

# The Implementation of RO DBT in Clinical Practice

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RADICALLY OPEN DIALECTICAL Behavior Therapy (RO DBT) is a relatively new evidence-based treatment supported by five published trials focusing on depression, personality dysfunction, and eating disorders, and one recently completed multicenter trial targeting chronic depression (see Codd & Craighead, 2018, this issue; and Lynch, 2018b, for review). Despite its relative novelty, the transdiagnostic nature of the treatment has spurred implementation in a wide variety of settings and clinical populations. As with any treatment, it takes time and money to conduct good-quality efficacy and effectiveness studies, especially with complex mental health disorders. This can result in long delays before randomized controlled trials in those areas are published, which can lead to valuable information and experiences stemming from clinical practice not being publicly available—despite their potential utility. The aim of this paper is to address this issue by providing an overview of how RO DBT has been implemented in a variety of clinical settings, including lessons learned.

We interviewed several programs implementing RO DBT and include descriptions and insights from leaders in these programs to highlight the various

aspects of RO DBT implementation across settings. These clinics treat patients suffering from a range of mental health difficulties, including, but not limited to, personality, depressive, trauma, and eating disorders. The client populations covered in this paper include adults in general mental health settings, military veterans, college students, forensic patients, and young people.

## Implementing RO DBT: Step by Step

### Step 1: Why Offer RO DBT in Your Clinic?

The first step in deciding whether or not to implement RO DBT in your practice is to assess whether you have any clients who might benefit from this treatment. RO DBT has been developed for patients with disorders of overcontrol (OC), including anorexia nervosa, chronic depression, and Cluster A and C personality disorders such as avoidant and obsessive-compulsive personality disorder (Keogh, Booth, Baird, Gibson, & Davenport, 2016; Lynch, 2018b; Lynch, Hempel, & Dunkley, 2015). Although this may sound straightforward, the idea that excessive emotional overcontrol can be problematic is not always recog-

nized and assessing for overcontrol is generally not part of regular clinical assessments (see Hempel, Rushbrook, O'Mahen, & Lynch, 2018, in this issue). Despite this, overcontrol is very common: problems of overcontrol occur in personality disorders, depressed patients, eating disorders, anxiety disorders, and those who have experienced trauma, and RO DBT is currently being used to treat all of these disorders in adults as well as adolescents.

## RO DBT Is Designed to Treat a Spectrum of Disorders Sharing Features of Overcontrol

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** Clients who are referred to the Intensive Psychological Therapies Service (Dorset Healthcare University NHS Foundation Trust, United Kingdom) commonly present with long histories of trauma, abuse, neglect, and loss. Over 90% have a personality disorder according to the Structured Clinical Interview for DSM (SCID-II; First et al., 1997). Comorbidity is high, with 80% of the population reaching criteria for more than one personality disorder. Typically, the majority of clients (90%) also present with Axis I disorders, most common being recurrent depressive disorder. In 2017, 30% of clients referred to our service were assessed as overcontrolled and started RO DBT.

**The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio (Nathan Tomcik and James Portner):** The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio, treats military veterans from all eras of service including those who served during the Iraq and Afghanistan conflicts and the Vietnam War. The primary presenting problems are chronic depression, anxiety, and PTSD, along with personality disorders.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** Opal: Food + Body Wisdom, an eating disorder treatment facility in the University District of Seattle, WA, offers partial hospitalization, intensive outpatient and traditional outpatient programs. About 80% of our clients in all levels of care have overcontrolled temperaments. Opal treats anorexia nervosa, bulimia nervosa, and

binge eating disorder as well as their common comorbidities. Opal is seeing overcontrolled temperaments and behaviors in not only anorexia nervosa, but bulimia nervosa. For example, overcontrol is seen in purging small amounts of food eaten, planned purging, rule-bound purging, purging as punishment for mistakes. The most common co-occurring disorders are generalized anxiety disorder, major depressive disorder, obsessive-compulsive disorder, and obsessive-compulsive personality disorder.

**Eating Disorder Unit, Uppsala University Hospital (Martina Wolf-Arehult):** The Eating Disorder Unit at the Uppsala University Hospital in Uppsala, Sweden, is an outpatient unit where about two thirds of the patients are diagnosed with anorexia nervosa or eating disorder not otherwise specified (ED NOS) with a restrictive eating behavior.

**Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):** The Child and Adolescent Eating Disorder Service (CAEDS), part of the South London and Maudsley NHS Foundation Trust, United Kingdom, consists of an outpatient service and an Intensive Day Treatment Program. CAEDS treats young people who present with all forms of eating disorders, however, more than 40% suffer from anorexia nervosa of which the majority have comorbid chronic anxiety, especially social anxiety and generalized anxiety disorder, depression, and low social connectedness. Some young people also have comorbid autistic traits. The Intensive Day Treatment program was specifically developed to treat young people with anorexia nervosa for whom outpatient family therapy for anorexia nervosa was insufficient, on its own, to support expected progress towards recovery. The National and Specialist CAMHS DBT Service treats young people presenting with self-harm and suicidal ideation, often alongside severe anxiety and depression.

**Psychology Department of St. Patrick's Mental Health Service, Dublin (Richard Booth):** Clients who attend RO at the Psychology Department of St Patrick's Mental Health Service (SPMHS) have typically been diagnosed with depression but other diagnoses, such as one of the anxiety disorders,

bipolar affective disorder (some of whom are overcontrolled), or certain eating disorders, are not uncommon. Most will have had an inpatient admission during which their overcontrolled traits will have been evident.

**University Counseling and Psychological Services, Rowan University (Amy Hoch):** The University Counseling and Psychological Services at Rowan University typically treats college students reporting significant stress, depression, (social) anxiety, trauma, eating disorders, and alcohol or drug problems. On the surface, these presenting issues often seem to be undercontrol-related disorders; however, upon closer assessment, we estimate that 60% to 70% of our students have overcontrol-related disorders.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** All patients on The Peaks Unit at Rampton Hospital are detained under the UK, Mental Health Act, having a mental disorder and deemed to be of grave and immediate danger to the public. All patients have a diagnosed personality disorder according to the International Personality Disorder Examination (IPDE; Loranger, 1999), over 95% have experienced multiple childhood traumas and many have other comorbid issues, such as depression, anxiety, substance dependency, subthreshold psychotic symptoms, and a minority have autistic spectrum conditions. Hamilton et al. (in preparation) identified 44% of patients referred to the Peaks Unit as overcontrolled, based on IPDE personality disorder diagnosis and consensus expert opinion ratings.

### Step 2: Training

To practice RO DBT, clinicians should complete the RO DBT intensive training that has been developed by the treatment developer, Dr. Thomas R. Lynch and colleagues (offered through [www.radically-open.net](http://www.radically-open.net)). The intensive training is split into two parts. During the first 5 days the necessary foundations are laid to allow clinicians to start applying RO DBT in their clinical practice. After a period of 6 to 9 months, during which clinicians have had the opportunity to practice their new skills, they return for the second part of training, in which more practical teaching and problem-solving takes place. To become more skilled at RO DBT and achieve treatment

adherence, additional supervision is available, although not compulsory. Therapists can also use the RO DBT adherence self-assessment checklist (see Lynch, 2018b). The checklist is designed to be used flexibly, depending on setting, and can be rated either by the therapist or an independent rater.

RO DBT does not require a minimum number of clinicians to be trained, although it is advisable to have at least 2 members complete the training. That way, skills classes can be run by two trainers, which is generally more effective and may help prevent therapist burnout. Learning RO DBT as a new treatment comes with challenges as well as benefits. Several clinicians share their experiences about this process.

### Advantages and Challenges When Learning RO DBT

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** Our introduction to RO DBT was when we were selected to be the pilot site on the RefraMED multisite randomized controlled trial of RO DBT for refractory depression (Lynch, Whalley, et al., 2015). As a group of adherently trained DBT therapists, one of our first challenges was learning how to let go of the emphasis in DBT on emotion regulation and replace it with a model emphasizing social signaling and social connectedness. In addition, as a team it became quickly apparent that we would need to practice radical openness and self-enquiry skills ourselves if we were going to be effective in delivering RO DBT—which made the work personally challenging at times. Other challenges included learning to give ourselves permission to therapeutically tease and be playful, repair alliance ruptures, use our own nonverbal behavior, eye contact, and body posture to enhance client engagement, and to keep physiologically in our social safety system when faced with flat faces, and target subtle maladaptive social signals hypothesized to be maintaining client loneliness.

Individual therapists have identified whether they have an overcontrolled or undercontrolled personality style. This is in order to socially sanction the different styles to our clients. It is also helpful to understand how personal reactions may be smuggled into the clinical work. For example, an overcontrolled thera-

pist who prefers the company of her cats might inadvertently signal that avoiding social situations is not only understandable but entirely valid. As an undercontrolled therapist I needed to learn to lean back, slow down, and take the heat OFF a patient when I noticed a possible therapeutic rupture. By outing ourselves and valuing different styles we are better able to recognize what we may offer. We may also identify, through team discussion, where our blind spots may be. Our staff reports enrichment through practicing RO DBT and applying it to our own lives. In addition, we have grown personally from working and building relationships with the many wonderful RO DBT clients that have passed through our doors.

**The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio (Nathan Tomcik and James Portner):** The clinicians at the VA enjoy practicing RO DBT; they have found it challenging to learn and we found that practicing RO skills seems to be an essential part of effective treatment delivery. The clinicians who earnestly practice the RO skills themselves find it an easier adjustment to make in incorporating into their clinical practice. As with learning any new treatment, it was initially challenging for the consultation team to meet and watch video-taped sessions to ensure fidelity to the model. Over time this has improved through clear supervisory support from facility leadership and routine weekly consultation meetings.

Overall the clinicians find it very effective (and fun, actually). The skill class leaders look forward to class. In addition, data from our national all-employee survey suggest that compared to clinicians at other VAs our clinicians are reporting higher job satisfaction and lower burnout. Providing treatments that work in the context of a supportive team not only has improved access for us, it has impacted employee health and wellness as well.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** Prior to implementing RO DBT at Opal, we were unknowingly reinforcing maladaptive rewarding a good deal of “Don’t Hurt Me’s,” or disguised demands that communicate fragility or incompetence indirectly. Now, with RO DBT knowledge, we are

able to identify ineffective bids for connection and reward direct communication. Our staff culture is more psychologically healthy as a result of RO DBT. As you can imagine, RO DBT has improved staff morale!

**Eating Disorder Unit, Uppsala University Hospital (Martina Wolf-Arehult):** The introduction of RO DBT 5 years ago changed many things for the unit. Not only did the awareness of each person’s own personality style and its influence on therapy increase, but the therapists also learned more about the importance of social signaling. These changes could at times be both inspiring and painful areas of new growth for team members—a team that primarily included therapists leaning toward OC themselves. Over time, the team became more flexible and open, and developed a habit of doing self-enquiry work, rather than automatically soothing, regulating, or validating when confronted with strong emotions. For therapists, the treatment is easy to like and it is fun to learn the basic strategies—in particular, how we could use our own nonverbal social signaling (e.g., eyebrow wags, closed-mouth cooperative smiling) to enhance client engagement and how our personal practice of RO and self-enquiry not only helped model core principles to our clients but also helped in our personal lives.

**University Counseling & Psychological Services, Rowan University (Amy Hoch):** The first big hurdle our therapists needed to get over when first learning RO DBT was to see the client from a social signaling perspective and let go of other treatment models we had been trained in that prioritized other targets or mechanisms of change (for example, emotion dysregulation, maladaptive schemas). As DBT-trained therapists, the CPS staff have struggled to learn RO DBT. Initially, we tried to apply DBT to RO DBT, without success. As we have tried to let go of initial preconceptions about RO DBT and not just fall back on our DBT skills when challenged, we have begun to have more success. We instituted a regular self-enquiry practice into the beginning of each RO DBT consultation team instead of our usual mindfulness exercise to open our team meeting. This practice was met with some hesitation by some therapists who reported feelings of fear that somehow

self-enquiry would generate too much vulnerability. This reaction triggered further personal self-enquiry about what we are asking our clients to do and not willing to do ourselves.

Professionally, therapists report that they can more effectively identify which therapy may best match a student’s presenting issues. Historically, because all therapists at CPS are trained in DBT, the language of CPS has centered on “wise mind decisions,” “therapy-interfering behaviors,” and “dysregulation.” Now, the language at CPS includes “self-enquiry,” “social signaling,” and “alliance ruptures.” Therapists enthusiastically identify themselves as overcontrolled or undercontrolled and think about diagnosis in a different way as they consider a continuum of overcontrol and undercontrol.

**Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):** Within the Child and Adolescent Eating Disorders Service at the Maudsley the primary treatment model is Family Therapy for Anorexia Nervosa (FT-AN; Eisler et al., 1997). Introducing a new treatment model within a team using a very well-established treatment model raised some challenges in how to integrate RO DBT in a way not to contradict the primary model of treatment. Identifying the young people who presented as struggling with ongoing comorbid difficulties related to overcontrolled tendencies, despite engagement and weight gain supported by FT-AN, allowed us to offer some adolescents RO DBT within the third phase of FT-AN. The third phase of FT-AN focuses on helping young people to move on from their eating disorder and achieve developmentally appropriate levels of individualization. It was clinically easier to introduce RO DBT skills classes to the Intensive Day Treatment Program for restrictive eating disorders, where previously delivered DBT skills groups were replaced with RO skills classes that were better suited to the needs of this specific population. Young people, both in the outpatient and day program setting, found the volume and density of the RO DBT material, along with the amount of acronyms and complexity of language, somewhat overwhelming. Therefore, we have worked with the young people to condense and simplify the material to make it more developmentally applicable. The main challenge that our DBT

clinicians faced in learning and implementing the RO DBT model was shifting the main focus of change to social signaling. Prioritizing the question, “What are you social signaling to others?” as opposed to focus on how internal cognitions interact with behavioral change has been an adjustment in process for many of our clinicians, but it has been a significant modification that has fit well with a number of our young people and has helped them to achieve increased social connectedness.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** A small multidisciplinary team (Nurse Consultant, Clinical Nurse Practitioner and two Forensic Psychologists) led on the implementation of RO DBT while also clinically managing the DBT-standard service. Synthesizing RO DBT with the existing DBT program helped ease the path for implementation, particularly as RO DBT was positioned as a new development to this existing DBT service. Our experiences of delivering RO DBT as forensic clinicians paralleled those recounted above; that is, we faced challenges in learning a new model, letting go of the familiar (DBT), shifting between treatment models during the course of our working day, and getting buy-in from other professionals. A big challenge for us as forensic therapists was balancing the dialectic of security and treatment. The standard security mantras in forensics of loose lips sink ships, keep mum, walls have ears, say nothing and tell “them” nothing about yourself, flew in the face of the RO DBT way of working. The idea that therapists should be open about themselves, share

their temperamental leaning to overcontrol or undercontrol, engage in radical genuineness, be spontaneous, and most of all that therapy could involve fun, did not fit with our existing norms. Indeed, when a colleague and I went to do the initial 1-day training we wondered whether it was just radical to be open. Much self-enquiry work, along with some exceptional self-enquiry questioning during the intensive training, helps us work with our fixed ideas about the capacity for openness when working in forensics. While we were initially uncomfortable with some of the RO DBT therapist stylistics, practicing these has not only been personally enlightening but professionally liberating. Our core implementation team have all said that we have changed, noting improvements in social signaling ability, permission-seeking to give feedback, and for all greater openness to what life brings. Contrary to our initial fixed ideas, there have not been any catastrophic consequences to being more open, and patients have commented positively on how different the RO DBT therapeutic relationships have felt and often we see staff looking in with envy as they walk by the skills class and see genuine laughter emanating.

### Step 3: Preparing the Physical Environment

Before commencing treatment with overcontrolled clients, clinicians should optimize the physical environment in which treatment takes place. Because overcontrolled clients tend to have higher threat sensitivity, they are more likely to respond with low-level defensive arousal to environmental stimuli that may go unnoticed to other people. In addition, and certainly early on in therapy, overcontrolled

clients are less likely to admit to feeling anxious or uncomfortable when asked about this. Feeling uncomfortable during therapy sessions will limit a client’s ability to fully engage with the therapist, feel safe, or learn new behaviors (Lynch, 2018b).

Chairs in an individual treatment setting should be placed at a 45-degree angle rather than face-to-face and the distance between them should be maximized. Overcontrolled clients generally have a greater need for personal body space relative to others and this arrangement avoids (unintended) nonverbal signals of intimacy or confrontation (Morris, 2002). Ideally, the chairs will have armrests, allowing the therapist to easily shift into body postures that nonverbally signal cooperation, safety, and nondominance, which are critical when confronting a client or repairing alliance ruptures. Furthermore, the room should be kept cool—a hot or very warm room triggers perspiration in most people, and for overcontrolled clients sweating can be a conditioned stimulus associated with anxiety or maladaptive avoidance. Interestingly, most people find it easy to tell others that they are cold, but people are amazingly reluctant to complain when they feel hot because feeling cold is not a symptom of anxious arousal, whereas feeling hot is. In general, the room should be kept cool unless the overcontrolled client requests that the temperature be increased (Lynch, 2018b). Figure 1 illustrates the ideal therapy room for individual RO DBT treatment.

The same principles apply to skills classrooms. The skills class should be set up in such a way that it signals that the purpose of the class is learning skills rather than participating in group therapy, engaging in interpersonal encounters, or processing feelings. Ideally chairs will be arranged around a long table and a whiteboard or

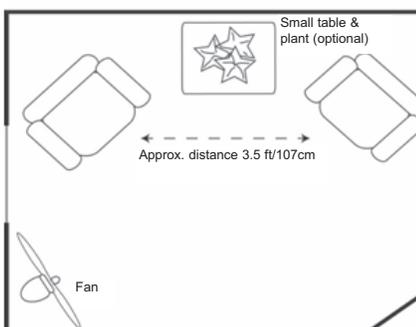


Fig. 1. Individual RO DBT treatment furniture arrangements.

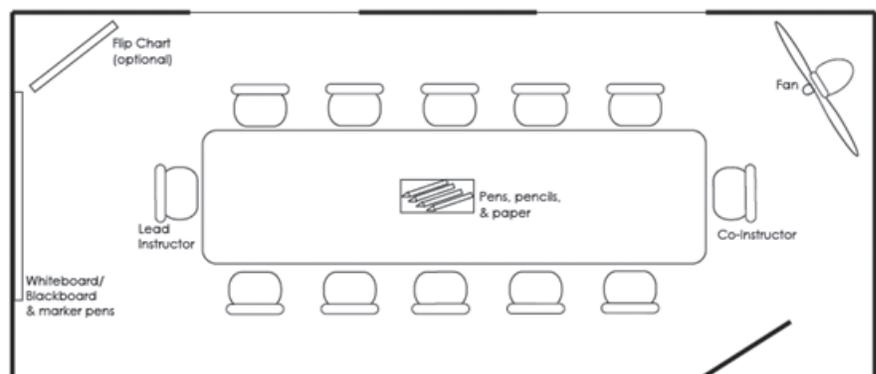


Fig. 2. RO DBT skills class training room arrangements.

flipboard is positioned at the front of the room for the instructor to write on. This arrangement provides a physical buffer between class members and functions to reduce feelings of being exposed, while at the same time providing practical space for note taking. The room is ideally light and airy with enough space for chairs to be moved around; this provides another opportunity for clients to move their chairs and create some distance without calling unwanted attention to themselves. As with the individual room, the skills classroom should be kept cool. So, turn on the fan and turn down the heat when working with overcontrolled clients; clients who tend to get cold easily should be encouraged to bring extra layers with them to keep themselves comfortable. Figure 2 shows the ideal skills class training room.

#### **Step 4: Assess Clients for Suitability of RO DBT**

Before treatment can commence, clients should be assessed to ensure the appropriate treatment is offered to them. For RO DBT, this means clients are predominantly overcontrolled: Their behavior prevents them from feeling socially connected, being open to feedback, and responding flexibly to environmental changes. The paper “How to Differentiate Overcontrol From Undercontrol: Findings From the RefraMED Study and Guidelines From Clinical Practice” provides an overview and guidelines for assessing overcontrol (see Hempel et al., 2018, this issue), including an overview of recommended OC-specific measures such as the Assessment Styles of Coping Word-Pairs, OC Trait Rating Scale and the Overcontrolled Global Prototype Rating Scale (Lynch, 2018b), as well as the Acceptance and Action Questionnaire-II (Bond et al., 2011), the Personal Need for Structure Scale (Neuberg & Newsom, 1993), the Social Connectedness Scale-revised (Lee, Draper, & Lee, 2001) and the Distress Overtolerance Scale (Gorey, Rojas, & Bornoalova, 2016).

Most clinics offer a range of treatments and have established assessment procedures as part of their intake to ensure the appropriate treatment is offered to each client. Below several experiences illustrate how learning to recognize and assess overcontrol has impacted clinical practice.

### **Clinical Reflections on Assessing Overcontrol**

**Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):** Reconceptualizing under- and overcontrol tendencies on a continuum has allowed us to develop an alternative treatment pathway for young people referred to our DBT service who present with self-harm and suicidal behaviors but, on assessment, do not present with underlying emotional dysregulation. Instead, they present with overcontrolled tendencies where longstanding depression and anxiety has led to self-harm that tends to be more secretive and sometimes ritualistic, and suicidal behaviors that tend to be the culmination of long periods of time of trying to cope in isolation by internalizing difficult emotions. Within our eating disorders day program we have also replaced DBT groups with RO DBT groups as the majority of young people with restrictive eating disorders tend to be assessed as being on the overcontrolled end of the spectrum. In the outpatient eating disorder service young people with anorexia nervosa with chronic anxiety and social isolation, once physically stable, are assessed for overcontrol traits, and RO is offered as alternative treatment with only occasional family reviews.

**Psychology Department of St. Patrick's Mental Health Service, Dublin (Richard Booth):** Initially the multidisciplinary teams doubted if there would be sufficient demand to form a group. However, it soon became evident that there were more clients with emotional overcontrol than emotional undercontrol, a pattern that has stood the test of time. Our work in RO DBT has identified an important and somewhat overlooked population in our service. They are often diagnosed as having “treatment-resistant depression,” at best an unhelpful term. The model has encouraged them to reveal a degree of emotional loneliness and desperation that they would not have previously expressed. A decade ago we might have seen signs of emotional leakage or acts of deliberate self-harm as indicators for traditional DBT. We are now much clearer as to how a more in-depth assessment will help reveal which group is likely to be most helpful for them to attend. Our own data suggest overcontrolled clients do not fare well in under-

controlled groups and can feel further alienated and confused by the experience. Having the choice of the two groups allows us to better understand the sometimes nuanced distinctions between these two populations. In making this discrimination clearer, we are in a better position to match service user to the most beneficial treatment.

It has not proved easy to assess motivation to attend the group. Clients typically shudder at the thought of being in any group, let alone one titled “Radical Openness.” We have found that once they have started, their identification with the model and with others in the group fosters a strong commitment. An early reluctance should not then be seen as a contraindication for joining the group.

**University Counseling & Psychological Services, Rowan University (Amy Hoch):** In the past, we have referred students with eating disorders and alcohol/drug problems to our standard DBT groups, thinking their presenting issues were a sign of impulsive behavior. In fact, we have discovered that these behaviors are often secondary to OC “emotional leakage” and/or a fixed mindset that is common among overcontrolled clients. A particular client of mine helped me rethink what was needed. She presented for therapy after being sexually assaulted. Her eating disorder behavior, restricting and purging, appeared after the assault. I assessed these as impulsive behaviors that helped her regulate after trauma reminders and other stressors. After a year of treatment, including DBT and Trauma Focused CBT, she revealed that she was secretly drinking most days and engaging in self-injurious behavior sporadically. My thought was to get her recommitted to DBT. My “willfulness” about what she needed seemed to fuel her own “willfulness” about finding the right answer for managing her anxiety. Looking back, we were both in fixed mind about the way to proceed. It was then that I happened to see the announcement for the RO DBT training and decided to attend. I had a new lens through which to assess her issues. In fact, her cutting and drinking were not impulsive at all. The behaviors were likely “leakage” that occurred after days or weeks of holding things in and trying to pretend that everything was OK. I learned that the mindfulness she always struggled with might be

better replaced with the practice of self-enquiry, a process of identifying a question that would help her approach her “edge” or discomfort, including her trauma. Wise mind then became flexible mind and the skills she learned helped her address the overcontrolled patterns that kept her restricting and purging. I also became aware of how often I signaled to my clients that I had the “right” answer for them and didn’t address how their own signaling to others maintained patterns of disconnection and loneliness. I now had a way of assessing for overcontrolled and undercontrolled tendencies and, based on the results, identifying a treatment that would more effectively address these underlying issues.

As a counseling service with limited resources we have to assess for level of care and often refer these students to higher levels of care because of the impairment to functionality. While their impairment may be significant, typically rendering a decision for a higher level of care, identified overcontrolled students are more responsive to outpatient care within the college counseling service. They respond well to the RO DBT program so that often a higher level of care is not needed.

**The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio (Nathan Tomcik and James Portner):** Most veterans respond well to routinely offered psychotherapy treatments. However, about one third of patients will not respond adequately. Over time, clinicians providing these treatments accrue a caseload of patients who are attending appointments dutifully yet not getting better. As a result, our ability to meet the VA’s mission of providing quick access to treatment depends upon our ability to identify those veterans who are less likely to respond to treatment as usual and match them with treatments that are more likely to work. Research investigating treatment-refractory depression has found a high comorbidity rate with personality disorders. It is these longstanding, rigid patterns of relating to others and the world that impact the flexibility needed to respond to treatments as usual. Therefore, understanding the severity and pervasiveness of problems of emotional undercontrol or problems of emotional overcontrol can help route veterans to a more appropriate treatment.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** All patients admitted to the Peaks Unit undergo a detailed assessment. Routinely this includes a diagnostic assessment for personality disorder, and clinical assessment of personality, anger, impulsivity, and interpersonal functioning. More recently, the Assessment Styles of Coping Word-Pairs has been added as screening measure for the assessment team. Similar to other services, identifying potential overcontrolled clients has been difficult, and team consultation has become our default managing referrals. Before accepting someone into the program we administer pretreatment psychometrics, gather prior diagnostic information, and then each case is discussed in RO DBT consult. This process not only helps ensure we get the right patients but helped develop a joint understanding of the RO DBT material and normed our conceptualization of overcontrol among offenders. Unlike other services, a common struggle for us was distinguishing narcissistic from overcontrolled patients. Both groups presented as good at hiding their true feelings, not acting on impulses in front of staff, high envy and bitterness was present, along with high need for control. A question that helped us disentangle these cases was: What is the function of that behavior? Often the narcissistic patient behaved in these ways to gain reward (e.g., wanting to be seen as low risk to get out) as opposed to avoiding disconfirming feedback or because it was in their nature to inhibit a lot. Narcissistic patients also rarely exhibited behaviors associated with social obligation or self-sacrificing, unless of course there was something in it for them.

One-day training events, targeted at those working with overcontrolled clients or on our admission ward also helped early identification. Comments from clinical teams responsible for managing overcontrolled patients were also helpful social signals supporting identification, and these often revolved around feeling stuck, not understanding a particular patient, difficulty matching good institutional behavior with staff perceptions of the person as high risk of lethal violence, and difficulty identifying gains from treatment despite multiple treatment completions.

### **Step 5: Starting Treatment— The Structure of the RO DBT Program**

RO DBT has originally been developed for outpatient settings, although it has been successfully implemented in inpatient settings as well (see, for example, Lynch et al., 2013). RO DBT is fully manualized and is ideally delivered weekly via both 1-hour individual sessions as well as 2.5-hour skills classes (Lynch, 2018a, 2018b). The full RO DBT treatment program consists of 30 skills class lessons (see Lynch, 2018a). It is recommended that clients attend one or two individual sessions before commencing skills classes. During these two sessions, the client gets a chance to explain his or her reasons for seeking treatment and is oriented towards the overall structure of the treatment. The client is also notified that their participation in skills class will begin during the third week of therapy.

The skills class can adopt an open or closed format. The recommended skills group size is 9 clients plus two skills class leaders (a leader and a co-leader). Skills classes can start with as few as 2 clients but overcontrolled clients generally do not like this: it means they are too much in the limelight. If there is no other option but to start with a small group, only one skills class leader should facilitate the class (up to 4 clients). However, not all clinics have the means or opportunity to offer the full RO DBT treatment program. Below is an overview of how the clinics have implemented the programs, including any challenges they faced.

### **Implementation of Individual Treatment and Skills Groups**

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** Members of our overcontrolled client group typically fear the limelight, commenting that they prefer larger classes over smaller ones. Thus, we have found that keeping the group up to capacity (i.e., class size approximately 10) is preferable both in terms of clinical outcomes and efficiency. One of our newest ways of enhancing class size has been to create multidagnostic classes—as long as all the members of the class share overcontrol as their style of coping (and have agreed to work on it) their diagnostic status is considered less relevant—meaning our classes might include individuals with diagnoses such as anorexia, autism, or depression (but all share overcontrol). We have also found that having new

clients attend classes with more experienced members facilitates active participation and reduces reluctance to participate in some of the experiential practices.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** The RO DBT team at Opal currently consists of three skills class co-leaders and one individual therapist. Currently, we offer RO DBT skills class twice a week for 1 hour each class and cycle through the full 30 lessons; this has taken the place of DBT skills class. One class of each week is focused on the new lesson and the other class hour of the week is homework review. Thus far, we have integrated RO DBT in to our leadership and staff values as well as our milieu therapy and meal support program. Our vision is to become a fully integrated RO DBT treatment program and our approach is to gradually smuggle RO DBT into our overall treatment. Next, we plan to integrate RO DBT into all of the groups offered in our 10-hour/day programming. Our hope is to intensively train several more staff members to increase the number of individual therapists.

**Psychology Department of St. Patrick's Mental Health Service, Dublin (Richard Booth):** Because of our health insurance arrangements, we only offer RO DBT in a group format. This started as skills-only sessions but has developed into Group Radical Openness (GRO; see article by Booth, Egan, & Gibson, 2018, in this issue). The RO DBT model still stays center stage and key skills are taught and rehearsed. However, change is fostered within the group and the group members are the main agents of change. Major responsibility passes to the tribe as new behaviors are trialled in group. There is now an average of six groups a year with an average of 10 clients in each. Some 300 service users have been through the program. Treatment currently consists of 26 group sessions, each lasting 3 hours. These are scheduled twice a week for the first 11 weeks and then once a week for 4 weeks. One-to-one sessions are offered as a review at midpoint and at the end of the program.

**Eating Disorder Unit, Uppsala University Hospital (Martina Wolf-Arehult):** At the Eating Disorders Unit in Uppsala,

the RO DBT program consists of 40 individual sessions and 30 skills class sessions. OC personality style and treatment rationale are introduced and discussed with the patient during the first two sessions. During sessions 3 to 10, with sessions taking place twice a week, the focus is on helping the patient to develop regular and sufficient eating habits. RO DBT treatment strategies are applied throughout this phase. RO DBT individual sessions continue from session 11 to session 40. These sessions focus on RO DBT for about 50 minutes and ED about 15 minutes, with a small break in between.

**University Counseling and Psychological Services, Rowan University (Amy Hoch):** College students' schedules revolve around the semester or trimester system; in our case, skills classes needed to fit into ten 90-minute parts that fit into a 14-week semester. For the past 3 semesters, when this author was the only trained RO DBT therapist, a closed RO DBT skills class was offered in an adapted form over 10 weeks in order to fit into a 14-week semester. It usually took 2 weeks to get students evaluated and referred to start the skills class and then 2 weeks at the end of the semester were not utilized for skills class because of final exams. The skills class was held weekly, 90 minutes in length and included the following skills: Radical Openness; Emotions Communicate to Others; Engaging in Novel Behaviors; Learning from Corrective Feedback (2 weeks); The Art of Validation; Enhancing Social Connectedness (2 weeks); Forgiveness and Compassion; and Enhancing Openness and Social Connection. After consulting with the developer of RO DBT and having additional clinicians trained in RO DBT, CPS is now offering the entire 32-week RO DBT program across Fall, Spring, and Summer sessions via a weekly, 90-minute, open skills class. In general, between 7 and 12 students attend skills class weekly. Students enter the skills class on any given week, after a brief orientation of the biosocial theory and social signaling by their individual therapist. If the student is not assigned an individual therapist, one of the skills class co-leaders will provide the orientation. If, however, the skills class does not fit into their schedule, students may only get some of the skills. In place of the skills class, we have tried to teach the

skills in individual sessions and/or groups of two to three students with one therapist who will teach the skills. Given the high acuity and volume of students seen at CPS, it is difficult to schedule these kinds of sessions and put more resources into RO DBT.

**Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):** National & Specialist Child and Adolescent Mental Health Services at the Maudsley offer RO DBT through three treatment pathways. Within the Eating Disorder Service young people attending the day program access RO DBT groups twice a week as part of a wider range of therapeutic groups, meal support, and Family Therapy for Anorexia Nervosa (FT-AN). The groups are condensed to 16 sessions. The majority of the treatment team has been trained in RO DBT and key aspects of the skills classes are reinforced by all the members of the team in their individual reviews, meal times, and other group activities. In the eating disorder outpatient service young people can be referred to RO DBT in the third stage of FT-AN (which focuses on helping the young people to reconnect with their adolescent life stage and goals) if they are assessed as having ongoing functional difficulties related to tendencies of overcontrol and if they self-identify with an overcontrolled coping style. The third treatment pathway is for those young people referred to the DBT service who at assessment present with difficulties in line with overcontrol rather than undercontrol tendencies (approximately 13% of the DBT service's total caseload). Young people in outpatient eating disorders service and DBT access the full RO DBT treatment model consisting of weekly individual sessions (1 hour) and weekly skills classes (1.5 hours) lasting 30 weeks. Within all three treatment pathways the group material is simplified and adapted to be accessible to adolescents. There is a fortnightly consult meeting for all clinicians providing RO DBT across these three treatment pathways. The clinical team consists of family therapists, psychiatrists, clinical nurse specialists, and clinical psychologists.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** We are still in the early stages of developing the RO DBT

service, and currently seven high-risk personality disorder offenders have completed both skills class and individual therapy components. We consciously made the decision to follow the prescribed RO DBT manual as much as possible, and looking back this was a great decision as we learned that the manual works with only minor tweaks. In particular, we needed to make examples more forensic, and we needed more sessions on emotions. The 10 emotions and associated worksheets outlined in Linehan (2015) were used to structure these sessions. These additional sessions were included based on patients saying they had difficulty labeling emotions and this need was verified by individual therapists. Hearing patients' ideas about emotions was particularly enlightening. There was a marked difference between our DBT-STD patients' views of emotions and our RO DBT patients, with the latter really disliking emotions and wanting to "eradicate" them. We also learned that our RO DBT patients had fixed ideas about prohibited and acceptable emotions; lots of disgust and hatred (towards self and others); and issues with love, which was generally prohibited but on occasion dysregulated when a patient found someone with whom he or she felt safe. Exploring emotions from an evolutionary and biological perspective helped take the heat off, and it also helped overcome the resistance to emotions noted in RO DBT Lesson 6 (myths about emotions; Lynch, 2018a). While patients said it was useful to explore all the emotions, they thought it got a bit repetitive and we are currently looking at how best to shorten these sessions in future groups. We think that covering all the emotions in skills class and as homework helped emotional labeling, normalized all emotions, and supported more open conversations about emotional experiences in class and individual sessions. The concept of forgiveness has also consistently proven a difficult issue, with many struggling to forgive themselves for the crimes they have committed and acknowledging, probably correctly, that many people will never forgive them for what they have done. This remains a challenging issue for therapists and patients alike, and links closely to the challenge of finding suitable avenues in a high-secure setting for overcontrolled patients to exercise their need to give back.

The first group had weekly individual sessions, and the second group moved to fortnightly individual sessions due to operational pressures. Getting patient buy-in to complete diary cards has been very difficult, primarily because of mistrust of the system, for example, the fear that their ratings will be used against them. Use of social signaling to support feedback was something we all found helpful (for instance, when giving in vivo feedback). The use of social signaling also helped side step plausible deniability and as a therapist being more open about my social signaling was particularly powerful for some clients once the therapeutic relationship was established. For example, one patient said that getting better at reading social signals meant he was able to see his sadness on my face and he said this was something he had never noticed before—"It was powerful." Also thinking about the nuances of the therapeutic encounter, and how subtle alliance ruptures may be, was particularly enlightening.

#### **Telephone Support**

In addition to individual and skills class sessions, telephone support may be offered to clients on an as-needed basis. In RO DBT this is optional but helpful in creating a sense of connection with socially isolated or distant OC clients. Interestingly, in general, overcontrolled clients do not tend to use this service very much. Despite OC clients often experiencing internally a great deal of inner anguish, they are strongly motivated not to let this be seen by others, even their therapists. As one OC client explained: "I just don't do crisis." Indeed, for most OC clients, keeping up appearances is a core way of behaving and OC clients may consider a crisis call unnecessary, socially unacceptable, or a sign of weakness. Thus, crisis calls and coaching calls can be anticipated to be less frequent in work with these individuals, although as noted below there are exceptions.

Some services offer 24/7 phone coaching that is being utilized by clients (e.g., Opal: Food + Body Wisdom) whereas others don't offer this at all since this is not practical or has not seemed relevant to the inhibitory style of this group in which crises are, for the most part, avoided (e.g., Rampton High Secure Hospital, St. Patrick's Mental Health Service). Others have found that, despite offering telephone support, it is not being used at all (e.g., U.S. Department of Veterans Affairs) or

patients prefer text messaging over phone calls (e.g., Eating Disorder Unit, Uppsala).

***Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):*** In our service, clients are able to access crisis telephone coaching between 9 AM and 4 PM. Outside of these hours they are provided with the telephone numbers of their Community Mental Health Team duty worker and the out-of-hour Crisis Service. However, due to a superior ability to inhibit urges and non-mood-dependent actions, our client group rarely experience crisis. They may experience emotional leakage, but this is often in the privacy of their own home. They also may describe their behavior as more dramatic than an observer might perceive. In the event of crisis services being contacted, we consider whether this may actually indicate progress, linked to sharing their distress rather than masking and pretending everything is fine. We have also set up a mobile phone for clients to text message individual members of staff to report on successful completion of homework set in individual sessions. We have found this to be very useful in encouraging contact between sessions. It affords clients the opportunity to have multiple experiences of being praised rather than criticized for attempts at learning a new behavior. If they do not use the mobile phone facility we explore barriers to use, including whether this might represent inadvertent or explicit social signaling. Typical responses include not wanting to waste our time or not having anything to say. We tend to draw on their social obligation to the tribe by saying how much we get out of the texts as we enjoy hearing about their skill use. In turn, this has been reported by staff to enhance their motivation and connection with the clients.

***Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):*** Young people accessing RO DBT within the DBT referral pathway at the Maudsley are offered phone coaching Monday to Friday, 9 AM to 5 PM. They use the phone to access skills support if they are at risk of engaging in any self-harming or self-destructive behaviors as well as skills coaching related to their target treatment themes. It has sometimes needed encouragement to help young people to begin to use phone coaching via calls or texts but when they

have been able to start using this aspect of the treatment program they have continued to use it and have reported finding it helpful.

### **RO DBT Team Consultation**

It is strongly recommended that any treatment program for OC clients include a means of supervision for therapists and, ideally, a supportive environment where therapists can practice RO skills together. Although optional, most clinics operationalize this in the form of an RO DBT consultation team. Consultation team meetings serve several important functions. For example, they provide support for therapists, reduce the likelihood of burnout, improve phenomenological empathy for clients, and provide guidance for treatment planning. A major assumption in RO DBT is that therapists, in order to help their clients learn to be more open, flexible, and socially connected, must possess and practice those attributes themselves so they can model them for clients. It is also a great training opportunity for new clinicians joining the RO DBT team.

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** Our RO DBT consultation team consists of four members, with one or two training spaces available for members of our NHS Trust working outside of our service. Our 2-hour supervision consult is held weekly. With client consent, we videotape all of our individual sessions and use these tapes for micro-supervision and for training new staff members. In each RO DBT consultation we watch the therapy tape, carry out role-plays, practice skills, engage in self-enquiry, provide teaching, and highlight sequencing structure and skills. This supervision, including role-plays, may also be video-recorded as a resource for training therapists.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** Self-enquiry is loved by our staff! We offer self-enquiry-focused staff consults every month and self-enquiry is regularly a part of our Thursday-morning staff consult time. Typically, we consult on cases for the 45 minutes and then leave the remaining 15 minutes for staff self-enquiry. These self-enquiry experiences have brought us closer as a staff and have helped create a staff culture oriented around learning and growth as people and practitioners.

As a largely OC staff, we have become more flexible and connected to each other.

**Psychology Department of St Patrick's Mental Health Service, Dublin (Richard Booth):** Our six-person team (four psychologists and two assistant psychologists) meet every week for consultation. Self-enquiry plays a central part at each meeting. Perhaps not unsurprisingly in the field of mental health, all six of us are on the overcontrolled side of the continuum. Our work together has allowed us to explore the variation in our own overcontrolled styles. This has led to personal growth as well as a deeper understanding of what brings about change.

**The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio (Nathan Tomcik and James Portner):** The RO DBT team consists of 14 clinicians, psychologists and social workers, who have all been through at least one RO DBT intensive training and are part of the consultation team. The team has made a commitment to practice RO, which is guided by weekly consultation meetings. Consultation is highly structured, using a hierarchy of both therapist and client behaviors to prioritize topics and to inform each meeting's agenda. Weekly consultation ensures continuity of care between skills class and individual therapy. Discussions between individual therapists and skills leaders often leads to opportunities to prioritize team education and role-plays. Equally important, this opportunity provides dedicated time to check in on our individual practice with self-enquiry and RO skills. Consultation team also provides grounds to give and receive feedback from taped therapy sessions and role-plays among team members.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** Our RO DBT consult group meets weekly. Our recent therapist evaluation study indicated that this was a valuable source of support—however, we all said at interview it could be used more effectively to reflect on our understanding and practice of RO DBT skills, and use of recorded individual therapy sessions for micro-supervision would help with building RO DBT adherence. Expert external supervision

was something we used occasionally and is something we would like to access more as the service develops.

### **Step 6: Monitoring Progress and Client Satisfaction**

It is generally a good idea to monitor clients' progress and their experiences throughout treatment. This can be accomplished through patient evaluations but also more systematically through validated questionnaires or interviews before and after treatment. These can be OC-specific measures as well as diagnostic measures, depending on the patient population.

### **Client Outcomes and Evaluations**

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** All client referrals and discharges are monitored and audited on a monthly basis in order to evaluate quantitative data on service performance. We use the NHS Friends and Family Service User Questionnaire and the IPTS Service User Satisfaction Questionnaire. Outcome measures are collected before and after therapy for each client. Following treatment, we provide clients with an individualized leaflet graphically representing their pre- and postscores on scales measuring trauma, personality disorder symptomatology, and other clinical outcomes. This gives staff and clients the opportunity to examine progress made throughout their time at IPTS. Although we are still early days when it comes to collecting outcome data in our RO DBT program, our pilot data suggests that we are moving in the right direction. For example, using data from the SCID-II (First et al., 1997), 67% of RO DBT clients reached diagnostic criteria for avoidant personality disorder pretreatment, but only 22% at posttreatment. Similarly, 56% reached diagnostic criteria for obsessive-compulsive personality disorder pretreatment compared to 11% posttreatment, and pretreatment percentages for paranoid, schizotypal, and schizoid personality disorder were 33%, 11%, and 22% respectively pretreatment and 0% posttreatment. For the two personality disorders not otherwise specified in the SCID-II, depressive and passive-aggressive personality disorder, the changes in percentages were 75% to 25% and 13% to 0%, respectively. None met criteria for histrionic, narcissistic, or borderline personality disorder. Thus, our data

provides some preliminary support for using RO DBT in treating overcontrolled personality disorders. Anecdotally, RO DBT has touched many people and continues to do so, both inside and outside the clinic. Previous clients who have completed RO DBT keep in touch with us from time to time through card, letter, or text message. When people engage with this treatment it can be quite life changing for them and, we imagine, for those around them. We have heard a number of stories that suggest ongoing progress and greater interaction with communities and relationships.

In addition, our dropout rates have improved substantially. In January 2016, our inaugural RO DBT class had 2 members. It took 5 months to reach a full cohort of 10, with a 27% dropout rate. In the following 8 months, dropout was 0%. In comparison, an RO DBT study with an eating disordered population reported a dropout rate of 27.66% (Lynch et al., 2013). Among the personality disorder population receiving standard DBT through the National Health Service in the UK, dropout rates are much higher, ranging from 52% to 67% (Gaglia, Esslezbichler, Barnicot, Bhatti, & Priebe, 2013; Priebe et al., 2012; Zinkler, Gaglia, Rajagopal Arokiadass, & Farhy, 2007). As part of the treatment we request a verbal commitment that they will return to meet us face to face to discuss their concerns. A number of our clients have told us that it was because they had given this promise that they stayed in treatment.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** Although we are still in the process of developing a systematic means of collecting outcome data, we have been encouraged by the self-reports from our clients about their experience and have witnessed the transformation of many previously considered untreatable or difficult clients as a result of their involvement in RO DBT. For example, recently, we received this written evaluation of RO DBT skills class from a partial hospitalization and intensive outpatient client: “Boy, did I learn A LOT about myself and my role in the dynamics of my interpersonal relationships! This information will continue to influence my approach to interacting with others for the rest of my life.” This evaluation is representative of

the feedback we receive from engaged RO DBT clients.

**Eating Disorder Unit, Uppsala University Hospital (Martina Wolf-Arehult):**

Last year eight patients participated in qualitative interviews after RO DBT treatment completion. The interviews were conducted by a colleague that does not work with RO DBT herself, but has over 20 years of clinical experience with CBT and standard DBT. According to these interviews, patients said that they were struck by the openness and the easy way of the therapists. Most patients reported that they experienced changes in areas of their lives not immediately related to eating disorders, such as how they act in social situations and increased warmth and closeness in relationships by using RO DBT skills (e.g., Match +1 skills that teach how to initiate friendships). Most patients described a strong improvement in eating disorder symptoms—despite those symptoms not being the focus in treatment. They often reported that RO skills were very helpful, such as the focus on understanding emotions and social signaling, skills to decrease emotion inhibition, skills to handle fixed and fatalistic ways of thinking/behaving, and skills designed to activate the social-safety system, to mention a few. In some cases, RO DBT was experienced as “life changing” and the skills motivated the patients to continue self-discovery as well as working with mindfulness in general. For a small group, the crises management and skills to handle suicidal ideation were also important; however, this focus decreased during treatment as clients improved.

**University Counseling and Psychological Services, Rowan University (Amy Hoch):**

The addition of RO DBT to our counseling services has had tremendous impact on both therapist and clients. In skills class, students complete satisfaction surveys after skills class ends. The feedback from those surveys as well as verbal feedback to individual therapists conveys high satisfaction with the therapy. Many of these students were previously in traditional DBT groups because there was no other option for them and we did not have an assessment process in place that allowed us to differentiate between overcontrol and undercontrol. In comparison to standard DBT, students report that RO DBT is relevant to

their issues, better addresses their overcontrolled tendencies and appropriately targets their core issue of loneliness. Importantly, our student clients, as well as their therapists, see progress where previously there has been stagnation.

**The U.S. Department of Veterans Affairs Outpatient Clinic, Columbus, Ohio (Nathan Tomcik and James Portner):**

Despite initiating RO DBT only relatively recently (approximately 2 years ago), we are seeing excellent clinical outcomes. Patients consistently report enjoying the RO skills class and we have observed that the class often leads to close bonds among class members. It's not uncommon for us to see veterans who have had treatment-resistant PTSD for decades start RO DBT and end up building more satisfying relationships and enjoying their lives in sometimes unexpected ways. For example, for many veterans we see PTSD symptoms improve without direct exposure-based interventions targeting the trauma. We are seeing veterans establishing and deepening relationships that have lacked intimacy or closeness for decades. One veteran said that for the first time in over 30 years he told his wife he loved her, another veteran recently returned from a wedding where he was actually handed a baby from a family member (he must have been signaling openness) and enjoyed the experience of trust it created. A very common response from veterans we are seeing is that for the first time they feel like someone “gets” them and that this treatment “feels” different than anything they have done before.

**Child and Adolescent Eating Disorder Service, London (Mima Simic and Katrina Hunt):**

We have introduced outcome measures from the introduction of RO into the service. Currently we have collected outcomes for nearly 100 young people who completed a course of RO skill classes or completed a full outpatient treatment program consisting of both individual therapy and 30 skills classes. Analysis of the results have shown positive outcomes following RO DBT with young people at the Maudsley on both quantitative and qualitative measures. Early quantitative data has shown improvements in social connectedness, experience of pleasure, eating disorder symptomatology, lack of withdrawal, and reductions in unhelpful per-

fectionistic and obsessive tendencies. Qualitative reports have revealed increases in social awareness, ability to take multiple perspectives and tolerance of uncertainty. One young person said, "I'm better socially; I'm able to validate others. People now want to talk to me. My friends now call me a social butterfly!" A number of young people in the day program commented that they find RO the most useful part of the program, and a few young people, who had previous experience of a range of psychotherapies, commented that they found RO DBT the most suited to their needs. The young people did report some feelings of being overwhelmed by the skills and amount of handouts and some lack of clarity around delineating the skills and how to implement them. However, we have been consulting with our service users to adapt the handouts and some of the names of the skills to be more "adolescent friendly." For example, the young people within the service have renamed the Big 3 + 1 skill (which activates the social safety system) the "Fantastic Four."

There was some initial hesitancy from clinicians to talk with young people about such complex emotions as envy and bitterness, but the feedback has shown that they relate to these emotions without difficulty and find skills classes on these topics very fitting, especially as they live within a culture of social media and continuous online social comparisons.

**Psychology Department of St. Patrick's Mental Health Service, Dublin (Richard Booth):** Despite their early reservations, OC clients quickly identify with the RO DBT model and with other group members. It is a source of hope and relief that they are finally hearing of a model that makes sense to them. Being in a group is also salutary. The experience of connection, trust, emotional expression, validation, fun, and challenge makes a durable impression. The group members often stay in touch with each other long after our formal sessions have come to an end. Because they tend to be better resourced in other areas of their lives, our data suggest that those with emotional overcontrol tend to make faster progress than their undercontrolled counterparts. The RO group has thus become a central part of our overall intervention package.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** The two pilot groups have been closely monitored through monthly reviews by the patients' clinical teams and weekly review of patient progress in RO DBT consult. In addition to progress monitoring, we aim to develop a more systematic means of collecting outcome data, including pre- and postpsychometric data and qualitative data involving interviews with RO DBT graduates. Like previous comments from other services, forensic patients' self-reports have been equally encouraging (e.g., "this is me"; "this fits with me"; and "staff need more training to understand us"). Nursing staff on the ward have noticed behavioral change—for example, greater attendance at named nurse sessions. Furthermore, staff feel more comfortable around OC patients, staff report that their RO DBT patients are more open to feedback, and staff seem more willing to give the patients feedback. A surprising source of feedback on the impact of RO DBT has been other patients, with comments like "I haven't seen him in a year and that treatment has worked for him—he came over to talk to me—I'm so happy it worked for him" and "he's the poster boy for RO DBT—he is just so different—he chats more, he's funny." The idea of under- and overcontrol temperamental biases has also generated lots of conversations between staff and patients, with staff and patients disclosing their personal style as overcontrolled or undercontrolled and using this knowledge to enhance relational bonding and navigating points of conflict.

### Future Directions

We continuously strive to learn more about our overcontrolled clients, improve assessment procedures, and encourage new research. Indeed, modifications and changes are considered a core part of effective treatment development (Carroll & Nuro, 2002; Waltz, Addis, Koerner, & Jacobson, 1993). We anticipate that RO DBT will likely evolve over time as new findings emerge and the treatment is applied in different settings, cultures, and patient groups. One such RO DBT adaptation is already showing promise (RO DBT skills training alone; see Keogh et al., 2016) and additional research on the utility and potential cost-effectiveness of RO skills

alone approaches are starting to emerge. It will also be of interest to investigate which other components of RO DBT contribute to clinical improvements in patients. For example, since consultation teams and phone coaching are optional, it would be interesting to see if clinics that provide these optional components have better outcomes or are more adherent. Other areas of study might be examining the extent treatment adherence impacts client outcomes, or whether a therapist who practices RO skills and self-enquiry themselves has better outcomes than a therapist who does not. As illustrated below, some clinics have already started creating after-care programs (e.g., graduate groups led by clients), and it will be interesting to see whether clients who attend RO DBT graduate groups after completing treatment fare better than clients who do not attend such groups. Research is also ongoing in populations not described in detail in this paper, including athletes.

Another future direction showing promise is with young children and parents. Overcontrolled styles are evident in children as young as 5 to 6 years and certain parenting styles exacerbate overcontrolled tendencies in young children. Ongoing research in young children is investigating observational indicators and neural markers that may help identify high-risk youth with overcontrolled styles. Additionally, research is examining how specific parenting behaviors and parent-child interactional styles may contribute to the development of overcontrolled coping. By gaining a more encompassing understanding of when OC tendencies in children lead to adaptation and success versus maladaptive social signaling and impairment, an important future aim is to adapt RO DBT to parents and their young children who are presenting with clinical symptomatology and social impairment.

One new and exciting area of research pertains to the development of reliable and valid nonverbal coding schemes for evaluating the extent to which an individual naturally engages in prosocial signaling behaviors during interactions with others (for example, by smiling frequently, offering eyebrow wags, and using a warm tone of voice). Another exciting area of development involves adapting RO DBT for families and couples, including multifamily skills training groups.

We are also interested in investigating the most effective ways of teaching clinicians how to practice RO DBT. For example, does the therapist's overcontrolled or

undercontrolled personality style affect their ability to learn and teach RO DBT, or does the extent of received supervision improve their outcomes with clients? Our mission is to improve accessibility of RO DBT to providers and patients worldwide, and we are committed to continuously improve the training we provide to clinicians, including new online learning opportunities.

**Intensive Psychological Therapies Service, Dorset HealthCare NHS (Sophie Rushbrook):** In 2016, we created a steering group consisting of service users and outside providers with the aim of evaluating and advising our clinic on service developments. One important outcome from this was the establishment of a community-based peer-led RO DBT Graduate Group, with the aim of maintaining treatment gains and providing a space and means for OC client graduates of our RO DBT program to continue practicing their skills and build social connection. This is run by former clients of our RO DBT program who liaise with us about new referrals to the group. Everyone who has been through treatment in our clinic is eligible to attend.

**Opal: Food + Body Wisdom Eating Disorder Treatment Facility, Seattle (Alexia Giblin):** In our clinical experience, OC temperaments are often seen in high-performance athletes as OC behaviors can promote achievement in sport. Since our clinic specializes in the treatment of athletes dealing with food and body concerns, we are planning on investigating this more directly. Specifically, we hypothesize that OC coping may function to enhance athletic performance but may also get in the way of optimal performance for some—e.g., those with high OC biotemperamental predispositions. For example, OC distress overtolerance may help an athlete persist when under stress but also lead to compulsive training and ignoring injuries. Similarly, we are interested in examining how maladaptive OC coping may be associated with disordered eating.

**Psychology Department of St. Patrick's Mental Health Service, Dublin (Richard Booth):** We have found it of interest to compare our emotionally under- and overcontrolled populations. It turns out that the central issue may not be as straightforward as each group

simply lacking particular and contrasting skills. It may be worth reflecting on some specific points to illustrate this. In comparison to those with undercontrol, the overcontrolled group tend to have less insight. They may see that their rules of living and coping styles have worked for them in many ways and can be confused by the notion that change may be asked of them. Second, they have fewer crises. It can be mystifying for them to be offered crisis support because they work so hard to avoid crises. Third, there is less immediate cost from their adopted coping strategies. Those who are overcontrolled strive for a life of calm and predictability, without fully appreciating that a life of such safety becomes desperately emotionally lonely over time. The approach to change in overcontrol thus needs to be more than skills provision. It needs to accommodate both the stronger ambivalence to change and the fact that any move to be more intimate, more in touch with emotions, and more flexible will not necessarily be reinforcing in the short term. One way we have used to meet this challenge has been to have the group members become more active agents of change, but there are likely to be other means to this end as we learn more about the common obstacles with this population.

**Rampton High Secure Hospital, Nottinghamshire NHS Foundation Trust (Laura Hamilton):** We will continue to develop the RO DBT service across the hospital in line with the transdiagnostic philosophy, and work towards a more open group format if the evaluation evidence supports such an adjustment. Our patients have suggested aftercare group and continuing education of forensic staff and service providers about the nature of maladaptive overcontrol, and we are currently thinking together about how these may work. Adapting materials and teaching for patients with lower intellectual functioning is something we are currently contemplating, as well as how to support our patients in finding ways to exercise healthy social obligation. We would also like to continue developing our understanding of overcontrolled offending cycles.

### Summary and Conclusion

RO DBT differs from most other treatments by positing that individual well-

being is inseparable from the feelings and responses of the larger group or community (Lynch, 2018b). Thus, when it comes to effective implementation, a core step in this process is the development of an RO community—one that instrumentally and psychologically supports both therapists and clients to join together in a mutual practice of radical openness skills. However, the emphasis on staff “practicing what they preach” in RO DBT can be both a personal and institutional challenge.

Treatment clinics may also have to work within certain limitations. For example, health insurers may only fund a limited number of sessions or young people may not be able to attend a full 30-week course because they have to attend classes or return home. Several clinics have been using adapted versions of RO DBT for these reasons, with good results. For example, St. Patrick's Mental Health Service in Dublin recently published a paper on a skills-only approach and reported that RO DBT skills alone compared to treatment as usual showed significantly greater improvements in global severity of psychological symptoms, social safeness, and effective use of coping skills (Keogh et al., 2016).

Current RO DBT research, training, and clinical work have been extended to different age groups (young children, adolescents, young adults, older adults), different disorders (anorexia nervosa, chronic depression, OC personality disorders, treatment-resistant anxiety), different cultures and countries in Europe and North America, and different settings (forensic, inpatient, outpatient). In addition, training has been extended to a wide range of providers (psychologists, nurses, social workers, psychiatrists, family therapists, occupational therapists).

In conclusion, at this early stage of dissemination, it appears that RO DBT's transdiagnostic nature has led to its implementation in a wide range of treatment settings and cultures. There is a growing number of OC-related disorders that RO DBT has been applied to clinically. Interestingly, the vast majority of clinics implementing RO DBT are doing so within a context that often includes a wide range of differing services, therapies, and theoretical orientations. Despite the difficulties of learning and integrating a new treatment into an existing service or paradigm, our collective experience suggests that the risk is worth taking.

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