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Clinical Guidelines for Improving Dialectical Thinking in DBT

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Cognitive dysregulation, often characterized by extreme, nondialectical thinking, is a core problem area identified in dialectical behavior therapy (DBT) and is posited to contribute to pervasive emotional and behavioral dysregulation. However, cognitive flexibility is understudied and rarely considered a direct treatment target in DBT. This paper provides clinical guidelines for increasing dialectical thinking with patients in DBT. We review the historical context of dialectical thinking in DBT and present the results of a survey examining DBT therapists' perspectives on nondialectical thinking as a treatment focus. We describe cognitive restructuring strategies from cognitive therapy models, and compare these with techniques targeting cognitive dysregulation in DBT. We highlight the rationale for incorporating dialectical thinking as a direct treatment focus in DBT, and offer strategies derived from cognitive restructuring to incorporate directly targeting dialectical thinking in conceptualization, treatment planning, and in session. These strategies are demonstrated with clinical vignettes and examples.

Dialectical behavior therapy (DBT) was originally developed by Marsha Linehan (1993a, 1993b) to treat symptoms and improve the lives of chronically suicidal and self-injurious women. DBT's theoretical underpinnings, which heavily guide the treatment, are rooted in radical behaviorism, Zen practices, and dialectics. Dialectics, as described by Linehan (1993a), is a worldview that is characterized by the principles of interrelatedness and wholeness, polarities and syntheses, and continuous change. Individuals with borderline personality disorder (BPD) often alternate between behavioral extremes that either overregulate or underregulate emotion. DBT therapists view these patterns of shifting between behavioral extremes as "dialectical dilemmas" for the patient, in that the patient utilizes each extreme, polar opposite approach to manage his or her emotion dysregulation, which is often ineffective and leads to even more emotion dysregulation and problem behaviors (Miller, Rathus, & Linehan, 2007).

As a therapist practicing DBT, one must actively model the concept of dialectics by balancing the core dialectic: wholeheartedly accepting where a patient is at any given moment and simultaneously pushing him or her to move toward change. In DBT, not only does the therapist model this dialectical construct and use a variety of dialectical strategies but there is also a goal for the patient to adopt a greater capacity for dialectical thinking and acting (Linehan, 1993a), often leading to a synthesis of the aforementioned dialectical dilemmas.

From a DBT case conceptualization standpoint, nondialectical thinking and acting are examples of "cognitive dysregulation," which is one of the five core areas of dysregulation often found among individuals with BPD (Linehan, 1993a, 1993b; Miller et al., 2007). Cognitive dysregulation is characterized by nondialectical or "all or nothing" thinking, difficulty tolerating and accepting change, and high levels of cognitive rigidity (e.g., "This shouldn't be"). These traits often transact with the other areas of dysregulation, including behavioral dyscontrol, emotion dysregulation, and problems in relationships. However, despite the fact that cognitive dysregulation is a core problem area, it has received the least amount of attention in the DBT literature. Following Linehan's (1993a) original DBT text, several other DBT therapists and researchers have written books about DBT and dialectical thinking, including Miller et al. (2007), Rathus and Miller (2015), Koerner (2011), and Swenson (2016), but they have offered only a few specific strategies to target dialectical thinking in clinical practice. The purpose of this paper is to highlight the historical context of dialectical thinking in DBT and posit why this area has been underemphasized, discuss how dialectical thinking is similar and differs from cognitive therapy (CT) models, highlight the

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clinical importance of targeting dialectical thinking, and provide clinical vignettes and examples of how dialectical strategies and techniques can be used in session.

Dialectical Thinking: A Historical Perspective

In her original text, Marsha Linehan (1993a) outlines the stages of and targets within each stage of treatment. In Stage 1 of DBT, the primary method for structuring the agenda of any given session is based on the target hierarchy, which consists of (a) life-threatening behaviors, (b) therapy-interfering behaviors, (c) quality-of-life interfering behaviors, and (d) skills deficits. A more in-depth description of the target hierarchy can be found in the Linehan text. Linehan emphasizes that superseding the target hierarchy is the general theme of DBT: increasing dialectical thinking and behaviors. Although Linehan suggests that cognitive modification strategies be woven throughout treatment, she suggests that the primary way that dialectical thinking be targeted is through therapist modeling and reinforcement of the desired behavior and that "dialectical behavior patterns as a specific therapy target are rarely discussed with the patient" (p. 166). The same is true of the secondary targets (dialectical dilemmas), discussed earlier in this paper. In other words, therapists are not instructed to formally address these targets by name with their patients, although targeting these nondialectical behavior patterns is expected if they are emerging as problematic links in the chain toward other target behaviors.

Linehan (1993a) suggests that the concept of dialectics may be too abstract for patients and that cognitions in individuals with BPD may not be easily modified. She also notes that formal CT procedures require the ability to engage in extensive self-monitoring of one's thoughts, which she believes is a skills deficit in patients with BPD. Nevertheless, Linehan does include cognitive modification as one of the four distinct change procedures to be used to help move patients toward behavior change in DBT. However, she does not offer guidelines for how formal CT techniques may be incorporated.

Linehan (1993a) also differentiates DBT from formal CT programs by stating that the goal of DBT is not to identify and change pervasive thoughts, assumptions, and schemas but more so to help patients "see both black and white thinking and to achieve a synthesis of the two that does not negate the reality of either" (p. 121). She encourages therapists to emphasize validation over modification when it comes to cognitions, given that patients with BPD have typically faced extreme invalidation over the course of their lives. Linehan expresses a concern that attempts to challenge that dysfunctional thoughts could be inadvertently invalidating. She suggests that therapists specifically focus on functional and "effective" thinking over "true" or accurate thinking, which is consistent with the DBT assumption that there is no absolute truth (Linehan, 1993a). In her chapter dedicated to validation, Linehan outlines cognitive validation strategies that encourage therapists to prioritize finding and highlighting the individual's valid and functional beliefs and interpretations instead of challenging their invalid beliefs and assumptions. According to Linehan, "an exclusive focus on patients' invalid beliefs, assumptions, and cognitive styles is counterproductive, since it leaves the patients unsure of when (if ever) their perceptions and thoughts are adaptive, functional, and valid" (p. 240). She recommends that therapists address dysfunctional beliefs informally through dialectical persuasion, and notes how each module incorporates cognitive skills to aid in this process (e.g., "encouragement" within the IMPROVE skill in distress tolerance, challenging of myths that get in the way of interpersonal effectiveness).

However, Linehan (1993a) does highlight several consistencies between DBT's focus on dialectical thinking and CT's focus on dysfunctional maladaptive thoughts, and lists problematic thinking patterns that are targeted in both approaches. She lists them as follows:

1. Arbitrary inferences or conclusions based on insufficient or contradictory evidence.
2. Overgeneralizations.
3. Magnification and exaggeration of the meaning or significant of events.
4. Inappropriate attribution of all blame and responsibility for negative events to oneself.
5. Inappropriate attribution of all blame and responsibility for negative events to others.
6. Name-calling, or the application of negative trait labels that add no new information beyond the observed behavior used to generate the labels.
7. Catastrophizing, or the presumption of disastrous results if certain events do not either continue or develop.
8. Hopeless expectancies, or pessimistic predictions based on selective attention to negative events in the past or present, rather than on verifiable data. (p. 123)

Acknowledging the efficacy of CTs, Linehan (1993a) outlines several strategies based on these therapies to address the aforementioned dysfunctional thinking patterns. She identifies four aspects of thinking that are of interest to the DBT therapist, including "non-dialectical thinking, faulty general rules governing behavior, dysfunctional descriptions such as automatic thoughts, and dysfunctional allocations of attention" (p. 364), and notes that these distortions can both influence and be influenced by one's emotional responses. She also discusses the use of observe and describe skills to build awareness of cognitions, confront and challenge specific dysfunctional rules in a dialectical manner, generate

alternative, more functional beliefs, and help them develop guidelines for when to trust and when to question one's own interpretations. See Table 1 for an outline of these strategies.

Therefore, although Linehan (1993a) provides basic guidelines for utilizing cognitive strategies in DBT and highlights the importance of increasing dialectical thinking, she also expresses concern about the efficacy of relying heavily on these strategies, potentially leaving DBT therapists confused about how and when to incorporate cognitive strategies effectively into treatment.

Later adaptations of DBT have incorporated more cognitive restructuring strategies to modify dialectical thinking. In their initial adaptation of DBT for suicidal adolescents, Miller, Rathus, Linehan, Wetzler, and Leigh (1997) added families into treatment (Miller, Glinski, Woodberry, Mitchell, & Indik, 2002). Directly working with teens and families made it easier to identify their intensely emotional and polarized ways of perceiving one another and the world, which they described as nondialectical thinking. Rathus and Miller (2000) extended this through the identification of specific teen–parent dialectical dilemmas (e.g., too loose vs. too strict, making light of problem behaviors vs. making too much of typical adolescent behaviors, and forcing independence vs. forcing autonomy). To help teens and families understand and change these ineffective behavioral patterns, Miller et al. (2007; Rathus & Miller, 2015), introduced worksheets to teach families about (a) dialectical philosophy, (b) how to think and act more dialectically (see example below), and (c) how to find a "middle path" and move away from the extreme polarized stances they are prone to take, especially when emotions are high. See Figure 1 for more details.

In later adaptations, teens and families are formally introduced to a list of "thinking mistakes" or cognitive distortions (Beck, 2011) to help them recognize how these directly impact nondialectical thinking and behavior. Linehan subsequently added many of the walking the middle path skills (Miller et al., 2007) to her adult *DBT Skills Training Handouts and Worksheets, Second Edition* (Linehan, 2015) and decided to formally teach dialectics within the interpersonal effectiveness skills module. In the second edition, Linehan developed the "check the facts" worksheet, which she placed in the emotion regulation skills module. This worksheet explicitly helps patients identify thoughts, interpretations, assumptions about events, assess the threat level/catastrophe, and determine whether the emotion and/or its intensity fits the actual facts.

Dialectical Thinking: Is It Really That Important?

Although later adaptations (Linehan, 2015; Miller et al., 2002, 2007; Rathus & Miller, 2000, 2015) have incorporated more cognitive strategies, it is unclear how DBT therapists are expected to acquire the skills to directly target dialectical thinking given that instruction on how to conduct CT techniques are often not a part of the traditional DBT intensive training curriculum (for reference, the traditional DBT intensive training curriculum consists of 80 hours of training plus the completion of a case conceptualization and a DBT knowledge exam).

Table 1
Linehan's Cognitive Restructuring Procedures Checklist

____T explicitly helps P OBSERVE AND DESCRIBE her own thinking styles, rules, and verbal descriptions.
____T IDENTIFIES, CONFRONTS, and challenges specific dysfunctional rules, labels, and styles, but does so in a dialectical manner.
____T assists P in GENERATING more functional and/or accurate thinking styles, rules, and verbal descriptions.
    ____T does not claim to have a lock on absolute truth.
    ____T values intuitive sources of knowing.
    ____T values getting data when none have been collected so far.
    ____T focuses on functional, effective thinking rather than necessarily "true" or "accurate" thinking.
    ____T pushes P to the limit of her ability in generating her own adaptive thinking styles, rules, and verbal descriptions.
____T assists P in developing GUIDELINES on when to trust and when to suspect her own interpretations.
____T applies contingency and skill training procedures in cognitive modifications.
____T helps P integrate cognitive strategies used in skills training modules into everyday life.
____T implements or refers P to a formal cognitive therapy program, as appropriate.

Anti-DBT tactics
____T tells P her problems are "all in her head."
____T oversimplifies P's problems, implying that all will be well if P can just change her "attitude," her thoughts, or her way of viewing things.
____T gets into a power struggle with P about how to think.

Table 11.6 Cognitive Restructuring Procedures Checklist. From *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (p. 365), by M. M. Linehan, 1993, New York, NY: Guilford Press. Copyright 1993 by The Guilford Press. Reprinted with permission.

WALKING THE MIDDLE PATH HANDOUT 2

Dialectics "How-to" Guide

Hints for Thinking and Acting Dialectically:

1. Move to "both–and" thinking and away from "either/or" thinking. Avoid extreme words: *always, never, you make me*. Be descriptive.

   Example: Instead of saying "Everyone *always* treats me unfairly," say "*Sometimes* I am treated fairly *and* at other times, I am treated unfairly."

2. Practice looking at all sides of a situation and all points of view. Be generous and dig deep. Find the kernel of truth in every side by asking "What is being left out?"

   Example: "Why does Mom want me to be home at 10:00 P.M.?" "Why does my daughter want to stay out until 2:00 A.M.?

3. Remember: No one has the absolute truth. Be open to alternatives.

4. Use "I feel . . ." statements, instead of "You are . . .," "You should . . .," or "That's just the way it is" statements.

   Example: Say "I feel angry when you say I can't stay out later just because you said so" instead of, "You never listen and you are always unfair to me."

5. Accept that different opinions can be valid, even if you do not agree with them.

   Example: "I can see your point of view even though I do not agree with it."

6. Check your assumptions. Do not assume that you know what others are thinking.

   Example: "What did you mean when you said . . .?"

7. Do not expect others to know what you are thinking.

   Example: "What I am trying to say is. . . ."

Practice:

Circle the dialectical statements:

1. a. "It is hopeless. I just cannot do it."
   b. "This is easy . . . I've got no problems."
   c. "This is really hard for me and I am going to keep trying."

2. a. "I know I am right about this."
   b. "You are totally wrong about that and I am right."
   c. "I can understand why you feel this way, and I feel different about it."

From *DBT® Skills Manual for Adolescents*, by Jill H. Rathus and Alec L. Miller. Copyright 2015 by The Guilford Press. Permission to photocopy this handout is granted to purchasers of this book for personal use only (see copyright page for details).

Figure 1. Walking the middle path handout 2: Dialectics "how-to" guide. From *DBT Skills Manual for Adolescents* (p. 310), by J. H. Rathus and A. L. Miller, 2015, New York, NY: Guilford Press. Copyright 2015 by The Guilford Press. Reprinted with permission.

To understand the importance and use of dialectical thinking in DBT by DBT therapists, Bonavitacola, Zoloth, Kamal, and Miller (2016) created a survey to assess whether DBT therapists actively target, monitor, and include nondialectical thinking in conceptualization and treatment, as well as surveying whether they believe that an increase in dialectical thinking is important for patient outcomes. It was hypothesized that many DBT therapists do not actively target nondialectical thinking as a primary target in either patient conceptualization or treatment, despite believing that an increase in dialectical thinking is important to consider when assessing readiness to terminate.

A sample of 108 DBT therapists, most of whom were intensively trained (92.6%), participated in this study. Participants completed an anonymous survey with results indicating that a majority of participant DBT therapists (80.5%) believed that an increase in dialectical thinking is at least moderately important to all of their patients' treatment outcome. Most participants (82.4%) also believed that dialectical thinking improved patients' overall functioning despite 73.1% of those polled stating that they did not specifically target nondialectical thinking as a target behavior, and 86.1% did not include dialectical thinking on diary cards for the majority of their patients. Thus, although therapists believe that increasing a patient's ability to think more dialectically is critical to target in therapy, is a key component of treatment outcome, and is a factor that influences overall well-being, they do not typically specifically target or monitor this skill in treatment.

These results highlight a gap between the identified importance of dialectical thinking and the lack of direct application in treatment. Cognitive strategies may indeed be difficult to implement in a validating manner with patients suffering from BPD, although this hypothesis needs to be empirically tested. However, this disparity may be due to a number of other factors. Given concerns voiced by Linehan (1993a) that cognitive restructuring may be invalidating, and her decreased emphasis of cognitive modification in her original text, DBT therapists may not use specific cognitive modification strategies when practicing DBT. Due to the low emphasis placed on these strategies in the original text and subsequently in formal DBT trainings, DBT therapists may not have the opportunity to acquire the requisite skills to formally implement cognitive restructuring. Cognitive restructuring strategies can be nuanced and require a high degree of skill. Consequently, DBT therapists may find it difficult to implement cognitive restructuring without specifically being trained to do so. While "dialectical thinking/acting" is listed as a skill on patient diary cards, historically, DBT therapists are not formally taught to target "nondialectical thinking" or list it as a specific problem behavior on the diary card. Additionally, therapists may find it confusing to address cognitive/dialectical change due to the inconsistency with which these strategies emerge in the skills manuals (i.e., they emerge as different skills across all skills modules). Finally, there may be some confusion between increasing dialectical thinking and more traditional CT techniques—therapists may be hesitant to implement cognitive restructuring techniques as a means to increase dialectical thinking, and yet may be unsure how else to do so. Given the importance of increasing dialectical thinking in DBT, it may be useful to incorporate knowledge and advances in CT.

Cognitive Restructuring: How Is It Different From or Similar to Thinking Dialectically?

CT was developed by Aaron T. Beck in the early 1960s as a short-term, symptom-focused treatment of depression (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979). Over time, CT has evolved into a more general theory of emotional disorders (Beck, 1975), and states that emotions are mediated by ongoing cognitive appraisals and that maladaptive information processing is central to understanding and remediating psychopathology. Using the evolutionary function of emotions as a foundational principle, the cognitive model helps explain the role of maladaptive cognitive processes in mediating intense negative emotions and maladaptive behavior.

In order to understand the nature of distressing emotional states or dysfunctional behaviors, cognitive therapists discern how individuals interpret events in their daily lives. Understanding how individuals appraise their environment is seen as a powerful therapeutic tool in helping therapists and patients develop empathy about the emotional and maladaptive behaviors that result from such appraisals, and in building commitment in patients to engage in cognitive modification (McGinn & Sanderson, 2001). Based on multiple ecological functional analyses of thoughts and their relationship to events, emotions, behaviors, and consequences, the cognitive therapist begins to understand patterns in the person's thinking and develops a conceptualization of the general assumptions and core beliefs these individuals may hold about their environment, themselves, and others so as to guide treatment on central cognitions. The therapist then works with patients to modify erroneous or unhelpful cognitions or the implications of these cognitions, even if they are accurate, so that individuals are better regulated and better able to engage in adaptive coping behaviors.

A key premise of CT is that if the therapist can help patients shift these interpretations, which take the form of rigid, maladaptive automatic thoughts and metacognitions, then the accompanying emotional states and behaviors will improve. With enough practice, the inflexibly held assumptions and beliefs on which these thoughts are based will also shift over time, leading to

more enduring change (McGinn & Sanderson, 2001). Patients are helped through the Socratic method (a verbal method of asking open-ended questions that patients can readily answer, that helps foster critical thinking to help them better understand their internal experience, that draws attention to information they may not be able to access on their own, and that helps them broaden and gain new perspectives). Through other forms of guided discovery (using a variety of strategies to discover answers rather than directly giving answers), patients are helped to identify and evaluate their inflexible thoughts to determine whether they are erroneous, overly rigid, or unhelpful, or if their implications are erroneous or unhelpful, even if the initial thoughts are valid. Patients are then helped to come up with newer thoughts that are more realistic, less polarized, and helpful (Kazantzis et al., 2018). For example, guided discovery processes are used to modify black-and-white thinking styles to help individuals form interpretations that have shades of gray. Patients who hold perfectionistic standards for themselves are helped to loosen the stringency of their standards. Those who consistently overestimate the danger of situations, catastrophize, and/or underestimate their ability to cope with such threats are helped to reduce their overestimation of danger, decatastrophize, and better estimate their ability to cope. Behavioral experiments are used to disconfirm or widen cognitions and metacognitions, and to help patients learn that they can cope with negative outcomes.

Cognitive therapists often help patients modify the believability of erroneous thoughts using evidence that may contradict the logic inherent in these thoughts (e.g., "I have never driven my car off a bridge or had a heart attack when I have had a panic attack, so it is unlikely that I will") or by helping them objectively evaluate their thoughts by examining them from the perspective of others (e.g., "If my friend had obsessions about killing his spouse, I would not judge him to be evil"). Additionally, cognitive therapists help patients develop multiple, benign, nonjudgmental interpretations to widen their narrow, polarized, judgmental perceptions of events (e.g., "It is possible that she did not say hello to me because she did not see me or because she was hurt by something I said, and not because she hates me or is selfish"). Individuals are helped to modify inaccurate thoughts (e.g., "I will never have a boyfriend because I was rejected today"), as well as implications of such thoughts even if the primary thoughts themselves are not inaccurate (e.g., "I am a loser because I have never had a boyfriend"). Cognitive therapists also help individuals learn that they can accept and cope, even if negative outcomes occur (e.g., "I will be anxious and upset if people look bored during my talk, but I can handle it").

Later evolutions of CT emphasize the modifications of metacognitive processes (Wells, 2000; e.g., "Worrying is unpleasant but it will not help me or cause me to have a nervous breakdown") and modifications of the individual's relationship to the thought (Salkovskis, 1985; e.g., "Thinking about killing my mother is just a thought that I can ignore; it does not mean I have killed my mother or that I am evil for having such thoughts"). Adaptations of CT to the treatment of personality disorders were borne of the constructivist movement in cognitive science. The therapeutic approach derived from this model added the use of experiential techniques to generate affect in individuals and the use of interpersonal techniques to alternate between building a close therapeutic alliance and confronting patients to help break maladaptive cognitions and behaviors (McGinn, Young, & Sanderson, 1995), similar to the dialectical stance that DBT therapists are taught to adopt.

In contrast to traditional CT and as mentioned previously, DBT is fundamentally a radical behavioral therapy with the addition of Zen philosophy, and balances the two using dialectical philosophy and strategies. This dialectical philosophy emphasizes accepting one's thoughts in lieu of actively changing them, although both strategies as they are taught in DBT are discussed above. Similar to the cognitive therapist, the DBT therapist teaches patients alternative, benign, and less polarized ways of thinking, but is less likely to use other cognitive restructuring techniques, such as examining the evidence, placing the individual in the position of the other, or helping patients see that their thoughts are unhelpful. However, just as the cognitive therapist guides patients to consider alternative, less threatening, and more benign ways of thinking in order to widen their narrowly held, rigid perceptions of events, the DBT therapist also uses cognitive restructuring to modify nondialectical cognitions and replace them with more dialectical or flexible patterns of thinking. However, the goal of cognitive restructuring in DBT is to understand that truth is not absolute and to achieve middle path solutions as advocated in Zen philosophy rather than to ask patients to consider that they may be misinterpreting events or thinking in unhelpful ways, or to reduce their emotional arousal.

Additionally, while cognitive therapists use subtler processes such as guided discovery to help patients learn from experiences and Socratic questioning to model and help patients generate alternative ways of thinking, the DBT therapist often uses more direct or confrontational strategies to achieve changes in thinking such as irreverence, extending, radical genuineness, and self-disclosure. Another cognitive-behavioral therapy model, rational emotive behavior therapy (Ellis & Ellis, 2011), employs elements of this irreverent and confrontational approach, which in practice feels more similar stylistically to DBT than traditional CT. Finally, the cognitive therapist targets alternative ways of thinking and designs behavioral experiments to help patients become aware of equally viable interpretations of events and thus to be less subject to extreme, emotionally driven cognitions so that they can better regulate emotions and

develop more adaptive coping behaviors. By contrast, the DBT therapist places a greater value on experiential knowledge (i.e., engaging in an opposite action in order to experience a shift in mood) over intellectual analysis of thought challenging as a means of shifting mood.

Case Conceptualization, Treatment Planning, and Implementation

Starting at the outset of the therapy process, dialectical thinking, or the lack thereof, can present itself in the case conceptualization. In DBT, case conceptualizations include an analysis of how the biosocial theory impacted the development of a patient's presenting problems, the development of a treatment target hierarchy, and an analysis of the secondary targets, or dialectical dilemmas. When targeting dialectical thinking in treatment, it is first necessary to understand how this skills deficit developed and is maintained through a conceptualization, which then directs the treatment.

Biosocial Theory

The biosocial theory in DBT was developed by Linehan (1993a) and posits that individuals with high emotion dysregulation, such as those with BPD, develop difficulties across five problem areas, or areas of dysregulation, as a result of having a biological vulnerability to emotions that transacts with an invalidating environment. These five areas of dysregulation include emotional, interpersonal, self, behavioral, and cognitive. Biological vulnerability is characterized by having high sensitivity, high reactivity, and a slow return to emotional baseline, whereas an invalidating environment is defined as people in one's life who inadvertently or deliberately communicate to the emotionally vulnerable person that what he or she is thinking, feeling, or doing is invalid in some way. The transaction between these two factors leads to the development of the five problem areas. Cognitive dysregulation is the area characterized by extreme "all or nothing" thinking and actions. Last, many BPD patients have a difficulty "mentalizing" (i.e., difficulty with perspective taking and specifically with understanding the impact of one's behavior on others [Bateman & Fonagy, 2006]). In essence, this could be considered another example of nondialectical thinking and behaving.

Clinical Example

We treated a 21-year-old adult female with a biological vulnerability to emotion dysregulation since early childhood and a history of a traumatic intimate relationship with a man who was physically and emotionally abusive. She reported feeling anxious around him, as if she were walking on eggshells trying to make sure that she did not say or do the "wrong" thing so they did not end up in a fight. She developed very intense nondialectical thinking, especially when misinterpreting and judging the facial expressions of others in her environment. In one such instance, she noticed that a coworker was less talkative and warm toward her on a particular day. She had the thoughts "What a bitch, she can't even smile at me while we are working? I must have said something to piss her off. She definitely does not like me. Why do I have such a hard time making friends? I am such a horrible person that no one likes. I deserve to die." As a result of the transaction between her emotional sensitivities and her traumatic past, this patient was quick to make very extreme and nondialectical interpretations of most interpersonal situations, often negatively directed toward herself. Therefore, a major treatment goal for her was to increase her dialectical and nonjudgmental thinking in interpersonal situations. At this stage, the patient could be guided via Socratic questioning to pinpoint the exact sequence of her myriad cognitions, and to understand the link between situational triggers, cognitions, emotions, and behaviors.

Treatment Planning and Target Hierarchy

Continuing with the case conceptualization, the next step involves the development of a target hierarchy. As noted previously, the hierarchy directs what ought to be addressed in treatment and is organized from the most severe behaviors to the least severe. Nondialectical thinking can appear with each target for patients who struggle with this skill. For example, for patients with suicidal ideation and/or urges to self-injure, nondialectical thinking often appears as a link on the chain toward this problem behavior.

Clinical Example

We treated a 19-year-old patient who struggled with binge-eating disorder and perfectionism. She had a pattern of "messing up" her extremely strict and self-imposed eating plan by eating more than she set out to do, which led to nondialectical and rigid thoughts that contributed to fear and shame such as "Because I messed up, the rest of the day is ruined!" and "I'm going to gain weight and feel out of control," and then "I'm such a failure (shame), I'm going to continue to be a failure (fear), my life is hopeless (sadness), I can't do this anymore." These thoughts then led to binge eating, more shame, and suicidal ideation (relief/escape function). See Figure 2 for a visual depiction of this chain.

In this case, the DBT therapist could target such cognitions by guiding the patient to identify and understand the impact of cognitions on emotions and behaviors in the chain, and by communicating empathy for the resulting emotions and behaviors, thereby building commitment for change. Once these targets are achieved, the therapist could work to modify cognitions and design behavioral

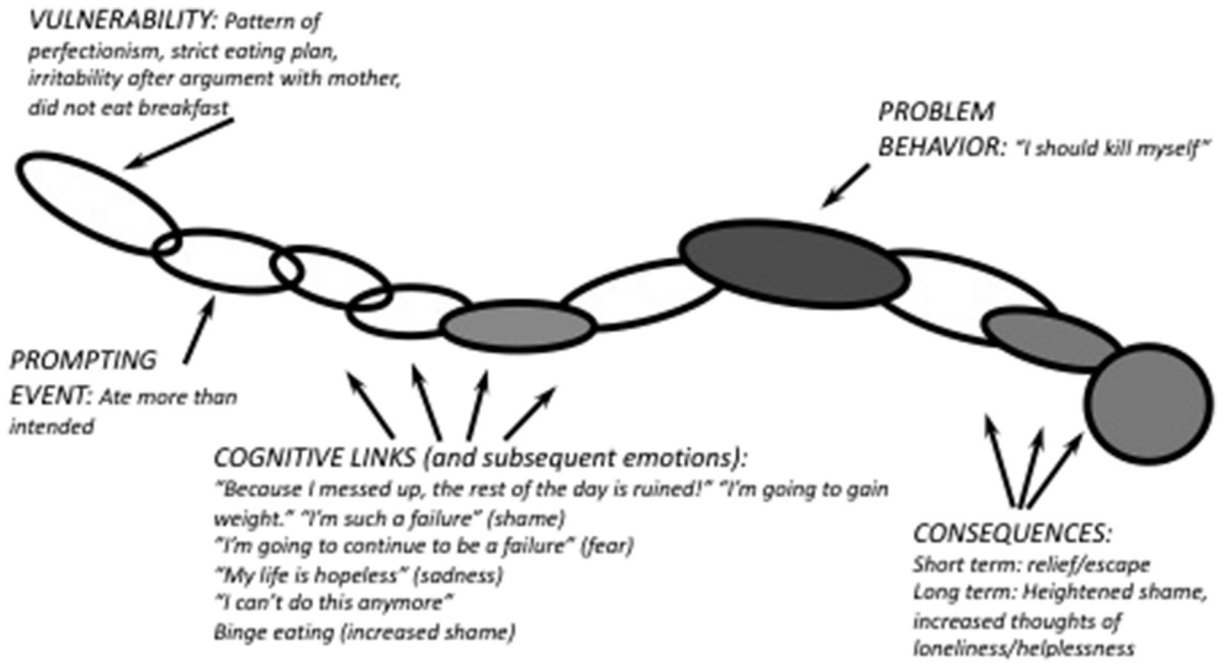

Figure 2. Example of DBT chain analysis with nondialectical thinking links.

experiments to enable more experiential learning and test the impact of modification strategies.

For others, nondialectical thinking may appear as a therapy-interfering behavior. Nondialectical thinking and behaving can interfere with treatment in countless ways for those who are extremely rigid and have difficulty with change. Some examples include difficulties with being flexible with scheduling changes (e.g., therapist asks patient to reschedule a session and patient refuses due to thoughts such as "It's not fair, my session time is 2 p.m. and it's always at 2 p.m. I won't change my schedule just because my therapist wants me to for her convenience!"), commuting changes (e.g., realizing the bus you typically take is no longer running and becoming willful with the prospect of problem solving an alternative: "It shouldn't be this way!"), or refusing to participate in group when new members join (e.g., "I'm never going to feel comfortable with this new stranger in group").

Other examples of nondialectical thinking targets, whether on the part of the patient or the therapist, may become evident within a therapy session. Patients may feel invalidated by their therapist due to a misinterpretation of a statement or the nonverbal cues the therapist makes, leading to emotional numbing in session or an anger outburst by the patient. Or a patient may use phone coaching ineffectively by texting statements that reflect her extreme, nondialectical thoughts about herself and her life such as "I'm gonna die" and "I hate myself," without asking for help to change this perspective. Such in vivo examples of a skills deficit in nondialectical thinking ("hot cognitions," as defined in CT) present key opportunities for the DBT therapist to highlight the problematic cognitions in the moment and to coach the patient to think and/or behave more dialectically right then. This is described in more detail below, in the "Implementation" section.

Therapy-interfering behavior on the part of the therapist may also emerge as a result of a transaction between the nondialectical thinking exhibited by both the patient and the therapist. Often when patients are extreme in their own thinking (especially when directed at therapists), it can pull therapists to dig their heels in on the opposite dialectical pole, resulting in therapists becoming nondialectical as well. When therapists become aware of this transaction occurring in the moment, it can be helpful for them to observe and describe the process that is occurring, model how to be more dialectical, and elicit new behaviors from patients.

Clinical Example

We treated a 31-year-old female diagnosed with BPD and generalized anxiety disorder whose highest-order target behavior was engaging in nonsuicidal self-injury (NSSI) of cutting her thighs with a razor blade. In order to prevent reinforcing NSSI behavior, a "24-hour rule" for coaching is put in place in DBT so that patients do not receive selective attention immediately following an NSSI behavior. This rule states that patients may not use coaching for 24 hours after they engage in NSSI, and

encourages patients to call for coaching prior to engaging in a problem behavior. When the therapist did not return this patient's phone calls one day after an instance of NSSI behavior, the patient became incensed at the therapist. In response to the patient, the therapist said, "Wow, I'm noticing this strong urge to defend myself and highlight my perspective each time you say that I'm intentionally hurting you by not calling you back for coaching when you've already self-injured. I'm noticing my heart rate increase and my face getting flushed too, which makes it harder for me to skillfully respond to you in a validating way. I think I am becoming nondialectical right here right now! I'm going to try to be dialectical right now—'I can see how it would feel punishing and hurtful not to have access to coaching after self-injuring, especially when it's hard for you to reach out in the first place. I also don't like not being able to help in those moments and yet we've talked about how in DBT there is a 24-hour rule so that you can access coaching before engaging in problematic behaviors.' Do you think I did okay? Would you be willing to give it a shot—to highlight both perspectives right now, as hard as that may be?"

Nondialectical thinking and increasing dialectical thinking can be added to the target hierarchy as quality-of-life interfering behaviors and skills deficits, respectively. Symptoms of other disorders are often addressed in DBT as quality-of-life interfering behaviors, and more pervasive difficulties in thinking and acting dialectically are common in certain disorders beyond BPD. This is especially true at the extreme end of their presentation, such as in obsessive-compulsive personality disorder or extreme perfectionism, eating disorders, autism spectrum disorder, major depressive disorder, posttraumatic stress disorder, substance use disorders, and generalized anxiety disorder. If a DBT patient presents with a symptom presentation consistent with one of these disorders and exhibits high levels of nondialectical thinking, simply using the evidence-based protocol for said disorder may not be enough for symptom relief, although this certainly is an empirical question worthy of investigation. Anecdotally, and as evidenced by the Bonavitacola et al. (2016) survey, DBT therapists who successfully terminate their DBT patients note that a majority of these patients demonstrated improvement in their dialectical thinking, therefore, one speculation is that the converse is true (i.e., those who do not successfully terminate DBT demonstrate deficits in dialectical thinking, although this hypothesis would need to be empirically tested as well).

Implementation: How to Directly Target the Increase in Dialectical Thinking

Once a case conceptualization has been created highlighting dialectical thinking and behaving as major skills deficits, the next phase of treatment involves directly targeting these deficits. Up until now, this case conceptualization process may not feel like much of a deviation from what most DBT therapists are already doing. The difference that we are attempting to highlight is the transparency with which dialectical thinking may be discussed and targeted in treatment. As the target hierarchy and treatment goals are being developed in collaboration with the patient in pretreatment, our suggestion is to directly highlight to the patient the particular thinking deficit(s) being addressed, note where it would fall on the target hierarchy, demonstrate empathy and provide validation for the emotional dysregulation it creates, and build motivation to work on this particular skill.

Chain Analysis and Diary Cards

Chain analyses are used not only as an assessment tool to help develop a case conceptualization but also to target problem behaviors once they have been established as therapy goals (Rizvi & Ritschel, 2014). Nondialectical thinking could be targeted directly as the main problematic target, or as a link on the chain toward a higher-level target as previously illustrated. When dialectical thinking consistently emerges as a link on the chain toward other problem behaviors, the motivation to target it may be much easier to build upon when the therapist has continued to highlight this particular deficit during each chain that is conducted. Guiding the patient to discover his or her cognitions using Socratic questions will also help identify and sequence the myriad automatic thoughts the patient expresses so that the therapist can more effectively communicate empathy, help build motivation to change, and begin modifying cognitions.

If guided discovery is unsuccessful or if willfulness emerges when working on modifying dialectical thinking, the therapist could make an irreverent statement to increase motivation (e.g., "I guess what you're telling me is that you'll be happy alone forever since if you continue to stick to those nondialectical beliefs about ALL men being jerks you will continue to end up in situations where your urge to fight men is prompted. Not sure how many men will find that endearing!"). As is the case whenever irreverence is used in DBT, it is important to ensure that there is sufficient rapport with the patient so that this technique is used effectively.

If a pattern of nondialectical thinking emerges on several chain analyses across sessions and the patient is motivated to work on it, our recommendation is to add it to the patient's diary card as an additional target behavior so that both the presence of nondialectical thinking/acting as well as its opposite (dialectical thinking/acting, which is already listed in the skills portion of the diary card) are monitored. If simply circling their use of the dialectical thinking/behavior skill on

INTERPERSONAL EFFECTIVENESS HANDOUT 16

(Interpersonal Effectiveness Worksheets 11, 11a, 11b)

How to Think and Act Dialectically

❑ **1. There is always more than one side to anything that exists. Look for both sides.**

- ❑ **Ask Wise Mind: What am I missing?** Where is the kernel of truth in the other side?
- ❑ **Let go of extremes:** Change "either-or" to "both-and," "always" or "never" to "sometimes."
- ❑ **Balance opposites:** Validate both sides when you disagree, accept reality, and work to change.
- ❑ **Make lemonade out of lemons.**
- ❑ **Embrace confusion:** Enter the paradox of yes and no, or true and not true.
- ❑ **Play devil's advocate:** Argue each side of your own position with equal passion.
- ❑ **Use metaphors and storytelling** to unstick and free the mind.
- ❑ Other ways to see all sides of a situation: _____

❑ **2. Be aware that you are connected.**

- ❑ **Treat others as you want them to treat you.**
- ❑ **Look for similarities among people instead of differences.**
- ❑ **Notice the physical connections** among all things.
- ❑ Other ways to stay aware of connections: _____

❑ **3. Embrace change.**

- ❑ **Throw yourself into change:** Allow it. Embrace it.
- ❑ **Practice radical acceptance of change** when rules, circumstances, people, and relationships change in ways you don't like.
- ❑ **Practice getting used to change:** Make small changes to practice this (e.g., purposely change where you sit, who you talk with, what route you take when going to a familiar place).
- ❑ Other ways to embrace change: _____

❑ **4. Change is transactional: Remember that you affect your environment and your environment affects you.**

- ❑ **Pay attention to your effect on others** and how they affect you.
- ❑ **Practice letting go of blame** by looking for how your own and others' behaviors are caused by many interactions over time.
- ❑ **Remind yourself that all things, including all behaviors, are caused.**
- ❑ Other ways to see transactions: _____

Note. Adapted from Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). *Dialectical behavior therapy with suicidal adolescents.* New York: Guilford Press. Copyright 2007 by The Guilford Press. Adapted by permission.

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Figure 3. Interpersonal effectiveness handout 16: How to think and act dialectically. From *DBT Skills Training Handouts and Worksheets, 2nd Edition* (p. 151), by M. M. Linehan, 2015, New York, NY: Guilford Press. Copyright 2015 by The Guilford Press. Reprinted with permission

the skills portion of the card does not give the therapist enough data, therapists could also add a column on the diary card rating the frequency (e.g., the number of times the patient said or did something dialectically that day), or the perceived efficacy of nondialectical or dialectical thinking (e.g., how successful the patient was at being dialectical that day on a scale of 0–5). Similar in function to monitoring other problem behaviors and skills, this will help the patient become more mindful to the presence of his or her nondialectical and dialectical thoughts in order to help him or her increase the use of the skill over time.

Solution Analyses

No chain analysis is complete without the subsequent solution analysis. Seasoned DBT therapists are skilled at weaving solution analysis into the chain as problematic links emerge or it can be done in a more didactic fashion once a pattern of behavior has been established. In Linehan (2015), there is a "how to" guide for practicing dialectical thinking within the interpersonal effectiveness module. See Figure 3 for a list of these strategies. The strategies listed include:

- Look for the kernel of truth from the opposing perspective.
- Let go of extreme language, such as "always" and "never."
- Play devil's advocate by arguing for another perspective.
- Look for similarities among people instead of differences.
- Notice the physical connection between all things or yourself and your environment.
- Practice radically accepting changes as they come along, and give yourself opportunities to accept change, such as taking a different route to work one day.
- Notice your effect on others.
- Let go of blame by accepting that everything has a cause.

The check-the-facts skill in the emotion regulation module also provides suggestions for ways to challenge beliefs. This skill emphasizes examining one's thoughts about prompting events to ensure that the thoughts are indeed based on the facts of the situation and not interpretations, with the understanding that if interpretations or judgments are being made, this can negatively impact one's mood. The skill includes taking various steps to check the facts, including thinking of other possible interpretations, labeling the threat and the probability of the threat occurring, and imagining the catastrophe or worst-case scenario occurring and how one would cope effectively if it happened. See Figure 4 for a reference of this skill.

In addition to the techniques listed in the skills manual, listed below are additional strategies from CT that could be used to enhance DBT's ability to successfully highlight deficits in dialectical thinking and lead patients toward a more dialectical stance. Through the use of guided discovery and Socratic questioning, therapists could help patients:

- Understand more thoroughly how thoughts mediate emotions and behavior
- Provide opportunity for self-validation and empathy for emotions and behavioral urges by linking them to their identified cognitions
- Contradict the logic inherent in their thoughts
- Use evidence to modify their cognitions when possible
- Widen their cognitive field by generating multiple, benign thoughts
- Modify unhelpful thoughts and/or the implications of their thoughts, even if the thoughts themselves are accurate
- Help patients learn that they can accept and cope if negative outcomes occur
- Challenge and modify metacognitions
- Modify the individual's relationship to the thought

These techniques could be practiced with the therapist using the nondialectical thinking that is being observed in the session. The goal is to highlight the non-dialectical thinking as well as engage in in vivo experience and practice of new dialectical thinking during the session itself.

In Vivo Detection of Nondialectical Thinking and Coaching to Reframe Statements Dialectically

In vivo coaching to think and behave more dialectically when opportunities arise are golden moments that, when done successfully, may lead to greater skills generalization for patients. The first challenge to successfully implementing such strategies is mindfulness on the part of the therapist to notice patterns of nondialectical thinking emerging in the moment ("hot" cognitions). Once these patterns are on the therapist's radar, the therapist may then nonjudgmentally describe these patterns for the patient in the moment, help patients see how these thoughts contribute to emotional arousal and maladaptive behaviors, and empathize with the resulting arousal or behavioral urge experienced by patients without validating the invalid. This often requires that the therapist use his or her own skills, such as opposite action, if anxiety or worry thoughts arise, such as "I don't know how this patient will handle me telling him or her this." Once the therapist skillfully highlights the problematic thinking pattern, it is important that the therapist elicit a commitment

EMOTION REGULATION HANDOUT 8

(Emotion Regulation Worksheet 5)

Check the Facts

FACTS

Many emotions and actions are set off by our thoughts and interpretations of events, not by the events themselves.

Event → Thoughts → Emotions

Our emotions can also have a big effect on our thoughts about events.

Event → Emotion → Thoughts

Examining our thoughts and *checking the facts* can help us change our emotions.

HOW TO CHECK THE FACTS

1. **Ask: What is the emotion I want to change?**
   (See Emotion Regulation Handout 6: Ways of Describing Emotions.)
2. **Ask: What is the event prompting my emotion?**
   Describe the facts that you observed through your senses.
   Challenge judgments, absolutes, and black-and-white descriptions.
   (See Mindfulness Handout 4: Taking Hold of Your Mind: "What" Skills.)
3. **Ask: What are my interpretations, thoughts, and assumptions about the event?**
   Think of other possible interpretations.
   Practice looking at all sides of a situation and all points of view.
   Test your interpretations and assumptions to see if they fit the facts.
4. **Ask: Am I assuming a threat?**
   Label the threat.
   Assess the probability that the threatening event will really occur.
   Think of as many other possible outcomes as you can.
5. **Ask: What's the catastrophe?**
   Imagine the catastrophe really occurring.
   Imagine coping well with a catastrophe (through problem solving, coping ahead, or radical acceptance).
6. **Ask: Does my emotion and/or its intensity fit the actual facts?**
   Check out facts that fit each emotion.
   Ask Wise Mind.
   (See Emotion Regulation Handout 11: Figuring Out Opposite Actions, and Emotion Regulation Handout 13: Reviewing Problem Solving and Opposite Action.)

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Figure 4. Emotion regulation handout 8: Check the facts. From *DBT Skills Training Handouts and Worksheets, 2nd Edition* (p. 228), by M. M. Linehan, 2015, New York, NY: Guilford Press. Copyright 2015]by The Guilford Press. Reprinted with permission.

from the patient to be willing to address these thoughts when they arise in the moment. After obtaining a commitment, the therapist can coach the patient through Socratic questioning as well as other CBT and DBT strategies to help the patient think more dialectically. Finally, it may be helpful for the therapist to obtain an agreement from patients to further highlight these moments in the future when they arise.

Case Conceptualization and Vignette

The following vignette showcases a portion of an individual session with a 16-year-old patient under the pseudonym Harry who met criteria for attention-deficit/hyperactivity disorder and major depressive disorder, severe. His chronic low mood and difficulty staying focused often led to low motivation to engage in chores at home, such as cleaning dishes, laundry, and taking out the trash. Instead, he spent many hours when home from school and on the weekends in his bed. His mother noticed this pattern of behavior and responded by yelling at him, calling him lazy, and threatening to take his phone away if he did not help out around the house. Harry experienced his mother's reaction to him as invalidating, which prompted an escalation in his mood dysregulation, resulting in a verbal fight with his mother. Over time, this pattern of emotional vulnerability transacting with an invalidating environment led Harry to experience much higher emotional reactivity, extreme difficulties effectively communicating with his mother, more frequent behavioral outbursts, including swearing at his mother and throwing objects across rooms, and heightened nondialectical thinking.

What follows is a clinical vignette that highlights several cognitive techniques described in this paper meant to enhance dialectical thinking as a skill.

THERAPIST (T): Harry, I noticed that you just said, "My mom never gives me a break! She always expects me to do the dishes when I get home from classes and never acknowledges when I do, only when I don't! F– her, I'm not doing the dishes again." You used a couple of nondialectical words in there, such as "never" and "always," and I'm wondering how that thought is making you feel? *(identifying nondialectical, all or nothing language, and eliciting connection to emotion)*

HARRY (H): I'm freaking pissed at her!

T: Yeah, I can tell! So much so that you don't even want to do the dishes at all anymore. I'm wondering if you'd be willing to try restating that phrase in a more dialectical way as an experiment, to see if it has an effect on how you're feeling and your urges. What do you think? *(initiating in vivo experiment to collaboratively practice thinking dialectically)*

H: Umm, okay, I guess.

T: Great! So give it a shot, how would you say it more dialectically, with less extreme language?

H: My mom expects me to do the dishes when I get home from school. Most of the time she forgets to acknowledge this and I've noticed that when I don't do it, she gets angry with me.

T: Nice job! How does that make you feel?

H: A little less angry, I suppose.

T: And what do you think is your mom's perspective? *(highlighting another perspective)*

H: I don't know, she's just easily pissed. That's how she is.

T: Is that the only explanation? That she's just an angry person? Is it possible that she has another reason for expressing her anger? *(identifying alternative explanations for behavior and looking for the kernel of truth from the opposing perspective)*

H: I mean yeah, I guess. She IS really busy. She works long hours, too. She probably also doesn't like having to do the dishes after a long day of work.

T: Yes! Excellent job highlighting another perspective! I also wonder if another perspective is that she may want to see that each person in the house keeps their responsibilities. I know we've talked about that doing the dishes is your one house chore. Your sister is supposed to do the laundry, right? *(using evidence to challenge a thought and generate alternative thoughts)*

H: Yeah. You're right. She may just want that. And I know I need to be more willing to help out, it's just that I don't have the energy sometimes.

T: Of course, it's super tiring at the end of a long day to have to clean dishes! I wonder if that's something you and mom have in common—that you're both tired when you get home. Could that make it more challenging for your mom to notice when you've done the dishes? *(looking for similarities among people and considering benign interpretations of other's behavior)*

H: I guess so, and I guess we both get pissed off more easily when we're tired.

T: That's a great point, that's another reason that you both might feel angry in this situation. Thinking in this way, do you feel any less angry or think you will still never do the dishes again? *(validating patient's perspective while also eliciting information about effect of dialectical thinking on emotions and behavior in vivo)*

H: Nah, I was just feeling pissed when I said that.

T: And how are you feeling now?

H: Still annoyed, but not as angry.

T: Wow, isn't that interesting! Sometimes our emotions push us to think in pretty extreme ways and if we can catch ourselves having that thought process, we can shift our perspective to be more dialectical, which helps us to feel less distressed and more in a wise mind. Would you be willing to allow me to highlight nondialectical thoughts if you voice them in session, so I can help you practice the skill of dialectical thinking in the moment? *(obtaining commitment to willingness to address these thoughts in session)*

H: Sure, but I don't want to just see the other side. My side matters, too!

T: You're absolutely right. Being dialectical means acknowledging both sides. You can be annoyed that you have to do the chores and still do them. You can be mad at your mom and still be respectful of her wishes. You can also DEAR MAN mom to reduce your responsibilities while still acknowledging the truth in her perspective. Both can be true! What do you think, shall we add dialectical thinking to your diary card so you can become more aware of using this skill daily? *(highlighting and modeling dialectical thinking while using validation, and obtaining agreement to target on diary card)*

Conclusions and Future Directions

A primary goal of this paper was to highlight additional cognitive techniques that could enhance a DBT clinician's ability to more effectively target dialectical thinking and behaving for patients receiving DBT. There appears to be a long list of similarities between strategies embedded in DBT to address dialectical thinking and more formal CT strategies that were highlighted here. In fact, it appears that there are more similarities than differences, especially as both CT and DBT have advanced and expanded their cache of techniques over time. The most salient differences appear to be that CT uses techniques such as Socratic questioning and other methods of guided discovery to identify and modify cognitions, tends to more transparently target nondialectical thinking through the direct observation and labeling of distorted or unhelpful beliefs, teaches and helps patients practice specific skills to challenge these thoughts, and emphasizes to a greater extent how these maladaptive patterns in thinking are direct links to more intense mood dysregulation and nondialectical or impulsive behavior. In DBT, it appears that these problematic cognitions are more indirectly and subtly addressed, shaping the patient's way of thinking through engaging in opposite actions to emotional urges, problem solving, and radical acceptance over time. In true dialectical fashion, it can be acknowledged that on the one hand, cognitive distortions or unhelpful cognitions can lead to problems in emotion regulation and subsequent behavioral dysregulation (the cognitive model), and it is also possible on the other hand that the presence of intense negative emotions leads to cognitive distortions and behavioral dysregulation (the emotion model). Ultimately, being able to artfully and strategically dance between both perspectives would likely improve a DBT therapist's goal of more frequently achieving movement, speed, and flow when working with DBT patients.

The authors also want to remind the reader that in DBT we strive to not treat our patients as fragile as highlighted in the consultation to the patient agreement (Linehan, 1993a). With this ideal in mind, one could see the use of CT strategies as an effort to abide by this idea, rejecting the idea that DBT patients "can't handle" having their thoughts challenged. In fact, the premise of CT is that understanding cognitions offers the therapist a powerful tool for empathy. However, to be dialectical, DBT therapists could implement CT strategies with a balanced and perhaps extra dose of validation and other acceptance strategies so as to minimize any risks of inadvertent invalidation. When implemented this way, it is possible that DBT patients would in fact find the use of CT strategies as more validating than its counterpart. Future training for therapists in how to implement these additional and more targeted forms of cognitive restructuring is recommended for DBT therapists to enhance this skill set.

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