistance.



On this side of the dilemma, the patient fails to communicate vulnerability clearly, inhibits emotional expression and appears on the surface to have it all together only to flip to the other side of active passivity when their needs are not recognized or met.



With this dialectical dilemma, the therapist needs to teach the patient to synthesize the ideas of both helplessness and competence, of control and no control and of needing and not needing help.

The Therapists' Tasks

- Teach how to:
  - Recognize their own internal distress
  - Ask for help effectively
- Maintain a collaborative relationship
- Validate the incredible difficulty of change **and** require active progress

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

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Therapists can teach patients how to recognize their own internal distress and how to ask for help effectively. A collaborative relationship between the therapist and the patient both participating actively is important. The therapist validates the incredible difficulty of change and requires active progress all the same in the face of whatever the difficulty is the two of them are addressing.

Key Points

- In **active passivity vs. apparent competence**, the patient fluctuates between appearing able to handle life issues and being completely incapable or unwilling to do so.
- Be alert to the risk of **over- or underestimating** the patient's true capacities in order to avoid **invalidation**.
- Synthesizing the idea of **helplessness** and **competence** (being capable and incapable) is the task of therapy in this dilemma.

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

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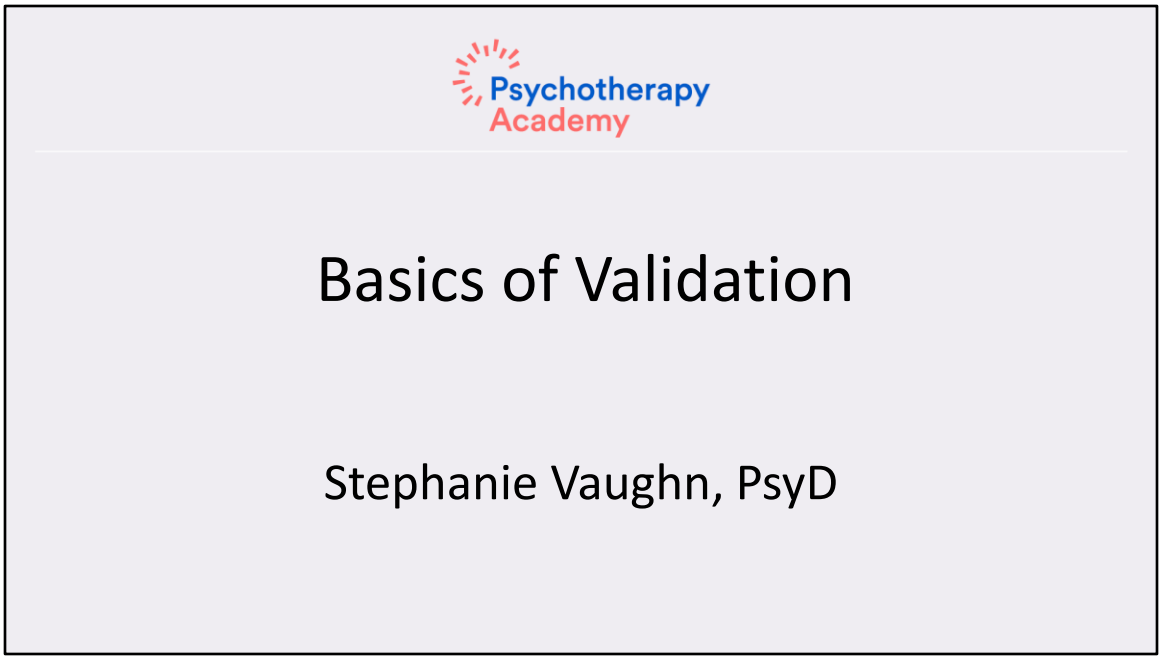
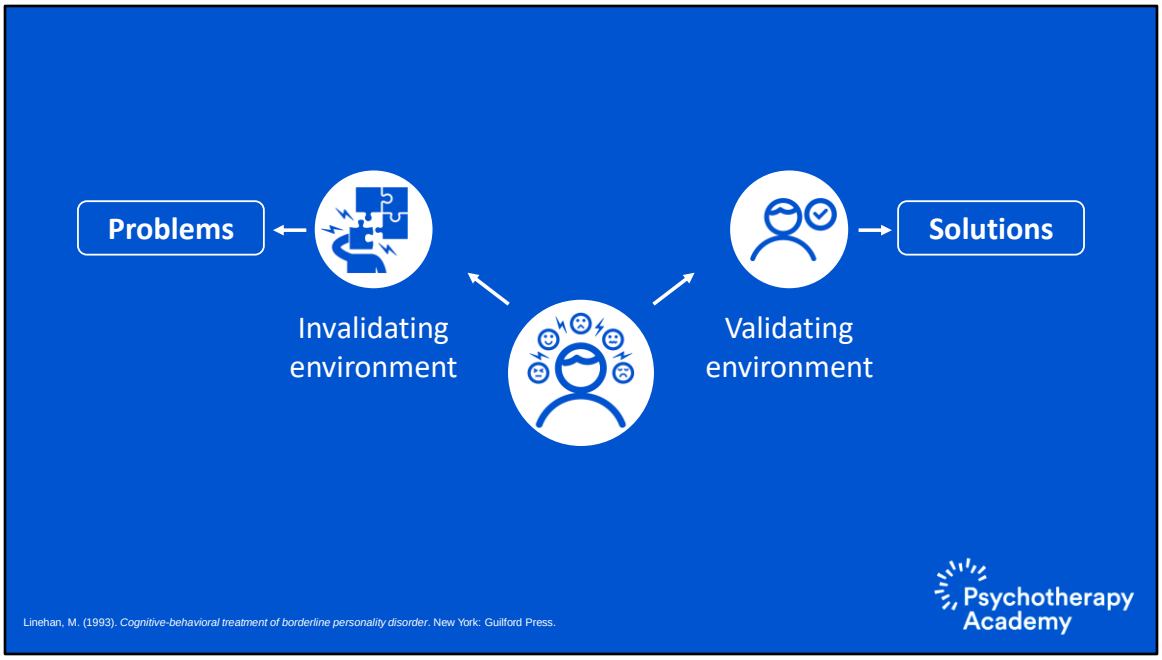
The key points :
In active passivity versus apparent competence, the patient fluctuates between appearing well able to handle life issues on the one hand and seemingly completely incapable or unwilling to do so on the other hand.
It is important that the therapist is alert to the risk of over- or underestimating the patient's true capacities in order to avoid invalidation. Synthesizing the idea of helplessness and competence and of being both capable and incapable is the task of therapy in this dialectical dilemma.

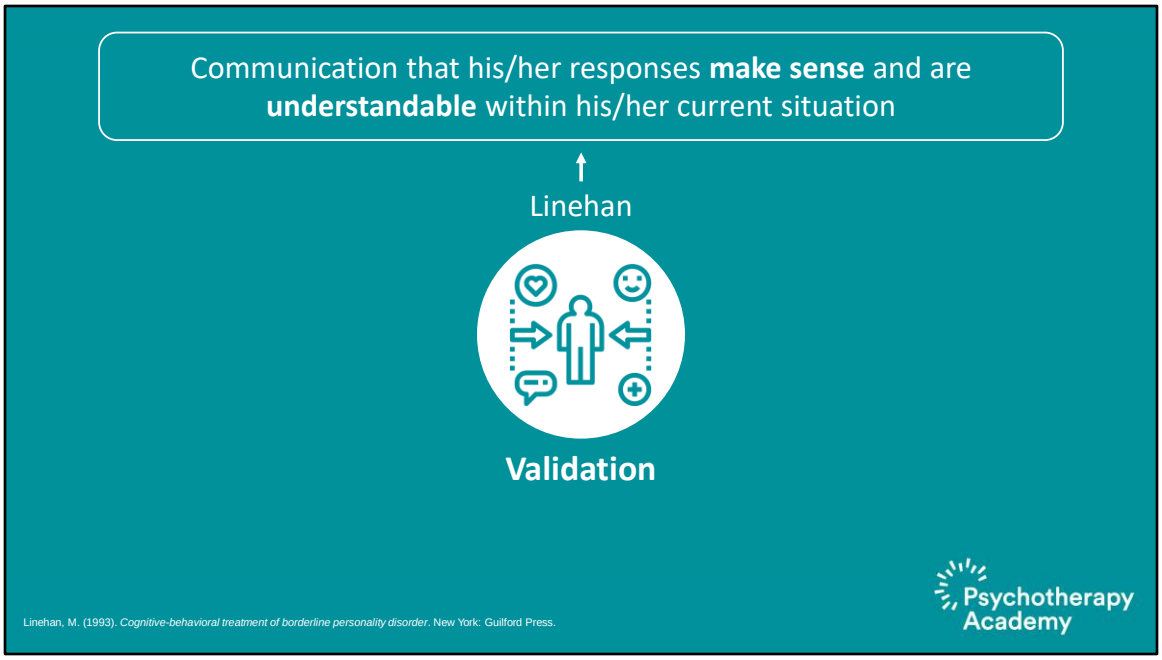

Next Presentation:
Basics of Validation
Psychotherapy
Academy



Basics of validation.



It stands to reason that if an invalidating environment creates problems for an emotionally dysregulated person then a validating environment would be part of the solution.



Linehan defines validation as a communication to the person that their responses make sense and are understandable within her current life context or situation.

I like to think of validation as a stubborn refusal to treat a person like they're bad, crazy or wrong no matter how they're behaving. Obviously, this can be challenging at times particularly when the behavior is difficult to validate.

What's the purpose of validation?

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

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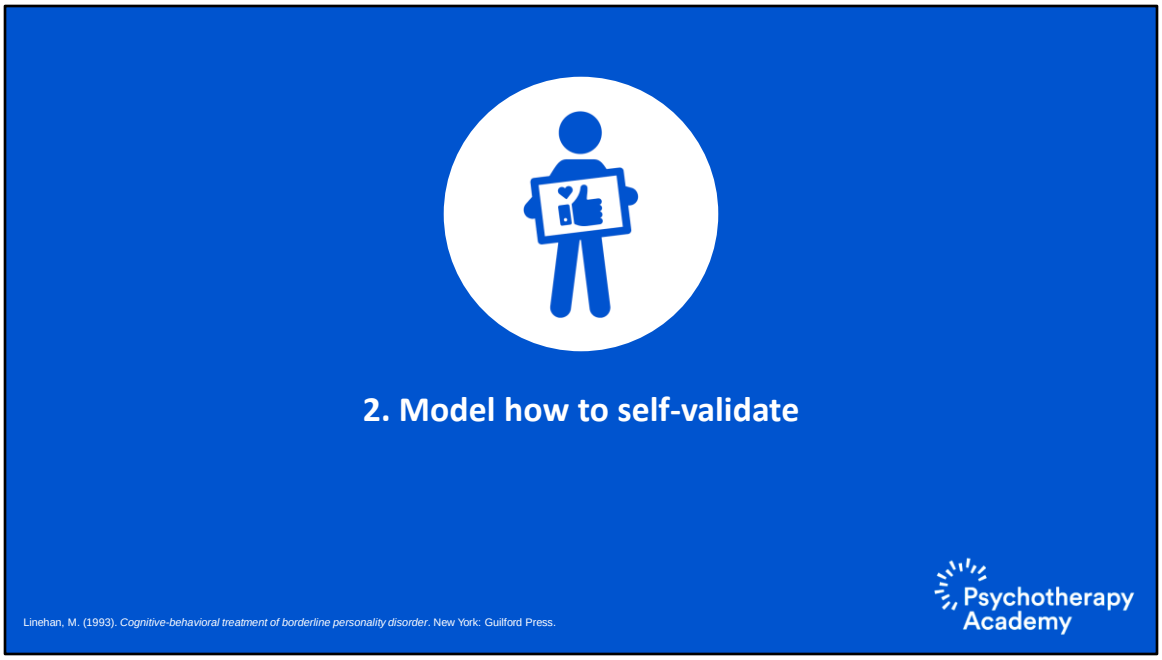
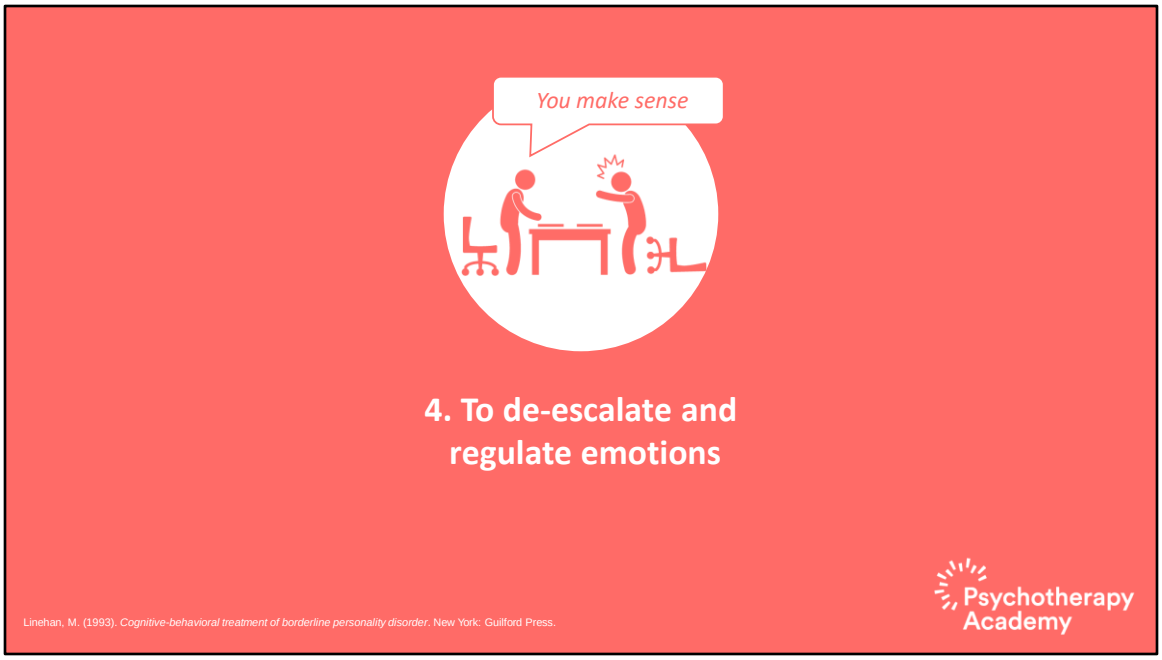
So what is the purpose of validation in DBT? Why do we do it?

We do it for a variety of reasons one being to balance all of the change strategies that DBT has. Each patient will require a certain amount of validation in order to balance that change and it will fluctuate from patient to patient. Some will need more than others.

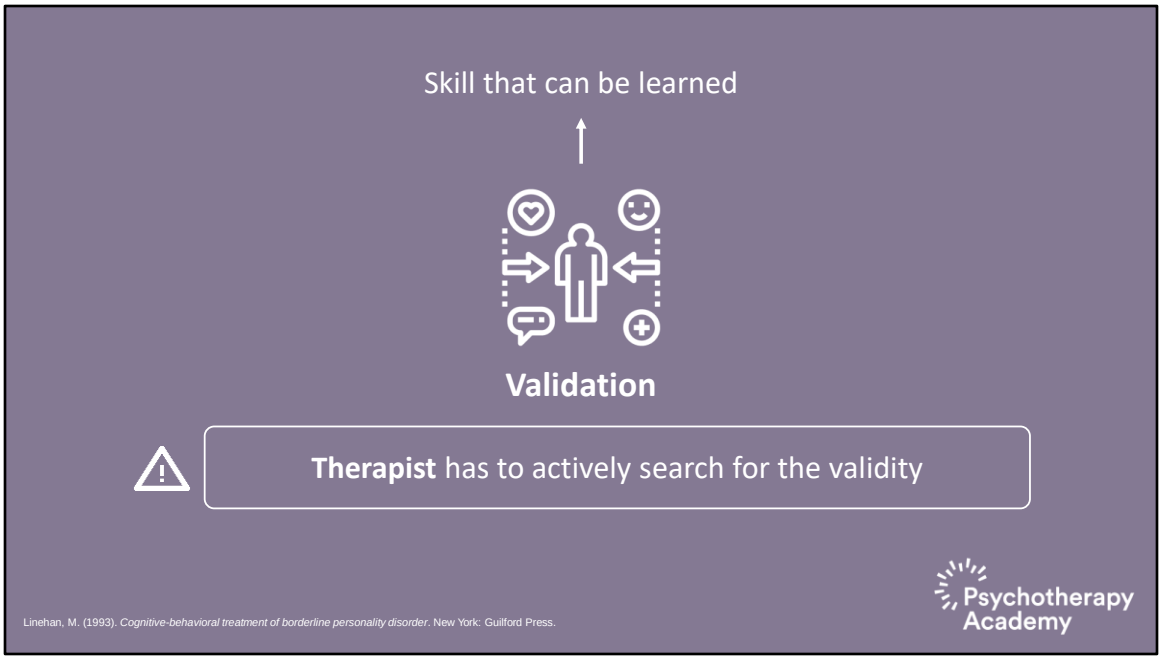


Another reason is to model for the patient how to self-validate. So when we are validating them, we're demonstrating to them how to validate. And ultimately, having the patient validate themselves is where we are headed.

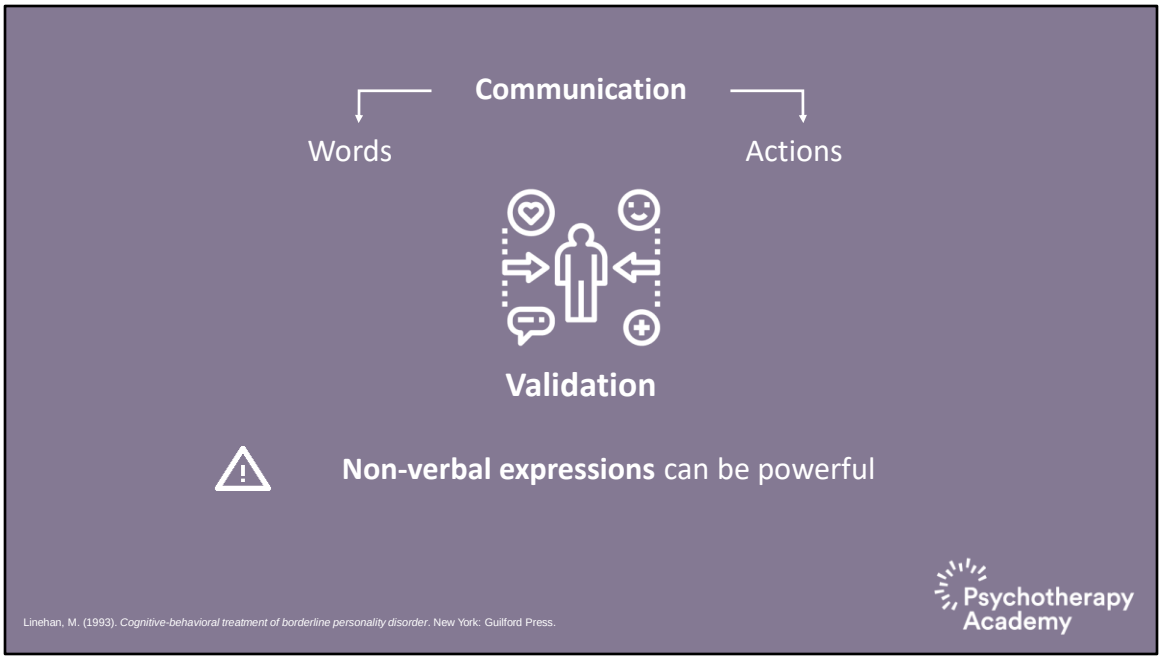
In addition, validation develops and maintains the relationship. It's much easier to build a relationship if someone is validating and you as the therapist are going to need to be able to do that from the very beginning.



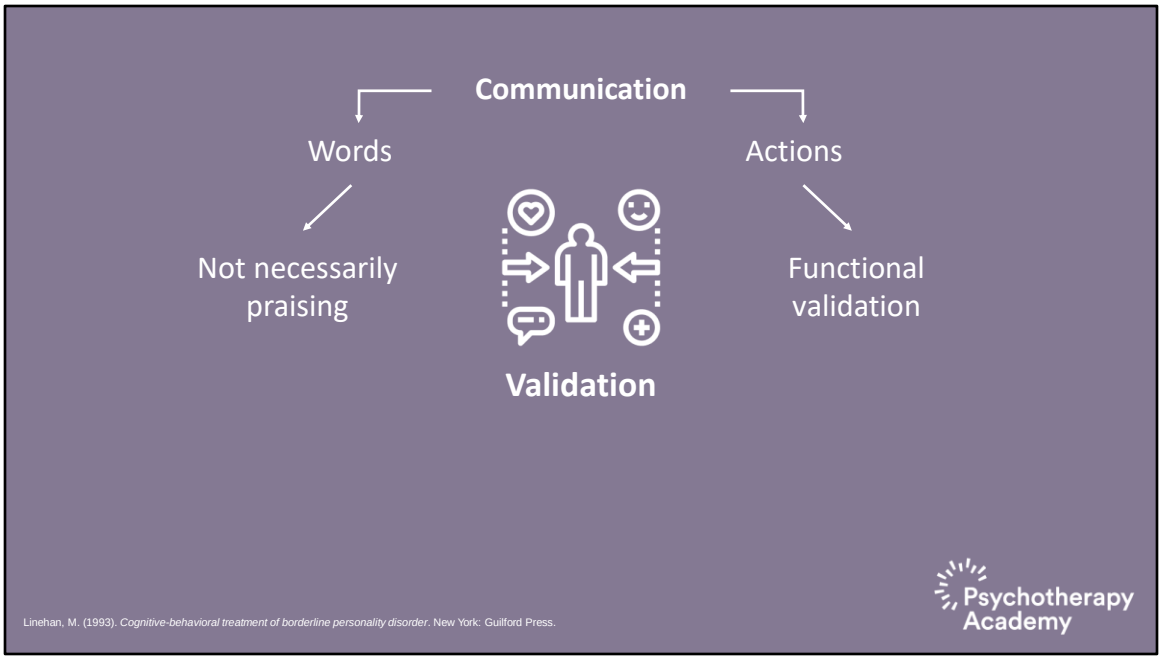
Finally, we use it to de-escalate and to help the patient to regulate their emotions. In addition, we're helping them to label these emotions as we're helping them to de-escalate and regulate them. We are constantly giving them the message you make sense. And even if you don't make sense, I know that it's only because I'm having difficulty figuring it out. And so can you help me get there?



Validation is a skill which can be learned and practiced by anyone and in this case we are mainly talking about the therapist. In order to validate, it is important to actively search for the validity. So this isn't something that will just fall in your lap. This is something that especially working with patients who have a lot of therapy-interfering behaviors is going to be more difficult. So you have to actively search for the validity much like trying to find a nugget of gold in a cup of sand as Linehan puts it.



Validation involves communicating with both words and actions. Non-verbal expressions like eye contact, nodding, smiling, eyebrow furrows and the like can be powerful tools to communicate validation. I once helped a couple by teaching the wife how to simply nod while her husband was trying to explain himself. Prior to that, as he would stumble through what seemed to be an awkward explanation, she would simply look at him. And watching from the outside, I could tell that that was part of the discomfort that he was feeling, was the lack of non-verbal validation. So I coached her on that and it made a ton of difference. So we also want to make sure that we're using not only our words but also our actions.



Beyond words, functional validation puts action behind them so not just non-verbals but actual actions. So for example, instead of validating how heavy that door is, you might step in to help a person actually open it. That would be an example of functional validation.

When validating verbally, it's not necessary or even advised to praise or to try to make someone feel good. Validation is not about making someone feel good although feeling good or feeling more peaceful might be an outcome. Although cheerleading and pointing out the positives may be validating for some, that can be actually highly invalidating for others. You might think about a time when you've been grieving a loss. This could be a profound loss or just an irritating loss of something and someone attempted to show you the positives and this is showing you the positives without you coming around and deciding that on your own or asking them to help show you the positives. So that experience was likely not so validating.

How to validate successfully

Location perspective

↓

Their view of where they are in their life

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

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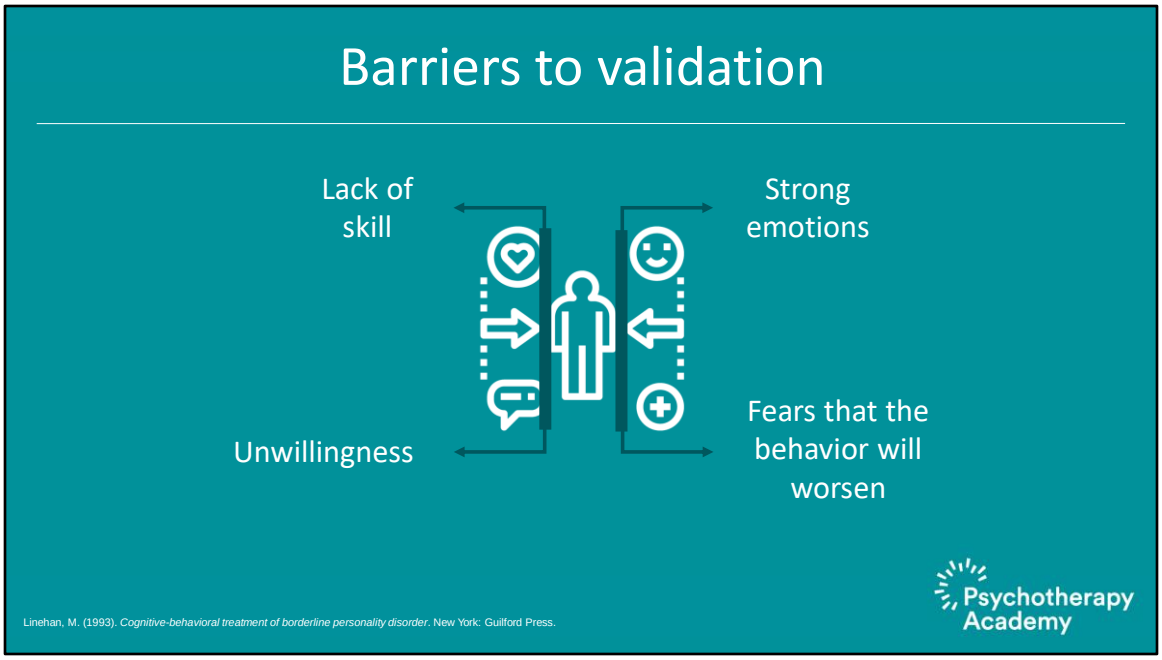
In order to successfully validate, you must identify with what we call the client's location perspective. In other words, can you see it their way? Can you put yourself in their position, where they are? That's the location, you know, where they are in time, where they are in their lives, where they are in terms of their experiences and what they've gone through, how they're feeling. Do you get them? Location perspective is their view about where they are in their life, how they see things at this point in time. Much like you wouldn't want to take driving directions from someone who had the wrong idea about where you are actually located to begin with, similarly clients don't want to take advice and aren't willing to take advice from someone who doesn't seem to understand where they're coming from and doesn't get them.



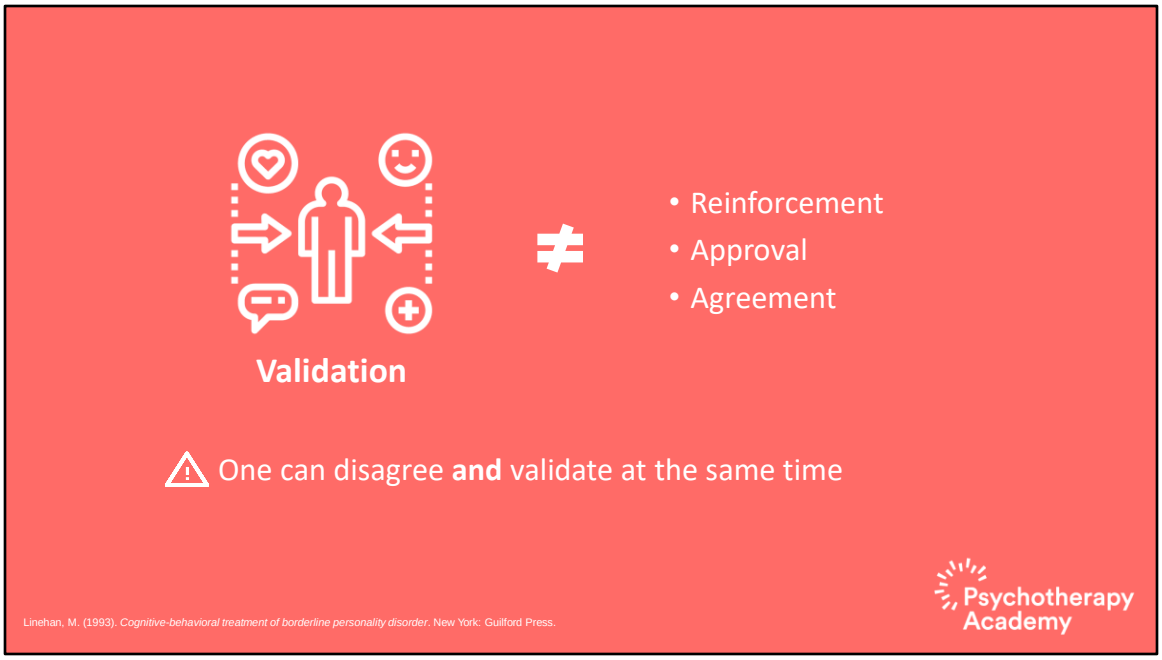
There are certain barriers to validation that come up for everyone. The first is just a general lack of skill. You may not know how. You may be a fine validator whenever you can organically see the validity, when you agree with the other person's perspective but when it gets beyond that, then you struggle. So that's where going to those six levels of validation that we're going to discuss later is going to be helpful to find that nugget of gold in the cup of sand. So a lack of skill or never having been taught.

Second, strong emotions. So when our emotions get intense, when things get heated, then of course, we have less access to information that would help us find what is actually validating about a situation. So we don't have as much access to our brain and strong emotions will definitely make it more difficult. So it's important to practice. And when you practice, it's important even to practice with someone else using something more emotionally salient. When I'm teaching graduate students, I will often have them role play with another student and have the other student criticize them. So it's definitely more difficult when you've got skin in the game so to speak.

Another barrier is a lack of willingness. Sometimes, due to multiple aversive interactions, the therapeutic relationship might be damaged to the point that validation is withheld as resentment grows. So you as a therapist might not be willing

to. You might wish that you were willing to but just generally might not be willing to validate. It's important to use peer consultation team when and if this occurs to discuss it and use your own skills to get yourself back to a place where you can be willing to validate.

And finally, there is at times especially with new therapists practicing DBT a fear that the patient's behavior will worsen. So if I am validating that a person cut themselves, for example, I might be afraid that this validation means that I'm condoning it or that I'm reinforcing it in some way. And it's important to recognize the difference between validation and reinforcement. And of course, we don't want to validate something that is reinforced, a problematic behavior that is reinforced by validation. But these are going to be less common than you would imagine and we want to make sure that we have some data to back that up.



And it's important to recognize the difference between validation and reinforcement. And of course, we don't want to validate something that is reinforced, a problematic behavior that is reinforced by validation. But these are going to be less common than you would imagine and we want to make sure that we have some data to back that up. Validating something again doesn't necessarily mean agreeing, condoning and it doesn't have to reinforce the behavior. Validation is not approval. It's not agreement. In fact, it's okay to disagree and to validate at the same time. That's the dialectic.

Validation

=

Communicate that you **respect** them and their point of view

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

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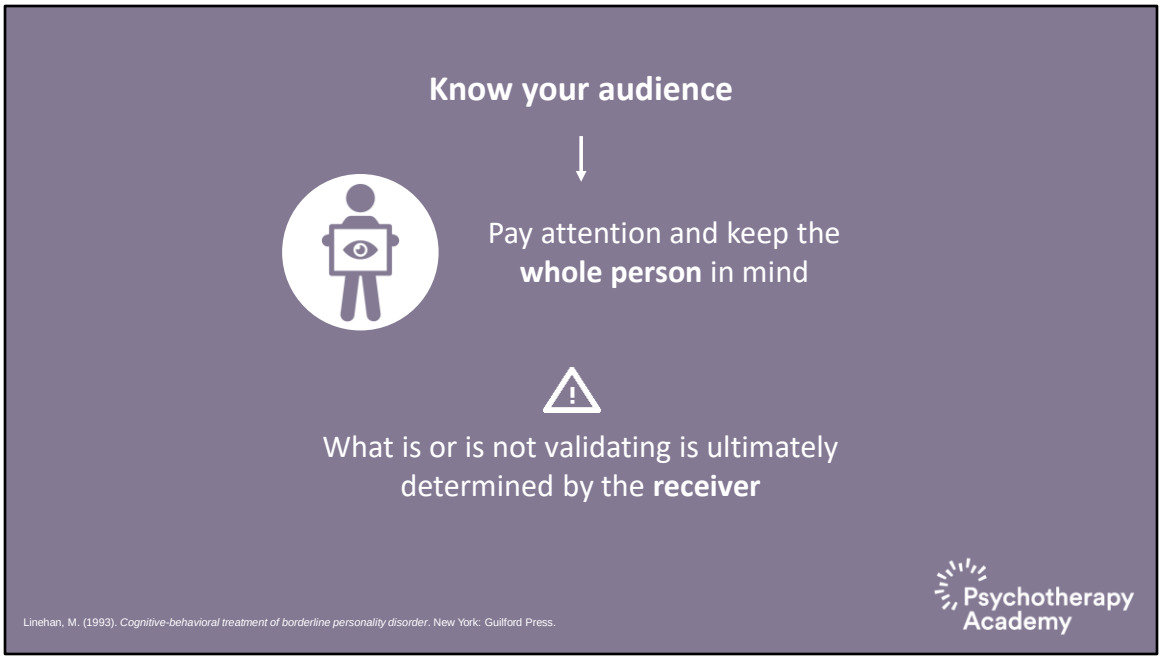
It's the ability to see things from their eyes and interact in a way that communicates that you respect them and their point of view even if you do not agree with it. So it's really helping reflect to them how they make sense even if you do not agree.



Because the same statement may be validating to a person one day but extremely invalidating the next and it may be validating to one person and then not to another, it's important to know your audience, being fully present, listening closely to what is said and what's implied, watching body language and remembering to keep the whole person in mind. Keep that whole person, everything that you know about them when you are verbalizing your validation so that you're not simply validating a statement. You're validating based on the context of what you know about the whole person. This will help inform your decisions about what to say or what not to say even.

It would be remiss if I didn't point out that what is validating or invalidating is ultimately determined by the receiver not the sender. When I'm writing notes and I teach supervisees to write notes, I always describe my interventions based on validation as that I attempted to validate. I don't want to say, oh, I validated so and so because I may not be aware of how it was received. That may have been experienced as extraordinarily invalidating. So I want to say I attempted to validate instead of that I did. Keep in mind that you can only do your best when it comes to validation and I can certainly validate the difficulty of validating.

Key Points

- Validation is used to balance **change strategies**, teach the patient **how to validate themselves**, maintain the **relationship,** and reduce **emotional dysregulation**.
- Validation is **not** necessarily **agreement, approval,** or **condoning** behavior but is a stubborn refusal to treat anyone like they're bad, crazy, or completely wrong regardless of their behavior.
- What is validating for one person is not necessarily the same for another.

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

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Key Points
Validation is used in DBT to help balance change strategies, to teach the patient how to validate themselves, to maintain the relationship and to help reduce emotional dysregulation.
Validation is not necessarily agreement, approval or condoning behavior but is a stubborn refusal to treat anyone like they're bad, crazy or completely wrong regardless of their actual behavior.
What is validating for one person is not necessarily validating for another person.


Next Presentation:
Invalidation in Therapy
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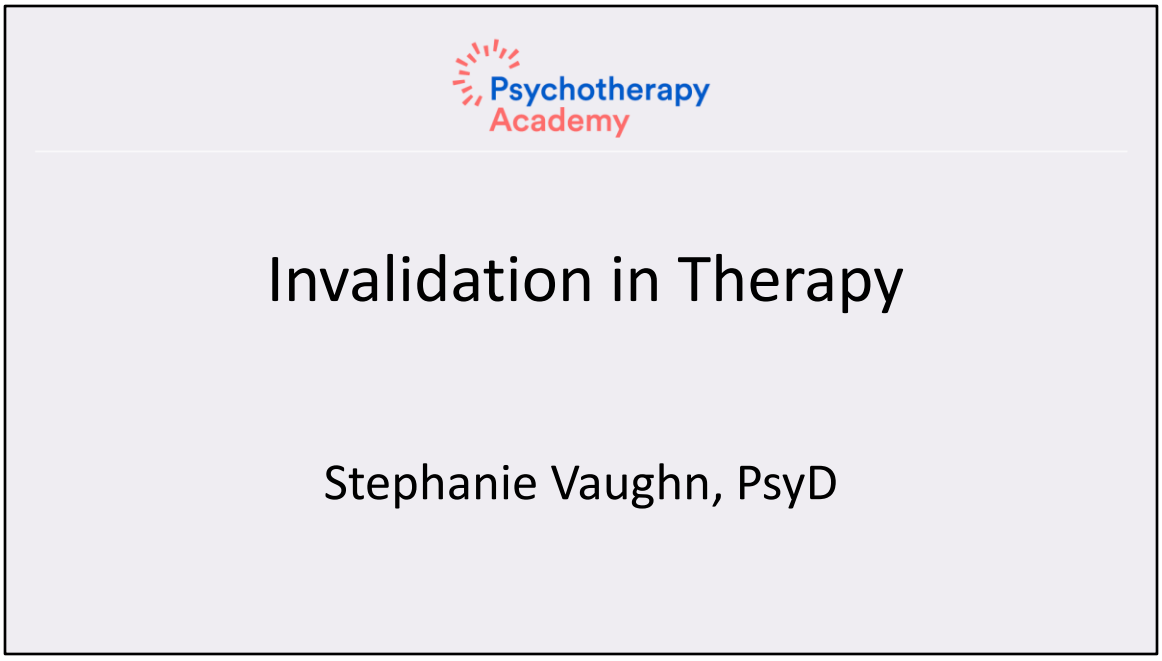
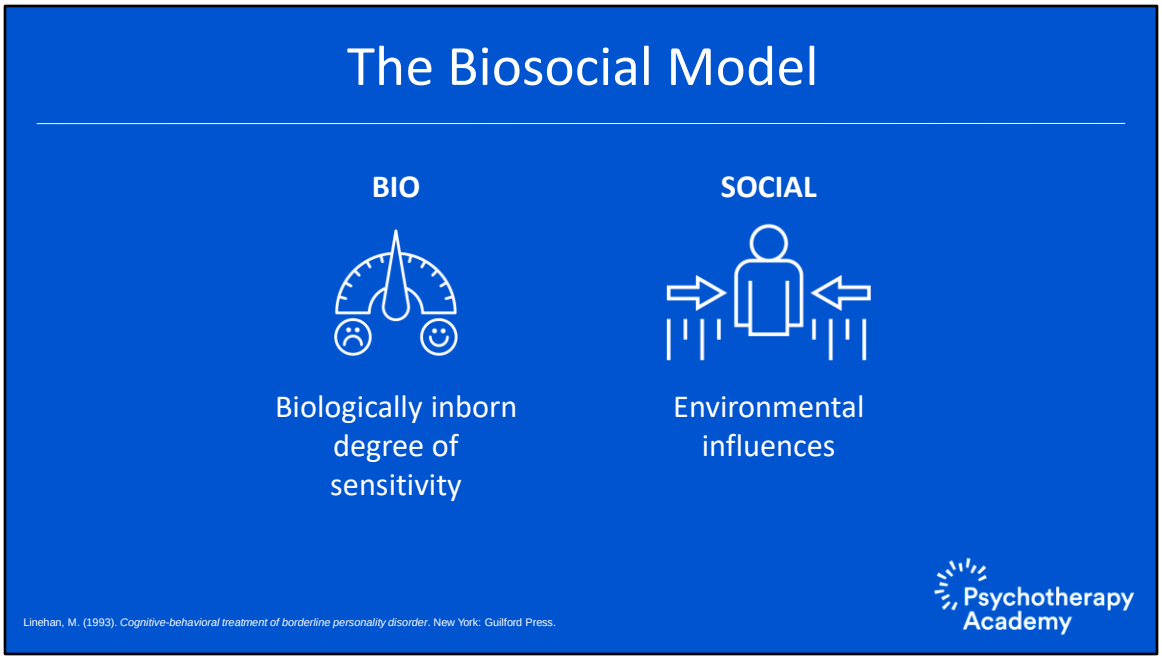
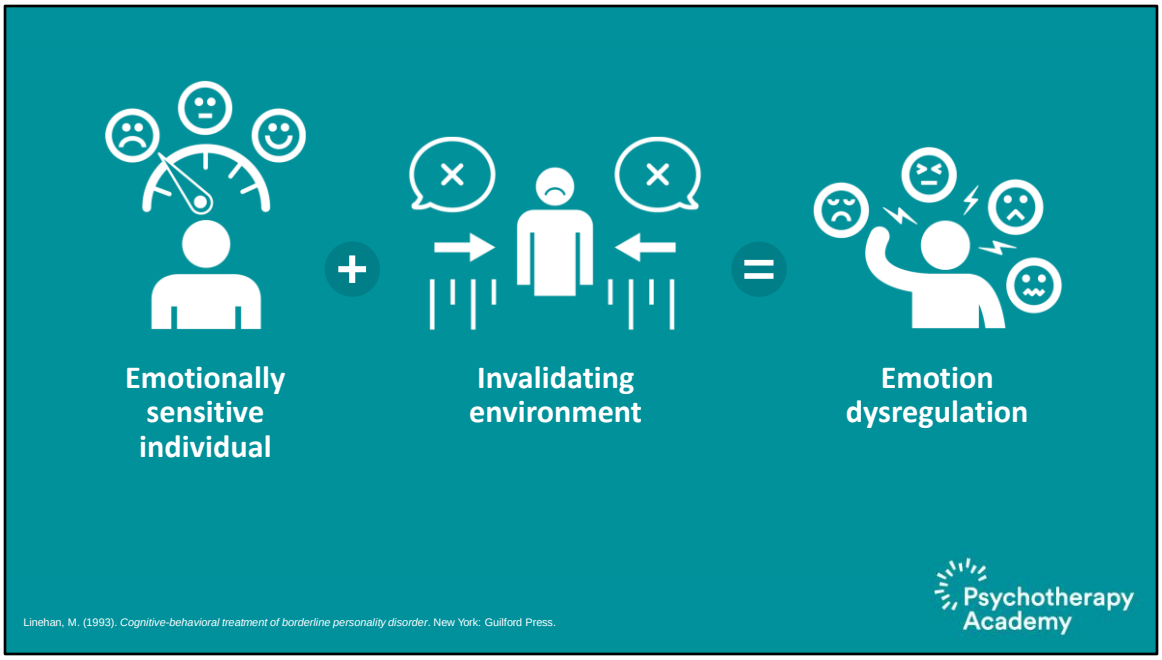
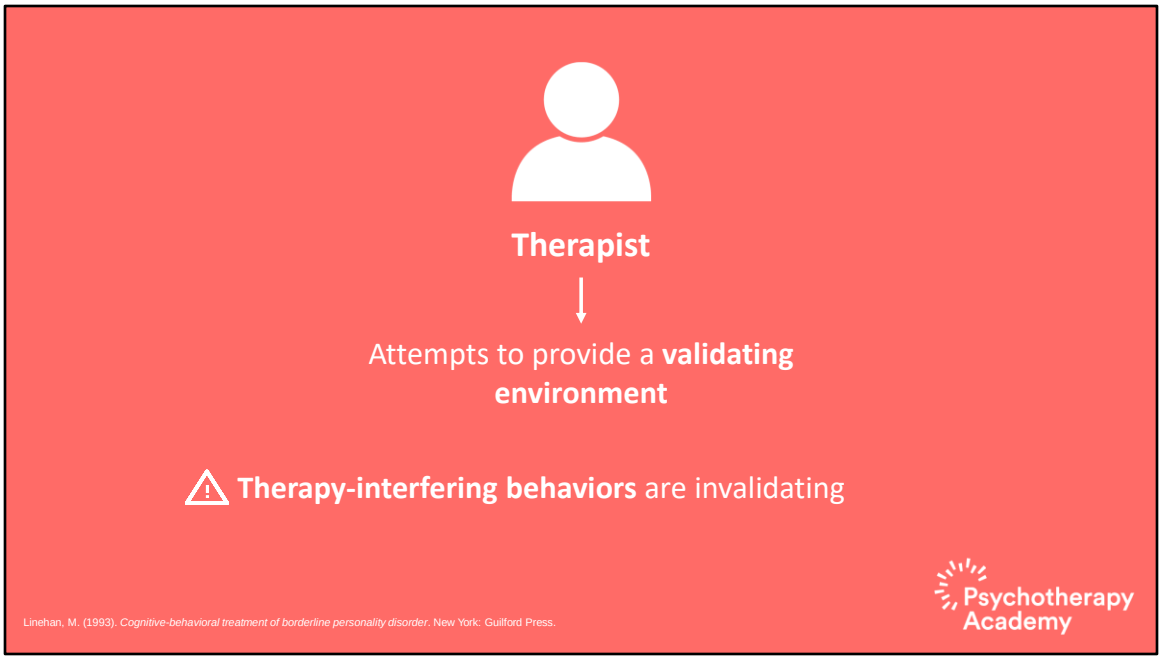

Psychotherapy
Academy
Invalidation in Therapy
Stephanie Vaughn, PsyD



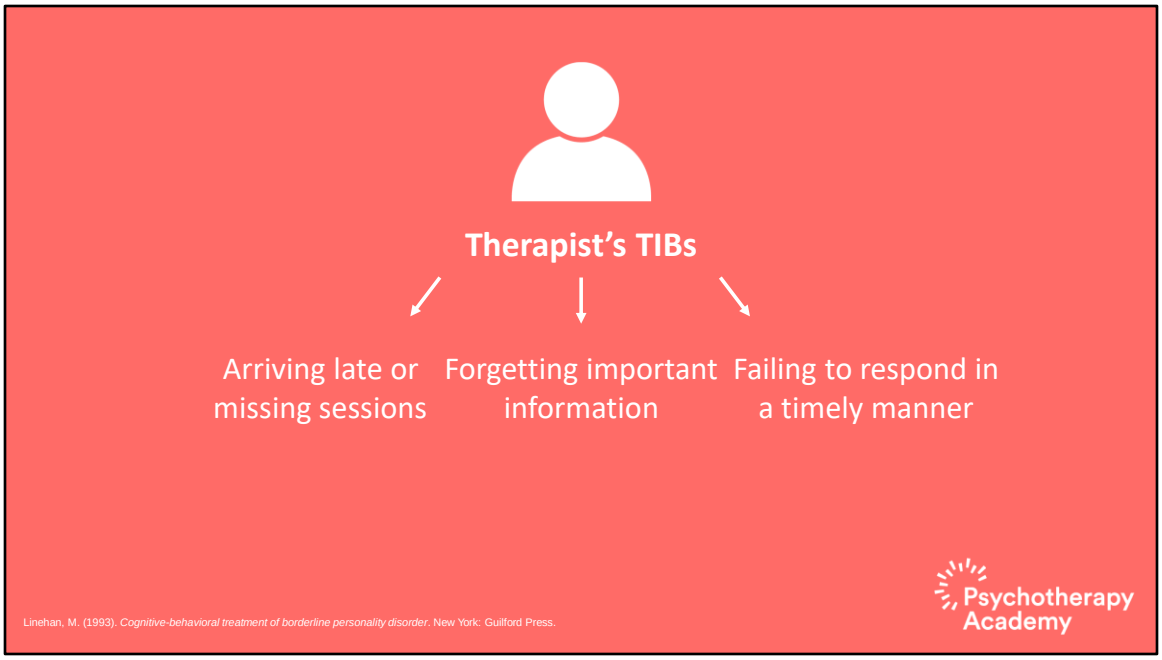
You may recall that DBT's primary theoretical stance on how problems arise involves consideration of the biosocial model. The bio half in biosocial accounts for the biologically inborn degree of sensitivity each of us is born with. And the social half accounts for the environmental influences we each experience on a daily basis.



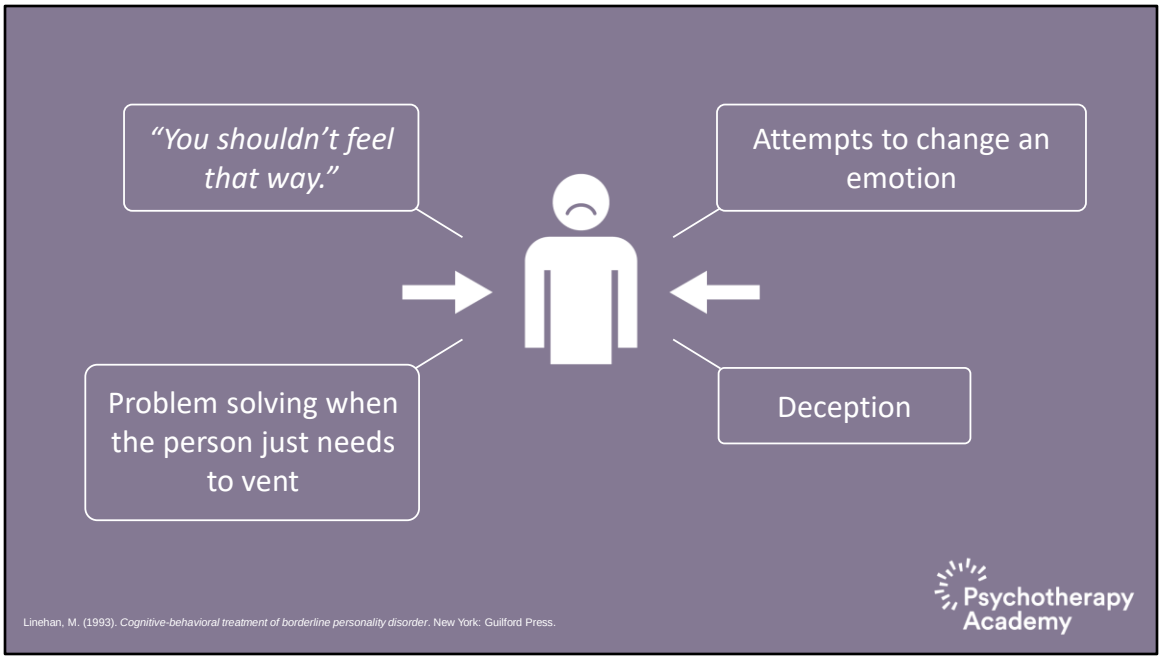
According to the theory, it is the transactions over time between an emotionally sensitive individual who is born that way and an invalidating environment which lead to extremes in behavior that can be seen in borderline personality disorder and other disorders characterized by emotion dysregulation.
Although an invalidating environment doesn't have to be abusive, abuse and neglect are certainly examples of invalidation.



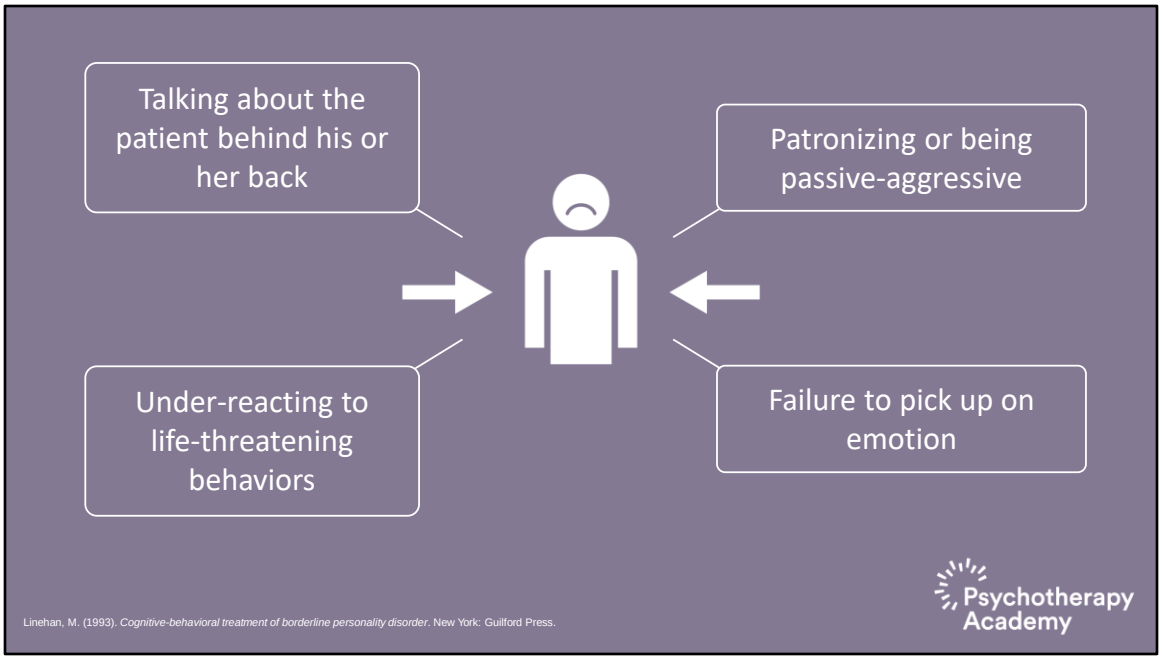
In DBT, the therapist attempts to provide a validating environment in which the patient may more easily change. While it's not expected or even advised that a therapist validate all the time, it is important to keep invalidation to a minimum. So therapy-interfering behaviors are considered invalidating.



DBT refers to behaviors of the therapist which interfere with therapy such as arriving late or missing sessions, forgetting important historical information about the patient or failing to respond in a timely manner to the patient's request for intersession contact as therapy-interfering behaviors.



There are subtle examples of invalidation that you may experience not within your role as a therapist and you may recognize some of them. Hopefully, these don't come up in therapy but it's important to discuss them in case they do. So an example would be saying you shouldn't feel that way or attempts to change or challenge an emotion. Keep in mind that attempts to change an emotion – We have an entire module based on changing emotion. So I'm not saying that changing emotion is always invalidating but we need to keep in mind that if we're constantly trying to change the other person's emotion, that can be perceived as extremely invalidating. And just the feel of, if you can imagine someone saying well, you shouldn't feel that way, just the feel of receiving that, you get some sense of what it means to be invalidated.
Another example would be problem solving when the person really just needs to vent. And reflexively at times, we tend to step in and try to problem solve. As therapists, we are often at our core problem solvers. But there are times when a person just wants to vent and we need to be able to validate that as well. Deception can be extremely invalidating and is. If you say that you're going to do something and then you don't do it or you find out that a person has lied about something outright, the feel of that is extremely invalidating.



When we're talking about the patient behind their back and the things that we say we would not say to them to their face. We're supposed to be using consultation-to-the-patient. That means as much as possible we want to have the patient be present when we're consulting. Obviously, that can't happen when we're doing peer consultation team meetings but outside of that, we want to have the adult DBT patient present as much as possible. Otherwise, that can be extremely invalidating.

Patronizing the patient or being passive-aggressive. I think it's easy to slip in to this sort of approach when you're frustrated with the patient. And even when you're working with an adult, you can end up finding yourself talking to them like they're a child. And we want to avoid that as much as possible. Remember this is a real relationship between equals and the way that you talk to the patient is important. Don't ask questions when you mean to make a statement. We have a way sometimes as therapists of being non-committal and asking a question like "well, what do you think would have happened?" when we really mean to say, I think that was a bad idea. So you want to make sure to watch your tone and ask yourself the questions: What am I trying to, what's my intent? What am I trying to bring about?

Being underreactive to life-threatening behaviors. We never want to dismiss or ignore life-threatening behavior. That is very anti-DBT to do so. So when someone has a life-threatening behavior, when they indicate on their diary card that they have self-harmed or that they have suicidal thinking, we want to make sure to address it. Failure to pick up on emotion and the close cousin to that is not calling out the elephant in the room. So if we aren't picking up on anger or we aren't picking up on fear or we're not picking up on frustration toward us as a therapist, then we may not be calling out the elephant in the room. So something has transpired and both the patient and the therapist are thinking about it but they're not talking about it. Then that is a huge barrier. It can make the feel in the room seem very stilted and fake. So we don't want to have that.

Thought challenging which is a cognitive behavioral technique can be a great tool. And as you know, DBT was founded with CBT in mind and uses everything that CBT has in its repertoire. And at the same time, we need to keep in mind that challenging thoughts can be invalidating particularly when we're challenging the patient's thoughts about their opinion of how therapy is going. So if the patient is saying, it's not going well and I'm not making any progress, to challenge that is a fool's game really. And if the person says that they're not making progress in therapy, then your best bet is to truly dive in with them and see what you can validate of that and then we're working together on the same page. Challenging their thought, challenging their opinion of themselves – Again, caveat being sometimes this can be helpful and sometimes this can be simply frustrating on behalf of both parties or it could even reinforce a problematic pattern of self-deprecation. So if a person has the opinion that they're selfish and then we're bringing up, we're challenging that and say, look at all these things that you do for others, then the other person can think that either we do not get it or we're just being nice. And either one of those is really not a great way that we want to be perceived. We don't want to challenge their degree of suffering that they are claiming to have because that's a subjective experience. They're the only ones who can speak to that. And from the outside, we may think that their degree of suffering is less than it is. And so we don't want to use thought challenging on any of those. And we always want to be cognizant when we're using thought challenging of the higher risk of invalidation when we are doing so. Another invalidating experience is doing nothing when something can or needs to be done. So the example from the previous video in which the door is heavy and rather than saying, wow, the door is heavy as a validation, we might actually open the door. So doing nothing, standing there watching someone struggle with the door when we could actually dive in and help could be the ultimate invalidation.

Everyone invalidates. That's important to recognize. When you invalidate the patient and you will, it's not a catastrophe. We have to invalidate at times. Sometimes, invalidation is an important aversive to apply. The ultimate goal is for the patient to be able to recover from invalidation and actually validate themselves.

Key Points

- **Biosocial model:**

  High degree of emotional sensitivity + invalidation over time
  = extreme behaviors (borderline personality disorder).

- DBT **therapists** work to keep **invalidation to a minimum** while recognizing that validating 100% of the time is not possible or advised.

- **Therapist's TIBs** are examples of invalidation.

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

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Key Points
Biosocial model posits that a person who is born with a high degree of emotional sensitivity experiences invalidation from the environment and over time, this reinforces extreme behaviors which characterize disorders such as borderline personality disorder.
DBT therapists work to keep invalidation to a minimum while recognizing that validating 100% of the time is not possible nor even advised.
Therapist's therapy-interfering behaviors are examples of invalidation.


Next Presentation:
Using Validation in Therapy
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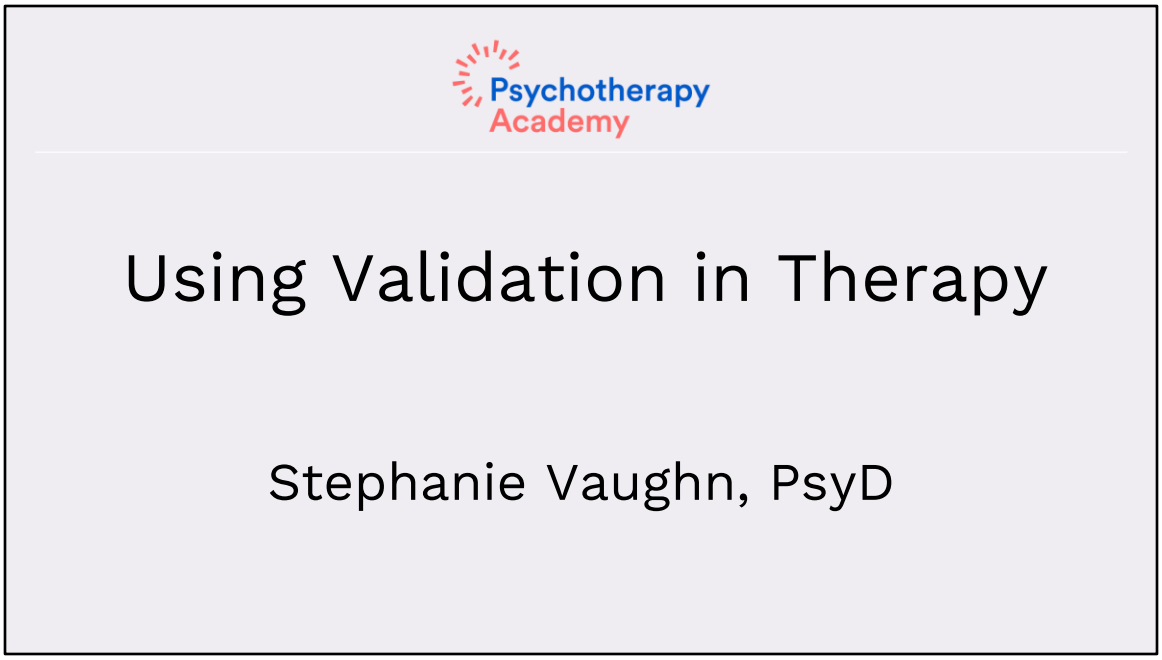
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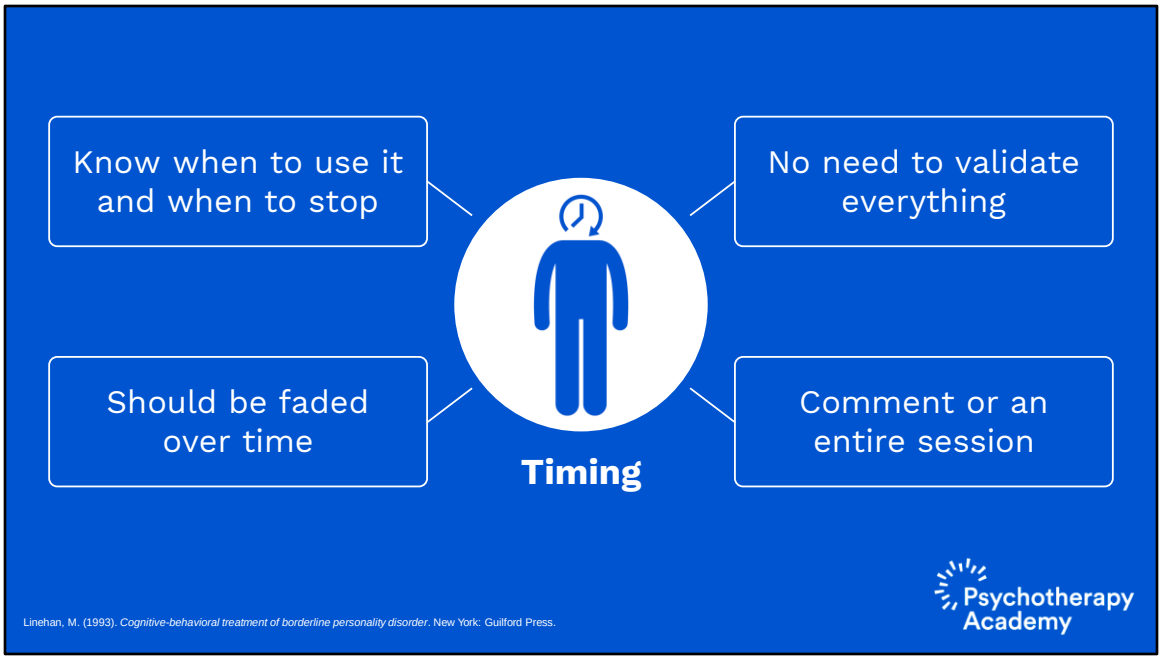
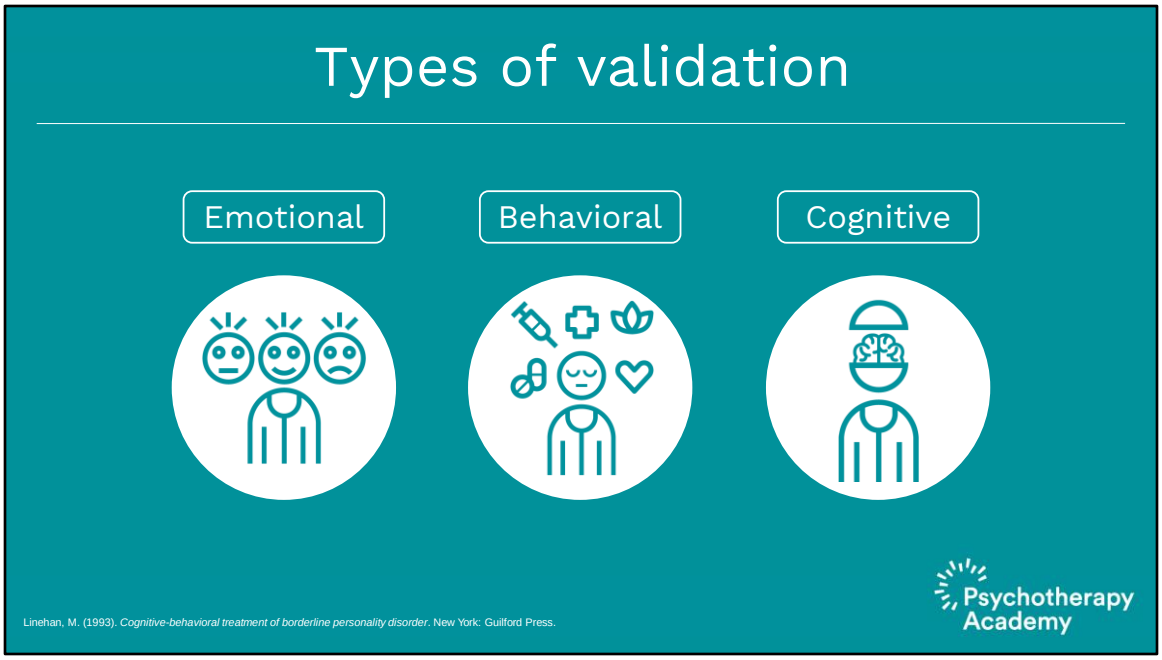
Using Validation in Therapy
Stephanie Vaughn, PsyD

There are many things that are important to consider when using validation in therapy but number one, we want to consider timing. You don't want to use validation immediately following problem behaviors that are maintained by validation. In other words, the behavior is continuing because validation is the fuel. We don't want to accidently reinforce so we've got to be aware of how validation is being received and what's happening with the behavior. Is it increasing, decreasing, staying the same over time?

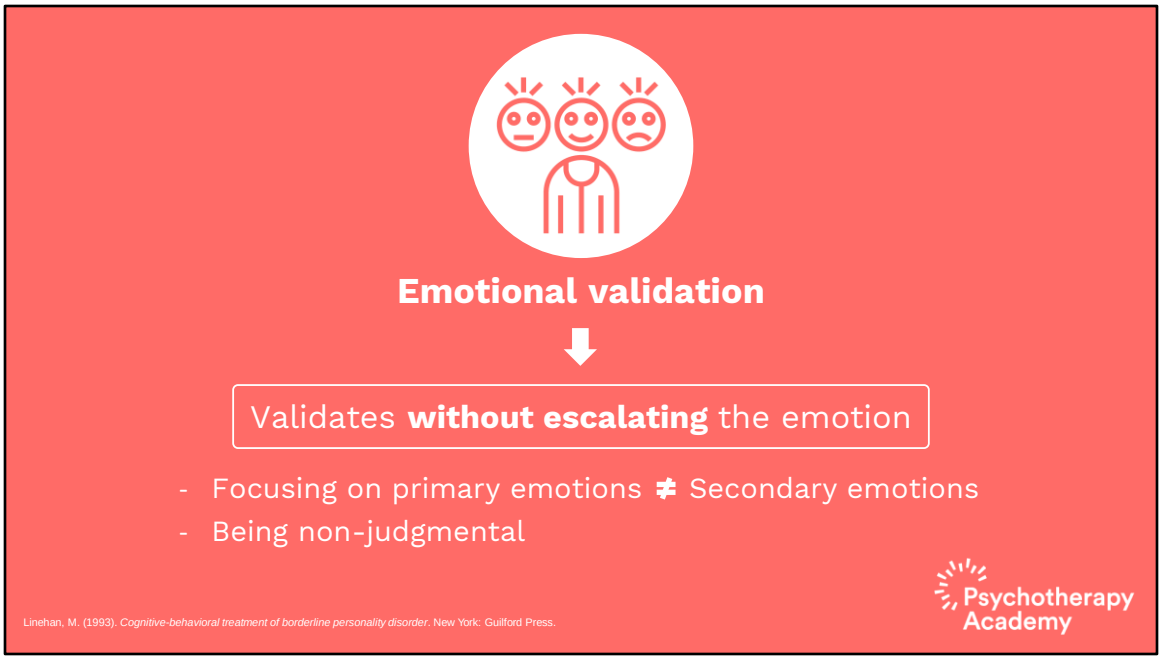


You want to know when to use it and when to stop. As you learned from the last video, it's not necessary to validate everything. And while we need those validation strategies to balance out the change strategies, in the beginning, we're going to be using a lot more validation but over time, we're going to fade that. It has to be faded over time or else it's like keeping the training wheels on a bicycle. We've got to be able to take that away so that the person ultimately learns how to validate themselves.

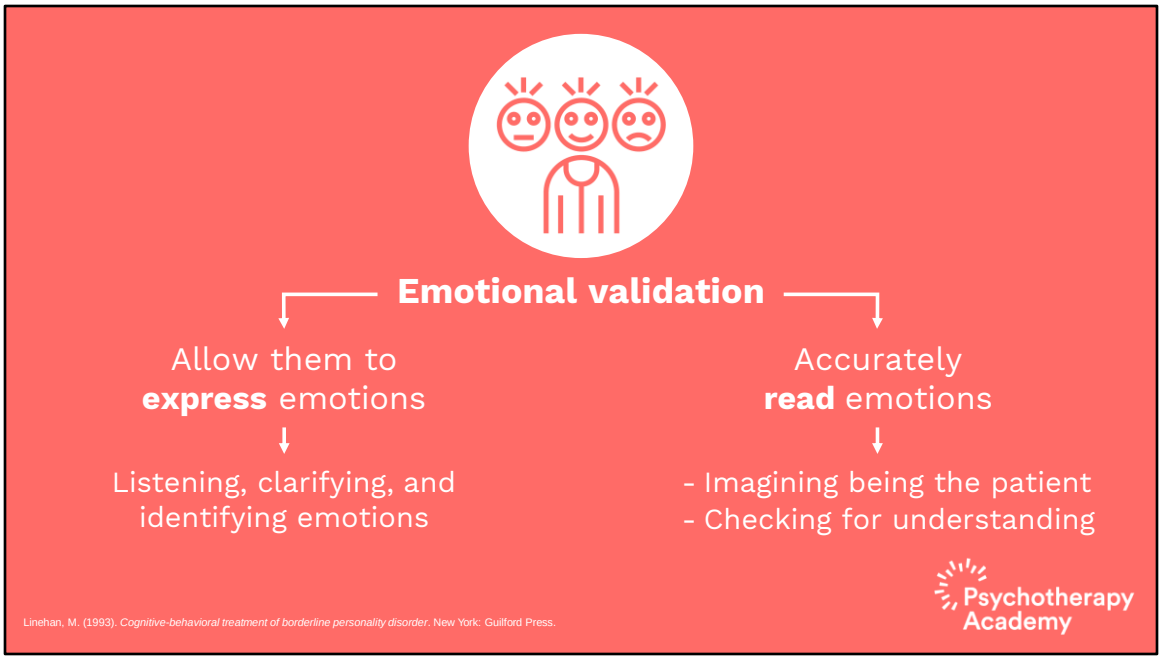
So validation can be a comment like that makes sense or it could be the context for an entire session. I once spent an entire session validating a patient who came in. It was my very first patient when I was doing my internship. And the patient was extremely angry with the front desk staff because they had messed up scheduling. This was not my fault and at the same time saying that it was not my fault was going to make no difference in the world other than making the problem worse. So I settled in. I had had some training on validation recently and decided that that was going to be my training for the day, was practicing validation no matter what. So I validated the entire session other than up to the last 10 minutes in which the patient apologized for complaining throughout the whole time and we went on to work together very effectively from there on out. So optimally, you're not going to need to validate for an entire session because we do need to be able to use some of those change strategies but also it is possible to validate for an entire session.



So the different types of validation, we have emotional and behavioral and cognitive validation.



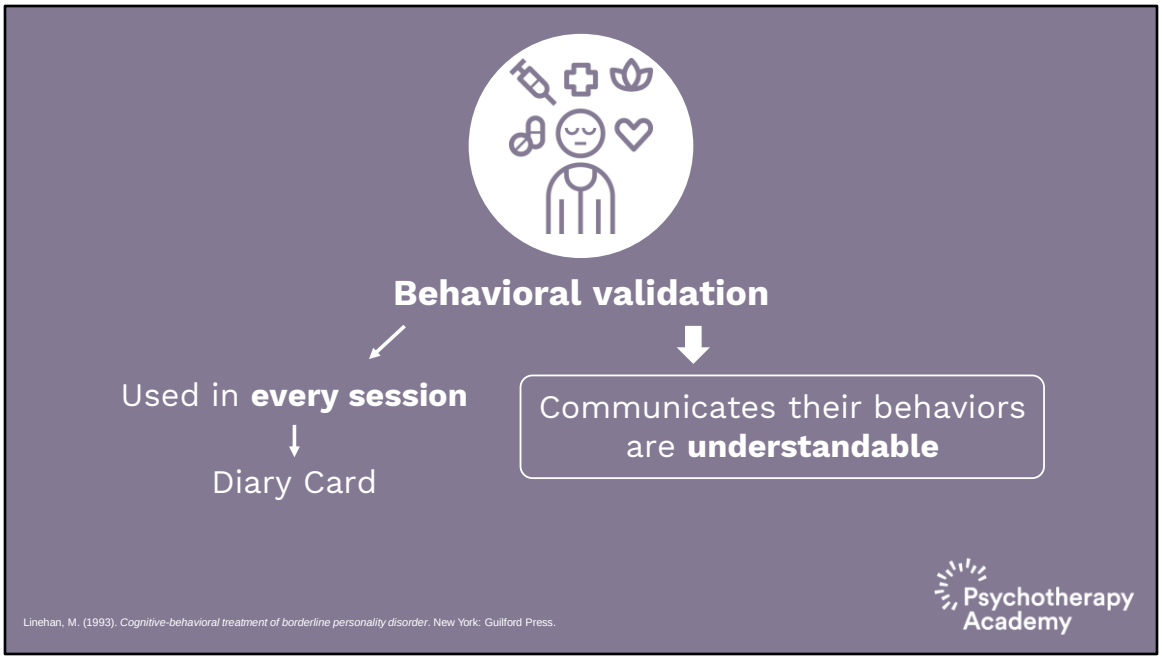
For emotional validation, that involves validating without escalating the emotion. And the way to do this is to focus in on the primary emotions that the patient is experiencing. So we talked about primary versus secondary emotions. Anger is a pretty common secondary emotion that's reported. People will feel angry. They will have a little more difficulty recognizing sadness or hurt or loss underneath. So when we validate, we can try to identify those underlying emotions as a way of de-escalating the emotional response. If we're validating the anger, that might be helpful but even more, validating the underlying hurt can really shift the feel for the patient and allow them to pay attention to the nuances of all of the different emotions that they're experiencing helping them improve their ability to identify a variety of emotions in any given situation. We want to identify the emotions non-judgmentally and we're helping to give them the language of primary and secondary emotions. So that would be something we would explicitly teach.



For emotional validation, it will also allow them to express emotions. The simple allowance of letting someone cry or letting them express themselves while you're listening, clarifying and identifying emotions. So we're not trying to change them all the time. We're not giving them the message that they need to stop or they need to feel better or they need to regulate themselves. DBT therapists need to be flexible in that regard because yes, at times, we are helping them to ground and regulate particularly in the beginning but we've got to be aware, acutely aware of those times when expressing emotion and feeling it deeply within session is adaptive and it's a normal experience. So we don't want to constantly be on the lookout for making them feel better.

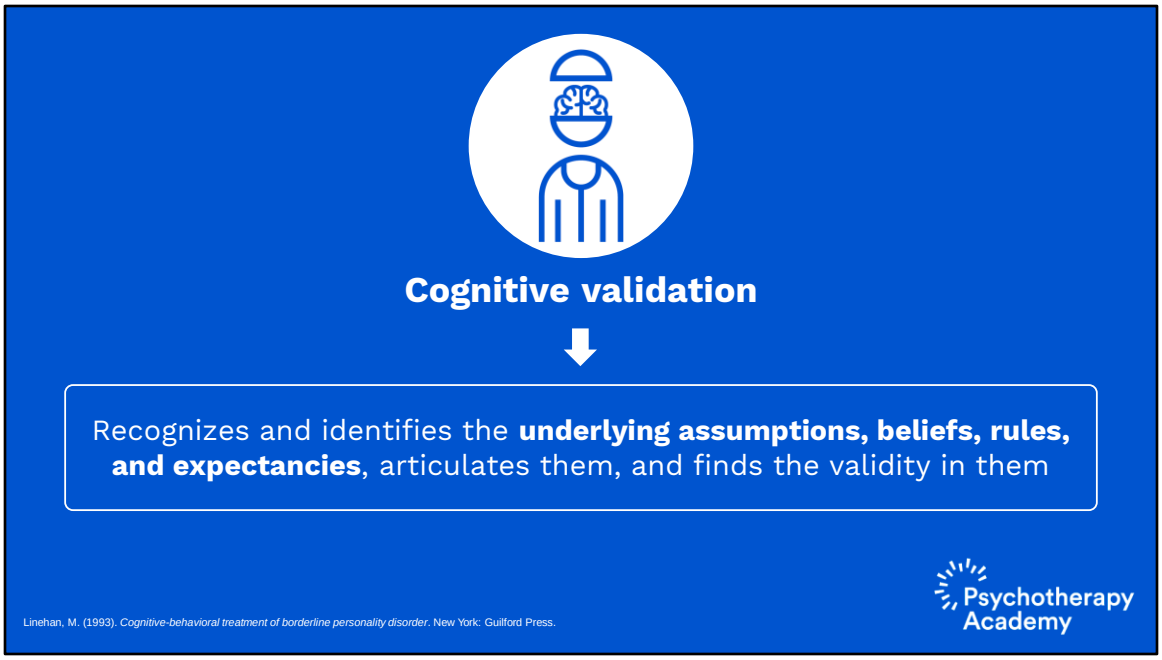
Emotional validation is something we can do when we accurately read their emotions. We can imagine being the patient in a similar circumstance. One of the questions that I ask is, in my head, I ask, have I been in a situation similar to this in some way? If it's not, don't look so much at the content as you do the situation itself and the circumstances. Leaving the content aside, can you imagine being in that same position? How did they feel? Based on what you know about what they likely think and how they feel, can you communicate that their perspective is understandable? Can you in essence read their mind? And of course, we're not mind readers. And in DBT and in any circumstance, we can often put ourselves in the other person's position and imagine what thoughts are going through their head or what feelings they have. And then we can articulate those and check for understanding, check that we're understanding things correctly, that we get it. We can directly say things like that makes sense or I can see that. And that would be an example of emotional validation.

Self-disclosure. Now, self-disclosure is not like telling a story about how things have happened to you. There's nothing wrong with that per se. But when we're talking about emotional validation, self-disclosure might be laughing when a person tells a story that's funny or crying, letting a tear fall when a person tells a very emotionally heart-wrenching story that anyone, you would have to be a hard-hearted Grinch to not have some emotional experience while listening to it. So those emotional expressions are actually self-disclosures and that's a type of emotional validation.

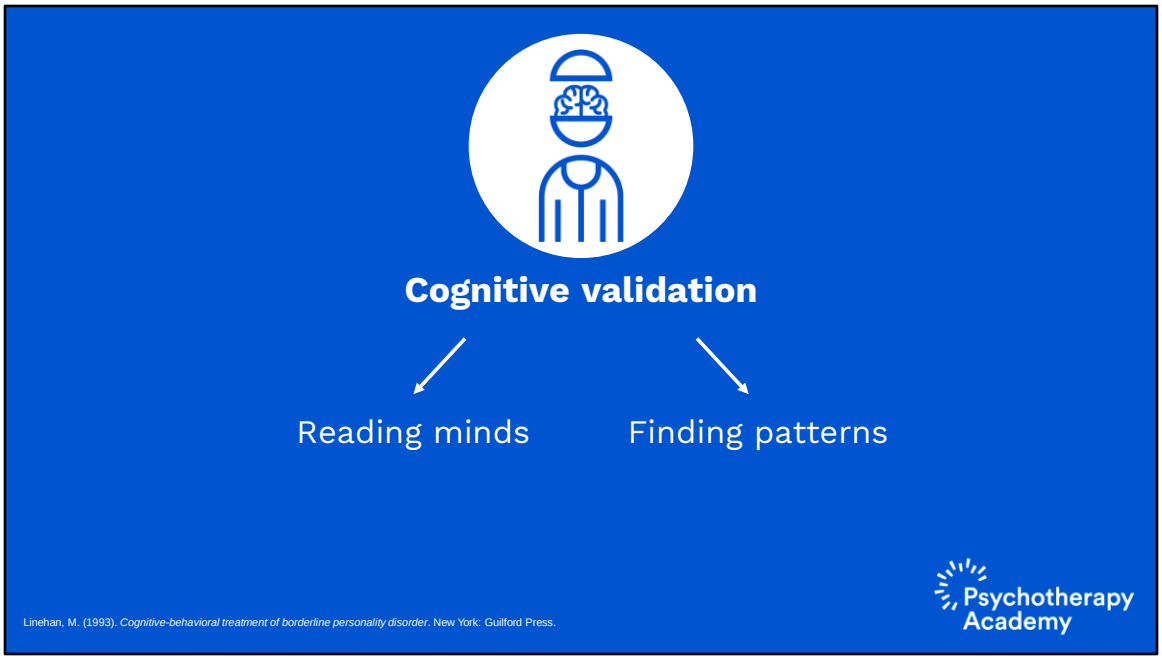


Next is behavioral validation. And we use behavioral validation in every session. We use it when we're looking over the diary card. So we get the diary card in the beginning of session and we're going through the patient's behaviors and we're getting a description of what's happened over the past week, a description of what behaviors they've engaged, adaptive and maladaptive. And we're communicating regardless of whether they are skillful or unskillful that they're understandable. For example, it makes sense that you would cut yourself before the interview because you really needed to be focused and it's worked before.

So again, there's the fine line between reinforcing and validating. It's important that you don't reinforce. At the same time, it's really important that you don't invalidate to the degree that the patient is unwilling to share things with you and thinks that you just don't get it and maybe afraid to tell you things or misrepresent themselves on the diary card. So you've got to be able to communicate to them that you are a person who gets it. Describing their behavior non-judgmentally without assuming intention can be validating in and of itself. So just being very matter of fact and practical, saying something like okay, so you used an emergency razor that you kept in the glove box, not getting too overly intense or trying to make something of it, just simply repeating back what the facts of the situation are, that can be a type of validation, behavioral validation.

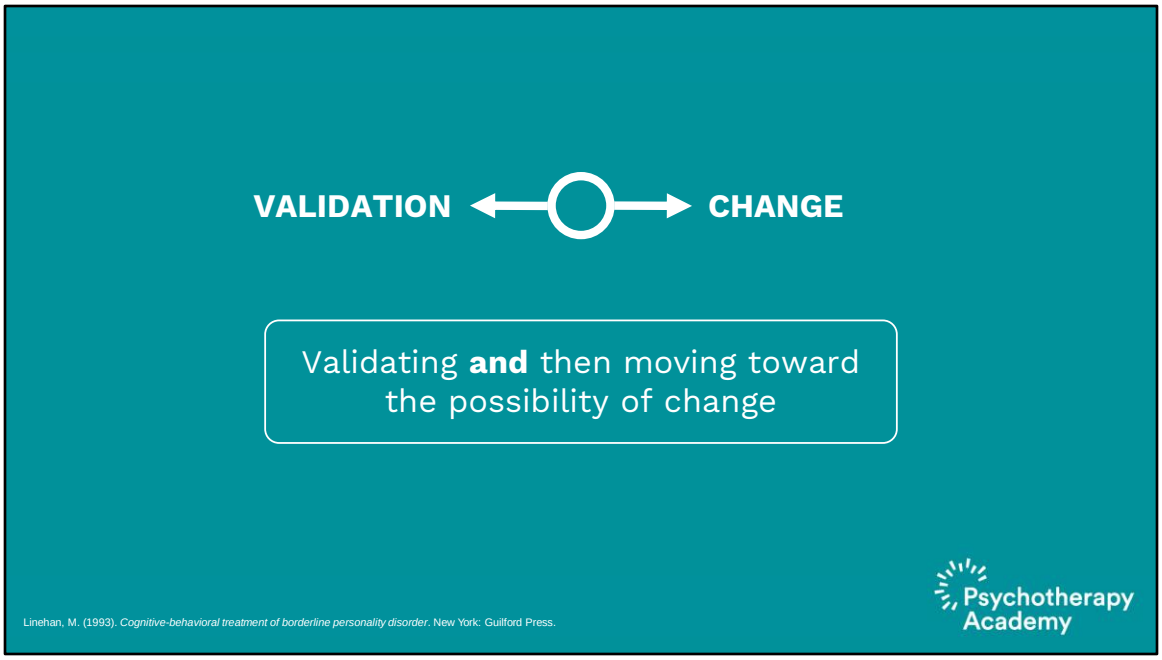


Next is cognitive validation. This is when the therapist recognizes and identifies the underlying assumptions, beliefs, rules and expectancies of the patient and we then articulate them and find the validity.



This again involves reading minds. And we're also looking at patterns that we may have picked up on over the course of time in treating this person or just patterns that we know about human beings in general. So an example, if we're using the same interview example, you didn't go for the second interview because you felt like you didn't deserve it after all that. So that would be reading minds based on what this therapist knows about the patient from the past that they have issues related to feeling like that they deserve things. Or the therapist could respond, are you feeling like giving up? So we're imagining what it would be like to have had an interview, to have had a history of self-harm and struggling emotionally, to have been excited about this interview but to have felt so nervous and emotionally dyregulated that you needed to do something. And so even though we're "not supposed to be" doing this thing, we have these two alternatives. We're either going to lose out on our future, the job that we want, this interview or we're going to fall back on some old maladaptive behaviors.

It makes sense that you go back to what you know. So then you go and self-harm and then immediately as we know the regret comes or the feeling of failure and then the self-talk of something to the effect of wow, you really cut yourself right before an interview and you think that you deserve this job. Why don't you just wrap it up and go on home? So we can imagine those sorts of things. If we have that sort of information about the patient from previously, that these are the types of patterns that would occur, then we can guess what they would feel like next. Yeah, they would feel like possibly giving up and just resigning themselves to never being able to get a job or even to feeling suicidal.



So the dialectic that we're using here with validation is we're using validation and change. So as the therapist, we're thinking, we're validating that yes, I could see that this is what you would be thinking. And I'm thinking there may be some other things we could try that will get you focused without needing to cut yourself. Could we talk about a couple? So you can see how we're validating and then we're moving toward the possibility of change. In the next video, I'll discuss the six levels of validation. And in theory, it's possible to validate anything at one of these six levels.

Key Points

- The three types of validation are **emotional, behavioral, and cognitive**.
- Do not use validation immediately following **problem behaviors** which are **maintained by validation**.

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

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Key points.
The three types of validation are emotional, behavioral and cognitive.
Do not use validation immediately following problem behaviors which are maintained by validation.


Next Presentation:
Six Levels of Validation
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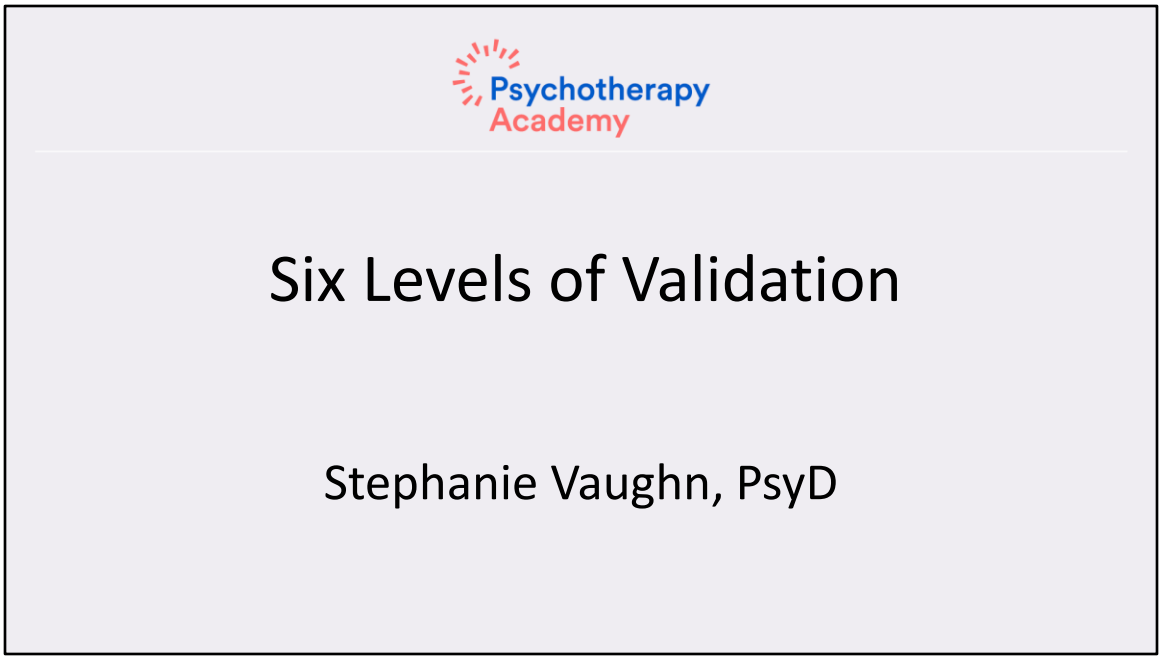
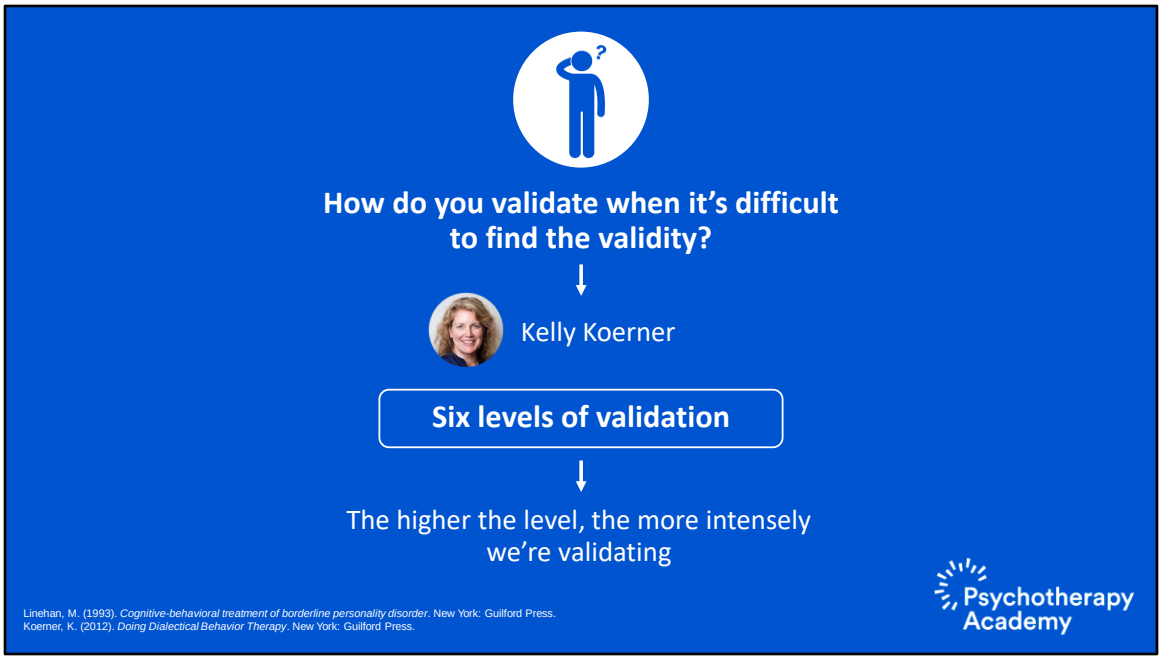
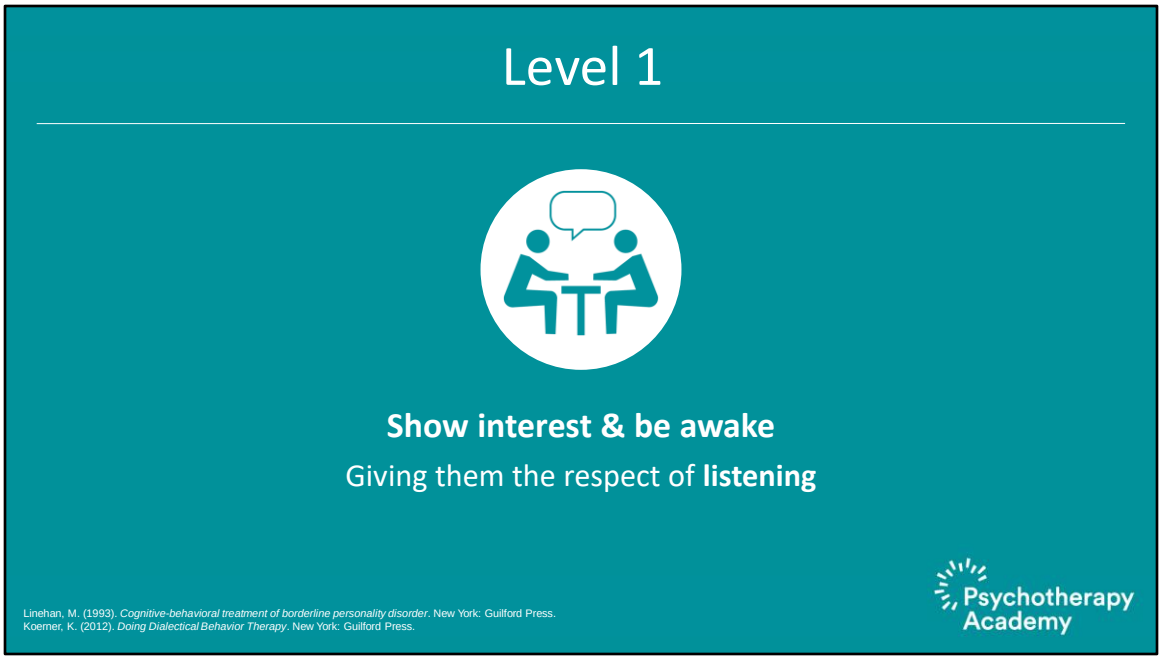


Six levels of validation

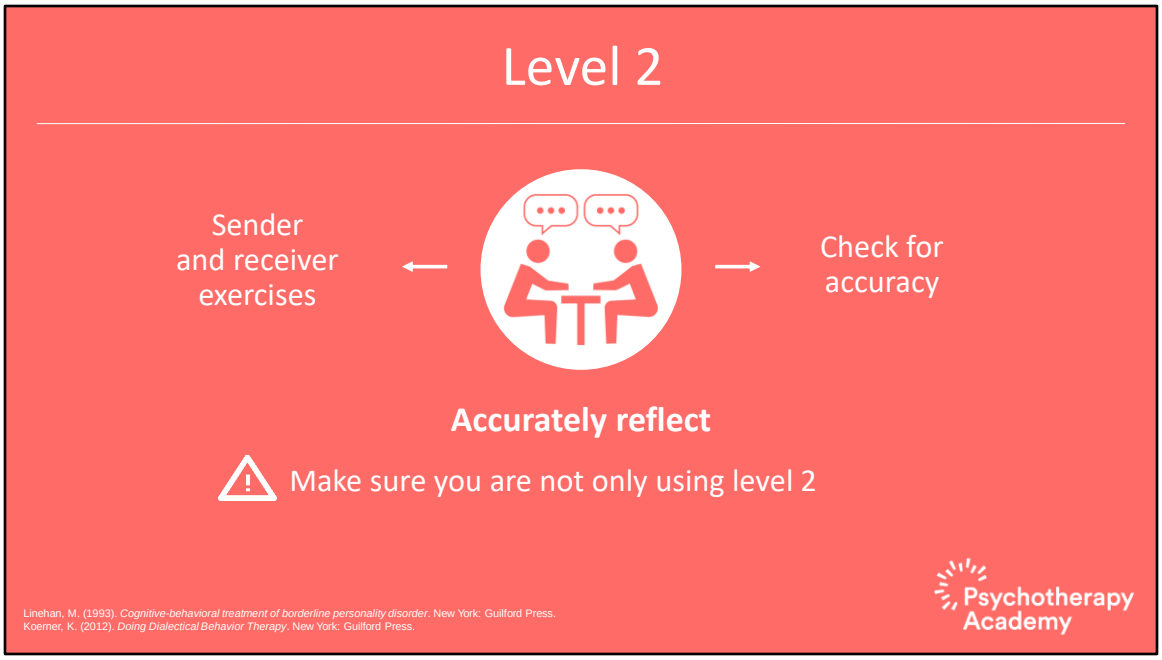


How do you validate when it's difficult to find the validity? In the book, Doing Dialectical Behavior Therapy, Kelly Koerner describes six levels of validation which can be helpful in referencing when you're struggling with finding the validity in another person's point of view. The higher the level, the more intensely we're validating. And of course, we want to try to validate at the highest level but that's not always possible.



At minimum on our level, we want to show interest and be awake. Now, this sounds fairly simple but if you've ever absolutely disagreed or been irritated with another person to the point that you didn't even want to listen, you know that achieving level 1 is a pretty magnificent accomplishment. You may have the desire to frown or shake your head or eye roll or put your hands over your ears or walk away even. So the showing interest and being awake involves giving the other person their time and giving them the respect of listening.

As a therapist, maybe we don't have the urge to walk out of the room but we may look at them in a way with our head cocked that looks skeptical. We may project some non-verbals out toward them that says, uhm, I don't really believe you or come on, give me a break. So at our level 1, we also want to make sure that we're listening and we're not checking our phone or writing something down instead of listening intently. And if you've ever had, if you've been a therapist and you've ever had the flu, been sick in some way, been up with a child the night before, staying awake is not a small task. So as long as we're doing this level 1, showing interest and being awake, we're at least on the path to our higher levels of validation.



Level 2 is accurate reflection. Now, we need to make sure we're not only using level 2 in sounding like a parrot or what other people make fun of therapists as sounding like just bouncing back what the other person said without putting any skin in the game and articulating an opinion. At level 2, we are reflecting what the patient is saying but again we're not only using a level 2. So there are some sender and receiver exercises. I know that the Imago model of couples therapy has some great practices and I use them in training new therapists, new students in how to send a message to, you know, you send a message to your partner and then the partner reflects back exactly what was said. It's much more difficult than it seems on the surface and I highly recommend practicing this in consult group, practicing the sender-receiver with short small messages to see just how difficult it is. And as you can imagine when emotions run high, our ability to accurately reflect what a person said drops down. So for example, the sender may say, I don't like it when you forget to take out the trash. And the receiver says, I heard you say that you don't like it when I forget to take out the trash. Did I get that? And the sender says yes. And then the receiver says, is there more? And the sender may say yes or no. So that would be an example of a practice exercise to use if you're trying to improve your ability to reflect. And of course, that checking for accuracy is important because we may think we heard something but one word can make a huge difference in the entire message itself.

If we're moving up in our levels at level 3, we want to put ourselves in the other person's position and want to be able to read emotions and thoughts and check for accuracy. Imagine what it is like to be them. So we're getting deeper here. And here's an example. Since you're feeling like things aren't changing, are you wondering whether you made the right decision to even start DBT to begin with? Okay, so with that statement, you can see that we have listened, we've shown interest and we're awake. We're reflecting back that the person feels like things aren't changing. They must've said this, you know, things aren't changing. But then we're going deeper into imagining what it's like to be them. I mean, if I'm in their situation, I'm feeling like things aren't changing. It doesn't matter if it's in therapy, if it's in an exercise class, if I'm seeing a physician and I'm feeling like I'm not getting any better, if I've got a gardener and they're trying to rehab my lawn. And if I'm having the thought that things aren't changing, one of the thoughts that I'm going to have and you're going to have is did I make the right decision choosing this individual? Did I make the right decision going down this path of potential progress? Should I have gone another route? Implied in that also is should I change paths? So we could even say that. We could say, are you thinking about doing something else? And that puts us at a level 3.

Level 4

I know you. I get you.

Validate based on history

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
Koerner, K. (2012). *Doing Dialectical Behavior Therapy*. New York: Guilford Press.

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If we're moving up to a level 4, we're going to validate based on history. Now, this is the history that we know that the patient came in with. We know about their past. And taking their past into consideration, what can we say then? So if we take this same example of since you're feeling like things aren't changing, are you wondering whether you made the right decision in even starting DBT to begin with? We can also take it up a notch and validate based on their history. So you could say something like that has to be extremely frustrating considering that you've been through five therapists before and none of them have been able to help you and no wonder you're as angry as you are. Another example if we're taking another example entirely, we might say, it makes sense you'd be irritated. You don't like to be told what to do because your abusive father did that. So we know the patient. We're privy to some of the private information that they've shared and we're taking that into context as we're validating. I'm giving you the message I know you, I know you, I get you.

Level 5

This behavior makes sense for anyone

Validate based on current circumstances

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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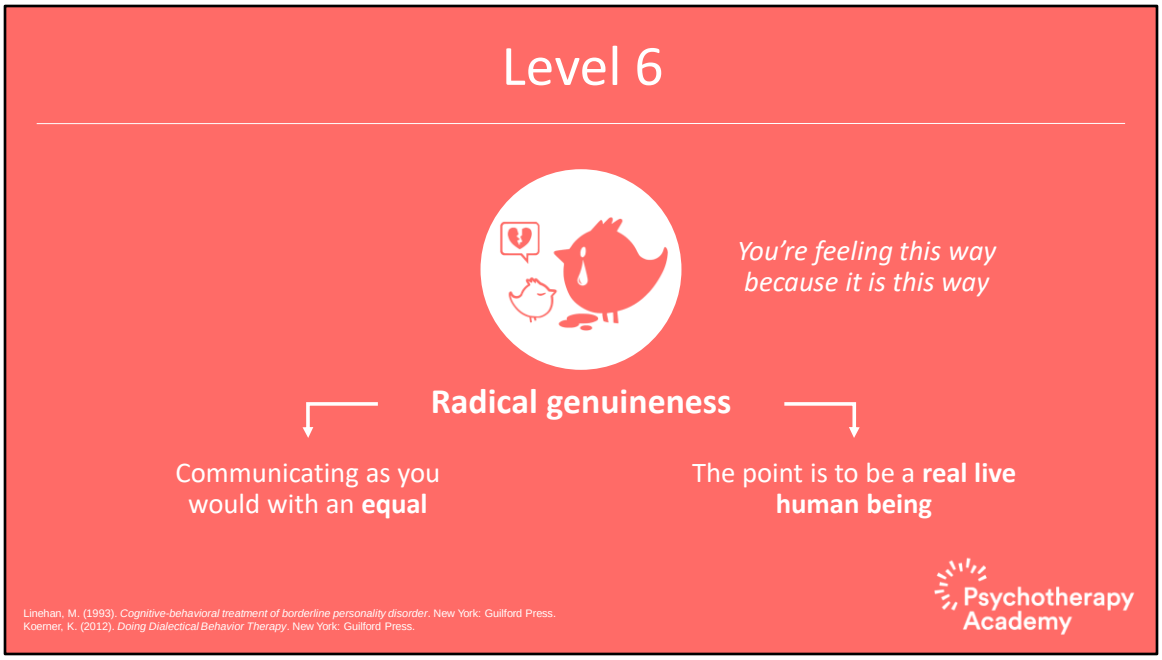
Higher than that, we're going up above, level 5, validate based on current circumstances not just on their history but that the behavior makes sense for anyone. So here's an example. It makes sense that you'd be irritated. I was being bossy.



Okay, so I hope you can see how this almost radical genuineness which is the level 6, this open, non-defensive therapist acknowledging their part can be super validating because we're not saying that oh, you're irritated because you're a patient or you've had abusive experiences. We're saying you're feeling this way because it is this way, that that is an extraordinary experience for the person to have their general circumstances validated based on anybody would feel this way.

So I started to mention radical genuineness. This is the ultimate, highest level, level 6. It's not possible that we're going to be able to validate at the level 6 all the time but when we can, it's great because radical genuineness involves communicating as you would with someone who is an equal rather than a patient or someone who's disordered or someone who needs help. If we're being radically genuine, we might laugh at a joke instead of redirecting it or implying that it's somehow inappropriate. We might self-disclose how many children we have when a client asks instead of asking, you know, why would you ask that? So we're going to relate with them like we would with anybody not like we're afraid of them or not like we are trying to therapize them. We might let tears fall. We might use expletives. We're going to be our true selves. At this level, we might even confront a client on their BS that is the calling out the elephant in the room. If we're both sitting here, we both know that's a bunch of BS and I'm going to say, hey, come on now, that's some crap and we both know it. Then that can be – It's speaking to the truth. It's speaking to the something that you and I both know. Particularly in substance abuse treatment, calling out that elephant in the room and being real is radical genuineness. The point is to be a real live human being not some weird space cadet therapist-y type who they could never be like. When we're not being genuine, when we're being false, then the patient has the idea that either something is wrong with them or something is wrong with you like there's something wrong with them that they could never be this magical angelic person like you are or thinking that you are just a fake and a fraud. And neither one of those options is something that we want to portray. So as long as we're communicating genuinely, truthfully, then we are more apt to hit that level 6 of validation.

Key Points

- There are **six levels of validation** in DBT, the highest of which is referred to as **radical genuineness**.
- Radical genuineness involves the therapist as **human** and an **equal**. It involves engaging in an **authentic manner,** not taking themselves too seriously or ignoring the obvious.

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