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SPECIAL ISSUE

RADICALLY OPEN
Dialectical Behavior Therapy

Special Issue Editor: **R. Trent Codd, III**

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New Thinking About Old Ideas: Introduction to the Special Issue on Radically Open Dialectical Behavior Therapy

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IT'S NOT OFTEN THAT WE GET TO WITNESS the launching of a new psychotherapy. The aim of this special issue is to introduce Radically Open Dialectical Behavior Therapy (RO DBT)—a new scientifically supported treatment targeting a spectrum of disorders characterized by excessive inhibitory control or overcontrol (OC). The treatment is fully manualized (see Lynch, 2018a, 2018b) and the feasibility, acceptability, and efficacy of RO DBT are evidence-based, supported by more than 20 years of clinical translational research. It is intended for clinicians treating clients with such chronic problems as refractory depression, anorexia nervosa, and obsessive-compulsive personality disorder.

The publication of this special issue of *tBT* coincides with the seminal publication of the RO DBT textbook and separate RO DBT skills training manual (see Lynch, 2018a, 2018b). Yet, this is not the central reason we describe the treatment as "new." In our opinion, RO DBT is "new" primarily because it introduces some new theoretical perspectives and treatment approaches not found elsewhere. For example, it is the first treatment in the world to prioritize

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INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

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social-signaling as the primary mechanism of change based on a transdiagnostic, neuroregulatory model linking the communicative function of human emotions to the establishment of social connectedness and well-being. Plus, RO DBT contends that one of the core reasons so many individuals fail to respond to adequately delivered interventions may be because the majority of treatment approaches are based on the erroneous assumption that categories of disorders are homogeneous in nature (Lynch, 2018a). For example, an estimated 40% to 60% of unipolar depressed clients meet the criteria for comorbid personality disorder (PD; Fava et al., 2002; Klein et al., 1995; Riso et al., 2003), and PDs of overcontrol are at once the most common PDs and the ones least likely to respond to treatment (Fournier et al., 2009). Thus, from an RO DBT perspective, personality matters when intervening with treatment-resistant and chronic conditions, signaling that broad-based personality dimensions with their associated overlearned perceptual and regulatory biases are interfering with psychological change. RO DBT posits that biotemperament may be the driving force behind this phenomenon, positing that what makes an individual's biotemperament so powerful is that it can influence his perception, learning, and overt behavior at the sensory receptor (or preconscious) level of responding as well as at the central cognitive (or conscious) level of responding (Lynch, 2018a; Lynch, Hempel, & Clark, 2015; see also Clark, 2005, for similar conclusions).

RO DBT also differs from most other treatments by positing that individual well-being is inseparable from the feelings and responses of the larger group or community. Thus, what a person feels or thinks inside (i.e., privately) may be less important in understanding their distress and dysfunction than in other conceptualizations. In RO DBT, what matters most is how a person communicates or socially signals their inner or private experiences to other members of the tribe and the impact that social signaling has on the experience of social connectedness. Treatment strategies are based on a premise that emotional well-being involves three overlapping elements or capacities: openness, flexibility, and social connectedness. The term "radical openness" represents the confluence of these three core features. As a state of mind, it entails a willingness to surrender preconceptions about how the world should be in order to adapt to an ever-changing environment. Relatedly, a core principle in RO DBT is that innate perceptual and regulatory biases make it impossible for a person to achieve heightened self-awareness in isolation; we need others to point out our blind spots.

RO DBT has many other distinguishing features. For example, RO DBT challenges linear assumptions regarding the nature of self-control—i.e., that one can never have too much self-control—by offering a developmental trajectory that accounts for both quadratic and linear relationships. The model contends that optimal self-control is an emergent capacity requiring receptivity or openness and the capacity to flexibly adapt to changing environmental contingencies.

RO DBT also contends that core genotypic/phenotypic differences between individuals necessitate different treatment approaches—i.e., "one size does not fit all." For example, treatments targeting problems of undercontrol should emphasize interventions that enhance inhibitory control and reduce mood-dependent behavior, whereas treatments targeting problems of overcontrol (OC) require interventions designed to relax inhibitory control and increase emotional expressiveness, receptivity, and flexibility. OC is hypothesized as a multifaceted concept involving complex transactions among biology, environment, and individual styles of coping. Maladaptive OC is considered a problem of emotional loneliness—not emotion dysregulation.

Another distinct feature is the RO DBT neuroregulatory model, which identifies five broad classes of emotionally evocative stimuli (safety, novelty, threat, reward, and overwhelming threat/reward) that are each linked to distinct, autonomic nervous system (ANS) action-urging components (i.e., response tendencies) and overt actions or behaviors. RO DBT skills teach methods to activate differing neural substrates—in particular the neural substrate associated with social-safety. Overcontrolled clients are posited to unintentionally bring biotemperamental mood states into social situations that function to isolate them from others. Based on research demonstrating neuroinhibitory relationships between the parasympathetic nervous system (PNS) and the sympathetic nervous system (SNS; Berntson, Cacioppo, & Quigley, 1991; Porges, 1995), RO DBT teaches OC clients bottom-up regulatory techniques to activate their social-safety system so that the influences of biotemperament are less powerful.

A further distinguishing characteristic is that RO DBT parses emotion regulation into three transacting temporal elements: (1) perceptual encoding factors (sensory receptor regulation) that precede (2) internal modulatory factors (central-cognitive regulation), which then result in (3) external behavioral expressions and overt actions (response selection regulation). Separating external regulation from internal regulation helps explain why a person can "feel" anxious inside yet not display any "overt" signs of anxiety on the outside.

The RO DBT approach to mindfulness is also unique. In particular, it can be distinguished from other mindfulness-based approaches via its emphasis on radical openness principles and self-enquiry practices.

RO DBT also differs somewhat from other behavioral approaches by training therapists to be alert for subtle in-session micro-expressions of emotion, changes in eye gaze directions or contact, shifts in body posture, changes in voice tone or rate of speech, and length of verbal responses—and to recognize them as possible social signals. Similarly, because RO DBT contends that human emotional expressions evolved not just to communicate intentions but to facilitate the formation of strong social bonds and altruistic behaviors among unrelated individuals, it teaches therapists nonverbal social-signaling strategies designed to enhance client engagement and learning—e.g., gestures, postures, and facial expressions that universally signal openness, nondominance, and friendly intentions. These nonverbal strategies often differ vastly from how therapists have been trained in other therapies.

These final features distinguishing RO DBT from other behavioral therapies relate to therapist playfulness, treatment compliance, and behavioral exposure. First, RO DBT teaches therapists how to balance playful irreverence with compassionate gravity and to use therapeutic teasing as a core means of challenging maladaptive behavior. RO DBT does not consider treatment compliance, declarations of commitment, or lack of conflict as indicators of a strong therapeutic relationship. Indeed, alliance ruptures (at least those that are repaired) are considered working proof of a solid therapeutic relationship in RO DBT. Last, RO DBT introduces a wholly unique approach to the use of behavioral exposure with particular relevance to OC populations. This involves the conditioning of consummatory reward experiences to brief

exposures to tribal participation (Lynch, 2018a).

Research Base Overview

The current research base for RO DBT is promising, suggesting that the approach is a viable way forward. For example, it has been shown to be highly effective in treating chronic forms of depression, with rates of full recovery from depression reported as high as 71% in some studies, and with significant reductions in depression and personality dysfunction that persisted and/or improved after RO DBT treatment ended (Lynch et al., 2007; Lynch, Hempel, & Dunkley, 2015; Lynch, Morse, Mendelson, & Robins, 2003). Research has also demonstrated the positive impact of RO DBT in the treatment of severely underweight adults with anorexia nervosa. Despite RO DBT's focus on overcontrolled coping rather than eating disorder pathology, studies have reported significant and large effect size increases in body mass index (BMI), low rates of treatment dropout, and significant improvements in eating-disorder-related psychopathology (Chen et al., 2015; Lynch et al., 2013). The evaluation of other RO DBT research programs is in progress, including RO DBT with violent offenders in forensic settings (Hamilton et al., in preparation), among young children (Gilbert, Barch, & Luby, in preparation), and with adolescent eating disorders (Simic, Stewart, & Hunt, 2016; Simic et al., 2017).

Overview of Special Issue

This special issue provides an introduction to RO DBT, discusses its core concepts and clinical procedures, and ends with discussion of implementation efforts.

The special issue begins with a précis on RO DBT from its developer (Lynch, 2018c; this issue). Next, Vanderbleek and Gilbert (2018; this issue) provide a thorough introduction to the constructs of under- and overcontrolled personality types, including their etiology and treatment implications. This is followed by a contribution from Hempel, Rushbrook, O'Mahen, and Lynch (2018; this issue) that addresses clinical assessment methods for the under- and overcontrol conceptualizations.

RO DBT shares many similarities with other psychotherapies. However, it also differs in many substantial ways. To assist in deeper understanding of RO DBT, Luoma, Codd, and Lynch (2018; this issue) provide a detailed comparison of RO DBT to several contemporary cognitive behavioral therapies across many features and dimensions.

Next, the focus shifts to clinical applications and implementation. The change in focus begins with a contribution from Astrachan-Fletcher, Giblin, Simic, and Gorder (2018; this issue), in which they discuss the contribution of RO DBT to eating disorder treatment. Then, Booth, Egan, and Gibson (2018; this issue) detail the implementation of a group adaptation of RO DBT in the treatment of diagnostically heterogeneous inpatient populations characterized by overcontrol. Next, Hamilton, Bacon, LongFellow, and Tennant (2018; this issue) discuss their work with violent offenders who traditionally were thought to be characterized by poor impulse control and emotion regulation difficulties. They discuss emerging evidence for an overcontrolled subtype. Finally, Hempel et al. (2018; this issue) describe the implementation of RO DBT in several different settings (e.g., a university counseling center, U.S. Department of Veteran Affairs).

Concluding Remarks

Scientific theories should not just be innovative frameworks for organizing existing data; new theories should ideally also generate and stimulate original research, and provide testable hypotheses (Popper, 1959/2002). Psychotherapy treatment development, like science in general, advances through paradigm shifts that challenge existing theories, approaches, and methods. Enormous progress has been made in psychotherapy treatment development and research—and strategies continue to evolve. For example, psychotherapy research over the last several decades has largely involved investigative strategies that relate treatment packages to specific DSM diagnostic categories. This paradigm represented a change from the earlier focus of behaviorally oriented researchers who had emphasized investigation of variables that transcended categorical diagnoses (i.e., they focused on function rather than form). Outcomes of interest have changed. Consistent with DSM conceptualizations of psychopathology, the vast majority of clinical trial research has focused on diagnostic symptom change, such as reductions in anxiety or depression. However, more recently there has been a growing interest in broader domains such as changes in meaning and quality of life, highlighting these as truly important outcomes rather than symptom change per se. Mental health funding priorities have also changed. For example, the NIMH Research Domain Criteria initiative (RDoC; Insel et al., 2010), broadly speaking, prioritizes funding for (a) transdiagnostic models—theory and research that integrate biological with behavioral science in order to identify new ways of classifying psychopathology, and (b) transdiagnostic treatments—treatment approaches that account for shared genotypic and phenotypic features rather than focusing on diagnosis. Overcontrolled coping, or excessive inhibition of emotional urges, impulses, and behaviors, is theorized to be a mechanism underlying many forms of psychopathology. Rather than focusing on diagnostic categories and symptom reductions, RO DBT is designed to target a spectrum of disorders sharing similar genotypic and phenotypic features. RO DBT posits social-signaling deficits stemming from maladaptive overcontrol as the core issue, which is based on evidence showing that OC coping preceded the development of psychopathology. For example, restricted eating, a critical diagnostic symptom of anorexia nervosa, is considered secondary to OC coping. RO DBT, therefore, is a treatment that fits within RDoC's new clinical trials' focus on mechanism-based treatments because it specifically targets OC coping rather than diagnostic symptoms. Our aim for this special section is to provide an overview of some of the core principles, interventions, and applications of RO DBT with hopes of encouraging additional research, dialogue, and discussion.

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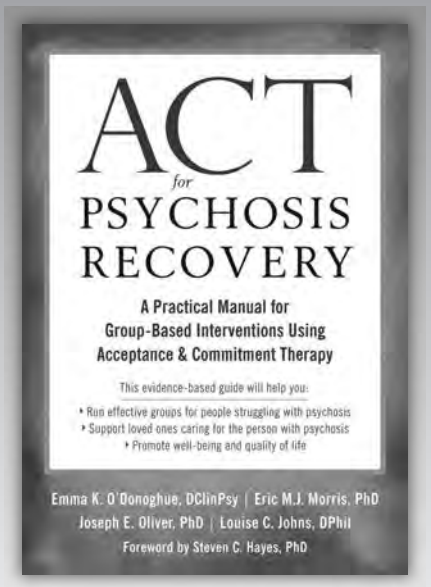

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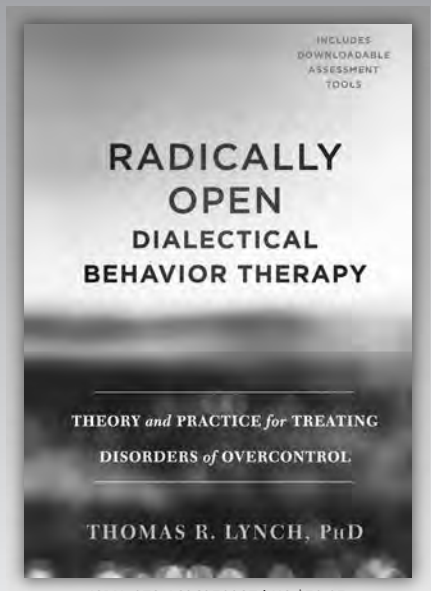

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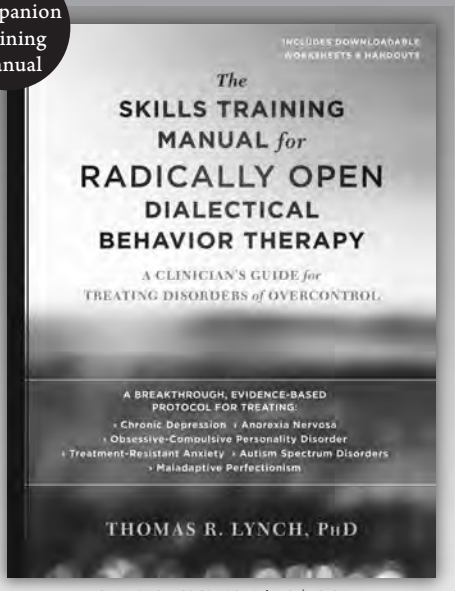

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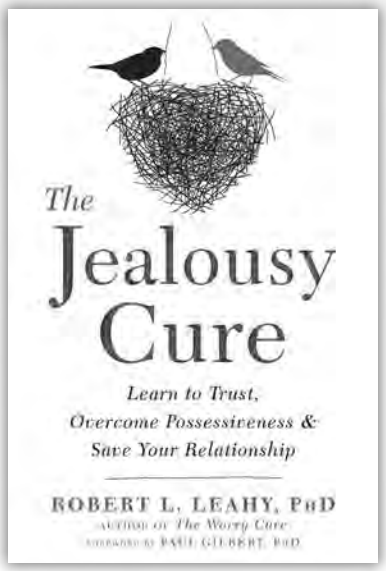

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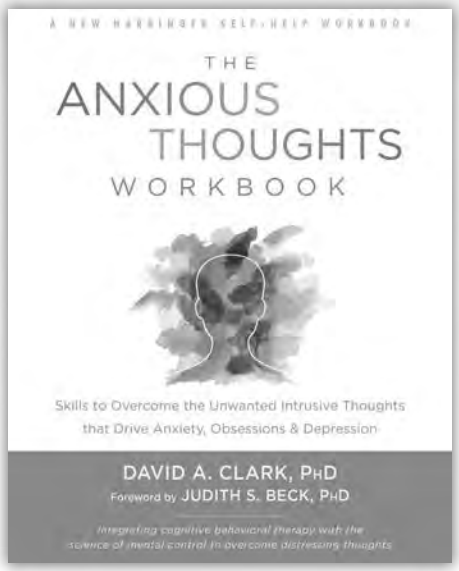

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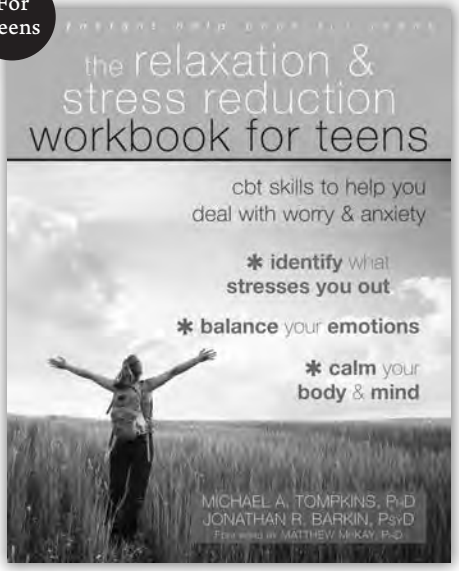

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Trent Codd provides RO DBT training through his practice Cognitive-Behavioral Therapy Center of WNC, P.A; Linda Craighead has no funding or conflicts of interest to disclose.

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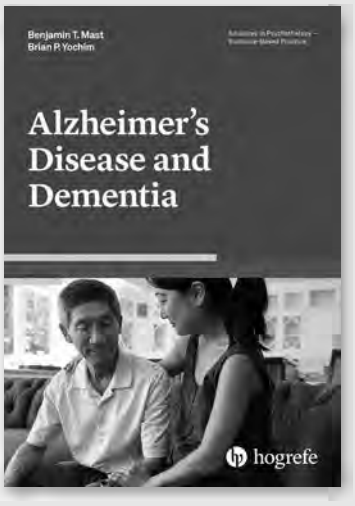

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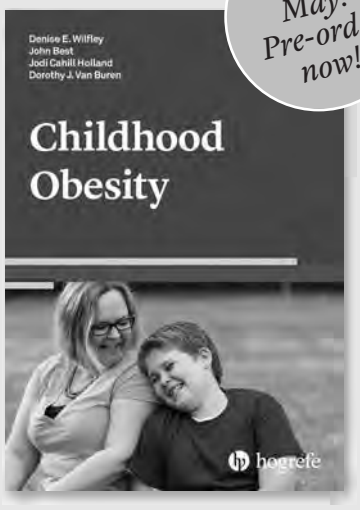

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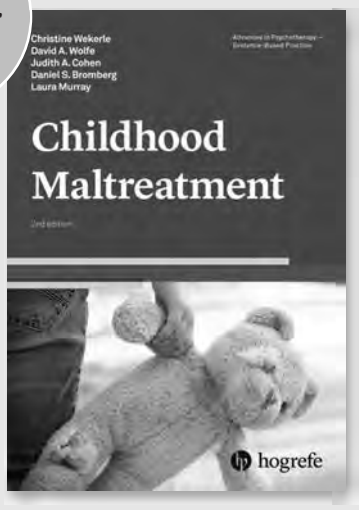

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Tribe Matters: An Introduction to Radically Open Dialectical Behavior Therapy

Thomas R. Lynch, *University of Southampton*

SUCCESS AND HAPPINESS are often equated with the ability to inhibit emotion-based response tendencies—a form of self-control linked with being able to postpone or suspend acting upon desires, urges, or impulses for immediate gratification in "exchange: for greater future benefits. Indeed, inhibitory control is highly valued by most societies and failures in self-control characterize many of the personal and social problems afflicting modern civilization. However, too much self-control can be equally problematic. Excessive self-control or overcontrol (OC; T. R. Lynch, 2018b) has been linked to social isolation, poor interpersonal functioning, hyperperfectionism, rigidity, risk aversion, lack of emotional expression, and the development of severe and difficult-to-treat mental health problems, such as chronic depression, anorexia nervosa, and obsessive-compulsive personality disorder (T. R. Lynch, Hempel, & Clark, 2015; Riso, Miyatake, & Thase, 2002; Zucker et al., 2007).

The purpose of this article is to provide a brief overview of a new transdiagnostic treatment for problems stemming from maladaptive OC—known as Radically Open Dialectical Behavior Therapy (RO DBT; T. R. Lynch, 2018a, 2018b). RO DBT is fully manualized and evidence-based; supported by two National Institute of Mental Health–funded randomized controlled trials (RCTs) for refractory depression, two open-trials targeting adult anorexia nervosa, one nonrandomized trial targeting treatment-resistant overcontrolled adults, and one multicenter Medical Research Council-UK funded RCT targeting overcontrol in refractory depression (Chen et al., 2015; Keogh, Booth, Baird, Gibson, & Davenport, 2016; T. R. Lynch et al., 2007; T. R. Lynch et al., 2013; T. R. Lynch, Morse, Mendelson, & Robins, 2003; T. R. Lynch, Whalley, et al., 2015). As a new treatment, it is both similar and dissimilar to its predecessors. The decision to retain the terms *dialectical* and *behavior therapy* in the name of this new treatment reflects the desire to acknowledge two of its fundamental roots, but the retention of these terms should not be taken to mean that they represent RO DBT's only roots.

How Overcontrol Develops: A Biosocial Theory

Maladaptive overcontrol is posited to represent a personality style that results from transactions between biotemperamental predispositions (nature) and family/environmental/cultural influences (nurture) that lead to the development of a style of coping characterized by excessive inhibitory control and aloof relationships (overcontrol or OC coping) that functions to limit new learning, flexible responding, and the development of close social bonds. A graphic representation of this model can be seen in Figure 1. There are four dimensions of infant temperament relevant to the "nature" component of this model:

1. Negative affectivity (threat sensitivity)
2. Positive affectivity (reward sensitivity)
3. Effortful control (self-control capacity)
4. Detail-focused (versus global) processing of stimuli

Children at risk for overcontrolled coping and social isolation are likely to have high threat sensitivity, low reward sensitivity, high detail-focused processing, and high effortful control and are characterized by the following: being behaviorally inhibited, shy, timid, risk-avoidant, emotionally constrained; having hyper-detail-focused processing; and by showing aloof/socially withdrawn behavior (see T. R. Lynch, 2018b).[1]

Yet, despite these inherent difficulties, overcontrolled coping is not always problematic. For example, superior capacities to inhibit impulses, plan ahead, and delay gratification make OC clients the doers, savers, planners, and fixers of the world. They are the guests who help clean up after the party and the people who save for their retirement so as not to burden others. They strive for moderation in all aspects of their lives and value honesty, fairness, and doing the right thing. They are the people you see working late at night and then rising early to ensure that things work properly; they are the reason why trains run on time. The problem is that overcontrolled coping works well when it comes to sitting quietly in a monastery or building a rocket, but it creates problems when it comes to social connectedness.

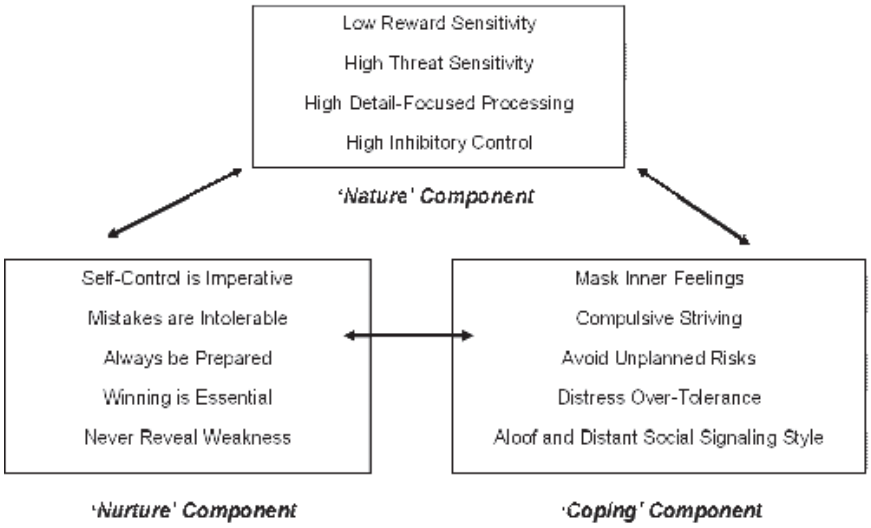

Figure 1. Biosocial theory of disorders of overcontrol.

Got Tribe?

Our species has not only survived—we have thrived. Yet, in comparison to many other animal species, we are physically frail (e.g., we lack fangs, claws, and thick skins)—suggesting that our evolutionary

[1]Undercontrolled (UC) individuals are hypothesized to possess high biotemperamental reward sensitivity (and often high threat sensitivity too), engage in impulsive mood dependent behaviors, and struggle with planning for the future and with inhibiting emotion-based action urges (T. R. Lynch, 2018b).

success depended on something more than individual strength, speed, or toughness. *So, what was the secret of our success?* We survived because we developed capacities to form long-term social bonds, work together in tribes, and share valuable resources with unrelated others. For our very early ancestors living in harsh environments, *being in a tribe* was essential for personal survival. Isolation or banishment from a tribe meant almost certain death from starvation or predation. Similarly, research shows that nonhuman primates who are socially isolated from their community die of exposure, lack of nourishment, or predation in a matter of days to weeks (Steklis & Kling, 1985). Indeed, we are a hyper-cooperative species, more so than any other animal species (Marean, 2015). We engage in highly complex and coordinated group activities with others who are non-kin and comply without resistance to requests from complete strangers.

Our hyper-cooperative nature allowed us to form large networked units that could coordinate actions and work together to achieve long-term goals, making it possible for us to decimate previously feared predators, defeat rival humanoids and thrive in harsh environmental conditions in a manner that less cooperative species found impossible. This necessitated us finding a way to "bind" genetically diverse individuals together in such a way that *survival of the tribe* could override older "selfish" response tendencies linked to *survival of the individual* (see Buck, 1999; Marean, 2015, for similar observations). Research shows that most humans, rather than falling apart or running amuck when disaster strikes, are calm, orderly, and work together to help others. During times of extreme crisis, we forget about our individual differences, backgrounds, and beliefs and unite for a common cause (ask people closely involved in the 9/11 crisis in New York City the extent to which they were worried about whether the people they were helping were homeless or millionaires, religious or atheist, black or white).

RO DBT posits that our collaborative advantages as a species entailed the development of three core transacting capabilities:

1. The ability to inhibit our propensities for action: This means that we developed capacities to regulate the outward expression of emotion-based action tendencies or impulses (for example, the urge to attack or run away). Not acting on every impulse allowed us to live in close proximity to each other because we could trust our fellow tribe members not to automatically express a potentially damaging action urge (for example, a desire to hit).

2. The ability to regulate how we signal our intentions and personal observations about the world: This means that we developed a highly sophisticated social signaling system that allowed us to communicate intentions and feelings (for example, an angry glare linked to a desire to attack), without having to fully express the actual propensity itself (for example, hitting someone). *Signaling our intentions* from afar (for example, via facial expressions, gestures, or vocalizations) reduced unnecessary expenditures of energy and provided us a safer means of resolving conflict and initiating collaborations with others, without having to fully commit ourselves. Plus, revealing intentions and emotions to other members of our species was essential to creating the type of strong social bonds that are the cornerstone of human tribes. *Communicating our observations* involved nonverbal behaviors, such as gaze direction and pointing, as well as with verbal observations. Revealing to others our observations about nature (for example, "I see a cow") and then receiving verification (or not) about our perception by another member of our species (for example, "No, I see a tiger—let's run!") provided a huge evolutionary advantage because our individual survival no longer depended solely on our personal perception. This helps explain why we are so concerned about the opinions of others.

3. The ability to persist and to plan for the future: The evolution of persistence and planning likely involved the development of areas of the brain associated with evaluating nonimmediate contingencies, as when we imagine a potential future consequence. But persistence and planning differ in that planning involves considering the consequences of taking a future action, whereas persistence involves considering the consequences of ceasing to do what one is already doing (Smith et al., 2007).

These evolutionary developments facilitated the ability of our species to survive in increasingly diverse and inhospitable environments. For example, our enhanced capacities for planning ahead allowed us to remember that in the past, food availability had depended on the season, and to use this knowledge to make plans for the future. At the same time, our ability to inhibit our excitatory response tendencies (for example, by not immediately consuming every valuable resource) and downregulate defensive response tendencies (for example, by not immediately attacking someone who stepped on our toe) allowed us not only to work together in groups, without fear of being attacked, but also to save valuable resources for a future time of need. Thus, the capacity for inhibitory control was the basis for community; combined with persistence, it allowed us to actualize our long-term goals and plans. For example, even though we may have been tired, we continued to pick apples over many weeks instead of simply lying back and feasting on the fruits of summer. And, as we've seen, the capacities for social signaling and communication helped save those nearsighted members of our tribe who tended to mistake tigers for cows, which meant that the tribe continued to benefit from the efforts of its myopic members throughout the apple-picking season.

Yet, tribes also come with costs. For example, tribes expect individual members to make self-sacrifices for the common good and conform to tribal norms. This can include anything from wearing similar clothing (e.g., uniforms), participating in tribal rituals (e.g., singing the tribal anthem), or even risking one's life (e.g., going to war). Moreover, our brains still respond "as if" we are still living in primordial times. We are evolutionarily hardwired to be hypersensitive to signs of social exclusion. Research shows that we can quickly spot the angry face in a crowd of people, and angry faces hold our attention (Fox et al., 2000; Schupp et al., 2004). We are constantly scanning the facial expressions and vocalizations of other people for signs of disapproval, that is, information about our social status, the extent to which our behavior is socially desirable, and/or the degree to which another person appears to like us. The cost of not detecting a true disapproval signal for our ancestors living in harsh environments was too high to ignore—since tribal banishment was essentially a death sentence. Thus, we are hardwired to construe the intentions of others as disapproving, especially when social signals are ambiguous. For example, simply reducing or limiting the amount of eye contact during interactions has been shown to trigger negative feelings associated with being ignored or ostracized (Wirth, Sacco, Hugenberg, & Williams, 2010). Blank expressions, furrowed brows, or slight frowns are often interpreted as disapproving (Butler et al., 2003)—regardless of the actual intentions of the sender (e.g., some

people frown or furrow their brow when intensely listening).

Unfortunately, for overcontrolled individuals—overlearned tendencies to inhibit, constrain, or mask inner feelings often result in unintended consequences—and biotemperamental predispositions may function to exacerbate this. Indeed, a major component of the RO DBT biosocial theory for overcontrol is that heightened biotemperamental threat sensitivity makes it more difficult for an individual with severe OC to enter into a neurologically based state of feeling safe, a state that is associated with feeling content and socially engaged (Porges, 2001, 2003). When we do not feel safe, our autonomic nervous system becomes defensively aroused and the fight-or-flight response becomes dominant. Facial expressions freeze and we lose the ability to flexibly interact with others. For the OC individual, defensive arousal and frozen expression (or appeasing/exaggerated insincere prosocial expression) is common—partly influenced by heightened biotemperamental threat sensitivity, and partly influenced by social feedback from an early age implying that it is imperative to control oneself and/or avoid appearing socially undesirable. As a consequence, OC patients work very hard to avoid mistakes, become increasingly sensitive to perceived criticism, and base their self-worth on how their performance compares to the performance of others. This can lead to rigidly controlled and risk-averse styles of interacting that interfere with new learning and the formation of social bonds (e.g., via avoidance of novelty, attempts to control social situations, automatic rejection of criticism, and frozen or disingenuous expressions). Essentially, extreme OC behavior elicits from others the very thing the OC personality style is "designed" to prevent; that is, people tend to avoid them and find their emotionally constricted, disingenuous, and inhibited style of expression uncomfortable to be around. As a consequence, OC individuals find themselves increasingly isolated and lonely, which functions to exacerbate psychological distress (T. R. Lynch, 2018b).

Social Signaling Matters

When it comes to social connectedness, social signaling matters.[2] Our nonverbal social signaling capacities are more powerful than most individuals realize, as they viscerally impact not only the person we are interacting with but our own physiology as well—most often at the preconscious level. Slow-motion film analysis has robustly revealed that we react to changes in body movement, posture, and facial expressions of others during interactions without ever knowing it. Indeed, we are constantly social-signaling when around others (e.g., via micro-expressions, body movements)—even when deliberately trying not to. For example, silence can be just as powerful as nonstop talking.

Robust research shows that context-inappropriate suppression of emotional expression or incongruent emotional expression (that is, a mismatch between outward expression and inner experience; see *fake smiles* illustration in Fig. 2) will make it more likely for others to perceive one as untrustworthy or inauthentic (Boone & Buck, 2003; English & John, 2013; Kernis & Goldman, 2006), thereby reducing social connectedness and exacerbating psychological distress (see Mauss et al., 2011). In this way, OC biotemperament-based threat sensitivity, combined with overlearned tendencies to mask inner feelings, are hypothesized to engender social ostracism and loneliness, thus exacerbating psychological distress.

Thus, RO DBT differs from other treatments by uniquely prioritizing social-signaling as the primary mechanism of change. *But what is a social signal?* A social signal is any behavior a person exhibits in the presence of another person; regardless of its intention (sometimes a yawn is just a yawn) or conscious awareness (for example, an involuntary sigh).[3] Interestingly, perhaps the most powerful nonverbal social signals are those expressed discreetly—not what was said or done and more about what was *not* said or *not* done. For example, a conspicuous absence of expected or customary prosocial signals during interactions (not smiling during greetings, low rates of affirmative head nods) is almost always interpreted to mean disapproval or dislike, regardless of the actual intentions of the sender.

However, social-signaling is only part of the evolutionary story. To be specific, why did *Homo sapiens* thrive while rival humanoids (for example, the Neanderthals in Western Europe) become extinct, despite presumably possessing inhibitory and tribal tendencies similar to our own? The answer may lie in our development of a unique way to enhance our group strength, whereby individual tribe members were able to viscerally experience others as themselves. It's this premise that underlies the core mechanism of change in RO DBT. RO DBT contends that human emotional expressions evolved not just to *communicate* intentions but to *facilitate* the formation of strong social bonds and altruistic behaviors among unrelated individuals. The biological basis underlying this advantage is posited to involve transactions between social signaling, micro-mimicry, and mirror neurons (K. G. Schneider, Hempel, & Lynch, 2013). A mirror neuron fires when a person acts or when a person observes another person performing an action. Neuroimaging studies examining the mirror neuron system have shown that viewing facial expressions automatically activates brain regions that are involved in the production of similar expressions (Montgomery & Haxby, 2008; Van der Gaag, Minderaa, & Keysers, 2007). For

[2] The reason I use "social-signaling" to describe the core OC deficits, rather than problems with "emotional expressivity" or emotional expressions (EE)—is because the data clearly shows that not all nonverbal social-signals are necessarily emotional. In fact, the data suggests that the clear link between internal emotional experience and external emotional expression is limited (see Russell, Bachorowski, & Fernandez-Dols, 2003). Plus, the data outside of Western societies is even less conclusive. For example, there is clear evidence showing that people can produce smiles—when feeling sad, anxious, angry, or neutral—clear evidence going against conventional wisdom that happiness is the cause of a smile. Despite there being good reason to claim that only smiles associated with genuine pleasure are "real" smiles—the data does not fully support this. For example, Duchenne smiles occur as much after failure as after success (K. Schneider & Josephs, 1991). Plus, "phony smiles," from my perspective, are not "all bad." For example, "polite smiles" (recognized by their quick onset and quick offset—compared to the slowly building and slowly fading "pleasurable smile") are an important part of everyday social interactions—they signal prosocial intentions, can help deescalate aggression, and/or function as an important "social-lubricant" during the initial phases of establishing a close social bond or important collaboration.

[3] The main point is that self-reported intentions or conscious awareness of a social signal are not necessary for effective targeting; instead, the maladaptive nature of a social signal is defined by the extent to which it interferes with social connectedness and interpersonal relationships.

Figure 2. Fake smiles

example, when interacting with a person who suddenly grimaces in pain, we automatically micro-grimace (that is, mimic the person's facial expression in milliseconds), thereby triggering or mirroring the same brain regions and physiological arousal inside ourselves that are being activated within the other person (albeit at lower intensity). According to RO DBT, our mirror neuron system and capacities for micro-mimicry of facial affect both make it possible for us to literally experience the pains and joys of nearby others and make empathy and altruism a reality. The stranger suddenly becomes part of our family, self-sacrifice feels easy, and we are more likely to behave toward others as we would like them to behave toward us. This helps explain why we are willing to risk our lives to save a stranger from drowning, or to die fighting for our nation.

From Maladaptive OC to RO DBT

A central tenet of RO DBT is that self-control is highly and perhaps universally valued in most societies, and that the value placed on self-control influences how a society defines deviant or abnormal behavior. For overcontrolled clients, societal veneration of self-control is both a blessing (these clients' capacity for self-control is often admired) and a curse (their personal suffering, linked as it is to overcontrol, often goes unrecognized). Indeed, OC clients set high personal standards for themselves (and others) and are expert at not appearing deviant on the outside (that is, in public). They are not the people you see yelling at each other from across the street or robbing convenience stores on a whim. They don't need to learn how to take life more seriously, or try harder, or plan ahead, or behave more appropriately in public. They have too much of a good thing—their self-control is out of control and its compulsive nature impairs relationships. As a consequence, they suffer from emotional loneliness—not lack of contact, but lack of intimate connection with others. Thus, rather than focusing on what's wrong with hyper-detail-focused perfectionists, RO DBT begins by observing what's healthy (about all of us) and uses this to guide treatment interventions. Psychological health or well-being in RO DBT is hypothesized to involve three core transacting features:

1. *Receptivity and openness* to new experience and disconfirming feedback, in order to learn.
2. *Flexible control*, in order to adapt to changing environmental conditions.
3. *Intimacy and social connectedness* (with at least one other person), based on premises that species survival required capacities to form long-lasting bonds and to work in groups or tribes.

The core idea is that OC clients are more likely to benefit from treatment approaches that emphasize openness, candid expression of emotion, flexibility, and social connectedness—rather than approaches valuing dispassionate awareness, self-constraint, impulse control, or delaying gratification.

Overview of Treatment Structure and Targets

The RO DBT outpatient treatment protocol consists of weekly 1-hour individual therapy sessions and concurrent weekly RO skills training classes, with individual therapy and skills training taking place over a period of approximately 30 weeks. Clients normally start skills training during the third week of individual RO DBT. The RO DBT skills training manual (T. R. Lynch, 2018a) includes a complete set of handouts, worksheets, and instructor notes for each of the 30 RO skill lessons (see Table 1 for an overview of RO DBT skills). Each skills training lesson is designed to occur within a 2.5-hour time frame, including homework review, a brief break, and new teaching. Telephone consultation with therapists outside normal working hours is encouraged on an as-needed basis. Although this optional resource is not often used by OC clients, it has proved invaluable in creating a sense of connection with socially isolated or distant OC clients. Finally, therapists using RO DBT ideally build into their treatment programs a means to support their own practice of radical openness in order to effectively deliver the treatment. This most often translates into a weekly therapist consultation team meeting that can be held in person or via the Internet. Consultation team meetings serve several important functions; not only do they provide a platform for therapists' practice of radical openness, they also help reduce therapists' burnout, enhance empathy in therapists, and promote therapists' adherence to the treatment.

Yet, before treatment can begin with OC clients, the client must be willing to see their overcontrolled style of coping as a core problem. Consequently, RO DBT individual therapy is designed to be delivered in sequential stages or steps, with each new component building on the previous one. The orientation and commitment phase is one of these stages, and it occurs during the first four sessions of therapy (see T. R. Lynch, 2018b). These first four sessions primarily focus on orienting the client to the theory and structure of the treatment, assessing willingness to change, and taking the first steps needed in order to develop a strong therapeutic relationship. Nonetheless, perfect agreement, compliance, or commitment is not expected at any time during these early stages or throughout the entire course of treatment. Indeed, alliance ruptures, disagreements, and misunderstandings are expected and considered a core part of client growth. The therapist explains to the client that she practices radical openness skills herself and that part of this means practicing openness to criticism and disconfirming feedback in order to encourage clients to feel free to criticize, voice disagreement, or express concern either about how she is delivering the treatment or about the treatment itself.

Broadly speaking, treatment targeting priorities in RO DBT are, first, to reduce life-threatening behaviors; second, to repair ruptures in the therapeutic alliance; and, third, to address deficits in the client's

social signaling, with reference to five OC behavioral themes. Problem behaviors that are imminently life-threatening are given *top priority*. Thus, when imminent life-threatening behavior is present, therapists should drop their agenda and prioritize keeping the client alive. The RO DBT manual describes in detail how to assess and manage OC imminent life-threatening behaviors (T. R. Lynch, 2018b).

Alliance Ruptures and Repairs

Since OC clients are experts at masking their feelings and not revealing vulnerability or anger and tend to abandon relationships when conflict emerges, the second most important target in RO DBT is a rupture in the therapeutic alliance between the OC client and the therapist. As defined in RO DBT, an alliance rupture involves one or both of two main themes:

1. The client feels misunderstood.
2. The client is experiencing the treatment as not relevant to his unique problems.

Both issues are the responsibility of the therapist to manage (that is, a client is not blamed for creating an alliance rupture). Although an alliance rupture represents a potential problem for the therapist (for example, it can lead to the client's premature dropout), in RO DBT an alliance rupture is also seen as an opportunity for the client's growth in that a successful repair can be instrumental in helping an OC client learn that conflict can enhance intimacy. Plus, because OC clients are overly cautious and hypervigilant for threat, they tend to be slow to warm up and trust other people (including therapists). Thus, in contrast to most other therapies, RO DBT is more conservative about how long it takes to establish a strong working alliance (that is, it tends to take about 14 weeks before a working alliance is considered to be possibly present).

So, how do I know I have a strong working alliance with my OC client? Three factors can be used as part of a self-assessment regarding a strong working alliance:

1. There have been multiple alliance ruptures *and repairs*.
2. The client's social signaling is reciprocal (when the therapist laughs, the client laughs, and vice versa) and less formal or polite (the client's body language is more laid back and his use of language is less formal).
3. The client directly challenges or disagrees with the therapist with an open mind and without abandoning the relationship.

Thus, therapists should be delighted (rather than concerned) when an OC client uses colorful language, teases them, cracks a joke, or openly disagrees, because the client is sending a powerful social signal suggesting that she trusts you and considers you part of her tribe. Yet perhaps the most powerful means of making genuine contact with an OC client is to practice what you preach. That is, practicing radical openness naturally brings humility into our lives, and your OC clients are likely not to be the only ones who benefit.

Targeting Indirect Social Signals and Disguised Demands

✓ "I am not like other people." *(Possible hidden message: "I am better than other people.")*

✓ "No, really. It's OK. I'm fine with the decision. Let's do it your way." *(Possible hidden message: "I disagree totally and will make you pay.")*

Importantly, although life-threatening behavior and alliance ruptures take precedence, RO DBT posits that social signaling deficits represent the core problem underlying OC emotional loneliness, isolation, and psychological distress. OC clients are expert at blocking feedback they don't want to hear and disguising intentions, without making it obvious that this is what they are doing (for example, pretending not to hear, answering a question with a question, subtly changing the topic). Thus, ideally, the vast majority of therapy time is spent on these issues. Five OC social signaling themes are posited to be uniquely influential in the development and maintenance of maladaptive OC, including (1) inhibited or disingenuous emotional expression, (2) extreme caution and excessive focus on details, (3) rigid, rule-governed behavior, (4) an aloof, distant style of relating to others, and (5) frequent use of social comparisons along with frequent feelings of envy or bitterness.

Essentially, the key to effective treatment targeting when treating problems of overcontrol is not to focus solely on inner experience (such as dysregulated emotion, maladaptive cognition, lack of metacognitive awareness, or past traumatic memories) as the source of OC suffering. Instead,

Table 1. RO DBT Skills Training Lesson Plan

Week/ Lesson	Title of Lesson
1.	Radical Openness
2.	Understanding Emotions
3.	Activating Social Safety
4.	Enhancing Openness and Social Connectedness via Loving-Kindness
5.	Engaging in Novel Behavior
6.	How do Emotions Help Us?
7.	Understanding Overcontrolled Coping
8.	Tribe Matters: Understanding Rejection and Self-Conscious Emotions
9.	Social Signaling Matters!
10.	Using Social Signaling to Live by Your Values: Flexible-Mind is DEEP
11.	Mindfulness Training, Part 1: Overcontrolled States of Mind
12.	Mindfulness Training, Part 2: The "What" Skills
13.	Mindfulness Training, Part 3: The Core Mindfulness "How" Skill: With Self-Enquiry
14.	Mindfulness Training, Part 4: The "How" Skills
15.	Interpersonal Integrity, Part 1: Saying What We Really Mean
16.	Interpersonal Integrity, Part 2: Flexible-Mind REVEALs
17.	Interpersonal Effectiveness: Kindness First and Foremost
18.	Being Assertive with an Open Mind: Flexible-Mind PROVEs
19.	Using Validation to Signal Social Inclusion
20.	Enhancing Social Connectedness, Part 1
21.	Enhancing Social Connectedness, Part 2
22.	Learning from Corrective Feedback
23.	Mindfulness Training, Part 1: Overcontrolled States of Mind (Repeated)
24.	Mindfulness Training, Part 2: The "What" Skills (Repeated)
25.	Mindfulness Training, Part 3: The Core Mindfulness "How" Skill: With Self-Enquiry (Repeated)
26.	Mindfulness Training, Part 4: The "How" Skills (Repeated)
27.	Envy and Resentment
28.	Cynicism, Bitterness, and Resignation
29.	Learning to Forgive
30.	RO Integration Week

RO DBT targets indirect, masked, and constrained social signaling as the primary source of OC clients' emotional loneliness, isolation, and misery. Indirect social signals interfere with social connectedness because they make it harder to know the sender's true intentions (for example, a furrowed brow can reflect intense interest or disagreement). They are powerful because they are elusive—e.g., they allow the sender to influence (control) others or get what he wants without ever having to admit to it; for example, the "silent treatment" signals anger without saying a word and is easy to deny: "Who me? No, I'm not angry. I just don't feel like talking." Plus, although words can help, words alone are not enough when it comes to forming intimate bonds. It's not what is said, it's *how* it is said (for example, a person can say the words "I love you" in a manner that leaves the recipient thinking otherwise). People trust what they observe. Therefore, targeting social signaling problems in OC clients, rather than inner experience, has the additional advantage of being undeniable because a social signal, by definition, is a publicly observable behavior, making it harder to ignore interpersonal problems or pretend that all is well.

There are three ways in which RO DBT incorporates these theoretical observations into treatment interventions:

1. *It teaches clients context-appropriate emotional expression* and nonverbal prosocial signaling strategies that have been shown to enhance social connectedness.

2. *It targets biotemperament-based OC deficits and excesses* by teaching OC clients skills designed to activate areas of the brain associated with the social safety system, and it encourages clients to use these skills prior to engaging in social interactions. This approach enables an overcontrolled client to naturally relax the facial muscles and send nonverbal signals of friendliness, thereby facilitating reciprocal cooperative responses from others as well as fluid social interactions.

3. *It teaches therapists how to take advantage of mirror neurons and proprioceptive feedback* in order to elicit activation of the social safety system in their overcontrolled clients by educating them about the deliberate employment of gestures, postures, and facial expressions that communicate relaxation, friendliness, and nondominance.[4] This aspect of RO DBT highlights the need for therapists to practice radical openness skills in their personal lives, since overcontrolled clients are unlikely to believe that it's socially acceptable to play, relax, admit fallibility, or openly express emotions unless they see their therapists model such behavior first.

Ultimately, when social signaling is targeted, the OC client loses his shield of plausible deniability. Even when a social signal (such as a yawn) occurs unintentionally or without conscious awareness, it should be examined as a potential target if it functions to damage or potentially damage relationships. For example, an OC client might have a habit of furrowing his brow and frowning whenever he is concentrating or listening intently; unfortunately for the client, however, most people interpret frowns and furrowed brows as signs of disapproval or dislike, and frowning often triggers reciprocal frowning in recipients as well as reduced desire for affiliation.

What Is Radical Openness?

Radical openness is the core philosophical principle and core skill in RO DBT. It can trace its roots (at least in part) to a spiritual tradition known as Malâmati Sufism. Malâmati Sufism originated in the 9th century in the northeast of Persia, in an area called Khorasan (what is now Iran), and in the present day it has a strong following in Turkey and the Balkan States. The name Malâmati comes from the Arabic word *malamah*, meaning "blame" and referring to the Malâmati practice of sustained self-observation and healthy self-criticism in order to understand one's true motivations (Toussulis, 2011). Malâmatis believe that one cannot achieve heightened self-awareness in isolation; as a consequence, emphasis is given to spiritual dialogue and companionship (in Arabic, *sohbet*). The Malâmatis are not interested so much in the acceptance of reality or in seeing "what is," without illusion; rather, they look to find fault within themselves and question their self-centered desires for power, recognition, or self-aggrandizement.

A core principle in RO DBT is that innate perceptual and regulatory biases make it impossible for a person to achieve heightened self-awareness in isolation; we need others to point out our blind spots. Truth in RO DBT is considered real yet elusive; thus, for example, "If I know anything, it is that I don't know everything, and neither does anyone else" (M. P. Lynch, 2004, p. 10). It is the pursuit of truth that matters, not its attainment. Rather than assuming we could ever know reality just as it is, radical openness assumes that we all bring perceptual and regulatory biases into every moment, and that our biases interfere with our ability to be open and to learn from new or disconfirming information.

Yet simply being frank or forthright with our opinions, observations, feelings, or beliefs is not sufficient to create the type of open dialogue and equal status that characterize experiences associated with optimal interactive learning or genuine friendship. As such, RO DBT contends that it is essential not only to reveal our inner experience or opinions to others but also and simultaneously to acknowledge our own potential for fallibility. Rather than automatically assuming that the world should change ("You need to validate me because I feel upset") or automatically prioritizing regulation or acceptance strategies that function to reduce arousal or lead to a sense of peace, RO DBT posits that the truth hurts. That is, often reaching the place of most personal self-growth involves coming to grips with (attending to) the very place we don't want to go. Thus, radical openness means developing a passion for going opposite to where we are. It is more than mindful awareness. It means actively seeking those areas of our lives that we want to avoid or may find uncomfortable, in order to learn. It involves purposeful self-enquiry and a willingness to be wrong, with an intention to change if we need to change. It enhances relationships because it models humility and willingness to learn from what the world has to offer. Yet it can be painful because it often requires sacrificing firmly held convictions or self-constructs. Examples of self-enquiry questions are:

4 Despite the influence of culture and learning, there is also an enormous amount of research supporting the universality of those nonverbal social signals that emotion theorists and evolutionary paleoanthropologists posit as having been essential to the survival of our species and to individual well-being. For example, regardless of culture, we raise our arms high with our palms facing outward when we celebrate success, almost as if we were embracing the world. Congenitally blind athletes, whether they win or lose a competition, display the same facial expressions and gestures as winning and losing athletes who are not blind (Matsumoto & Willingham, 2009).

- *Is it possible that my bodily tension means that I am not fully open to the feedback? If yes or possible, then: What am I avoiding? Is there something here to learn?*
- *Do I find myself wanting to automatically explain, defend, or discount the other person's feedback or what is happening? If yes or maybe, then: Is this a sign that I may not be truly open?*
- *Do I believe that further self-examination is unnecessary because I have already worked out the problem, know the answer, or have done the necessary self-work about the issue being discussed? If yes or maybe, then: Is it possible that I am not willing to truly examine my personal responses?*

In Conclusion

A major underlying premise in RO DBT is that *personality matters* when intervening with treatment-resistant or chronic problems—indicating that broad-based personality dimensions and overlearned perceptual and regulatory biases are interfering with change. Biotemperamental predispositions combined with family-cultural-environmental experiences are hypothesized to severely handicap *openness and flexible responding*; resulting in habitual *overcontrol or undercontrol* of socio-emotional behavior, sharing features with the well-established division between internalizing and externalizing disorders (Crijnen, Achenbach, & Verhulst, 1997). Thus, RO DBT contends that core genotypic and phenotypic differences between groups of disorders necessitate different treatment approaches (i.e., one size does not fit all). Broadly speaking, treatments targeting undercontrolled problems require interventions designed to enhance inhibitory control and reduce mood-dependent impulsive responding, whereas overcontrolled problems require interventions designed to relax rigid inhibitory control and increase emotional expressiveness, receptivity, and flexibility.

The biosocial theory for OC provides the basis for subsequent treatment interventions in RO DBT, hypothesizing (1) that OC individuals are biologically hard-wired to perceive new or unfamiliar situations as dangerous rather than rewarding; (2) that their natural tendency to mask their inner feelings makes it less likely for OC clients to form close social bonds with others; and (3) that OC clients consequently suffer increasing social isolation, loneliness, and psychological distress. The end result is that the "transmitting" channel needed for effective prosocial and flexible social exchanges becomes impaired. Essentially, OC self-control efforts designed to sidestep social difficulties combined with biotemperamental predispositions function to create the very consequences the OC individual fears the most. That is, people see them as inauthentic, disingenuous, or untrustworthy and prefer not to interact with them.

As a consequence, RO DBT uniquely targets nonverbal prosocial signaling deficits as the core issue keeping emotionally lonely OC clients "out of the tribe." RO DBT hypothesizes that human emotional expressions evolved not just to *communicate* intentions but to *facilitate* the formation of strong social bonds and altruistic behaviors among unrelated individuals.

Our facilitative advantage required our species to develop complex social signaling capabilities that allowed for a quick and safe means to evaluate and resolve conflict and that resulted in unprecedented collaboration among unrelated individuals, a unique human feature that to this day is unparalleled in the animal world. Treatment interventions prioritize strategies that activate areas of the brain associated with the social safety system (Porges, 2001) and context-appropriate emotional expression and nonverbal social signaling strategies shown to enhance social connectedness.

Radical openness is the core philosophical principle and core skill in RO DBT. Radically open living is posited to impact not only how we see the world (we are more receptive to critical feedback) but also how others see us (people like people who are open-minded). Thus, it is considered both a state of mind and a powerful social signal that influences personal and other perception. As a social signal, it enhances relationships. For example, we tend to trust open-minded people because they are more likely to reveal than hide their inner feelings during conflict. We desire to affiliate with open-minded people because they are humble—they are more likely to give others the benefit of the doubt during interactions and don't automatically assume that their way is the best, right, or only way. As a state of mind, radically open living involves actively seeking our personal unknown in order to learn from an ever-changing environment. Rather than automatically assuming that the world needs to change so we can feel better, radical openness posits that we often learn the most from those areas of life that we find most challenging. Yet, radical openness does not mean approval, naively believing, or mindlessly acquiescing. Sometimes being closed is what is needed in the moment, and sometimes change is unnecessary. Ultimately, radical openness is not something that can be grasped solely via intellectual means—it is experiential. Similar to mindfulness, it requires direct and repeated practice, ideally with a fellow practitioner who can reflect back our blind spots; plus, one's understanding of RO evolves over time as a function of continued practice.

Lastly, 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. Thus, when it comes to long-term mental health and well-being, what a person feels or thinks inside or privately is considered less important in RO DBT, whereas, what may matter most is how a person communicates or socially signals inner or private experience to other members of the tribe and the impact that social signaling has on social connectedness. Feeling happy is great, but when you are lonely it's hard to feel happy, no matter how much you might try to accept, reappraise, or change your circumstances, keep busy, exercise, practice yoga, or distract yourself. In the long run, we are tribal beings, and we yearn to share our lives with other members of our species. Essentially, when we feel part of a tribe, we naturally feel safe and worry less.

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Too Much Versus Too Little Control: The Etiology, Conceptualization, and Treatment Implications of Overcontrol and Undercontrol

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SELF-CONTROL CAN BE DEFINED as "the ability to inhibit competing urges, impulses, behaviors, or desires and delay gratification in order to pursue distal goals" (Lynch, 2018, p. 9). Self-control is a broad construct that can be implemented across multiple domains, including cognition (e.g., concentrating and ignoring distractions while driving), emotion (e.g., suppressing emotions based on social cues), regulating impulses (e.g., not eating the doughnut in the break room), and goal-directed behaviors (e.g., persevering on manuscript writing in hopes of tenure; Baumeister, 2002, pp. 670-671). The ability to delay gratification and inhibit impulse is necessary to meet societal expectations and to pursue long-term goals, and thus, in most societies, the ability to exercise self-control is highly valued and often equated with success. Dating from the 1960s and Walter Mischel's famous "marshmallow test," research has repeatedly shown a greater capacity for self-control to be associated with positive outcomes in both child and adult populations, including better school and work performance, greater relationship satisfaction, and better psychological adjustment (e.g., Mischel et al., 2010; Tangney, Baumeister, & Boone, 2004). However, research has also indicated that both too little and too much self-control are associated with dysfunction.

In this vein, Block and Block (1980) identified two theoretical constructs related to personality functioning in children: ego-control and ego-resiliency. The concept of ego-control broadly refers to "the threshold or operating characteristic of an individual with regard to the expression or containment of impulses, feelings, and desires" (p. 43) and is related to current conceptualizations of self-control (e.g., Block & Block, 2006). The authors describe ego-control as a continuum, with one end representing "overcontrolled" individuals and the other representing "undercontrolled" individuals. Overcontrol is characterized by the containment of impulse, the ability to delay gratification, and an overall tendency towards inhibition and constraint. On the opposite end, undercontrol is characterized by insufficient regulation of impulses, immediate gratification of desires, and a tendency towards outward expression and spontaneity (p. 43). Ego-resiliency refers to an individual's capacity to "[adapt] to changing circumstances and environmental contingencies," and individuals low on ego-resiliency tend to exhibit poor adaptive flexibility and problem-solving strategies, and are "generally fixed in [their] pattern of adaptation" (p. 48-49). Importantly, individuals at either the low or high end of the ego-control continuum could demonstrate poor ego-resiliency.

Subsequent studies have demonstrated that ego-control and ego-resiliency have an inverted U-shaped relationship. Specifically, low resiliency is associated with both high and low control, and high resiliency is related to intermediate scores on control (e.g., Asendorpf, Borkenau, Ostendorf, & van Aken, 2001; Asendorpf & van Aken,

1999). These findings suggest that very high and very low scores on ego-control represent two distinct maladaptive personality profiles (i.e., overcontrolled and undercontrolled types, respectively), which have been replicated in both children and adults (e.g., Block & Block, 2006; Costa, Herbst, McCrae, Samuels, & Ozer, 2002).

Undercontrolled individuals are generally expressive, spontaneous, distractible, and emotionally labile. Based on the Five Factor Model (FFM) of personality, undercontrolled individuals are characterized by low scores on agreeableness and conscientiousness and high scores on neuroticism (e.g., Claes et al., 2006; Schnabel, Asendorpf, & Ostendorf, 2002). In contrast, overcontrolled individuals express emotion minimally or indirectly, and are generally perseverative, organized, rigid, and conforming (Block & Block, 1980; see Table 1 for summary of differences between overcontrolled and undercontrolled personality styles reviewed in this article). Overcontrolled individuals are often described as shy, inhibited, anxious, and withdrawn (e.g., Robins et al., 1996). Based on the FFM, overcontrolled individuals demonstrate low scores on extraversion and elevated scores on neuroticism (e.g., Asendorpf et al., 2001). Despite high neuroticism and negative affectivity, overcontrolled individuals mask their inner feelings unduly, and overcontrol is associated with social isolation and poor interpersonal functioning (e.g., Lynch, Hempel, & Clark, 2015; Steca, Alessandri, & Caprara, 2010). It is worth clarifying that over- and undercontrol are not simply low and high extraversion, respectively. The trait of extraversion consists of high positive affectivity and high agency (Watson & Clark, 1977). Whereas overcontrolled individuals may be low in positive affectivity, they are often high in agency and proactive coping, suggesting that current measures of extroversion may "clump" constructs that would appear to differentiate over- versus undercontrolled individuals on the surface (Lynch, 2018). Over- and undercontrol are broad or superordinate personality "types." Each is a multifaceted construct reflecting core genotypic (related to biology) and phenotypic (related to behavioral expression) differences between spectrums of disorders that have been shown to predict a broad range of outcomes and are relatively stable starting in early childhood (e.g., Asendorpf & Denissen, 2006; Steca et al., 2010).

Development of Over- and Undercontrol in Youth

Self-control develops rapidly in early childhood, and greater self-control is thought to be protective against onset of psychopathology in youth (Moffitt et al., 2011). However, self-control is not always adaptive and overcontrolled and undercontrolled tendencies appear to be identifiable in young children by age 5 (Derryberry & Rothbart, 1997; Eisenberg, Spinrad, & Eguum, 2010; Kochanska, Murray & Harlan, 2000). From early childhood, these personality types demonstrate relative continuity and stability across the lifespan (Asendorpf et al., 2001; Hart, Atkins, Fegley, Robins, & Tracy, 2003).

Much of the developmental literature posits that these personality types originate in temperamental differences. For instance, Eisenberg and colleagues theorize that compared to more adaptive effortful control, defined as "the ability to inhibit a dominant response to perform a subdominant response" (Rothbart & Bates, 2006; p. 137), over- and undercontrol develop from temperamental "reactive control processes," or involuntary motivational response tendencies (see Eisenberg et al., 2010, for review). One form of reactive control includes impulsivity, disinhibition, and elevated approach behaviors (i.e., "reactive undercontrol"). Within this conceptualization, undercontrolled youth are high on activational and approach behaviors, usually approaching an incentive and reward, high on impulsivity, and low on effortful control, attentional regulation and inhibitory control (Eisenberg, Spinrad & Morris, 2002; Eisenberg et al., 2010). Conversely, "reactive overcontrol" involves rigid and inflexible behavior and is equated with behavioral inhibition in novel situations. Overcontrol in youth is characterized by low impulsivity, low approach motivation, and high involuntary (e.g., reactionary and automatic) inhibition, resulting in shy, restrained, and passive children who lack flexibility or spontaneity and are highly sensitive to threat (Eisenberg et al., 2002). Both reactive under- and overcontrolled response tendencies are not under conscious control, whereas effortful control consists of voluntary emotion-related self-regulation (Eisenberg et al., 2010).

Person-centered personality research has similarly identified overcontrolled, undercontrolled, and resilient personality types in middle childhood and adolescence (Asendorpf & van Aken, 1999; Robins et al., 1996). Resilient youth are characterized by emotional stability, self-confidence, and self-direction. Overcontrolled children and adolescents present as emotionally sensitive, introverted and tense, but also agreeable, cooperative, well-liked and prosocial (Asendorpf & Aiken, 1999; Robbins, John & Caspi, 1998). Undercontrolled children and adolescents appear disobedient, energetic, restless, impulsive and very physically active (Asendorpf & Aiken, 1999; Robins et al., 1996).

It is important to note that over- and undercontrol are distinct conceptualizations from the internalizing and externalizing framework often used in developmental research. For example, while externalizing and internalizing presentations are different manifestations of high negative affect, neither under- nor overcontrol load onto negative emotionality in youth (e.g., Rothbart et al., 2001). Second, internalizing and externalizing classifications are based on the presentation of symptoms, internal thought processes, and external behaviors (Achenbach, 1966). Under- and overcontrol are not defined by the outcome (e.g., symptoms presentations, such as depression and anxiety), but rather, take a more bottom-up approach that includes internal and external processes and repeated transactions between the individual's personality type and environment that result in learned coping styles and social signaling styles (e.g., Lynch, 2018).

Distinguishing overcontrol and internalizing presentations, inhibitory control may play a unique role. Specifically, internalizing symptoms (e.g., symptoms of depression) have been associated with both low inhibitory control (Eisenberg, Hofer, & Vaughan, 2007; Riggs, Blair & Greenberg, 2004) and high inhibitory control (Aksan & Kochanska, 2004; Murray & Kochanska, 2002), indicating inhibitory control may not show a direct relationship with internalizing symptoms. Conversely, elevated inhibitory control is a core feature of overcontrol (Henderson, Pine, & Fox, 2015; Lynch, Hempel, & Clark, 2016). A second distinguishing factor of internalizing symptoms and overcontrol in youth is conscientiousness. Meta-analytic findings in adults demonstrate that conscientiousness is low across adult psychopathology (Kotov, Gamez, Schmidt & Watson, 2010) and is also low in childhood internalizing and externalizing disorders (John et al., 1994; notably, high conscientiousness is associated with some psychopathology; Samuel & Widiger, 2011). However, in line with agreeable, cooperative, and prosocial tendencies,

there is some indication that overcontrolled youth display elevated conscientiousness (Asendorpf & van Aken, 1999; Dubas et al., 2002; Robins et al., 1998). Although overcontrolled youth often are behaviorally inhibited and less likely to approach novel situations, over the course of development and learned coping, this elevated conscientiousness may translate into more approach-coping, positive agency, and problem-solving behaviors that are also characteristic of overcontrol in adults.

Outcomes of Under- and Overcontrol in Youth

Under- and overcontrolled youth exhibit a host of maladaptive outcomes. Undercontrol, in conjunction with elevated negative emotionality, has been shown to be associated with onset of externalizing symptoms as well as poor social adjustment, including more conflict in relationships in youth (Asendorpf et al., 2001; Frick & Morris, 2004; Nigg, 2006). Additionally, undercontrol in childhood leads to greater physical health problems and social difficulties in adulthood, including hypertension, stroke, and aggressiveness in relationships (Asendorpf, et al., 2001; Chapman & Goldberg, 2011). Overcontrol in youth is associated with internalizing symptoms, especially anxiety (Asendorpf, Denissen, & van Aken, 2008; Eisenberg et al., 2002; Henderson et al., 2015; Murray & Kochanska, 2002; Robins et al., 1996) and a variety of social functioning deficits, including social withdrawal, poor relationships and loneliness (Asendorpf et al., 2001; Asendorpf & van Aken, 1999; Eisenberg, Fabes, Guthrie, & Reiser, 2000; Eisenberg et al., 2004). Overcontrol in young children also longitudinally predicts delays in finding a stable partner and full-time job and is associated with lower social self-esteem in adulthood (Aspendorpf et al., 2001; 2008).

In addition to temperamental and biological individual differences, parenting styles also contribute to the development of over- and undercontrolled coping styles and maladaptive outcomes in youth. Overcontrolled children are more likely to have rigid and conflict-inducing mothers and more passive fathers (Block, 1971). Moreover, overcontrolled children whose parents are overprotective, harsh, intrusive, and critical are more likely to develop internalizing disorders, including anxiety disorders (Degnan, Almas, & Fox, 2010; Rapee, 1991; Rubin, Burgess, & Hastings, 2002). Undercontrolled children are more likely to have parents that are more inclined to harsh punishment and punitive and critical parenting, or parents who are indifferent, ignoring, and lacking warmth, and are passive in parental responsibilities (Block, 1971; Dubas et al., 2002; Pulkkinen, 1996). This harsh and inconsistent discipline or nonresponsive, uninvolved parenting style moderates the relationship between undercontrol and onset of externalizing disorders (Reid, Patterson, & Snyder, 2002; Van Leeuwen et al., 2004) and internalizing problems (Dubas et al., 2002). Interestingly, it has been theorized that over- and undercontrolled youth may be more sensitive to parenting than resilient youth, for whom parenting may minimally influence outcomes (Dubas et al., 2002; O'Connor & Dvorak, 2001; Van Leeuwen et al., 2004). It appears that specific parenting styles exacerbate both over- and undercontrolled childhood types as well as increase vulnerability for psychopathology in youth.

Outcomes of Over- and Undercontrol in Adulthood

Much of the literature focusing on maladaptive outcomes in adults has examined undercontrolled individuals, given their overt symptom presentations, high levels of psychopathology, and seemingly greater chronicity of psychological conditions (Bastiaens, Claes, Ceulemans, Vanwallegham, & de Hert, 2014). Undercontrolled individuals report the highest rate of psychiatric hospitalizations and are first hospitalized at an earlier age than their peers (Thompson-Brenner & Westen, 2005). With their high threat sensitivity and low modal threshold for response, they are often described as impulsive, confrontational, or aggressive (Block & Block, 1980; Robins et al., 1996). This often leads to undercontrolled individuals presenting with externalizing problems, particularly substance abuse and antisocial behavior (e.g., Krueger, Markon, Patrick, & Iacono, 2005). Namely, undercontrol is associated with higher risk for alcohol-related problems (e.g., Schuckit & Smith, 2006), younger age of onset for alcohol-related problems (e.g., Hawkins et al., 1997), and greater severity of problems related to alcohol use (e.g., Zucker, Heitzeg, & Nigg, 2011). Undercontrolled individuals are also at elevated risk for substance dependence, including cannabis, prescription

drugs, and street drugs (e.g., Moffitt et al., 2011). Additionally, undercontrol is considered a risk factor for delinquency and criminality (e.g., Blackwell & Piquero, 2005; White et al., 1994), including being more likely to be convicted of a criminal offense and scoring higher on measures of antisocial behavior and criminality. Undercontrol is also associated with problematic gambling (Caspi, Moffitt, Newman, & Silva, 1996; Slutske, Moffitt, Poulton, & Caspi, 2012), higher rates of binge eating disorder and bulimia in samples of eating disordered patients, and greater eating-related pathology in nonclinical samples (Perkins, Slane, & Klump, 2013; Turner et al., 2014).

Due to the high societal value placed on self-control, maladaptive outcomes associated with excessive self-control in adults have historically received little attention. However, synthesizing the developmental and adult literatures, Lynch (2018) has recently proposed a novel model of overcontrol, in which overcontrol is posited to be the product of genetic disposition towards inhibition and constraint, early environmental experiences, and an avoidant and rigid coping style that limits one's ability to learn from past experiences and form close relationships (Lynch, Hempel, & Dunkley, 2015). Based on this model, overcontrol in adulthood is characterized by four core deficits: low receptivity and openness (e.g., low openness to disconfirming feedback, avoidance of ambiguity or uncertainty, hypervigilance to potential threat), low flexible-control (e.g., need for structure and order, perfectionism, compulsive planning, rigid and rule-governed behavior), inhibited emotional expression (e.g., suppression of negative emotions, incongruent expression of emotion, underreporting of distress), and low social connectedness (e.g., aloof and distant relationships, envy and bitterness, reduced empathy).

This conceptualization of overcontrol is associated with a number of severe mental health problems (e.g., Zucker et al., 2007). Anorexia nervosa (AN), for instance, can be considered a prototypical disorder of overcontrol, characterized by restrictive and ritualized eating representing a form of maladaptive inhibitory control that has been intermittently reinforced (Hempel, Vanderbleek, & Lynch, in press). Many core features of overcontrol are also associated with AN, including heightened threat sensitivity (Harrison, Sullivan, Tchanturia, & Treasure, 2010), perfectionism and cognitive rigidity (e.g., Bulik et al., 2003; Schmidt & Treasure, 2006), inhibited emotional expression and impaired recognition of emotion in others (Geller, Cockell, Hewitt, Goldner, & Flett, 2000), and aloof/distant relationships (Zucker et al., 2007). In a sample of eating disordered inpatients, Claes et al. (2006) found that the majority of overcontrolled individuals presented with symptoms of AN (versus other eating disorder diagnoses), which is consistent with other research in eating disordered samples (Bohane, Maguire, & Richardson, 2017).

Overcontrol has also been found to be a risk factor for treatment-resistant depression (e.g., Caspi et al., 1996), and depressed individuals frequently exhibit characteristics of overcontrol (e.g., Candrian et al., 2008). Overcontrolled features, particularly rigidity and excessive emotional control, are related to chronic (versus acute) depression (e.g., Huprich, Porcerelli, Keaschuk, Binienda, & Engle, 2008). Additionally, perfectionism has been shown to be related to the chronicity of depressive symptoms (e.g., Hewitt, Flett, Ediger, Norton, & Flynn, 1998). Maladaptive overcontrol also shares many features with anxiety disorders, and personality traits that are thought to characterize overcontrolled individuals (i.e., high neuroticism and low extraversion) have been shown to be associated with elevated risk for anxiety disorders (e.g., Brandes & Bienvenu, 2006). Obsessive-compulsive disorder, in particular, overlaps with maladaptive overcontrol, including rigid patterns of thinking, preoccupation with details, and intolerance of uncertainty (e.g., Gallagher, South, & Oltmanns, 2003). Typical overcontrolled personality traits are also associated with poorer treatment outcomes and lower likelihood of remission from anxiety disorders (e.g., Massion et al., 2002).

Last, personality disorder (PD) diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) reflect pervasive difficulties with cognition (i.e., ways of interpreting the world), affectivity, interpersonal functioning, and impulse control. Maladaptive self-control tendencies (i.e., undercontrol and overcontrol) are strongly associated with dysfunction in these areas and thus the PD diagnoses reflect underlying problems with undercontrol and overcontrol. In the DSM-5, undercontrolled PDs (i.e., Cluster B personality disorders; borderline, histrionic, antisocial, and narcissistic PDs) are characterized by low inhibitory control and chaotic/dramatic relationships, whereas overcontrolled PDs (i.e., certain Cluster A and C personality disorders; obsessive-compulsive, avoidant, paranoid, and schizoid PDs) are characterized by excessive inhibitory control and an aloof/distant interpersonal style (Lynch et al., 2015). This distinction has been supported by numerous studies that show significant differences in PD profiles between undercontrolled and overcontrolled individuals (e.g., Borges & Naugle, 2017; Claes et al., 2006; Westen & Harnden-Fischer, 2001). The majority of the PD literature to date has focused on Cluster B PDs, most prominently borderline and antisocial PDs (e.g., Clark, 2005). There has been a dearth of research examining Cluster A and C personality disorders (i.e., overcontrolled PDs), but evidence suggests that they are associated with impaired functioning and increased health care use (Maclean, Xu, French, & Ettner, 2014). Moreover, these disorders are characterized by grave social impairment, mirroring findings above as a core deficit of the overcontrolled type.

Over- and Undercontrol as Guides for Treatment

The National Institute of Mental Health has developed the Research Domain Criteria (RDoC) framework as a means of supporting research towards a system that classifies mental disorders based on shared pathophysiology, rather than observed symptoms (e.g., Insel et al., 2010). The RDoC approach specifically encourages the development of transdiagnostic interventions, taking a bottom-up approach and targeting underlying mechanisms that contribute to multiple disorders, rather than treating symptoms and specific disorders. Though disorder-specific interventions have proven to be beneficial for many patients, the efficacy of these interventions is limited by within-diagnosis heterogeneity, high rates of comorbidity, and the prevalence of Not Otherwise Specified diagnoses (e.g., Brown, Di Nardo, Lehman, & Campbell, 2001; Goldberg, Simms, Gater, & Krueger, 2011). Conversely, transdiagnostic treatment approaches focus on identifying "common and core maladaptive temperamental, psychological, cognitive, emotional, interpersonal and behavioural processes that underpin a broad array of diagnostic presentations" (Newby et al., 2015, p. 93). Identifying the specific mechanisms that maintain symptoms across disorders is necessary, and overcontrol and undercontrol certainly represent transdiagnostic and multifaceted con-

structs that underlie many treatment-resistant forms of psychopathology.

Although an overcontrolled and an undercontrolled individual may meet criteria for the same mental health diagnosis, they will exhibit very distinct symptom presentations, and will likely respond differently to the same interventions despite sharing a diagnosis. Thus, targeting over- or undercontrol would not focus specifically on symptoms, but rather on the underlying etiological processes (i.e., over- and undercontrolled tendencies) that are contributing to psychopathology. Lynch (2018) asserts that clinicians should target the characteristic difficulties of undercontrolled individuals with interventions that enhance inhibitory control and reduce mood-dependent behavior. For overcontrolled individuals, clinicians would emphasize interventions that relax inhibitory control and increase emotional expressiveness, receptivity, and flexibility. Targeting self-control as a mechanism of psychological change will allow for meaningful growth across many domains of functioning.

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ABCT Leadership & Elections 2018

This year we do not have a second candidate to run for President-Elect. No nominations from colleagues or self-nominations were received, and our extensive outreach efforts to encourage senior members to run were unsuccessful. While this is frustrating, we do not believe that it reflects poorly on the organization or the esteem in which it is held by its senior members. ABCT has a long history of a democratic nominations and elections system known for its integrity. Your Board of Directors is aware that it is a violation of our bylaws not to have two candidates for President-Elect and therefore, we are making this announcement early so you are aware of the situation too. We believe in following that process and encourage you to vote for the candidate put forth on the ballot, or to provide a write-in. We implore you to vote, as ABCT is a member-driven organization and it is your right and responsibility as a member to elect your officers. Thank you.

ABCT Leadership and Elections Committee

David Pantalone, *Chair*
Patricia DiBartolo and
Kristen Lindgren, *Members*

Candidate for President

Martin Antony

Candidates for Representative-at-Large

Jeffrey Goodie
Shireen Rizvi
David Tolin

Candidates for Secretary Treasurer

Jessica Cronce
Sandra Pimentel

How to Differentiate Overcontrol From Undercontrol: Findings From the RefraMED Study and Guidelines From Clinical Practice

Roelie J. Hempel, *Radically Open Ltd.*

Sophie C. Rushbrook, *Dorset Healthcare University NHS Foundation Trust*

Heather O'Mahen, *University of Exeter*

Thomas R. Lynch, *University of Southampton*

ALTHOUGH THE CONCEPTS of overcontrol and undercontrol have been around for some time in various literatures (see, for example, Asendorpf & van Aken, 1999; J. Block, 1971; J. H. Block & Block, 1980; B. P. Chapman & Goldberg, 2011; Eisenberg, Guthrie, et al., 2000; Megargee, 1966), assessing for overcontrol is generally not part of regular clinical assessments. One barrier to assessing overcontrol is that existing self-control scales and assessments assume that as self-control increases, well-being also increases: in other words, more is better (e.g., Baumeister, Heatherton, & Tice, 1994; Kanfer & Karoly, 1972; Mischel, Shoda, & Peake, 1988). Scales measure maladaptive undercontrol, but fail to assess maladaptive overcontrol. Issues in detecting overcontrol are further compounded by the fact that clients with problems with overcontrol often minimize their distress, and some overcontrolled behaviors can mask as undercontrolled behaviors, which can lead to misdiagnosis and being offered a treatment that does not address the issues associated with overcontrol. Misdiagnosis of overcontrol is now being more widely recognized in clinical practice. For example, the Intensive Psychological Therapies Service (Dorset HealthCare University NHS Foundation Trust, United Kingdom) found that 37% of their overcontrolled clients had initially been misdiagnosed with Emotionally Unstable Personality Disorder[1] by external referrers, and only after reassessment by their own clinic staff—who are trained in recognizing the difference between undercontrol and overcontrol—were these clients assessed as overcontrolled and were offered Radically Open Dialectical Behavior Therapy (RO DBT).

Both professional training and more recent papers on overcontrol versus undercontrol indicate a need to better identify problems with overcontrol, thereby improving access to the most appropriate treatment for patients (Bohane, Maguire, & Richardson, 2017; Lynch, Hempel, & Dunkley, 2015): treatments targeting problems of undercontrol should emphasize interventions that enhance inhibitory control and reduce mood-dependent behavior, whereas treatments targeting problems of overcontrol require interventions designed to relax inhibitory control and increase emotional expressiveness, receptivity, and flexibility.

This paper presents baseline data and clinical observations from a subset of participants who were part of the larger study RefraMED ("Refractory Depression—Mechanisms and Efficacy of Radically Open Dialectical Behavior Therapy: A Randomized Controlled Trial"; Lynch, Whalley, et al., 2015). Following this, we summarize clinical recommendations informed by both these data and clinical experience, emphasizing those features that can be used to differentiate between overcontrolled and undercontrolled behaviors during assessment. The paper ends with a brief overview of existing measures that have been found useful for assessing problems of overcontrol.

[1]This is an ICD-10 diagnosis frequently seen in the UK and conceptually similar to Borderline Personality Disorder.

Overcontrol Masking as Undercontrol: Findings From the RefraMED Study

There is evidence that many people who have refractory depression, defined as treatment-resistant and chronic depression, suffer from problems of untreated overcontrol, such as maladaptive perfectionism, greater self-criticism, rigid internalized expectations, excessive control of spontaneous emotion, inordinate fears of making mistakes, aloof interpersonal functioning, and social isolation (Asendorpf, Denissen, & van Aken, 2008; A. L. Chapman et al., 2007; B. P. Chapman & Goldberg, 2011; Eisenberg, Fabes, Guthrie, & Reiser, 2000; Riso, Miyatake, & Thase, 2002). RO DBT is a novel, transdiagnostic treatment for disorders of emotional overcontrol (Lynch, 2018b). Therefore, the RefraMED study aimed to test whether RO DBT could help reduce refractory depression relative to treatment as usual (TAU). The RefraMED study (registration number ISRCTN85784627) is a recently completed multisite randomized controlled trial comparing 7 months of RO DBT with TAU offered at three different locations in the U.K.: Dorset, Hampshire, and North Wales (Lynch, Whalley, et al., 2015).

Methods

For the RefraMED trial, patients were eligible if they were 18 years or older; had a Hamilton Rating Scale for Depression (HRSD; Williams et al., 2008) score of at least 15; had a current diagnosis of major depressive disorder in the Structured Clinical Interview for DSM-IV Axis I (SCID-I; First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002); were suffering either refractory or chronic depression; and, in their current episode, had taken an adequate dose of antidepressant medication for at least 6 weeks without relief. We excluded patients who met criteria for dramatic-erratic PD (Cluster B), bipolar disorder or psychosis; or had a primary diagnosis of substance dependence or abuse because these disorders are more likely to be associated with undercontrolled problems, which RO DBT is not designed to treat; these types of problems require interventions that enhance inhibitory control and reduce mood-dependent behavior. Thus, RefraMED purposefully excluded potential participants who met criteria for dramatic-erratic personality disorders (such as borderline personality disorder; BPD).

Screening Process

At each of the three sites, one recruiter (a clinical studies officer, employed by the local treatment site) and one trained assessor (employed by the research sponsor) conducted eligibility interviews during the recruitment phase of the study. The recruiter conducted the initial phone screenings while the assessor conducted the in-person interviews with potential participants who had passed the phone screening stage. The assessors all had psychology degrees and were trained to competence on the SCID and HRSD by a clinical psychologist (HO) experienced in administering the SCID and HRSD in clinical trials.

The phone screen consisted of several questions about antidepressant medication use and the duration of their depression; the first 8 questions of the Patient Health Questionnaire-9 (Kroenke, Spitzer, & Williams, 2001) to assess depression severity; three questions to screen for possible psychosis; two questions to screen for bipolar I disorder; and 6 questions to screen for borderline personality disorder (BPD).

The assessment interview consisted of the full SCID-I and II interviews (First et al., 1997; First et al., 2002), the HRSD (Williams et al., 2008), the Modified Scale for Suicidal Ideation (Miller, Norman, Bishop, & Dow, 1986), and an adapted version of the Adult Service Use Schedule (Kuyken et al., 2008) for health economics analyses. The assessors conducted these interviews at baseline and a shorter version hereof (without SCID-I and II) again at follow-up 7, 12, and 18 months after randomization. During follow-up interviews assessors were blind to treatment allocation; blindness was checked after each assessment and, if broken, a new assessor was assigned for future sessions. A total of 2,678 patients were referred to the trial, 913 were screened, 444 were assessed, and 250 were randomized.

The primary outcome of the trial was difference in HRSD scores between patients allocated to RO DBT versus TAU. To ensure high interrater reliability of the HRSD assessments, all assessors coded a selection of audiotaped interviews conducted by another member of the team at regular intervals. Four assessment interviews were coded for interrater reliability by 9 individual assessors (note: due to staff changes a total of 11 different assessors worked on the trial). Across all measurements, Krippendorff's alpha (Hayes & Krippendorff, 2007)—conducted at the item level—was 0.89 (95% CI 0.86–0.92), suggesting the raters attained "very good" to "near perfect" interrater reliability (Landis & Koch, 1977).

Expert Consensus Diagnosis Meetings

To facilitate accurate diagnosis and decision-making around the inclusion and exclusion criteria, RefraMED instituted a weekly expert consensus diagnosis meeting facilitated by the trials' assessment core lead (HO). All recruiters and assessors, up to two clinical psychologists (one of whom was the treatment developer), a psychiatrist and the project manager attended. A secondary purpose of these meetings was to develop clinical guidelines for researchers and clinicians interested in differentiating between overcontrol and undercontrol more broadly. Assessors were trained to prioritize discussion of diagnostically ambiguous "cases" and/or questions pertaining to particular symptoms that had been identified by Lynch (2018b) as particularly relevant in the assessment of maladaptive OC, including:

- Degree that actions are dependent on possible future negative consequences as opposed to current mood;
- Extent of compulsive planning, rehearsal, and premeditation;
- Degree they display spontaneous excitement that is unrelated to achievement;
- Degree of planning and perseverance;
- Extent of social comparisons;
- Ability to tolerate distress and delay gratification;
- Degree they feel attached or desire attachment with others;
- The extent that self-injury or angry outbursts occur in public;
- The degree they link positive mood states to accomplishment and/or pride in having resisted successfully a temptation;
- Degree of moral certitude (i.e., there is a right and wrong way to do things);
- Degree they publicly display emotions and use extreme emotional language.

The discussions and decisions of these meetings were carefully recorded and subsequently used to identify key areas of diagnostic misinterpretation in individuals with refractory depression who presented with ambiguous symptoms, making it difficult for the assessor to differentiate overcontrolled from undercontrolled symptoms. Although issues relating to the other exclusion criteria of the study were also discussed during these meetings, potential borderline personality symptoms were the most common cause for discussion. This was in part due to the fact that we received referrals from clinicians who had assumed—without reading the guidance notes—that RO DBT was for borderline or emotionally unstable personality disorder, and in part due to clinicians who had read the guidance notes and suspected that some of their clients who had previously been diagnosed with BPD or emotionally unstable personality disorder might not be undercontrolled after all and may benefit from RO DBT instead. As a result, the assessors were instructed to assess for possible BPD symptoms early on during the eligibility interview to ensure ineligible patients would not have to go through the entire interview before the assessor realized they met the exclusion criterion for BPD.

Finally, BPD can be considered a prototypical undercontrolled disorder and the nine BPD criteria listed in the DSM serve as a useful template for comparing undercontrolled and overcontrolled coping styles during assessment.

Coding

All expert consensus diagnosis meeting notes that were recorded between March 2012 and March 2015 were checked for any cases in which potential borderline symptoms were discussed. Thirty-six cases were found that described the cases in sufficient detail for coding: for each of the nine BPD criteria two independent raters coded (1) whether a specific borderline criterion was discussed during the meeting and (2) whether after discussing a specific criterion, the participant was still deemed eligible for the study; in other words, although the participant—on the surface—reported behavior that met the criterion, after further inspection the participant was still deemed eligible for the study because the behavior was not considered undercontrolled. The two independent raters achieved a good interrater agreement of kappa 0.74. Below are the nine criteria used for coding the cases:

1. Frantic efforts to avoid real or imagined abandonment [Abandonment];
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation [Interpersonal Problems];
3. Identity disturbance—markedly and persistently unstable self-image or sense of self [Identity Disturbance];

4. Impulsivity in at least two areas that are potentially self-damaging [Impulsivity];
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior [Suicide/Self-harm];
6. Affective instability due to a marked reactivity of mood [Affective Instability];
7. Chronic feelings of emptiness [Chronic Emptiness];
8. Inappropriate, intense anger or difficulty controlling anger [Anger];
9. Transient, stress-related paranoid ideation or severe dissociative symptoms [Dissociation].

Results

Of the 36 cases that were coded as part of this study, 23 were eligible and 13 were ineligible for the study. Reasons for ineligibility were: PD-NOS (4); borderline (3); bipolar disorder (3); substance or alcohol abuse (2), and not taking antidepressant medication (1).

First, we counted the number of times a particular potential BPD symptom was brought to the meeting. Then, we assessed whether that discussed symptom was considered a problem for the patient and met the BPD criterion. Finally, we counted the number of cases that were eligible after endorsing a specific BPD symptom. This allowed us to assess whether certain BPD symptoms also occurred in overcontrolled patients.

Figure 1 shows a histogram of the frequency of the number of discussed symptoms per case split between eligible and ineligible participants: as can be seen, for most cases we discussed between 4 and 6 symptoms. Interestingly, some eligible participants endorsed as many as 8 or 9 symptoms yet were still deemed eligible for the study after closer inspection of their responses and behaviors.

Table 1 reports the number of cases in which a specific BPD symptom was discussed, the number of cases in which those discussed symptoms were considered undercontrolled, and the number of cases that were still eligible after endorsing specific BPD symptoms.

As can be seen in Table 1, impulsivity (72%), suicide/self-harm (81%), affective instability (69%), chronic emptiness (67%), and anger (64%) were the symptoms that most often resulted in discussion and uncertainty for assessors.

When looking at whether the participants subsequently met BPD criteria, chronic emptiness (83%), dissociation (65%), affective instability (64%) and suicide/self-harm (62%) were most common. Importantly, however, individuals who endorsed feelings of chronic emptiness (80%), identity disturbance (78%), abandonment (70%) or suicide/self-harm (67%) were still highly likely to be eligible for the study. In contrast, if clients demonstrated anger (22%) or impulsivity (33%) issues they were less likely to be considered eligible for the study (i.e. more likely to be undercontrolled).

The above findings suggest that a number of symptoms that, on the surface, appear to reflect undercontrolled tendencies (i.e., self-harm/suicidality, chronic emptiness, identity disturbance and fear of abandonment) are also problems that individuals with overcontrol report. These initial data suggest that if a client endorses these symptoms then it may be important to ask more specific details about how the symptoms are expressed, in what context, and to what degree. Table 2 gives a comparison of typical responses from individuals with problems with under- and overcontrol when they were assessed for possible BPD symptoms as part of the RefraMED study.

In summary, the findings from the RefraMED study indicate that, generally speaking, individuals who are overcontrolled have problems about which they are private. The problems are often more prominent in the past than in the present, they are usually attributable to an external source and have a potential, foreseeable end. In contrast, individuals with difficulties with undercontrol have problems that often occur in public, are chronic and currently occurring, and happen across all contexts. In the next section we will discuss some of these behaviors and additional traits within the context of clinical decision making.

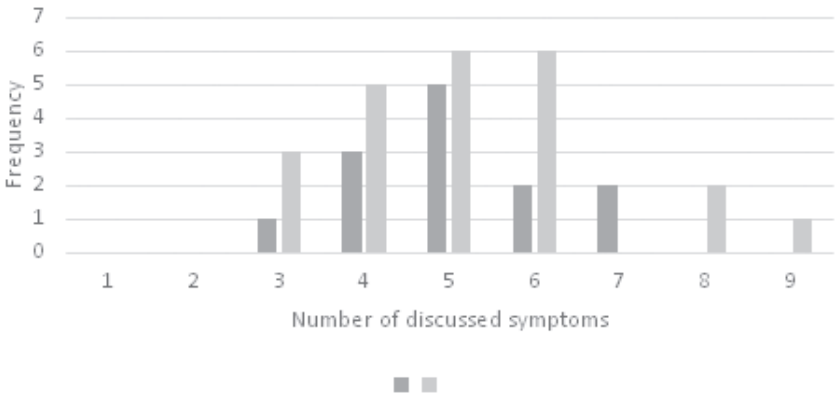

Fig. 1. Histogram of the number of endorsed symptoms per case (i.e., participant) split between eligible and ineligible participants.

How to Differentiate Overcontrol From Undercontrol Behaviors: Guidelines From Clinical Practice

Public Versus Private

The idea of public as opposed to private behavior does not appear in any diagnostic system for mental disorders, such as the DSM-5 (American Psychiatric Association, 2013), or in any personality trait–based model of psychopathology (for a review of current models, see Krueger & Markon, 2014). The word *public*, broadly speaking, refers to any behavior expressed in the presence of another person who is not in one's immediate family (or similar social analogue), whereas the word *private* refers to any behavior expressed in a setting or situation in which we believe we are unidentifiable, anonymous, or alone. But what happens in private may be very different from what happens in public. For overcontrolled individuals, dramatic displays of emotion (such as temper tantrums and yelling, also known as emotional leakage) most often occur in private rather than public settings. Overcontrolled individuals abhor public displays of emotion or behavior that may attract unwanted attention or criticism; they are highly capable of inhibiting an overt behavioral response in public, if they choose to do so. Indeed, assessors' failure to distinguish between public and private behavior with respect to the setting in which a maladaptive behavior is expressed may be one of the core reasons why overcontrol is so often misdiagnosed (Lynch, 2018b).

Self-Injury, Suicidal, and Risky Behaviors

Despite the fact that people with disorders of overcontrol appear composed and self-controlled on the outside, suicidal and self-injurious behaviors occur at disproportionately high rates in this group. These patients tend to feel isolated and alone on the inside, and social isolation and low social integration are core risk factors for suicide, over and above demographic and diagnostic covariates (Darke, Williamson, Ross, & Teesson, 2005). For example, people with anorexia nervosa—a prototypical disorder of overcontrol— have a fifty-sevenfold greater risk of death from suicide than their age-matched peers (Keel et al., 2003). Similarly, 86% of treatment-resistant depressed clients—who also have numerous overcontrolled traits—have been shown to report suicidal thoughts or plans (compared to 53% of nonchronic depressed clients), and 29% attempted suicide during their treatment phase (compared with only 3% of nonchronic clients; see Malhi, Parker, Crawford, Wilhelm, & Mitchell, 2005).

One of the key areas of differentiation between overcontrol and undercontrol is in the way self-injurious behavior is carried out. Unlike undercontrol, where self-injurious behavior is typically an impulsive act that results during periods of strong emotion and may involve others (e.g., emergency room) or may communicate messages to others, in overcontrol self-injurious behavior tends to be planned (often hours, days, or even weeks in advance and sometimes longer), done privately, and rarely requires immediate medical attention. Overcontrolled self-harming behavior is usually a well-kept secret. It may have been occurring for years without anyone knowing, or knowledge about it may be limited to immediate family members (or very close friends and therapists). Due to their overlearned habit of inhibiting, the self-harm is typically not an impulsive act. Clients with overcontrol might inflict neat cuts on places of their body that are not normally exposed to others, and they may clean and suture the wounds themselves in order to avoid hospitalization. Exceptions to hiding behavior can occur, most often among clients with a long history of psychiatric hospitalization, whereby dramatic displays of self-injury are often intermittently reinforced (for example, self-injury gets an overcontrolled client placed in a private observation room).

Table 1. Number of RefraMED Cases in Which a Specific BPD Symptom Was Discussed, If Discussed, the Number of Cases in Which the Symptom Met the BPD Criterion, and Number of Eligible Cases Despite Endorsing BPD Criterion

	Number of cases in which a specific BPD symptom was discussed (%)	Number of cases in which that specific symptom met the BPD criterion (%)	Number of eligible cases despite endorsing specific BPD symptoms (%)
Abandonment	17 (47%)	10 (59%)	7 (70%)
Interpersonal Problems	19 (53%)	7 (37%)	3 (43%)
Identity Disturbance	16 (44%)	9 (56%)	7 (78%)
Impulsivity	26 (72%)	12 (46%)	4 (33%)
Suicide/Self-Harm	29 (81%)	18 (62%)	12 (67%)
Affective Instability	25 (69%)	16 (64%)	8 (50%)
Chronic Emptiness	24 (67%)	20 (83%)	16 (80%)
Anger	23 (64%)	9 (39%)	2 (22%)
Dissociation	17 (47%)	11 (65%)	6 (55%)

Importantly, clients with overcontrol will frequently minimize thoughts of self-harm and suicide on rating scales, so it is important to do a thorough assessment of this behavior. As with other socially undesirable behaviors, "normalizing" the behavior and pointing out that it can serve functions other than wanting to kill oneself can help to elicit information about self-harm: "Often people, when they are struggling with feeling low, may end up cutting or harming themselves in some way to try and control their mood. This may not be obvious to others. Have you ever done this?"

When asking clients about any risky behavior (risky sex, cutting, suicide), it is important to ask about the pattern of these behaviors. Frequently, clients with overcontrol will describe "holding it in" or "bracing" themselves for a period of time before they can't tolerate the pain anymore and then they plan to engage in the behavior by taking time to buy the razor or set the stage for a suicide attempt rather than spiraling out of control in the moment and doing whatever works to ease the pain.

Helpful questions to determine whether the self-harm is in the context of overcontrolled or undercontrolled behavior are "Does anyone know?" and if so "Who?" and "How do they know?" Further exploration is required to identify the level of impulsivity: "If you wanted to stop, could you?" The RO DBT textbook (Lynch, 2018b) provides more detailed instructions on how to assess and intervene with suicidal and self-injurious behavior when working with overcontrolled clients.

Social Signaling Differences

Undercontrolled social signaling tends to be dramatic, disinhibited, unpredictable, and mood-dependent. The emotional expressions of undercontrolled individuals are diverse and labile, both in valence and intensity. Although in general they strive to inhibit or control extreme expressions of negative emotion (often without success), they rarely attempt to control or inhibit expressions of positive emotion. In contrast, overcontrolled social signaling tends to be understated, controlled, predictable, and generally non-mood-dependent. Overcontrolled individuals display little variability in how their emotions are expressed, either in valence or intensity. Their low reward sensitivity makes spontaneous displays of excitement or joy less likely. There are two overcontrolled signaling styles that each function to block expressing vulnerable emotions: patients either display inhibited, muted and flat expressions or they display overly prosocial, insincere, and feigned expressions.

Undercontrolled individuals are painfully aware of (and may be embarrassed or ashamed about) their inability to control their expressions of emotion. They typically lack the inhibitory capacities needed to prevent an emotional outburst from occurring when under stress or conflicting demands. In contrast, overcontrolled individuals may have secret pride in their innate capacity for superior self-control and their ability to control expressions of emotion in any situation. An overcontrolled client can appear calm and disinterested on the outside despite feeling anxious on the inside, and they are likely to down-

play their personal distress when queried ("I'm fine").

Undercontrolled individuals are generally less self-conscious than most others in public, enjoy being the center of attention, and are less likely to spend their free time preparing, planning, or rehearsing prior to an upcoming social event. Overcontrolled individuals have been intermittently reinforced to inhibit or mask emotional expressions in public or around people who are not in the immediate family. They are highly self-conscious and dislike the limelight, unless they have had time to prepare.

As a consequence, they are less likely to seek mental health treatment. Oftentimes no one outside the immediate family is aware of the individual's inner psychological distress. Thus, deficits (not excesses) in social signaling are considered the core problem and source of overcontrolled clients' emotional loneliness. One key means of improving accurate assessment of maladaptive overcontrol is for assessors to continuously ask themselves (silently) during their clinical interview: How might this client's social signaling behavior impact their social connectedness with others?

Emotional Leakage

Because individuals with overcontrol have strong beliefs about maintaining control in public, they would typically abhor the idea of behaving in an emotionally expressive way in front of people they did not know. However, like all people, individuals with overcontrol have limits on their capacity to inhibit their emotions. For individuals with problems with overcontrol the strategy to manage their emotions is by controlling them. So, when their limits are reached, often after a long period of negative emotion and strong control, they may have emotional outbursts, or emotional leakage. Although typically these outbursts will occur in private with individuals they know well, there are, however, some circumstances where individuals with overcontrol may have a public display of emotion and feel justified in doing so. Emotional leakage in public settings should be expected at least occasionally from OC individuals, especially in situations that feel anonymous (such as a political demonstration) or where strong displays of emotion are expected or socially sanctioned (such as a therapy session). These circumstances typically arise when the individual perceives that someone else has broken a rule or law that the individual

Table 2. Overview of Typical Responses From Undercontrolled and Overcontrolled Individuals When Assessing the Nine BPD Criteria

Suicidality/Self-Harm	• Public • Impulsive • Multiple (and recent) hospitalizations • Long and current history • May be proud of self-harm o *"I'm addicted to it and am an expert at self-harm"*	• Private, doesn't want others to know about it. • May plan self-harm instances • Behavior only occurs in the context of depression • Most self-harming or suicidal incidents are in the past. • Self-harm or suicidality follows long periods of overcontrol
Anger	• Explosive • Expressed outwardly • May be violent, throwing things regardless of context (public or private) • Lack of patience	• Reporting 'no anger' or 'having anger under control' • Describing it as feeling 'irritable', but will not express it • In private, angry outbursts may occur but are typically directed at family members or close friends • May involve shouting or throwing things, but only in private • Angry at themselves more than at others
Chronic Emptiness	• Chronic • No source to attribute it to o *"Something missing form inside me."* *o "Searching for something. Don't know what"* o *"Always waiting for something better"*	• Comes and goes, has a potentially discrete end • Has an attributable source (e.g. depression, medication) o *"I feel dead inside – but it's because of my depression."* o *"I feel empty, it's a side effect of my medication"*
Affective Instability	• Extreme and large mood swings • Often in relation to external events or not related to triggers • Lashing out at others, externally • Accompanied by irritability or anger demonstrated towards others	• Mood changes due to internal perfectionistic standard not being met. • Directed inwards, not displayed to others. Others don't 'register' the mood change. • If there is an outward expression of negative emotion, the negative mood has been bottled up for a long period of time and then the individual has a mood 'explosion' that appears extreme from the outside • Low chronic mood, with tendency to overestimate extent of any moments of happiness and then describe it as a significant mood swing (then mislabeled by professionals as "bipolar")

[Table 2 continued on next page]

[Table 2 continued]

Impulsivity	• Current • Extreme • Impairs Functioning • Habitual (e.g. drinking 2 liters of rum per week)	• Past (often teens/early 20s – may have history of childhood maltreatment, then settled down) • Impulsive but not extreme, not affecting functioning (e.g. spending a lot of money but can afford it, some binge eating)
Interpersonal Problems	• Problems in multiple relationship domains • Related to ambivalent/preoccupied attachment fears (e.g. fears abandonment) • Related to impulsive responses to emotional content in relationships (regrets it later) • Emotions: anger, hurt, betrayal, desperation	• Problems in one relationship domain, but not in others (i.e., with romantic relationships in the current or past, but have long term friends and colleagues) • May report having no relationships at all • Social relationships lack closeness. • Social engagement motivated by rules and obligations rather than anticipated pleasure. • Emotions: envy, bitterness, suspicion, irritation, detached
Dissociation	• Feeling separate from reality, 'spaced out' • Occurs when stressed (may occur during assessment) • May be severe and long duration (e.g. days)	• Feeling disconnected with others • When stressed 'feeling blank and hazy' • Suspicious of people, may be very paranoid
Identity Disturbance	• Not knowing who they are • No sense of self	• Self-image problems from 'putting on an act' during efforts to maintain a healthy presentation to others
Abandonment	• Frantic reactions, pleading and begging • May threaten with or result in suicide attempts • Fears abandonment	• May push people away, but most often linked to anxiety • Abandonment of the relationship is their solution to interpersonal conflict

feels a strong sense of moral certitude about. For example, people with OC might describe their indignation at cars using the feeder lanes as if queue jumping, and purposefully drive to block other drivers. This "road rage" may appear as if mood dependent until the rule behind the behavior is identified.

It is therefore important to assess the context in which strong emotional displays might occur and the social signaling aspects of the behavior by determining the magnitude of the public exposure, for example, as well as its frequency, its intensity, and the extent to which an outside observer would consider the behavior abnormal or context-inappropriate. For example, you might ask: *Did the emotional display follow a long period of control? Did it occur in public, or only in front of trusted others? Did it occur in the context of breaking a rule or law they highly valued? After the outburst occurred, what did the individual do?* The RO DBT textbook provides additional questions to assist with assessing emotional leaking (Lynch, 2018b).

Typically, individuals with overcontrol will perceive these outbursts to be unacceptable lapses of control, and will take them to be a sign that they need to work harder at controlling their behavior. Unlike individuals with undercontrol, they will not perceive them to be a "release" or a means of communication, or having any other justification. If the outburst was in public, it is critical to establish a timeline of outbursts. Individuals with overcontrol will only have rare public outbursts and these will usually be earlier in their lives, rather than later. It is not unusual to learn that in a rare instance in their late teens or twenties they had an outburst—for which they then received a diagnosis of a Cluster B personality disorder—but have never had such an outburst again. This is in marked contrast to individuals with undercontrol, whose outbursts are more frequent and public in nature.

Social Rewards

Individuals with overcontrol are likely to participate in social events out of a sense of duty or obligation rather than anticipatory pleasure. Their actions may appear to act in socially desirable ways, but their motivations for these behaviors are more likely rule-governed rather than motivated by anticipatory pleasure. Overcontrolled individuals generally do not enjoy social events and frequently report mental exhaustion when they have attended a social event that others usually find

rewarding, exciting, or invigorating. It is not uncommon for individuals with overcontrol to ask their family members to leave them alone or retire to bed after having attended a social event.

Attending unplanned parties can be overwhelming for overcontrolled individuals. One reason for this may be because social interactions are highly unpredictable: we can never know for certain how other people will respond to us. This lack of predictability together with a heightened threat sensitivity make it more likely for social interactions to be perceived as potentially hostile. Overcontrolled individuals participating in unstructured social events often feel clueless about how to behave or what to say. They much prefer social interactions involving a set agenda, clearly defined goals, or preassigned roles such as business meetings or choir rehearsals to unstructured social events such as birthday parties or team-building activities, where conversation flows freely and there are no assigned roles. This does not mean they do not attend unstructured social events, but when asked why they attended such an event, an overcontrolled individual is likely to say, "Because I thought it was the right thing to do." In contrast, and undercontrolled individual is likely to respond with, "Because I felt like going."

Thus, much of an overcontrolled individual's behavior is excessively rule-governed rather than driven by moods. This overly serious attitude toward life makes it hard to know how to celebrate with others, without feeling self-conscious—it is this pattern that is posited to be a key factor underlying the loneliness that overcontrolled individuals often experience.

Reporting Mood and Mood Changes

Despite a general desire to hide vulnerable emotions, individuals with overcontrol regularly report or display mood changes or labile moods within the therapeutic environment, in which these behaviors may be seen as socially sanctioned or expected. For example, an expression of extreme emotion during a therapy session or diagnostic assessment is considered appropriate, whereas the same behavior would be frowned upon if it were displayed in a shop.

However, the assessor should be careful not to base their diagnostic decision solely on the basis of the individual's verbal reports. It is not uncommon for individuals with overcontrol to report experiencing mood changes or overreport experiencing positive emotions. Often, after further examination, these mood changes range from a very low to a moderately low mood and not necessarily from a low to a high mood, or from a low to a normal mood. Individuals with overcontrol rarely experience highly positive mood states or joy. It is useful for the assessor to ask clients to compare their current moods to their moods during periods when they felt more "normal" or less depressed, or to their moods during periods when they felt some joy. Some clients may report they can't remember such periods; in those cases, the assessor should ask them to imagine someone they know who seems to have normal moods (in terms of both sadness and happiness) and to use this person as a comparison for how they are feeling. Thus, whenever possible, the assessor should ask the individual to demonstrate or show what his self-reported behavior actually looked like.

An overcontrolled individual's experience of positive mood states is often linked to achievement-oriented outcomes. They might have pride in being able to resist temptation, winning a competition (provided it involved effort, not fortune), or being stoical. Although they may experience positive emotion following success, they frequently blunt these positive emotional responses. Unlike undercontrolled depressed individuals who may be fearful of the "fall" after experiencing a positive emotion, individuals with overcontrol do not believe satisfaction should be gained from achievement. A helpful question may be, "How do you celebrate your successes?"

In addition, individuals with overcontrol often underreport the levels of their distress: they tend to have high capacities for distress tolerance. Distress tolerance refers to the ability to tolerate negative affect or aversive psychological or physical states (Bernstein, Trafton, Ilgen, & Zvolensky, 2008). While individuals with undercontrol exhibit poor distress tolerance, manifested by a wide range of escape or avoidance behaviors that function to minimize short-term distress yet lead to long-term negative outcomes (Brown, Lejuez, Kahler, Strong, & Zvolensky, 2005; Daughters et al., 2005; Nock & Mendes, 2008), individuals with overcontrol exhibit distress overtolerance, manifested by rigid or compulsive engagement in energy-depleting or distressing activities despite evidence suggesting that the desired goal may be unobtainable or that continued persistence may be damaging (for example, exercising despite injury, restricting food despite being underweight; see Lynch & Mizon, 2011). Distress overtolerance is linked to compulsive striving and secret pride in self-control. Because they may have a sense of pride about their ability to be uncomplaining about physical and emotional pain, they may underreport their distress and report feeling "fine" despite their internal experience of emotional distress, and they may even convey a sense of contempt towards individuals who are "emotional." The assessor needs to be alert to minimization of problems in the process of assessment. A helpful question might be: "If you are hurt physically or emotionally, what do you do to cope with this?"

Mood Dependency and Impulsivity

Individuals with overcontrol may report being impulsive during assessments. However, it is important to ask the client about the function of the behavior, whether it was mood-driven, and what the consequences of the behavior were. It is important for the assessor to realize that not all problematic behaviors are necessarily mood dependent, or that they always represent some form of escape or avoidance coping. Individuals with overcontrol are more likely to engage in excessive approach coping behaviors rather than excessive avoidance, for example by immediately fixing problems or working obsessively on completing a task even when it's clear they would be better off resting or avoiding the task altogether.

If eating or shopping binges are reported it is important to enquire about the nature of the binge as it may turn out that the binge may be planned rather than impulsive, and may be within predesignated limits (e.g., they could afford the spending spree they went on, the eating "binge" was "allowable" within the calories they had allotted for themselves).

An important point to remember in assessing an individual for overcontrol is that a great deal of overcontrolled behavior may stem from rule-governed and sensory receptor processes that are relatively emotion-free (Lynch, 2018b).

Interpersonal Relationships

Overcontrol is fundamentally a problem of emotional loneliness (Lynch, 2018b). Individuals with overcontrol may experience themselves as outsiders and are often clueless about how to join with others or form intimate relationships, although they may not immediately report this during assessments. Unlike individuals with undercontrol, those with a maladap-

tive overcontrolled coping style may report having steady relationships—but upon further examination these frequently lack depth and closeness. For example, they may be in marriages and long-term relationships but the nature of the relationship often lacks sexual, physical, and emotional intimacy. They are not necessarily alone but they are lonely.

Thus, it is important to assess the quality of the relationships the individual has with others, as well as the specific behaviors that accompany his or her aloof and distant interpersonal style. For example, clients may covertly change the topic of conversation or get others to talk to avoid having to disclose personal information, or they may display stern glances of disapproval towards someone who is doing something they dislike. Helpful questions are, "Does it take time to get to know you?" "Is it hard to impress you?" "Are you likely not to reveal your opinion immediately but wait until you get to know someone better?" "How connected do you feel to people in your life?"

Social Comparisons Leading to Envy and Bitterness

Moreover, relationships with others can be strained because individuals with overcontrol often seek to communicate their superior social status and/or unique competencies to others, and they are often secretly competitive. Since being correct, winning, and achieving matter greatly to most overcontrolled clients, they are more likely to engage in social comparisons than less performance-focused people in order to ensure that their performance is at least adequate and hopefully better than their peers. Unfortunately, the search for evidence that they are better, faster, smarter, or fitter than others can become a compulsive means of regulating negative affect and enhancing self-esteem.

In addition, individuals with overcontrol will make self-sacrifices in order to care for others or to fulfil social obligations. They may appear sociable but their behavior reflects what they perceive is the right thing to do rather than a desire to engage. They will tend not to boast but that does not necessarily mean that they do not want people to appreciate the efforts they go to and the self-sacrifices they make. If they perceive that they are unappreciated, this can lead to bitterness and feelings of envy towards others whose achievements are noticed. For example, they might be looking after an elderly parent and may be resentful that their siblings are not so dutiful. Unwilling to boast or make a fuss, they may nevertheless convey a sense of bitterness that their efforts have gone unappreciated.

These social comparisons can result in frequent experiences of unhelpful envy and desires for revenge. Unhelpful envy arises when a person compares herself disapprovingly to others and believes that others' advantages are unjust. It is an important emotion to understand because it can prompt passive-aggressive and sometimes overtly aggressive behavior. Individuals with overcontrol are more likely to hold grudges and believe that it is morally acceptable to punish a wrongdoer. It is therefore critical to assess not only how they perceive themselves to be doing in relation to their own goals, but also how they react and manage circumstances where they believe they have been "outperformed" and assess desires for revenge and urges to harm others as part of a risk assessment.

The RO DBT skills manual offers a self-assessment tool for envy and resentment using the Flexible-Mind DARES skill (Lynch, 2018a). Helpful questions during an initial assessment might be as follows: "Are you the kind of person who believes it is important to do things 'properly' or 'right'?" If so, "can this be to your personal cost?" "Do you sometimes feel you have been wronged, neglected, or passed over by this person or others?" "Do you sometimes find yourself thinking that others have an unfair advantage over you?" "Do you have a desire to punish or beat the person who wronged you, or do you desire to prove them wrong?"

Planning, Persistence, and Compulsive Rehearsal

Individuals with overcontrol tend to be rigid and rule-governed, most often manifested by compulsive needs for order and structure, strong desires to be correct, hyperperfectionism, compulsive problem fixing, maladaptive hoarding, hyperplanning, excessive rehearsal, and insistence on sameness (Lynch, 2018b). They work beyond what is needed in order to be seen as competent, for example by overrehearsing a speech. They have difficulty changing their planned course of action, even after circumstances have changed that warrant a different course of action or after having received feedback that their current way of doing things is unhelpful.

Typically, people with overcontrol have superior capacities for detail-focused processing, unlike individuals with undercontrol, who process more globally. This attention to detail can be valued in society and they may do very well in their employment as a result. For individuals with maladaptive overcontrol, the problem is that they become so committed to the task that this can be at the cost of relationships. Often these people work, or study, for long hours at the expense of social and leisure opportunities. Helpful questions may be: "How long does it take you to complete a task?" "How does this compare to colleagues doing a similar task?" "Do you consider yourself to be conscientious and meticulous?" "Is there a cost to you?"

It is also common for individuals with overcontrol to compulsively rehearse. They may be reluctant to reveal the extent of their preparations for fear that this may be perceived as a sign of weakness, bearing in mind their desire to be seen as competent and their endeavors to not make mistakes. However, in the room they might be slow in speech as they allow themselves time to consider how they will reply and select the "best" answer. They might provide examples of rehearsing routes to a new location and preparations prior to a social engagement. It is helpful to clarify vague answers given their penchant for minimizing the extent of the difficulties they face by asking, for example, "Exactly how much time did you prepare?" "How preoccupied were you?"

Early History

It is also important to look at early history, and this can be particularly helpful if the current presentation is confusing. As children, overcontrolled individuals may have been described as shy or timid. They tend to control or constrain expressions of emotion and are able to delay gratification and tolerate distress for long periods of time in order to achieve long-term goals. They tend to set high personal standards and are likely to work harder than most to prevent future problems, without making a big deal of it. Yet inwardly they often feel lonely, not part of their community or excluded from it, and feeling clueless about how to join with others or form intimate relationships, and they often feel isolated. We have also noted, anecdotally, that neglect and absence of emotional connection is often in the histories of overcontrolled clients. There is often a lack of play or fun in their childhoods and they are less likely to have received physical contact or received emotional expressions of love and care.

Patients with overcontrol often report feeling an outsider throughout their childhood and into adulthood. They often report being bullied at school and have memories of not fitting in and not understanding how to fit in. Teasing is associated with bullying so they are often awkward around playful friendly exchanges, leading them to be more serious and flat faced or disingenuously prosocial. Social interactions are an enigma to them. They will have been the shy children hanging back waiting to be asked whether they can join the game and they are more likely to have been neglected by their peers, rather than rejected. Because they follow rules, can delay gratification, and are diligent, they often describe spending inordinate amounts of time studying and being given more responsibility than other children of equal age.

Assessor Emotional Response to Overcontrolled Social Signaling

When assessing people for overcontrol, it is important to both "listen" to your own physical internal experience to track the subtle social signals that can occur in the room at a preconscious level and practice open curiosity. Tension in our own body can indicate our threat system has been activated. We need to be curious about these reactions and to use the information to inform possible hypotheses regarding how the client is socially signaling and what might make it more, not less, likely that they are ostracized from the tribe. We need to be alert to a desire to avoid asking particular questions, any urges to soothe or placate, or indeed any behaviors that are different from our normal practice.

In addition, clients can subtly shape a therapist to behave in an overcontrolled manner, even when the therapist's personal style normally leans toward undercontrol. Overcontrolled clients may have rules or expectations about how the therapist should behave. For example, they may believe that the therapist should never express vulnerable emotions or disclose personal information during sessions. If the therapist violates these expectations, clients may signal their disapproval in subtle ways, such as a slight frown, avoidance of eye contact, apparent lack of interest, an abrupt change of topic. If not recognized, these reactions can condition the therapist to avoid certain topics, to be less genuine, to be less directive, or they may reinforce the therapist to behave more cautiously around the client. Moreover, the therapist may, without conscious awareness, begin to match the overcontrolled client's constrained style of expressing emotions.

Video recording of the session can be an invaluable resource to view with the clinical consult team and identify social signals that have been missed during the assessment appointment. Social signals to look out for might be the smile dropping when the therapist looks away, frozen in movement over the course of the session, a pattern of answering but avoiding the question, providing lots of information with little revealed about how they feel, monotonic, not finishing sentences, bitter voice tone, excessive nodding, appearing overly agreeable, flat faced, poor eye contact, sighs and a pattern of using statements like "I guess so" or "maybe."

Self-Report Questionnaires Assessing Overcontrol

The RO DBT textbook (Lynch, 2018b) describes in detail how to assess and diagnose problems of overcontrol (OC) and provides several scales to help with this, including the Assessing of Styles of Coping-Word-Pair Checklist, the Clinician Rated OC Trait Rating Scale and the Clinician Rated OC Prototype Rating Scale. In addition, clinicians are encouraged to augment assessments with other scales that are linked to core OC issues; such as the Acceptance and Action Questionnaire-II (Bond et al., 2011) that measures psychological inflexibility, the Personal Need for Structure Scale (Neuberg & Newsom, 1993), the Social Connectedness Scale-revised (Lee, Draper, & Lee, 2001), or the Distress Overtolerance Scale (Gorey, Rojas, & Bornovalova, 2016). Further OC scale development is ongoing, including the development of brief self-report measures and a scale to measure mechanisms of change following RO DBT.

Conclusion

Clients with a maladaptive overcontrolled coping style are complex. As shown in the first part of this paper, individuals with overcontrol, when asked during an assessment, regularly endorse symptoms that may seem more typical for individuals with undercontrolled disorders such as BPD, including impulsivity, suicidality and self-harm, affective instability, chronic emptiness, and anger. An unaware assessor may mistakenly conclude that a patient endorsing these symptoms meets criteria for BPD. However, on closer inspection, symptoms such as suicide and self-harm, chronic emptiness, identity disturbance, and abandonment were also endorsed by individuals with overcontrol, although the way in which the behaviors are expressed and the reasons behind them differ. Thus, it is important to understand these differences and to ask additional questions when assessing clients for undercontrol or overcontrol.

While undercontrolled behavior stands out and is more easily recognized by assessors, overcontrolled behavior is often much more subtle. This paper has aimed to provide the reader with a better understanding of how to differentiate undercontrolled from overcontrolled behavior and what kinds of questions to ask during the assessment.

In conclusion, assessors should look for the behavioral characteristics in context and across time, rather than a moment in time, and aim to understand the degrees of planning, control and concealment as opposed to openness and flexibility that are present. Identifying the reason behind the behavior can afford a very important distinction between overcontrolled and undercontrolled clients. Being able to more effectively differentiate overcontrolled from undercontrolled individuals is crucial for assigning clients to the type of treatment that meets their needs: undercontrolled individuals need interventions that enhance inhibitory control and reduce mood-dependent behavior while overcontrolled individuals need interventions that enhance flexibility, openness, and social connectedness.

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Radically Open Dialectical Behavior Therapy: Shared Features and Differences With ACT, DBT, and CFT

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ALTHOUGH COGNITIVE BEHAVIORAL THERAPY (CBT) is commonly discussed as if it were a single, unified treatment, it is better thought of as a broad family of psychotherapies (Herbert & Forman, 2013) that tend to share common elements, such as an active and collaborative therapeutic relationship, an emphasis on learning as central to the development and maintenance of problems, the use of traditional behavioral strategies, an emphasis on scientific empiricism, and the importance of cognition in maintaining problems. However, cognitive and behavioral therapies also vary. Their conceptualizations of the etiology of problems differ as do the strategies they emphasize, the outcomes they desire, the hypothesized mechanisms of action, and the theoretical guidance specifying when and how treatment methods are implemented. For example, both Cognitive Therapy (Beck, 1979) and Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 2012) are considered forms of CBT, even though their approaches to problematic cognition are vastly different, one emphasizing cognitive change and the other acceptance (Wilson, Bordieri, Flynn, Lucas, & Slater, 2010).

As new forms of CBT emerge it is important for scientists and clinicians to accurately discriminate their central features, especially when distinctions may, at times, be fine-grained. Such discriminations afford greater precision in the clinical application of these treatments and the testing of specific predictions that can be contrasted in studies of underlying mechanisms of action, as opposed to focusing solely on comparisons involving treatment outcomes. Accordingly, the primary aim of this paper is to facilitate this discriminative process by comparing and contrasting key features found in Radically Open Dialectical Behavior Therapy (RO DBT) with those found in several other newer forms of CBT. More specifically, RO DBT's core features are compared to Dialectical Behavior Therapy (DBT; Linehan, 1993), Acceptance and Commitment Therapy (ACT; Hayes et al., 2012), and Compassion-Focused Therapy (CFT; Gilbert, 2010). These therapies were selected for comparison because they share important elements with RO DBT and thus provide a useful vehicle for describing distinctive elements. First, we briefly describe RO DBT and some of its unique features that differentiate it from other treatments. Second, we provide a brief overview of each of the selected comparison treatments—that is, DBT, ACT, and CFT. Third, we offer an analysis of the similarities and differences between the treatments, ending with an integrative discussion.

Overviews of the Treatments

RO DBT

RO DBT targets disorders characterized by overcontrol (OC; i.e., excessive self-control) and is strongly informed by translational research on the facilitative and communicative functions of emotions in facilitating close social bonds (Lynch, Hempel, & Dunkley, 2015). According to RO DBT theory, biotemperamental differences transact with social context to lead OC individuals to exhibit risk aversion, a strong need for structure, perfectionism, cognitive rigidity, high detail orientation, and a tendency to mask inner feelings. These vulnerabilities interfere with the formation of close social bonds, resulting in social isolation, loneliness, and associated psychological distress (Lynch, 2018). RO DBT focuses on changing social signaling deficits in OC individuals, resulting in more context-appropriate emotional expression. This, in turn, leads to a change in others' response to the OC individual, including increased trust in and desire to

affiliate with the person, which thereby increases social connectedness for the OC individual. RO DBT aims to enhance a person's capacity for "radical openness," which involves the confluence of three capacities: openness, flexibility, and social connectedness (Lynch et al., 2015). It involves a willingness to surrender prior conceptions about oneself and how the world "should" be and is thought to strengthen relationships by modeling humility and the willingness to learn from others and the world. The treatment is typically delivered over 30 sessions of concurrent individual therapy and skills training classes. The most established outcomes are for chronic, treatment-resistant depression and anorexia (Lynch, 2018; see also Codd & Craighead, 2018, this issue).

In contrast to other treatments, RO DBT uniquely targets social signaling deficits and low openness as core factors underlying OC emotional loneliness. Indeed, the vast majority of interventions in RO DBT are designed to enhance prosocial signaling and openness—with radical openness representing the core skill. As a species, we instinctively recognize the value openness brings to relationships. For example, we tend to trust open-minded people because they are more likely to reveal than hide their inner feelings during conflict. We desire to affiliate with open-minded people because they are humble—they are more likely to give others the benefit of the doubt during interactions and don't automatically assume that their way is the best, right, or only way. Thus, radically open living not only influences how *we see the world* (e.g., we are more receptive to critical feedback) but it also influences how others see us (people like people who are open-minded).

Essentially, openness is a powerful social safety signal. It helps ensure that cooperative intentions are perceived as intended, especially during times of potential conflict. Consequently, RO DBT considers openness a type of tribal glue. It evolved in our species as a core means for establishing strong collaborative relationships with genetically dissimilar individuals, and it represents the cornerstone of all new learning. In RO DBT, feeling safe, contented, or relaxed is not in itself a necessary precursor of psychological health—but belonging to a tribe may be. Thus, radically open living is learning how to create a life worth sharing (with others), based on the premise that our personal happiness is highly dependent on other people and the extent to which we feel part of a tribe. According to RO DBT, when we feel connected, we naturally feel less agitated, less anxious, less depressed, and less hostile. Importantly, radical openness does not mean approval, naively believing, or mindlessly acquiescing. Sometimes being closed is what is needed in the moment, and sometimes change is unnecessary.

Core treatment assumptions. Many of the core assumptions in RO DBT differ from other approaches. For example, in contrast to many therapies, RO DBT considers it essential for individual therapists to introduce certain strategies at precise times during treatment. These sequencing strategies in RO DBT are designed to address OC biotemperamental biases that may interfere with learning and make premature treatment dropout more likely. Sequencing also provides a framework for predicting when certain key issues are most likely to occur when working with OC individuals—e.g., a strong working alliance is not expected until the 14th session. That said, treatment assumptions are not truths. They help guide behavior, but if they're held too tightly, they can interfere with new learning. Other RO DBT core assumptions include the following:

1. Deficits in prosocial signaling are the core problem in disorders of overcontrol and are posited to be the source of OC clients' loneliness.
2. Radical openness assumes that we don't see things as they are but rather as we are.
3. One secret of healthy living is the cultivation of healthy self-doubt. Radically open living means being able to question oneself in order to learn without falling apart.
4. RO DBT therapists practice radical openness and self-enquiry themselves, since RO is not something that can be grasped solely via intellectual means.
5. RO DBT therapists recognize that the lives of their OC clients are often miserable, even though their clients' suffering isn't always evident.
6. RO DBT therapists recognize that OC clients take life very seriously and that they need to learn how to chill out, laugh at their own foibles, and play.

DBT

DBT (Linehan, 1993) was initially designed as a treatment for chronically suicidal patients, many of whom were diagnosed with borderline personality disorder (BPD). Since then, DBT has been reformulated and conceptualized as a treatment for multidiagnostic treatment-resistant populations. DBT draws its principles from behavioral science, dialectical philosophy, and Zen practice. The therapy dialectically balances acceptance and change, with the overall goal of helping patients not only to survive, but also to build a life worth living. Comprehensive DBT consists of weekly individual therapy sessions, weekly skills training group sessions, and telephone coaching for the client, as well as consultation team meetings for clinicians. The skills training groups teach clients distress tolerance skills, emotion regulation skills, mindfulness skills, and interpersonal effectiveness skills—with mindfulness considered the core skill. The delivery of DBT is organized by an overall dialectical framework—of which the dialectic between acceptance and change is a core and guiding element—and by a clear set of treatment targets, which are organized hierarchically (life-threatening behaviors, therapy-interfering behaviors, quality-of-life behaviors, and skills acquisition). For example, an organizing assumption dialectically considers clients to radically be doing the best that they can while at the same time recognizing that they need to do better and behave more effectively.

Across studies DBT has resulted in reductions in several problems associated with BPD, including self-injurious behavior, suicide attempts, suicidal ideation, and bulimic behavior (Dimidjian et al., 2016; Lynch, Trost, Salsman, & Linehan, 2007). For example, a recent meta-analysis examining outcomes from RCTs for adults diagnosed with BPD concluded that DBT was significantly better than TAU at reducing suicide attempts and some evidence of significant improvement in parasuicidal behavior compared to control conditions (Panos, Jackson, Hasan, & Panos, 2013).

ACT

ACT (Hayes et al., 2012) is a psychotherapy based on modern behavioral and evolutionary principles, including Relational Frame Theory, a novel theory of language and cognition (Luoma, Hayes, & Walser, 2017). According to ACT, language processes lead us to attempt to escape or avoid our feelings, become entangled in our thoughts, lose flexible contact with the present, and get caught up in defending and believing our stories about ourselves, the world, and others. As a result, people get disconnected from what

really matters to them (i.e., their values) and effective action is impeded. In response, ACT attempts to foster psychological flexibility, which is defined as the ability to contact the present moment more fully as a conscious human being and, based on what the situation affords, to change or persist in behavior in order to serve valued ends (Hayes et al.). ACT targets six flexibility processes to develop psychological flexibility: (1) willingness or acceptance of experience; (2) cognitive defusion, in which thinking can be seen as an active, ongoing, relational process that is historical in nature and present in the current moment; (3) flexible attention to the present moment; (4) contact with a transcendent or perspective-taking sense of self (self-as-context); (5) clarity and articulation of values; and (6) effective action aimed at building larger patterns of values-based living. ACT has empirical support from over 200 randomized trials across a wide variety of psychological problems and in nonclinical contexts such as workplace stress, prevention and health maintenance (Hayes, 2018). In addition, ACT has empirical support for its processes of change from mediational analyses, component analyses, and studies of processes of change (e.g., Levin et al., 2012).

CFT

CFT (Gilbert, 2010) is an integrative and multimodal approach that draws from evolutionary psychology, neuroscience, and social psychology, particularly research on the psychology and neurophysiology of caring (Gilbert, 2010). CFT originally emerged out of attempts to address the difficulties of people who experience high levels of shame and self-criticism and those with complex mental health difficulties (Gilbert, 2010, 2012), but since appears to have extended beyond this focus to address a broad range of client problems (Leaviss & Uttley, 2015). Compassion in CFT is operationalized as involving various attributes such as care for well-being, sensitivity to and being moved by suffering, sympathy, empathy, distress tolerance, and nonjudgment (Gilbert, 2009). A key focus of CFT involves compassionate mind training to help clients cultivate compassionate social mentalities that help them relate compassionately to themselves, others, and challenging situations and emotions (Gilbert, 2014). Social mentalities are defined by Gilbert (2000) as internal systems that organize the individual's physiology, emotions, thinking, and behavior around specific social motives (for example, competitive or caregiving motives) that shape how the individual relates both to others and to themselves. CFT emphasizes the cultivation of a "compassionate self" that is used to help the individual work with inner blocks to extending compassion and warmth to both themselves and others in addition to blocks with receiving compassion from others. In addition, a compassionate self is capable of being sensitive to suffering in the self and others and motivated to engage in the behaviors needed to alleviate and prevent suffering, as well as acquire the wisdom to know how to do this effectively. CFT has preliminary evidence from open trials including people suffering from self-criticism, personality disorders, schizophrenia, bipolar disorder, and eating disorders, among other difficulties. At least three randomized trials have been published, focused on schizophrenia-spectrum disorders, smokers, and a nonclinical sample (Leaviss & Uttley, 2015).

Comparisons Between RO DBT, DBT, ACT, and CFT

In this section we outline how RO DBT differs from other treatments—specifically DBT, ACT, and CFT. These four treatments are complex and many fine-grained distinctions exist between them. Toward this end we examine their differences with respect to the core problem targeted, the primary populations intended for, their model of emotional health or well-being, their theorized mechanisms of change, their differing approaches to mindfulness, the therapeutic relationship, and how they differentially conceptualize kindness and compassion. In choosing these particular areas for comparison, we do not imply that these are the only ones or even necessarily the most relevant ones.

Core Problem

RO DBT. The core problem that RO DBT aims to address is emotional loneliness resulting primarily from low openness and social-signaling deficits. According to this theory, overcontrolled individuals tend to perceive new or unfamiliar situations as dangerous, rather than rewarding, due to biotemperamental differences and social/historical learning experiences. Their tendency to mask inner feelings makes it less likely that they can form close social bonds with others, and as a result, they suffer from social isolation, loneliness, and associated psychological distress (Lynch, 2018). Many of the resulting problems seen in overcontrolled individuals (e.g., food restriction in anorexia, perfectionism and cognitive rigidity in OCPD, social disengagement in chronic depression) are viewed as attempts to cope with this more fundamental problem of social disconnection.

DBT, ACT, and CFT. DBT sees the core problem to be emotionally dysregulated, impulsive, and mood-dependent responding secondary to low inhibitory control, poor distress tolerance, and heightened emotional reactivity. The core problem of ACT is psychological inflexibility. This can be further broken down into six inflexibility processes, namely: dominance of the conceptualized past and future/limited self-knowledge, cognitive fusion, experiential avoidance, attachment to a conceptualized self, lack of values clarity/contact, and ineffective action (Hayes et al., 2012). CFT holds that evolution has led to humans having brains that increase the potential for emotional problems through a range of mechanisms. Client problems are conceptualized as resulting from life experiences that shaped drive/achievement, threat, and soothing/safeness systems, which result in safety strategies to manage threat that are integrated into a person's sense of self. These safety strategies have unintended consequences that maintain and worsen the person's problems (Gilbert, 2012).

Target Populations

RO DBT. RO DBT is designed for clients who are characterized by problems related to emotional overcontrol, such as chronic depression, anorexia nervosa, obsessive-compulsive personality disorder, avoidant personality disorder, and autism spectrum disorders (Lynch, 2018). RO DBT posits that "one size does not fit all," but rather that there are core genotypic/phenotypic differences between individuals that may necessitate vastly different treatment approaches.

DBT, ACT, and CFT. Similar to RO DBT, DBT was developed to target a specific population of individuals, those exhibiting excessive behavioral dyscontrol, typically Cluster B, "dramatic/erratic," personality styles, mainly borderline and antisocial personality disorders and other similar disorders characterized by poor self-control (e.g., bulimia, bipolar disorder). ACT targets the transdiagnostic process of psychological inflexibility. As such, its application is very broad (Hayes et al., 2012). Similar to ACT, the target populations for CFT are conceptualized to be broad. CFT has been applied to many dif-

ferent disorders and suggests that shame, self-criticism, and lack of affiliative feelings and responses are important targets of intervention across many different disorders (Gilbert, 2014).

Model of Healthy Functioning

RO DBT. RO DBT posits psychological health or well-being to involve three transacting elements: (a) receptivity and openness to new experience and disconfirming feedback in order to learn, (b) flexible control, in order to adapt to changing environmental contingencies, and (c) intimacy and connection with at least one other person (Lynch, 2018).

DBT, ACT, and CFT. DBT does not explicitly define healthy functioning per se—but implies it via four levels of disorder (severe behavioral dyscontrol, quiet desperation, problems in living, and incompleteness). The fourth level, incompleteness, is posited to involve "existential" concerns, emptiness, and loneliness/nonattachment rectified by the capacity for sustained joy, expanded awareness, peak experiences, and spiritual fulfillment (Linehan, 1993). ACT considers psychological flexibility to be its model of healthy functioning, which is defined as the ability to contact the present moment more fully as a conscious human being and, based on what the situation affords, to change or persist in behavior in order to serve valued ends (Hayes et al., 2012). While both ACT and RO DBT focus on flexibility and ability to learn from ongoing experiences as a core aspect of mental health, RO DBT differs from ACT in that it also includes social connectedness as an additional key aspect. CFT's model of healthy functioning focuses on the development of a compassionate self, characterized by kind/caring motivation, courage, and wisdom and the development of the compassionate attributes and skills described above.

Primary Mechanisms of Action/ Processes of Change

RO DBT. In contrast to other approaches, RO DBT uniquely prioritizes social signaling deficits as the core problem underlying OC emotional loneliness—and social signaling skills as the core means of targeting maladaptive social-signaling—based on the premise that our species' survival and individual well-being is highly dependent on being able to form close social bonds, share resources, and work together with genetically unrelated individuals. To accomplish this, our species is posited to have developed a highly sophisticated social signaling system that allowed us to communicate intentions and feelings (e.g., an angry glare linked to a desire to attack) without having to fully express the actual propensity itself (e.g., hitting someone). Plus, revealing intentions and emotions to other members of our species was essential to create the type of strong social bonds that are the cornerstone of human tribes.

RO DBT proposes a unique neurobiological theory to explain these species-specific advantages involving transactions between social signaling, micromimicry, proprioceptive feedback, and the mirror neuron system (Lynch, 2018; Schneider, Hempel, & Lynch, 2013). Robust research shows that humans reciprocally mimic the facial expressions exhibited by an interacting partner, and facial micromimicry functions to trigger similar emotional experiences in the receiver (Hess & Blairy, 2001; Moody, McIntosh, Mann, & Weisser, 2007; Vrana & Gross, 2004). Neuroimaging studies examining the mirror neuron system have shown that viewing facial expressions automatically activates brain regions that are involved in the production of similar expressions (Montgomery & Haxby, 2008; van der Gaag, Minderaa, & Keysers, 2007).

Consequently, according to RO DBT, emotions evolved in humans not only to *motivate* actions (for example, the fight-or-flight response) and *communicate* intentions (via facial expressions, for instance) but also to *facilitate* close social bonds and altruistic behavior among genetically dissimilar individuals through micromimicry, mirror neurons, and proprioceptive feedback. This process is posited to have provided our species with a huge evolutionary advantage and to be a core element in the development of empathy and altruism. Micromimicry and mirror neurons allowed us to be able to viscerally experience another person, becoming more likely to treat other people as we would like to be treated ourselves (for example, we may be willing to risk serious injury or even death to save someone we hardly know).

Thus, the central mechanism in RO DBT can be distilled down to the following process: context-appropriate and open expression of emotion results in increased trust from others and desires to affiliate with the client, thereby leading to enhanced social connectedness. This is seen as particularly important when it comes to treating problems characterized by emotional loneliness—such as overcontrol (Lynch, 2018).

DBT, ACT, and CFT. Within the DBT theoretical framework, people with BPD are self-destructive because they lack self-regulation (including emotional regulation), interpersonal effectiveness, and distress tolerance skills (Dimeff & Linehan, 2001). On the basis of Linehan's biosocial theory for BPD, many of these mechanisms can be further distilled down to the following process: *the reduction of ineffective action tendencies linked with dysregulated emotions* (Chapman & Linehan, 2005; Lynch et al., 2006) The core process of change in ACT is the development of psychological flexibility, which can be further broken down into the six flexibility processes already reviewed above. CFT attempts to cultivate compassion as a specific embodied process. Compassion cultivation most centrally involves the concepts of differentiation, integration, flexibility, and transformation. Differentiation refers to the ability to have a clear understanding and working knowledge about specific processes, be they thoughts, emotions, or motives. Integration refers to the ability to hold various processes in mind and engage them in a coordinated way. Psychological flexibility, according to CFT, is defined as our ability to contact the present moment fully, optimally configuring our mental resources, flexibly shifting our perspective, and balancing competing desires and needs in various life domains. Transformation refers to changing the fundamental organization or pattern of our minds and behaviors, including self-organization (Tirch, Silberstein, & Gilbert, 2017).

Mindfulness

RO DBT. Although RO DBT includes a number of core principles found in mindfulness-based treatments, it can be distinguished from other approaches to mindfulness via its emphasis on radical openness and self-enquiry practices that are informed by a spiritual tradition known as Malâmati Sufism. The name Malâmati comes from the Arabic word *malamah*, meaning "blame" and referring to the Malâmati practice of sustained self-observation and healthy self-criticism in order to understand one's true motivations (Toussulis, 2011). The Malâmatis are not interested so much in the acceptance of reality or in seeing "what is" without illusion; rather, they look to find fault within themselves and question their self-centered desires for power, recognition, or self-

aggrandizement. Thus, mindfulness practices in RO DBT emphasize radical openness and self-enquiry.

Radical openness is more than awareness or simply engaging in new behavior; at its most extreme, it involves actively seeking the things one wants to avoid or may find uncomfortable in order to learn. Rather than prioritizing mindfulness practices designed to cultivate equanimity, nonreactivity, or attentional control—RO DBT considers it essential when working with OC clients to prioritize mindfulness practices involving participation without planning, self-enquiry, and outing oneself. Self-enquiry is a type of mindfulness practice wherein the practitioner purposefully and mindfully turns their attention inward, asking questions with the aim of fostering learning. A self-enquiry practice in RO DBT involves repeatedly redirecting attention back to a nonneutral object (e.g., thoughts, feelings, images, sensations associated with something you want to avoid, are embarrassed about, and/or don't want to think about) in order to learn (referred to as "finding one's edge"). Self-enquiry is particularly useful whenever we find ourselves strongly rejecting, defending against, or agreeing with feedback that we find challenging or unexpected. It begins by asking: "Is there something here for me to learn?" Participating without planning, mindfulness practices in RO DBT are designed to help loosen the evolutionarily hardwired grip of self-conscious checking and concerns about tribal status. Outing-oneself practices in RO DBT involve some form of personal self-disclosure to a fellow practitioner, based on a Malâmatis principle emphasizing spiritual dialogue and companionship (in Arabic, *sohbet*; Toussulis, 2011) and beliefs that one cannot achieve heightened self-awareness in isolation. Outing one's personality quirks or weaknesses to another person goes opposite to OC tendencies to mask inner feelings.

DBT, ACT, and CFT. The mindfulness component in standard DBT was derived from Christian contemplative practices and Zen practice, with a goal of being awake to present reality. DBT encourages cultivation of Wise Mind responses that focus on reducing mood-dependent impulsive responding and increasing abilities to delay immediate gratification in order to pursue distal goals. ACT considers mindfulness to be a core treatment component and considers it an aspect of the four mindfulness and acceptance processes—acceptance, defusion, flexible contact with the present, and contact with a transcendent and flexible sense of self. In ACT, no particular mindfulness practices are required and mindfulness practices are not derived from any particular spiritual tradition. Mindfulness in CFT is rooted in Buddhist thinking and is a central component of a range of formal compassion cultivation techniques involving breathing, posture, facial expressions, voice tones, acting, compassionate imagery, recall of previous experiences involving compassion, and compassionate actions to stimulate affiliative emotions, motives, and competencies connected to the experience of having a compassionate self with a central focus to be able to feel, express, and receive affiliative emotions (Gilbert, 2010, 2012, 2014).

Therapeutic Relationship

RO DBT. RO DBT considers the development of a strong working alliance during individual therapy an essential component of the treatment. What differentiates RO DBT from other psychotherapeutic approaches are the specific factors hypothesized to lead to the development of empathy and the nonverbal social-signaling strategies therapists use in-session to enhance it. These nonverbal strategies often differ vastly from how therapists have been trained in other therapies.

The primary aim in RO DBT is to help OC clients learn how to rejoin their tribe and establish strong social bonds with others. Consequently, this is reflected in the role of the therapist, who is likened to a tribal ambassador who metaphorically encourages socially isolated OC clients to rejoin their tribe by communicating, "Welcome home. We appreciate your desire to meet or exceed expectations and the self-sacrifices you have made. You have worked hard and deserve a rest" (Lynch, 2018, p. 161). As ambassador, an RO DBT therapist adopts a stance that models kindness, cooperation, and playfulness rather than fixing, correcting, restricting, or improving. Yet ambassadors also recognize that sometimes kindness means telling good friends painful truths in order to help them achieve their valued goals, and they tell these painful truths in a manner that acknowledges their own potential for fallibility.

Plus, ambassadors speak to people from another country as if they were good friends. When among friends we feel naturally less self-conscious; we relax and drop our guard. In the context of therapy, dropping one's guard means dropping one's professional role (at least to some extent). When we are with our friends we are likely to stretch out, lie back, and lounge around; our body gestures and facial expressions are more expansive and our use of language is less formal. By adopting a manner most often reserved for close friends or family, RO DBT therapists signal to OC clients that we consider them to be part of our tribe (recall that OC is a disorder characterized by loneliness).

This style of therapeutic alliance in RO DBT is also reflected in how RO DBT challenges maladaptive behavior. Therapists are taught to emphasize "asking, not telling" when confronting a client, which parallels the kind of open curiosity, playfulness, teasing, and humility often observed during interactions among good friends—manifested by the core dialectic in RO DBT known as "playful irreverence versus compassionate gravity." Compassionate gravity represents the dialectical opposite of the stance of playful irreverence. Rather than aiming to challenge, compassionate gravity seeks to understand and signal sobriety (that is, it signals that the therapist is taking the client's concerns or reported experience seriously). The "playful irreverent" part of this dialectic is the therapeutic cousin of a good tease between friends.

Research shows that teasing and joking are how friends informally point out flaws in each other, without being too heavy-handed about it (Keltner, Capps, Kring, Young, & Heerey, 2001; Keltner, Young, & Buswell, 1997). Learning how to tease and be teased is an important part of healthy social relationships, and kindhearted teasing is how tribes, families, and friends give feedback to each other. Plus, a good tease is kind. Most often it starts out with an unexpected, provocative comment that is delivered with an unsympathetic (expressionless or arrogant) voice tone and/or an intimidating facial expression (such as a blank stare), gesture (such as finger wagging), or body posture (such as hands on hips) that is immediately followed by laughter, gaze aversion, and/or postural shrinkage. Thus, a kindhearted tease momentarily introduces conflict and social distance but quickly reestablishes social connectedness by signaling nondominant friendliness. The nondominance signal is critical for a tease to be taken lightly (that is, as a friendly poke; see Keltner et al., 1997).

Therapeutic teasing in RO DBT is considered an essential skill for therapists to learn when working with OC clients. Not only do OC clients take themselves very

seriously, they also subtly reinforce everyone around them to behave seriously as well. Essentially, a therapist who adopts a playful, irreverent style is challenging the client with humility, in a manner that is reserved for our most intimate relationships. Thus, therapeutic teasing functions to playfully provide corrective feedback while simultaneously sending a strong, powerful message of social safety.

RO DBT also differs from other approaches by positing that OC biotemperamental predispositions combined with an avoidant/dismissive attachment style and overlearned tendencies to mask inner feelings and avoid conflict make the development of a genuinely intimate therapeutic relationship extremely difficult when working with OC clients. This difficulty is expected, regardless of how competent a therapist may be at delivering the treatment, validating clients, or behaving in a genuine manner. RO DBT does not consider treatment compliance, declarations of commitment, or lack of conflict as indicators of a strong therapeutic relationship. Indeed, alliance ruptures (those that are repaired) are considered working proof of a solid therapeutic relationship in RO DBT. Alliance ruptures provide the practice ground for learning that conflict can be intimacy-enhancing and that expressing inner feelings, including those involving conflict or disagreement, is part of a normal healthy relationship. Thus, RO DBT is skeptical about the ease by which a solid therapeutic relationship can be developed when working with OC clients and considers a therapeutic relationship relatively superficial if by the 14th session a therapist-client dyad has not had several alliance ruptures and successful repairs. Specific strategies are outlined in the RO DBT treatment framework for how to repair alliance ruptures (Lynch, 2018).

DBT, ACT, and CFT. Standard DBT also values the development of a strong therapeutic relationship. A strong therapeutic alliance in standard DBT is posited to involve validation, warm engagement, self-disclosure, and genuineness balanced by problem solving and change strategies. Similarly, ACT maintains that a strong therapeutic alliance is important for successful treatment. However, less emphasis is generally placed on the alliance and alliance ruptures are not considered a primary mechanism of change. Instead, the interpersonal behavior of the client is understood in terms of whether it exhibits psychological flexibility or inflexibility and the relationship as an opportunity to develop greater psychological flexibility in interpersonal spheres and in relation to interpersonal values. CFT also sees the development of a strong alliance as important and encourages therapists to model compassion and work to facilitate relational safeness. In CFT, a major focus of the therapeutic relationship is de-shaming and de-pathologizing (Gilbert, 2014). In CFT, alliance ruptures are thought to inform the therapist of potentially important client relational patterns (e.g., fears, safety strategies, and forms of self-to-self/self-to-other relating). Repairs are considered an opportunity to help the client learn to work compassionately in relational context (Kolts, 2016).

Kindness Versus Compassion

RO DBT differs from other approaches via its emphasis on kindness. Lynch (2018) argues that kindness may be our species' ultimate survival weapon because it allowed us to prioritize *survival of the tribe* over older "selfish" tendencies linked to *survival of the individual* (for example, the stranger who dives without forethought into an icy river to save a drowning child, the soldier who throws himself over a grenade to protect his unit, the whistleblower who risks all to expose an injustice).

RO DBT defines kindness as "the willingness to make self-sacrifices for another person without always expecting something in return" (Lynch, 2018, p. 231). Moreover, RO DBT differentiates kindness from compassion. Broadly speaking, compassion is a response to suffering: "It has but one direction, which is to heal suffering" (Feldman & Kuyken, 2011, p. 152). Compassion involves a feeling state of sympathetic understanding that can be directed either outward (for example, empathy regarding another person's suffering) or inward (self-compassion). Interestingly, kindness entails affection or love, whereas compassion entails empathy, mercy, and sympathy; for example, judges reduce punishments because they feel merciful toward the accused, not affectionate. Thus, compassion emerges as a response to pain, whereas kindness can occur independent of pain. Kindness does not require the other person to be suffering for it to emerge; that is, we can be kind to happy people, not just to those who are suffering. Plus, although kindness is always caring, it is not always nice (sometimes the kindest thing a person can do is say no to someone), Thus, kindness is emphasized in RO DBT because it is considered a broader prosocial signal than compassion and more closely linked to development of close connections with others.

DBT, ACT, and CFT. Standard DBT does not explicitly address issues of kindness or compassion—focusing instead on related constructs, such as nonjudgmental thinking. ACT encourages therapists to be kind and compassionate to clients and to teach clients to be kind and compassionate to themselves. However, kindness and compassion are not specifically defined or central theoretical concepts. Instead, ACT focuses on the six flexibility processes, with kindness and compassion thought to be implicitly a part of those six processes. In contrast, CFT explicitly highlights the importance of compassion and compassionate living, which is defined as "a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (Gilbert, 2014; p. 19). CFT fosters kindness as well, sometimes including methods such as lovingkindness meditation, but kindness has a less central role in CFT than it does in RO DBT.

Conclusion

In 2011, Hayes and colleagues offered an update on the definition of what constitutes "third wave" behavioral therapies by proposing that they can be differentiated by their shared value on the importance of being "open, active, and aware" (Hayes, Villatte, Levin, & Hildebrandt, 2011; see also, Dimidjian et al., 2016). RO DBT expands this definition via its emphasis on social signaling and social connectedness in emotional health—positing that individual well-being is inseparable from the feelings and responses of the larger group or community (Lynch, 2018). What is important from an RO DBT perspective is not solely based on how we relate to our own thoughts and feelings but how we relate to others—that is, communicate or socially signal our needs, wants, and desires to others—based on the premise that our species is fundamentally tribal in nature. Thus, when it comes to long-term mental health and well-being, what a person feels inside or thinks privately is considered less important in RO DBT, whereas what matters most is how a person communicates or social signals inner or private experience to other members of the tribe and the impact that social signaling has on social connectedness.

Our primary aim in this paper was to compare three "third wave" treatments to RO DBT in order to encourage both greater precision in the clinical application of these treatments and new research pertaining to mechanisms of action. All three treatments share many overlapping features—many of which, due to space limitations, have not been fully explained or accounted for in the current article. Yet, despite their similarities, their differences may be more important to account for if one assumes that therapeutic techniques and/or relationship factors actually matter when it comes to successful treatment.

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Radically Open Dialectical Behavior Therapy for Anorexia Nervosa: Connection, Openness, and Flexibility at the Heart of Recovery

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ANOREXIA NERVOSA is one of the most life-threatening mental disorders (American Psychiatric Association, 2013; Berkman, Lohr, & Bulik, 2007). Clinical, academic, and scientific communities continue to struggle with determining the most effective course of treatment for adults with anorexia. While adolescent anorexia does have empirical support for Family-Based Treatment (Lock & Le Grange, 2015), and full recovery is expected, adult anorexics have proven more difficult to treat. Anorexia nervosa in adults frequently becomes chronic in nature, and often presents with high rates of comorbidities, such as depression, anxiety, and personality disorders like obsessive-compulsive personality disorder. To date, treatment for adults has been multidisciplinary, typically focused on weight restoration and skills acquisition (CBT, DBT, ACT, and ERP; Fairburn, 2008; Linehan & Chen, 2005; Sandoz, Wilson, & Dufrene, 2010; Steinglass et al., 2011); however, at present, no specific treatment for adult anorexia nervosa has proven to be superior (Watson & Bulik, 2013).

The primary aim of this paper is to provide an overview of how Radically Open Dialectical Behavior Therapy (RO DBT; Lynch, 2018a, 2018b), a new transdiagnostic treatment for disorders of overcontrol (OC), offers a novel means for understanding and treating anorexia nervosa (AN). The paper begins with a brief overview of the preliminary clinical evidence supporting the use of RO DBT for the treatment of AN and how RO DBT reconceptualizes AN as fundamentally a problem of overcontrol. Next, we describe how RO DBT theory informs treatment interventions with a focus on AN-specific approaches and then conclude with a brief overview of future directions.

Research Examining Efficacy

The evidence base for RO DBT applied to AN is highly promising. Lynch et al. (2013) tested a modification of RO DBT for the treatment of restrictive-type anorexia nervosa (AN-R) in an inpatient setting. In this study, 47 individuals diagnosed with AN-R (the mean admission body mass index, or BMI, was 14.43) received inpatient RO DBT (the mean length of treatment was 21.7 weeks). Intent-to-treat (ITT) analyses demonstrated significant improvements in weight, despite the fact that RO DBT does not emphasize weight gain and focuses instead on the client's gaining a life worth sharing. The increase in BMI demonstrated in the ITT analyses was equivalent to a large effect size of 1.71, by contrast with an effect size of $d = 1.2$ reported for other inpatient programs (see Hartmann, Weber, Herpertz, & Zeeck, 2011). Lynch et al. further reported significant and large improvements in eating disorder (ED)-related psychopathology symptoms ($d = 1.17$), ED-related quality-of-life issues ($d = 1.03$), and psychological distress ($d = 1.34$). Ninety percent of treatment completers achieved full or partial remission. Rates of remission are comparable to those achieved in outpatient settings and are noteworthy because they were achieved in a more severely underweight and more chronic population.

Chen et al. (2015) used a small case series design ($n = 9$) to examine the utility of RO-DBT for adult AN within an outpatient setting by supplementing standard DBT individual therapy with RO DBT skills training classes. Independent assessors conducted standardized clinical inter-

views both before and after treatment. At the conclusion of treatment, patients who received RO DBT skills demonstrated significant improvements in weight restoration (d = 1.12), which were sustained at both 6-month (d = 0.87) and 12-month (d = 1.21) follow-ups and menses resumption occurred for 62% of the sample at the end of treatment.

RO DBT has also been applied to the treatment of AN adolescents (Simic, Stewart, & Hunt, 2016). In this study, 45 adolescents diagnosed with AN completed a battery of self-report questionnaires related to their temperament, personality traits, and eating disorder psychopathology (Simic et al., 2016). The study had two aims: to explore the link between social connectedness, temperament, and personality traits and to explore the association between eating disorder symptoms and the main RO DBT concepts of overcontrol—e.g., social connectedness and the reward system (Lynch, 2018b). Results supported hypotheses derived from Lynch's neuroregulatory model and theory of overcontrol (Lynch, 2018b), revealing that in a group of adolescents with AN, social connectedness measured on the Social Connectedness Scale (SCS; Lee & Robbins, 1995) was significantly positively correlated with the high anticipatory reward (r = .46) on the Temporal Experience of Pleasure Scale (TEPS; Gard, Gard, Kring & John, 2006) and significantly negatively correlated with the high threat (r = - 0.72) on the negative temperament subscale of the Schedule for Nonadaptive and Adaptive Personality for Youth (SNAP-Y; Linde, Stringer, Simms, & Clark, 2013), ambivalence over emotional expressions (r = - 0.53) on the Ambivalence Over Emotional Expressiveness Questionnaire (AEQ; King & Emmons, 1990) and the four of five personality traits on the Five Factor Obsessive Compulsive Inventory (FFOCI; Samuel, Riddell, Lynam, Miller, & Widiger, 2012), i.e. inflexibility (r = - 0.62), risk aversion (r = - 0.55), perfectionism (r = - 0.39), and workaholism (r = - 0.32). By the same token the social connectedness and reward responsiveness correlated negatively with all composites on the Eating Disorder Inventory-3 (Garner, 2004; r > -.55, r > -.50), indicating that lower social connectedness and sensitivity to reward were associated with more severe eating disorder psychopathology. In a subsequent study the effects of RO DBT treatment were explored in a group of 56 adolescents with AN who were treated either as outpatients or in a day treatment program (Simic, Stewart, Bottrill, Zirit, & Hunt, 2017). Again, adolescents included in the study completed a battery of self-report questionnaires before and after completed RO DBT treatment. The self-reported levels of social connectedness (Cohen's d = .60, medium effect), and consummation of pleasure (Cohen's d = .53, medium effect) significantly increased while the withdrawal subscale on self-report youth (Cohen's d = .69, medium effect), perfectionism (Cohen's d = .44, medium effect), and negative temperament (Cohen's d = .34, small effect) significantly decreased over the course of RO DBT.

In summary, the strength of the findings from the three pilot studies reviewed above provide preliminary support for the use of RO DBT in the treatment of adult and adolescent AN. Yet, study limitations, such as a lack of comparison control conditions, highlight the need for additional research—particularly studies using randomized controlled trial methodology.

Reconceptualizing AN as Maladaptive Overcontrol

Although conceptualizing AN as overcontrolled is not new, prioritizing maladaptive overcontrol in therapy as the core underlying problem is. Indeed, AN has long been conceptualized as a disorder of overcontrol. For example, robust research shows that AN clients are more likely than others to exhibit propensities for aloofness and social withdrawal, cognitive rigidity, insistence on sameness, low reward sensitivity, low novelty-seeking behavior, strong personal needs for structure and symmetry, heightened threat sensitivity, and hyperperfectionism (Fairburn, 2005; Franco-Paredes, Mancilla-Díaz, Vázquez-Arévalo, López-Aguilar, & Álvarez-Rayón, 2005; Harrison, Sullivan, Tchanturia, & Treasure, 2010; Lynch, Hempel, Titley, Burford, & Gray, 2012; Rossier, Bolognini, Plancherel, & Halfon, 2000; Safer & Chen, 2011; Zucker et al., 2007). Yet, to date, other than Family-Based Treatment (Lock & Le Grange, 2015) and Kate Tchanturia's work (Tchanturia & Davies, 2010) on rigid cognitive styles, most treatments in the field of eating disorders have focused primarily on strategies designed to improve self-control, tolerate distress, regulate emotion, and/or manage maladaptive cognitions.

RO DBT offers an original perspective on the etiology and treatment of AN (Lynch et al., 2013; Lynch, 2018b) by conceptualizing restrictive and ritualized eating as symptoms or consequences stemming from rigid maladaptive overcontrolled coping, based on research showing that OC coping preceded the development of the eating disorder. Biotemperamental predispositions for heightened threat sensitivity, diminished reward sensitivity, high inhibitory control, and heightened detail-focused processing are posited to transact with early family, environmental, and cultural experiences to result in a risk-avoidant, emotionally constrained, and aloof/vigilant style of socioemotional coping that limits opportunities to learn new skills and exploit positive social reinforcers. High inhibitory control refers to superior capacities to inhibit emotion-based action or expressive tendencies (for example, by masking inner feelings), delay gratification (for example, by resisting temptation), attend to nonimmediate future contingencies (for example, by planning ahead) and persist in nonrewarding behavior in the short term in order to achieve a long-term goal (for example, by tolerating distress)—all of which have been robustly linked with AN (e.g., Zucker et al., 2007).

However, simply possessing superior capacities for inhibitory control is not the problem. High inhibitory control becomes maladaptive when it is rigidly applied, irrespective of circumstances or potential consequences. Indeed, self-starvation (arguably the core phenotypic feature of AN) is a prototypical example of how an innate biological advantage for high self-control can become a person's worst enemy. Not only is there no compelling environmental reason for an AN patient to severely limit caloric intake (e.g., during times of famine, parents will purposefully eat less in order to save food for their children) but actively engaging in food restriction is self-defeating. Ignoring intense cravings for food, obsessive monitoring of caloric intake, and repeated efforts to conceal or control food intake requires enormous willpower and persistence—making obsessive caloric control an exhausting enterprise that also negatively impacts relationships.

In addition, the neuroregulatory theory that underlies RO DBT, informed by polyvagal theory (Porges, 1995; 2007), provides a potentially novel means for understanding compulsive self-starvation. Specifically, after periods of intense restrictive eating, the client's neuroregulatory system is posited to "perceive" the body's depleted metabolic state as life-threatening, thereby triggering the dorsal vagal complex of the evolutionarily older parasympathetic ner-

vous system (the PNS-DVC), which inhibits energy-depleting action tendencies (urges to flee or fight) mediated by the sympathetic nervous system while reducing sensitivity to pain and increasing emotional numbing (as seen, for example, in the client's flat affect). Thus, the client's restrictive eating develops as a means of downregulating anxious arousal—but it comes with a price. The unfortunate consequence is that although the individual with anorexia nervosa may feel calmer when the PNS-DVC is activated, their regulation strategy is literally killing them. Plus, their flattened affect secondary to PNS-DVC activation makes it harder to flexibly signal genuine desires for social connectedness, exacerbating social ostracism, and leading to an increasing sense of social isolation (Lynch et al., 2018b).

Interestingly, in addition to restrictive eating, other symptoms of eating disorders, including obsessive exercise, binge eating, and purging, may also be linked to overcontrolled coping in some individuals. For example, compulsive exercise and overexercise in the face of inadequate nourishment requires discipline, persistence, distress tolerance, and willpower—all core features of overcontrol. The negative consequences of maladaptive overcontrol can be seen in rigid and obsessive exercise, exercising despite awareness of an injury, and difficulties deviating from exercise routines and/or choosing exercise over social connection. It is possible that an overcontrolled temperament may be more drawn to repetitive, known, predictable movement (e.g., running) rather than movement that requires unpredictability, spontaneity, or social interaction (e.g., basketball).

Moreover, despite robust research linking binge-purge behaviors with undercontrolled coping—e,g., individuals diagnosed with bulimia and binge/purge disorders have been shown to be low on persistence, perseverance, perfectionism, rigidity, and obsessiveness and high on impulsivity, sensation seeking, and novelty seeking (see Cassin & von Ranson, 2005, for review). Our clinical experience suggests the possibility of a subset of clients who plan their binge/purge episodes in advance and/or for whom binge/purge episodes represent brief failures in self-control whereby the overcontrolled individual has a short-term experience of lowered inhibition after chronic sustained inhibition (i.e., emotional leakage). We also have noted a more common example of bingeing related to overcontrol that we refer to as "subjective bingeing." That is, the person reporting a binge episode (usually to a therapist) has objectively eaten only a small amount or a normal portion of food, but for them it is experienced and described as an out-of-control binge. Rather than solely a consequence of poor inhibitory control or emotion dysregulation, compensatory purging (e.g., vomiting or laxative use) may reflect, for some, punishment for deemed "mistakes" and/or rigid rule-governed behavior rather than emotionally driven or mood-governed behavior. In summary, our clinical experience suggests that overcontrolled purging is planned in advance, often involves purging small amounts of food, and is more likely to be rule bound.

RO DBT Specific Treatment Approaches for Eating Disorders

RO DBT individual therapy targets are arranged in a hierarchy of importance: (1) reduce life-threatening behaviors; (2) repair alliance-ruptures; and (3) reduce overcontrolled (OC) maladaptive behaviors linked to common OC themes. Because of the mortality risk associated with eating disorders, RO DBT prioritizes treating any medical instability or suicide risk first. If there is a safety concern at hand, the first order of business is ensuring safety. Life-threatening behaviors are defined in RO DBT as: (a) actions, plans, desires, urges, or ideation, the goal of which is to intentionally cause tissue damage or death (e.g., nonsuicidal self-injury, suicidal ideation/urges, suicide attempt); and (b) behaviors that are not intentionally aimed at dying/tissue damage but are an imminent threat to life. Thus, according to this definition, being underweight, restricting food, or purging would be considered non-life-threatening until a physician (or other medical health-care provider) says it is imminently life threatening. This allows therapists to avoid expressions of overconcern about medical risk when doing so might reinforce maladaptive behavior. According to RO DBT, heightened concern about a non-life-threatening low BMI might inadvertently reinforce future restrictive eating or desires to appear medically ill because the additional attention conveys a "special status" to the patient, may excuse a patient from normal expectations or responsibilities, and/or may block work on non-eating-disorder issues that may be essential for recovery. As one AN patient reported: "I fear that if I don't look fragile then I will be ignored or disappear and lose my status as a princess" (Lynch et al., 2013, p. 4). If there are no life-threatening behaviors present and the client is medically stable, RO DBT proceeds with treatment and works to reduce overcontrolled maladaptive behaviors. This means going beyond the presenting food and body concerns and addressing the neurobiological and environmental factors as well as coping style that preceded the onset of the eating disorder.

In addition, RO DBT considers it essential for therapists to identify goals and values that are not solely linked to food, weight, body shape, or other similar ED issues when treating AN. Thus, from the outset RO DBT therapists "smuggle" the idea to their AN patient that they are "much more than an eating disorder." "Smuggling" refers to an RO DBT communication strategy designed to introduce new information to an OC patient by "planting a seed" of the idea first using an easy manner. This strategy allows patients the opportunity to reflect on the new information without feeling compelled to accept or reject it immediately. The basic idea is that committing to change is easier if one self-identifies the problem behavior needing to be changed. Examples of non-ED-related goals or values include: to raise a family, to be gainfully and happily employed, to be more self-aware, to develop or improve close relationships, to establish a romantic partnership, to become better educated.

Importantly, RO DBT reconceptualizes unwarranted self-starvation as a social signal. Indeed, for some individuals, food restriction may become a badge of honor (e.g., a way to socially signal an indomitable will) whereas for others it may represent an attempt to signal acceptability or social status by striving to adopt an ideal body weight that is culturally reified to be associated with success or attractiveness. Unfortunately for the restrictor, the physical consequences of severe food restriction make it increasingly difficult to conceal their emaciated body and associated odd behaviors needed to maintain their emaciated state from others—making social isolation and avoidance of intimacy the preferred method for a hyper-achievement-focused OC client to retain their sense of self as a competent person. The good news is that RO DBT has a way forward that does not require abandonment of innate capacities for self-control. Instead, the approach focuses on how to effectively reveal inner experience to others, including innate capacities for self-control, in order to build

better connections with others. Consequently, along with interventions designed to increase social safety (see Lynch, 2018c, this issue), the vast majority of RO DBT skills focus on improving openness and prosocial signaling that reflect valued goals and enhance social connection.

RO DBT also addresses the cognitive inflexibility and rigid rule-governed behavior that characterizes problems of overcontrol. For example, a person with an eating disorder commonly has rules about maximum daily caloric intake and personal weight maximums. Through confirmation bias, food and body information that conflicts with existing assumptions may tend to be dismissed by the client because it does not fit into current belief systems. RO DBT teaches skills designed to increase receptivity and openness and helps clients recognize when rigid closed-minded thinking may be interfering with social connectedness. Moreover, RO DBT does not assume that food aversion or body dysmorphia is necessarily exclusively about food or the body. Instead, RO DBT considers dysregulated expressions of body dysmorphia and food restriction to represent indirect social signals that function to separate the client from their tribe, block unwanted feedback, and/or help maintain a special status linked to being medically fragile. In other words, the food and body dysregulation that is characteristic of AN and other ED conditions, according to RO DBT, represents indirect and disguised demands for soothing, attention, and/or special treatment. RO DBT encourages AN clients to use self-enquiry to learn from their body dysmorphic experiences rather than automatically seek to regulate them.

RO DBT uniquely targets ED-specific social signaling deficits that are interfering with social connectedness. RO DBT considers any eating disorder behavior that is displayed in the presence of another person as a social signal. For example, cutting food into tiny bites, pushing food around the plate, smiling while not eating, or looking despondent when food arrives all send important social signals or messages to nearby others, whether intended or not (see definition of social signal; Lynch, 2018c, this issue). For example, when eating or when around food, AN clients tend to exhibit a wide range of body movements, gestures, and facial expressions that indirectly communicate dislike, discomfort, or distress—often without conscious awareness. Consequently, rather than focusing on how to get rid of eating disorder behaviors, RO DBT asks, "What are you trying to tell me with this food dysmorphic behavior?" Essentially, RO DBT gets curious about how a client's indirect social signaling has caused difficulties with social connectedness and intimacy—and encourages clients to behave similarly.

RO DBT also deviates from traditional approaches emphasizing nutrition counseling and meal plan compliance. Rather than focusing on how to eat mindfully, do better or try harder, the primary aim in RO DBT is to help the overcontrolled client learn how to rejoin the tribe and establish a strong social bond with at least one other person. In RO DBT, the core problem for AN is emotional loneliness secondary to low openness and social signaling deficits that interfere with social connectedness—not a problem of food. Plus, since overcontrolled clients are assumed to have superior inhibitory control and, as such, can choose to eat or not—when an individual with an overcontrolled personality chooses not to eat, an RO DBT therapist considers the possibility that the behavior is intentional rather than a skills or capability deficit.

RO DBT assumes that clients with eating disorders can eat healthily despite how they may feel inside or how emotionally dysregulated they are. Consequently, nutrition counseling from an RO DBT perspective does not assume that anxiety must be reduced in order to be fully meal compliant. RO DBT clinicians are deeply caring, but tough as nails and hold a strong, unwavering belief in the strength and ability of clients. Indeed, in RO DBT, the dysregulation experienced by clients during mealtimes is seen as an opportunity for growth and self-enquiry—rather than an overwhelming challenge or harbinger of doom.

Concluding Remarks and Future Directions

Historically, most eating disorder treatments have prioritized food and body image problems as primary. In contrast, RO DBT considers maladaptive overcontrol the driving force behind AN and its evil twin, emotional loneliness. Rather than solely focusing on food intake, weight gain, emotion regulation skills, or family dynamics, RO DBT prioritizes for treatment maladaptive overcontrol and social signaling deficits posited to exacerbate social isolation, emotional loneliness, and feelings of ostracism (Hempel, Vanderbleek, & Lynch, in press; Lynch et al., 2013). Although the efficacy research to date is promising, we are still in the very early days of understanding the many ways RO DBT can and will be applied to the treatment of those who struggle with AN and other eating disorders. Studies using randomized controlled trial methodology and examining mechanisms of change are needed. Other directions currently being pursued include research aimed at understanding a hypothesized overcontrolled subtype of bulimia nervosa and adaptations of RO DBT for AN adolescents and their families.

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Group Radical Openness

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RADICALLY OPEN DIALECTICAL BEHAVIOR therapy (RO DBT) is a new evidence-based therapy. With any novel approach, there needs to be clarity as to what it involves. The publication of the RO DBT training manual (Lynch, 2018), along with this special edition of *the Behavior Therapist*, mark an important point in the provision and evaluation of RO DBT. They open the way for more trials using this approach that will assist us in learning both whom RO DBT helps and the means through which change comes about.

It may seem an early point to consider variants to the standard protocol, but here at St. Patrick's Mental Health Services, we have been developing an adapted version of RO DBT over the last 5 years. This started as a skills-only approach but has moved to group therapy over time. This article aims to explain how Group RO (GRO) came about and to present ways in which the work Lynch carries out through a skills class and individual therapy has been combined into a group treatment. This promises to show the flexibility of the model in general and to open new possibilities for GRO in particular.

History

Over the last decade we have offered a DBT-informed skills group to service users who engage in deliberate self-harm behaviors. Our research with this group demonstrated reductions in both self-harm behaviors and inpatient lengths of stay (Booth, Keogh, Doyle, & Owens, 2014; Gibson, Booth, Davenport, Keogh, & Owens, 2014). There was, however, a small group of participants who seemed adrift of the others both in their identification with the group and in their progress. When we first heard of Lynch's distinction between emotional undercontrol and overcontrol, this struck us as potentially significant. As we started to use his assessment tools, it turned out that these measures picked up this subgroup with accuracy. When these individuals joined others who met criteria for overcontrol, they could identify with each other and with Lynch's model. We provided a skills-only, closed group, based on a set of skills tailored to their needs.

Our initial RO paper was based on data from the period when we were doing skills-only. This was the first study to report positive outcomes from a group-only intervention for emotional overcontrol (Keogh, Booth, Baird, Gibson, & Davenport, 2016). The fact that we were running groups for individuals who struggle with both emotional under- and overcontrol opened interesting possibilities. In research just completed, yet to be submitted (Keane, Booth & Bramham), we compared undercontrol and overcontrol samples on sociodemographic characteristics, similarities and differences at baseline, and responses to DBT-informed interventions. An interesting observation was that those who were classified as undercontrolled tended to be diagnosed with Axis II disorders and those who were overcontrolled tended to be diagnosed with Axis I disorders. The latter followed a different treatment path, often resulting in a referral to GRO after they were classified as "resistant" to psychiatric medication. We are working on how they could be offered this intervention at an earlier point of contact with our service.

The Evolution of an Adapted Version of RO-DBT

Standard RO-DBT includes both individual therapy and weekly skills training classes (Lynch, 2018; Lynch, Hempel & Dunkley, 2015). In our first adaptation we dropped the individual therapy and doubled the group time. This was a pragmatic decision based on the resources we had available. We did not expect that this would match the impact of a full RO-DBT model but felt that participants might still benefit from learning the theory and some of the new RO skills. In fact, we discovered that participants readily identified with the model and were able to utilize skills that directly addressed some of their difficulties associated with maladaptive overcontrol. The demand for this group quickly became apparent. It had initially been anticipated that the numbers presenting with emotional overcontrol would be much smaller than those with emotional undercontrol. However, it turned out that while they may be a less conspicuous group within our inpatient population, they were even greater in number.

After a period of providing a skills-only intervention, we moved to a second phase. Instead of trying to replicate the skills section in our pilot study (Keogh et al., 2016), we moved to a more flexible format. Teaching and practice of skills were still center stage, but the style was more spontaneous, more participative, more aware of process. As we moved towards more engagement, this necessitated a simpler model that responded to participant feedback of "less is often more." For example, the five OC themes proposed by Lynch were cut to three: inhibited emotional expression, aloof and distant relationships, and rigid and rule-governed behavior. Skills were taught in turn and participants carried out homework assignments related to each theme at the same time.

Our results improved but we still had concerns, particularly about treatment generalization. At a major review, we explored some key elements of RO-DBT that were not being addressed with our group approach. In discussion with Lynch (personal communication, 2015), four such areas were identified:

- *Personally meaningful goals*: It is usual that individual sessions allow for the formation of personal goals and targets.
- *Chain analysis:* This is a key method in RO-DBT for functionally analyzing client problems with an emphasis on social signaling deficits and working out how change might best be approached. It represents a core part of individual RO DBT therapy.
- *The opportunity to share significant and often shameful past experiences*: There was a concern that important instances of shame or resentment, which are often a key block to progress, might never be aired in a group.
- *The experience of repairing alliance ruptures*: In RO DBT alliance ruptures and repairs are posited to be a key means for helping socially isolated OC clients learn that conflict can be intimacy enhancing.

In our group approach we have responded with important changes such as an individual review session and a different version of the chain analysis. Building a tight, cohesive group allows for secret resentments and shameful past experiences to be aired. Indeed, we would now see that many of the common presenting features of overcontrol may be particularly suited to group

work. Table 1 presents an overview of the common features of overcontrol and how they are addressed within the group format.

GRO: An Overview

Phase I

The initial task is to explain Lynch's neurobiosocial model of how overcontrolled styles develop and are maintained (Lynch, 2018). We then move to help the group members understand their personal overcontrolled strategies and explore the current costs in their lives. They can begin to reflect on the patterns they wish to hold on to and those they would like to change. The new skills that are introduced are linked directly to one of the three themes: inhibited emotional expression, aloof and distant relationships, and rigid and rule-governed behavior. The group practice these together and discuss their homework examples as part of each session.

The aim of Phase I is twofold: first, that participants engage with the model; second, that the group becomes a cohesive tribe. Formal teaching is often replaced by exercises in pairs, discussions that foster identification with others, and exercises that encourage participation.

Individual review. The main reasons for the individual reviews (60 to 90 minutes in length after about 8 group sessions) are to give each participant the opportunity to talk about their response to the model and to work out their individual goals and aspirations. It is an opportunity to build commitment and to discuss issues they may not wish to disclose in group. It is striking that these tend to be aired in the group at a subsequent point. The review is also a time for participants who may want to pull out gracefully without feeling that they are letting the group down or breaking the rules of their own commitment. The review also forms a natural exit point for participants who, for example, are not group ready or who have attended only a limited number of sessions. With careful screening, we have found this to be a low number.

Phase II

In the second phase, participants are invited to share personally meaningful goals related to the three themes. The RO tracker is introduced to promote awareness of overcontrolled patterns and to highlight points at which change has or might have occurred.

The aims of Phase II are that participants increase their awareness of the opportunities for being radically open and apply RO skills daily. Generalization is promoted through repeated practice.

Table 1. Addressing Common Features of Overcontrol in Group

Common Presenting Features of OC	How These Are Addressed in a Group Approach
Poor social signaling	In group therapy, there is opportunity to observe social signalling. Participants receive feedback and practice change.
Tendency to externalize blame	Feedback from peers encourages taking responsibility and can be more powerful than feedback from an individual therapist.
Masking emotions	Speaking in front of peers, engaging in self-enquiry and hearing feedback encourages expressing emotions. This allows participants to tune in to their emotional experience.
Envy and bitterness	It can be de-shaming to open up about envy and bitterness with trusted peers. Curiosity can be fostered about underlying factors.
Difficulties asking for help	Being part of a cohesive group requires commitment to each other. This includes asking and seeking help in session, being open about struggles and using skills to accept feedback and support.
Difficulties with secret pride/ unpardonable outsider	Use of self-enquiry and skills allow 'secret pride' and 'unpardonable outsider' issues to be aired, explored, gently challenged, and addressed. The group forms a natural 'tribe' in which outsider status can be resolved.
Emotional loneliness	Being with people who share similar experiences tackles emotional loneliness. This sense of common humanity helps to understand how overcontrolled patterns may have developed.
Interpersonal difficulties	The group often highlights interpersonal difficulties sooner than in individual therapy. Participants have the opportunity to learn about their impact on others and how this influences their relationships.

Description of the RO Tracker

The RO tracker is the only concept that will be detailed here since it is a novel feature of GRO. It is an adapted form of chain analysis, an important feature of RO-DBT, simplified in a way that facilitates group feedback.

Participants initially declare to the group which of the three themes they are working on. Then they give the context for a recent example related to this theme. In front of the group, the participant approaches a whiteboard on which there are five horizontal lines (see Figure 1). Each section has its own meaning. With inhibited emotional expression, for example, the five sections represent the following states:

5: A state of very high emotional arousal in which functioning is impaired
4: Engaged with or moving towards a primary emotion
3: Open to the possibility of emotion but none being currently experienced
2: Purposefully inhibiting emotion
1: Emotionally shut down, numbed or frozen

The participant then draws a series of Xs between the horizontal lines while explaining what each X means. They are encouraged to give an example in which there has been a move between sections, referred to as a "crossing of the lines." For example,

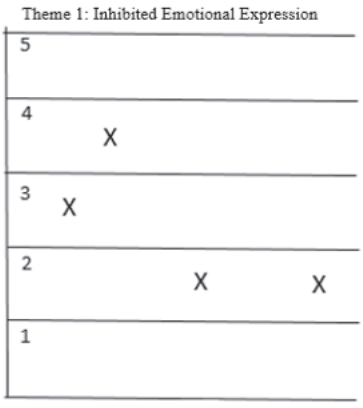

Figure 1. Sample of an RO Tracker.

with inhibited emotional expression, a participant may state, "I began in a 3, I heard distressing news and found myself feeling sad, therefore moving into a 4. I let some tears come and my thoughts were consumed with how sad I felt and my stomach felt sick. I remained there for about a minute but found this very difficult. I then purposefully went back down to a 2 and stayed there so that I wouldn't have to continue feeling this way." After the participant has detailed their specific and brief example, the other group members are invited to ask questions and give feedback. The participant gets live experience of using RO DBT skills such as outing themselves, showing openness to feedback to enhance learning, and self-enquiry. This in turn also builds the tribe's connection with each other and allows for other group members to identify similar patterns.

The questioning and engagement by the group is a critical feature of the tracker. Group members are encouraged to participate in reflecting on the examples shared by fellow group members. The sense of a tribe should now be palpable with an accompanying openness to exploring together. Participants use core RO DBT skills related to giving and being open to feedback and validation as well as gaining practice in "outing themselves." This is carried out in a safe way. The role of the therapist is to gently guide and manage questions when required. Examples of questions the group members might ask include:

- Can you give us a brief context for this tracker?
- What are you curious about in the pattern you have drawn?
- How does the example relate to your current work on this theme?
- How did you know you moved between lines at this point?
- Which moments would you see as significant?
- Is this a new pattern you would be keen to replicate or an old pattern you are having difficulty shaking off?
- What have you learned from this tracker, what are your take-home messages?

As the group progresses, there is growing interest in RO skills so that more pathways are opened up to bring about flexibility. Participants become more willing to challenge each other and to use the group experience itself as a vehicle for in vivo practice of core RO DBT skills and principles (e.g. openness, humility, kindness, candidness). The focus on these key moments using the RO tracker provides opportunities to see choice that might not previously been evident. Table 2 lists more specific features of the RO tracker.

Conclusion

GRO is firmly based in the theory and practice of RO DBT. Its format, however, differs from how RO DBT training classes are typically conducted in other settings (see Lynch, 2018b)—most prominently by its emphasis on using the group experience and peer feedback as a core vehicle for change. As such, GRO represents a hybrid model of delivering RO DBT by combining methods from interpersonal/psychodynamic group therapy (e.g., Yalom, 2005) with RO DBT therapy and skills training principles (e.g., Lynch, 2018b). The RO tracker provides a structured means to practice core RO skills and identify personal blind-spots. The role of peer feedback in GRO may be a significant factor in generalizing and maintaining gains (see Lynch, 2018, for similar conclusions). Connection, authentic emotional expression, social signaling, and flexibility are all developed in this new tribe. GRO is an example of the possibilities that may open up as the RO DBT framework becomes more widely known.

Table 2. Specific Features of the RO Tracker

- Personalizes treatment targets – with an emphasis on OC social-signaling difficulties
- Highlights moments of movement/blockage/resistance – referred to in RO DBT as 'locating one's personal edge' (Lynch, 2018b)
- Links personal life experiences to OC themes, ensuring work is relevant and meaningful
- Invites collaboration and feedback from others. Uses group feedback to identify personal 'blind-spots' and practice radical openness
- Highlights moments of choice that might not previously have been noted
- Provides opportunity to share shameful experiences
- Encourages a take-home message each session
- Fosters repetitive practice that aids generalization

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Not Everything Is as It Seems: RO DBT and Overcontrolled Disorders in Forensic Settings

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ON THE NIGHT of Sunday, October 1, 2017, 64-year-old Stephen Paddock of Mesquite, Nevada, opened fire on a crowd of concert-goers at the Route 91 Harvest music festival on the Las Vegas Strip in Nevada, leaving 58 people dead and 851 injured. About an hour after Paddock fired his last shot, he was found dead in his hotel room from a self-inflicted gunshot wound. Despite perpetuating the deadliest mass shooting committed by an individual in the United States, police investigators reported that Paddock had no prior criminal record that would indicate he was dangerous. Plus, the shooting was carefully planned (e.g., researching SWAT tactics, renting other hotel rooms overlooking outdoor concerts, and investigating potential targets in other cities). Paddock was twice divorced and single at the time of the shooting, with no known children. His ex-wife described him as intelligent and great with numbers. His doctor described him as "odd" and showing "little emotion." To date his motive remains unknown.

Contrary to common assumptions that all (or most) violent acts stem from poor impulse control, emotion dysregulation, and low distress tolerance (i.e., undercontrol), both prior and emerging research has identified an overcontrolled violent offender subtype, for whom acts of violence are rare but seem to be disproportionately more violent and planned compared to undercontrolled offenders. For example, the Congressional Research Service (CRS; Bjelopera, Bagalman, Caldwell, Finklea, & McCallion, 2013) recently released a report that described the most common characteristics and behaviors likely to be seen in perpetrators of public mass shootings based on interviews and data from 78 public mass shootings in the U.S. since 1983. Findings revealed that most perpetrators act alone and carefully planned in advance (see similarities in the description of the Las Vegas shooter above). They reported pervasive feelings of social persecution and ostracism—and were described by others as a loner. Rumination about real or imagined rejections, envy, bitterness, resentment, and revenge were common (CRS; Bjelopera et al., 2013). The Las Vegas gunman (Paddock) described above appears to fit much of this profile. Yet, our understanding of the overcontrolled violent offender and the type of violence associated with moral certitude, excessive inhibitory control, planning ahead, envy, bitterness, and desires for revenge remains poorly understood.

The aim of this paper is to outline how recent research in forensic settings may provide a potential way forward to the conundrum posed by the Las Vegas gunman and other violent offenders sharing similar overcontrolled characteristics. The paper outlines how we have used RO DBT to reexamine the diagnostic features of incarcerated offenders and also describes the developmental trajectory our team experienced implementing RO DBT in a maximum-security forensic hospital.

The Beginning

It was nearly 20 years ago that the lead author (LH) first encountered violent offenders with high inhibitory control while conducting forensic assessments with male prisoners who had killed their partners. These spousal homicide cases were not easily explained by commonly accepted explanations of criminal behavior or violent crime. They were not routinely violent to intimate partners, nor were they cold-hearted psychopathic killers who instrumentally used violence to achieve a goal. Rather than presenting with low self-control, these offenders exhibited high self-control, which, theoretically, "effectively reduces the possibility of crime—that is, those possessing it will be substantially less likely at all periods of life to engage in criminal acts" (Gottfredson & Hirschi, 1990, p. 89). Their anger was not poorly regulated and they did not endorse criminal attitudes, thinking, and lifestyles, which were considered major risk factors for offending (Andrews & Bonta 2003; Novaco, 1997). Rather, they were typically nonaggressive, quiet, hard-working, and law-abiding citizens, but they still seriously harmed another person, possibly more than one person, and often no one saw their acts of violence coming. The apparent conundrums posed by the above observations spurred additional reading and research.

Using Prior Research to Deepen Our Understanding

Megargee (1966) hypothesized that unlike undercontrolled violent offenders who were impulsive, had poor self-control, and were chronically aggressive, the overcontrolled violent offender was "often a fairly mild-mannered, long-suffering individual who buries his resentment under rigid but brittle controls. Under certain circumstances [s]he may lash out and release all his[her] aggression in one, often disastrous, act. Afterwards he reverts to his usual overcontrolled defenses" (p. 2). This description captured perfectly the spousal homicide cases the lead author was dealing with in the late 1990s. Cluster analytic studies using personality and clinical measures confirmed Megargee's idea of over- and undercontrolled offenders, and UK-based studies in forensic psychiatric services, such as Blackburn (1975 ; 1986) and Blackburn, Logan, Donelly, and Renwick (2008), suggested that as many 40% to 52% of high-secure hospital patients could be categorized as overcontrolled, with this reducing to 16% to 25% in prison populations (McGurk 1978; McGurk & McGurk). Overcontrolled groups were also identified in generic offending populations (McGurk & McGurk), intimate partner violent offenders (Hershorn & Rosenbaum, 1991), prison officers (McGurk & McGurk), and sex offenders (Worling, 2001). McGurk and McGurk concluded that perhaps overcontrol was a generic personality characteristic as opposed to a violent offender typology; however, this idea was not picked up. Rather, evidence of over- and undercontrol in nonviolent populations was used to refute Megargee's typology.

Cluster analytic studies confirmed clinical observations, as the overcontrolled offenders typically had later onset of offending, lower levels of pro-criminal beliefs and thinking, fewer institutional problems, and limited use of violence. Personality and clinical measures revealed that those in the overcontrolled clusters typically reported high levels of impulse control, rigidity, cautiousness, and social and emotional isolation. However, both cluster

analytic and comparison studies failed to consistently support the main mechanism outlined in Megargee's theory, that is overcontrolled offenders had clinically significant problems with excessive anger regulation and low anger expression (D'Silva & Duggan, 2010; Henderson, 1983; Low, 2013). These inconclusive findings resulted in Megargee's over- and undercontrolled violent offender typology falling out of favor, with only a handful of studies published on the topic after 1990.

A systematic review of research examining overcontrolled offending is being conducted by the lead author, and it seems this rejection was premature (Hamilton, in preparation). The original research is marred by small samples predominantly drawn from incarcerated populations, inadequate sample classification caused by an absence of a good measure of maladaptive overcontrol, and many studies relied on the Over-controlled Hostility Scale (OHS), which has questionable psychometric properties (Hutton, Miner, Blades, & Langfeldt, 1992), and different OHS cutoffs were used across studies to identify over- and undercontrolled groups. More recent research has been using larger samples and preexisting datasets to explore the posited relationship between self-control and offending (Baglivio, Wolff, DeLisi, Vaughn, & Piquero, 2016; Brad, Coupland, & Olver, 2014). Mears, Cochran, and Beavers (2013) directly tested three models of association between self-control and violent offending (n = 5,681) and nonviolent offending (n = 5,672), that is a linear, nonlinear exponential and a nonlinear, two-threshold effect. They concluded that "self-control and offending are nonlinearly related in a manner that involves two thresholds" (p. 447), and "greater attention to the functional form of the self-control and offending relationship has the potential to lead to greater insight into how precisely self-control contributes to offending" (p. 470).

Despite the posited complex relationship between self-control and offending, traditional offender treatment programs still ubiquitously teach skills aimed at increasing inhibitory control (Lee & DiGiuseppe, 2018). The perils of assuming all offenders are undercontrolled was outlined by Megargee over 50 years ago and more recently by Davey, Day, and Howells (2005), who commented that "teaching specific [anger inhibition] strategies to those who already overuse these strategies is likely to be at best ineffective and at worst counterproductive in that they are likely to reinforce and entrench the problem" (p. 631). To date, only one study has tested how over- and undercontrolled offenders respond to standard violent offender treatment, and Low and Day (2015) confirmed the hypothesis that overregulated offenders did not benefit from standard violence-reduction treatment.

Getting Started

Our clinical experience concurred with our theoretical experience. The ideas and empirical findings we discovered in RO DBT provided us with a new way of thinking and potentially treating what we now recognized to be a substantial group of overcontrolled offenders. A small multidisciplinary team of four experienced standard DBT therapists attended a 2-week intensive RO DBT training program led by the treatment developer (Lynch). Hearing more about Lynch's new theory of maladaptive overcontrol gave us additional and novel ways of conceptualizing overcontrolled offenders, and further convinced us that we had offenders in our service with too much self-control, and that this was keeping them out of the tribe.

Interestingly, the idea of translating Lynch's work to offending populations was initially met with skepticism by some. Those who knew of Megargee's original theory of overcontrolled offenders highlighted how it had been debunked, and others worried that teaching RO DBT skills to our severely personality disordered offenders could be skilling up "psychopaths" to become better criminals. While these challenges were at times disheartening, our small cohesive implementation group used this disconfirming feedback as an opportunity to practice living by the principles of RO DBT, and it energized us to try to articulate what we were seeing clinically in ways that others may appreciate our patients' plight.

Proof of Concept

We decided to answer our skeptics by collecting data. Put simply, we confirmed statistically the prevalence of overcontrolled offenders referred to our service; that is, 44% of our sample could be classified as overcontrolled based on personality disorder diagnosis (International Personality Disorder Examination [IPDE]; Loranger 1999) and consensus expert ratings (Hamilton et al., in preparation). We cited prior research that highlighted that there was around twice as many overcontrolled offenders in expensive high-secure UK forensic psychiatric samples (Blackburn, 1968, 1975, 1986, 1996; Blackburn et al., 2008) compared to UK prison samples (McGurk, 1978; McGurk & McGurk, 1979).

We also clarified important differences between Megargee's theory and Lynch's—e.g., Lynch does not conceptualize maladaptive overcontrol as primarily a disorder of excessive anger regulation, which had already been refuted by previous research; rather, Lynch posits maladaptive overcontrol as a disorder of emotional loneliness. In developing our research strategy we prioritized a study testing Lynch's new neurobiosocial theory of maladaptive overcontrol (Hamilton et al., in preparation). This study used subscales from the following measures: Personality Assessment Inventory (PAI; Morey, 1991), State Trait Anger Expression Inventory-2 (STAXI-2; Speilberger, 1999), Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE; Blackburn & Renwick, 1996), and UPPS Impulsive Behavior Scale (UPPS; Whiteside & Lynam, 2001). While unable to test all aspects of Lynch's new theory due to the limitations imposed by using preexisting data, it provided sufficient evidence to support further research and a trial of RO DBT. In brief, this study confirmed some of the biotemperamental biases predicted by the RO DBT biosocial theory, such as superior inhibitory control and heightened threat sensitivity. It confirmed adverse developmental experiences, typically involving multiple childhood traumas. Expected differences in interpersonal functioning were evidenced and the following subscales proved discriminatory between over- and undercontrolled personality disordered offenders: PAI-Warmth, PAI-Social Detachment, CIRCLE-Withdrawn and CIRCLE-Gregarious. Interestingly, overcontrolled patients self-reported lower levels of PAI-Dominance than undercontrolled patients. However, nurses providing 24-hour care to these patients observed no discernible differences in dominance behaviors when rating CIRCLE-Dominance items. As anticipated, undercontrolled forensic patients had significantly more problems with anger, and overcontrolled forensic patients reported scores in the normal range even for STAXI subscales linked to keeping anger in. No difference in PAI validity scales were noted between over- and undercontrolled offenders, which is contrary to Gudjonsson, Pétursson, Sigurdardotter, and Skulason (1991),

who found high levels of self and other deception among overcontrolled offenders.

Implementation Phase: Developing a Viable RO DBT Service

Having identified an unmet therapeutic need and then trained in a new treatment (RO DBT) targeting excessive self-control, we next had to deal with the process of trying to implement RO DBT in a context dominated by fiscal austerity, with budget reductions and treatment rationalization/cutbacks. If we were to be successful we recognized that we could not depend solely on our clinical expertise. We dialogued with senior management and took time to educate other staff about RO DBT. We also began to work with our colleagues to determine how we could integrate RO DBT within existing services. Finally, we recognized that the best way to garner support from management and other staff was to show them that it works. Expert supervision kept us motivated and on track through this process, and taking a systematic and conservative approach when pioneering this new initiative was essential for keeping key stakeholders engaged.

Although we are still in the early stages of developing the forensic RO DBT service, our initial trials of RO DBT in a maximum-security forensic hospital have been promising. As of this time we have treated two cohorts of patients—both receiving skills class and individual therapy. All RO DBT patients had DSM diagnoses of personality disorder, with a range of comorbid conditions, such as complex trauma, self-harming behaviors, autistic spectrum conditions, depression, and anxiety. Our first pilot group consisted of three patients, all of whom had been forensic high-secure inpatients for more than 15 years on average, and our second pilot group initially had six patients with equally lengthy stays in hospital and maximum-secure prison. Two patients in our second pilot group dropped out of treatment that, upon reflection, we believe may have been partly due to precommitment work that failed to differentiate between genuine engagement versus overcontrolled, overly agreeable subtype desires to please (see Lynch, 2018). Both groups received 40 sessions, plus a minimum of 2 precommitment sessions. As treatment progressed it became apparent that many also had previously unidentified eating disorder issues, which included planned binge eating episodes or restrictive eating. We made minor amendments to the RO DBT manual, mostly around the standard examples so that they applied to offenders and some additional focus on emotions to overcome difficulties with labeling and differentiating between emotions. We also had to move from weekly to fortnightly individual sessions due to operational pressures.

Overall, the majority of patients in both cohorts reported feeling connected to the theoretical premises in RO DBT and reported enjoying learning the science behind the treatment as well as the new skills. We have also noticed a significant willingness for applying the new theory of maladaptive overcontrol to understanding their offending behavior and risk of reoffending. Patients have started hypothesizing about how their maladaptive overcontrol may be related to their offence cycle and how their prior social signaling deficits and habitual attempts to mask inner feelings may exacerbate a cycle of self-defeat. Interestingly, without exception, all RO DBT recipients reported a deeply experienced sense that no one else gave a damn as central in their offending cycle. Rather than challenge this worldview head-on, we chose to practice what we preach by using RO DBT skills in our personal lives and sharing what we learned with our clients (when needed). This helped clients recognize that in order to get someone to give a damn about you—you have to give a damn about them (or at least signal you care about someone other than yourself). Additional implementation experiences are outlined in Hempel et al. (2018; this issue).

In Conclusion

Application of Lynch's new theory of maladaptive overcontrol and RO DBT in forensic settings is still in its infancy, but we believe, based on years of prior forensic work across a range of secure settings and offending types, that the forensic application of the theory and treatment will prove to be highly beneficial. For instance, social exclusion is a recognized risk factor for many offences, including some of the most extreme violence blighting our communities (e.g., mass school shootings and violent extremism). In our service RO DBT is helping our patients feel more safe and connected to people, it is helping staff build more effective therapeutic relationships with these patients, and perhaps it might reduce the number of people who become disillusioned and isolated from their community—especially if we were to apply it early in life. For example, teaching RO DBT social signaling skills to shy kids is predicted to not only help them learn how to become part of a tribe (e.g., by knowing how to tease and be teased or signal friendliness or Match+1 skills to make a friend) but also to reduce bullying from peers, social ostracism, and possibly later engagement in crime.

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The authors of this paper are the forensic RO DBT implementation team, and the lead author was the RO DBT clinical lead at Rampton Forensic Psychiatric Hospital (UK). Cumulatively, the RO DBT forensic implementation team have over 80 years experience working with offenders, and during this time they have all pioneered new initiatives including some of the first standard DBT pilots in a forensic setting.

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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 recognized 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). 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

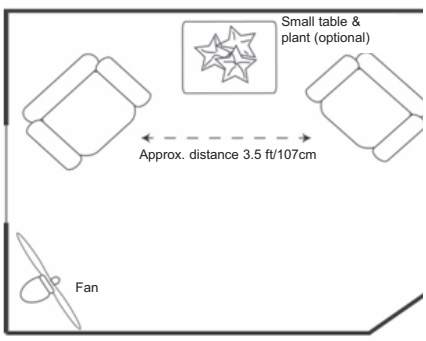

Fig. 1. Individual RO DBT treatment furniture arrangements.

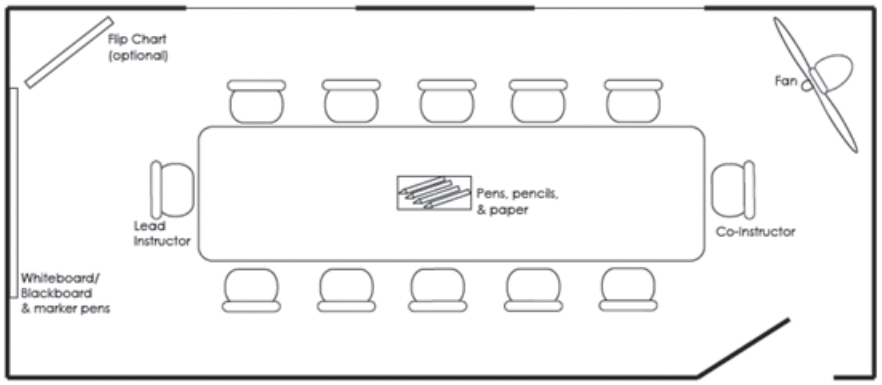

Fig. 2. RO DBT skills class training room arrangements.

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, & Bornovalova, 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 overcontol 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 undercontrolled 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 multidiagnostic 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, Essletzbichler, 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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Dr. Thomas R. Lynch receives personal fees from New Harbinger Publishing and from Radically Open Ltd; Dr. Roelie J. Hempel is co-owner and director of Radically Open Ltd, the RO DBT training and dissemination company; Dr. Sophie Rushbrook provides RO DBT Supervision through her company S C Rushbrook Ltd.; Dr. Alexia Giblin is co-owner and Executive Director of Opal: Food + Body Wisdom.

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ABCT's 52nd Annual Convention

November 15–18, 2018 • Washington, DC

Preparing to Submit an Abstract

The ABCT Convention is designed for scientists, practitioners, students, and scholars who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions, Targeted and Special Programming, and Ticketed Events.

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the Abstract Submission Portal, and the ABCT home page. Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events. As you prepare your submission, please keep in mind:

• **Presentation type**: Please see the two right-hand columns on this page for descriptions of the various presentation types.

• **Number of presenters/papers**: For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

• **Title**: Be succinct.

• **Authors/Presenters**: Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for "ABCT category" are *current member*; *lapsed member* or *nonmember*; *postbaccalaureate*; *student member*; *student nonmember*; *new professional*; *emeritus.*)

• **Institutions**: The system requires that you enter institutions before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.

• **Key Words**: Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword "military" is already on the list and should be used rather than adding the word "Army." Do not list behavior therapy, cognitive therapy, or cognitive behavior therapy.

• **Objectives**: For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the objectives of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."

Overall: Ask a colleague to proof your abstract for inconsistencies or typos.

Thinking about submitting an abstract for the ABCT 52nd Annual Convention in DC? The submission portal will be opened from February 14–March 14. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 51st Annual Convention. The deadline for submissions will be 11:59 P.M. (EST), Wednesday, March 14, 2018. We look forward to seeing you in Washington, DC!

52nd Annual Convention

November 15–18, 2018 • Washington, DC

general sessions

Call *for* Papers

Program Chair: Kiara R. Timpano, Ph.D.

Theme:
COGNITIVE BEHAVIORAL SCIENCE, TREATMENT, *and* TECHNOLOGY

ABCT has always celebrated advances in clinical science. We now find ourselves at the cusp of a new era, marked by technological advances in a range of different disciplines that have the potential to dramatically affect the clinical science we conduct and the treatments we deliver. These innovations are already influencing our investigations of etiological hypotheses, and are similarly opening new frontiers in the ways that assessments and treatments are developed, patients access help, clinicians monitor response, and the broader field disseminates evidence-based practices. Building on the strong, theoretical and practical foundations of CBT, we have the exciting opportunity to use our multidisciplinary values to identify new and emerging technologies that could catapult our research on mental health problems and well-being to the next level.

The theme of ABCT's 52nd Annual Convention, "Cognitive Behavioral Science, Treatment, and Technology," is intended to showcase research, clinical practice, and training that:

- Uses cutting-edge technology and new tools to increase our under standing of mental health problems and underlying mechanisms;
- Investigates how a wide range of technologies can help us improve evidence-based practices in assessment and the provision of more powerful interventions; and
- Considers the role technology can have in training a new generation of evidence-based treatment providers at home and across the globe.

The convention will highlight how advances in clinical science can be strengthened and propelled forward through the integration of multidisciplinary technologies.

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters. Information about the Convention and how to submit abstracts will be on ABCT's website, www.abct.org , after January 1, 2018.

Portal opens
February 15, 2018

Deadline for submissions:
March 15, 2018

Submission deadline: ***March 15, 2018***

Understanding the ABCT Convention

➡ GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. An individual must LIMIT TO 6 the number of general session submissions in which he or she is a SPEAKER (including symposia, panel discussions, clinical round tables, and research spotlights). The term SPEAKER includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 11:59 PM ET, Thursday, March 15, 2018. General session types include:

Symposia. In responding to convention feedback requesting the presence of senior researchers/faculty to present papers at symposia along with junior researchers/faculty and graduate students, special consideration will be made for symposia submissions that include some senior researchers/faculty as first-author presenters. Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. No more than 6 presenters are allowed.

Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgement in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Panel Discussions. Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Spotlight Research Presentations. This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Poster Sessions. One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

➡ TARGETED and SPECIAL PROGRAMMING

Targeted and special programming events are also included with the registration fee. These events are designed to address a range of scientific, clinical, and professional development topics. They also provide unique opportunities for networking.

Invited Addresses/Panels. Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge.

Mini Workshops. Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long.

Clinical Grand Rounds. Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Research Facilitation Sessions. Organized by members of the Research Facilitation Committee, these events aim to highlight research resources for those who study or practice behavioral and cognitive principles.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years, the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings. More than 39 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

➡ TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment. The deadline for these submissions is 11:59 PM ET, Thursday, February 1, 2018.

Clinical Intervention Training. One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

Institutes. Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, they are 4 hours long and limited to 40 attendees.

Research and Professional Development. Provides opportunities for attendees to learn from experts about the development of a range of research and professional skills, such as grant writing, reviewing manuscripts, and professional practice.

CE Opportunities: visit http://www.abct.org/Conventions/?m=mConvention&fa=ceOpportunities

CE Opportunities

At the ABCT Annual Convention, there are Ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and General sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. See the end of this document for a list of bodies that have approved ABCT as a CE sponsor. Note that we do not currently offer CMEs. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be mailed early in the new year following the Annual Convention.

➡ TICKETED EVENTS Eligible for CE

All Ticketed Events offer CE in addition to educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee. For ticketed events attendees must sign in and sign out and complete and return an individual evaluation form. It remains the responsibility of the attendee to sign in at the beginning of the session and out at the end of the session.

Clinical Intervention Trainings. One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.

Institutes. Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees. Participants in these Workshops can earn 3 continuing education credits per workshop.

Master Clinician Seminars (MCS). The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees. Participants in these seminars can earn 2 continuing education credits per seminar.

Advanced Methodology and Statistics Seminars (AMASS). Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

➡ GENERAL SESSIONS ELIGIBLE FOR CE

There are 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few other sessions. You are eligible to earn 1 CE credit per hour of attendance.

General sessions attendees must sign in and sign out and answer particular questions in the CE booklet regarding each session attended. The booklets must be handed in to ABCT at the end of the Convention.

General session types that are eligible for CE include:

Clinical Grand Rounds. Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Invited Panels and Addresses. Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.

Mini-Workshops. These 90-minute sessions directly address evidence-based clinical skills and applications. They are offered at an introductory level and clinical care or training issues.

Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgement in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Panel Discussions. Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Spotlight Research Presentations. This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Symposia. Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

➡ GENERAL SESSIONS *NOT* ELIGIBLE FOR CE

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Poster Sessions. One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,400 and 1,600 posters are presented each year.

Special Interest Group (SIG) Meetings. More than 39 SIGs meet

each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training. These sessions are not eligible for continuing education credit.

Other Sessions. Other sessions not eligible for CE are noted as such on the itinerary planner and in the program book.

Great, how do I get CE at the ABCT Convention?

The continuing education fee must be paid (see registration form) for a personalized continuing education credit letter to be distributed. Those who have included CE in their preregistration will be given a booklet when they pick up their badge and registration materials at the ABCT Registration Desk. Others can still purchase a booklet at the registration area during the convention. The current fee is $99.00.

For ticketed events attendees must sign in and sign out and complete and return an individual evaluation form. For general sessions attendees must sign in and sign out and answer particular questions in the CE booklet regarding each session attended. The booklets must be handed in to ABCT at the end of the Convention. It remains the responsibility of the attendee to sign in at the beginning of the session and out at the end of the session.

Which Organizations Have Approved ABCT as a CE Sponsor?

Psychology. ABCT is approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

Social Work. ABCT is approved by the National Association of Social Workers (NASW) (Approval # 886427222-7448) for 34 continuing education contact hours.

Counseling. ABCT is approved by the National Board of Certified Counselors (NBCC) Approved continuing education provider. ACEP No. 5797 and may offer NBCC-approved clock hours for events that meet NBCC requirements. Programs that do not qualify for NBCC credit are clearly identified. ABCT is solely responsible for all aspects of the program.

Licensed Professionals. ABCT is approved by the California Association of Marriage and Family Therapist (CAMFT) to sponsor continuing education for counselors and MFT's. This conference will provide up to 26 hours of continuing education credit for LMFT's, LCSWs LPCC's and/or LEPs required by the California Board of Behavioral Sciences, ABCT maintains responsibility for this program/course and its contents. (Approval #133136)

➡ CONTINUING EDUCATION (CE) GRIEVANCE PROCEDURE

ABCT is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. ABCT will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Coordinator of Convention and Education Issues in conjunction with the Director of Outreach and Partnerships.

Although ABCT goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances.

All grievances must be filed in writing to ensure a clear explanation of the problem.

If the grievance concerns satisfaction with a CE session the Director of Outreach and Partnerships shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision.

If the grievance concerns a speaker and particular materials presented, the Director of Outreach and Partnerships shall bring the issue to the Coordinator of Convention and Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs.

Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Director of Outreach and Partnerships.

A copy of this Grievance Procedure will be available upon request.

If you have a complaint, please contact Tammy Schuler, Ph.D., Director of Outreach and Partnerships at tschuler@abct.org or (212) 647-1890 for assistance.

ABCT Comment on Initiative Regarding Full Range of Career Level Representation in Convention Symposium Abstracts Review Criteria

ABCT Convention Committee and Board of Directors

ABCT has always prided itself on creating a welcoming environment for students, trainees, and junior clinicians and faculty. Education is a key aspect of our mission statement, and as such, the organization has worked for many years to balance the needs of those more junior in the field, with more advanced and senior clinicians and scientists. However, in recent years, the Board of Directors and the Convention Committees have received consistent feedback that our efforts to welcome students have shifted symposia a little too far away from more seasoned presenters. This has influenced both convention attendance and ABCT membership, with fewer of our senior colleagues joining the organization and attending the convention. A consistent request has been for ABCT to encourage and increase the attendance of more senior presenters at the conference – not just as discussants, but as presenters of data and clinical concepts themselves. In response to these requests, for the first time last year (submissions for the 2017 convention), seniority of authors was considered as a factor in the review process. **The ultimate goal of this decision was to ensure a greater number of program offerings in which there is a full range of career levels represented.**

From a logistical perspective, this decision was easily folded into the existing review process. The review of submissions involves several steps and tends to be an iterative process. First and foremost, the scientific merit of the submission is considered, as determined by the reviews. Next, we consider a number of secondary factors, including relevance to the conference theme, balance across categories, representation of underrepresented populations, along with others. It is at this point then, that the full range of career levels factor is taken into consideration. The important point to note is that this factor reflects just one of multiple, secondary elements which influence final decisions about submissions.

ABCT recently reviewed the effects of this new initiative on presentations, to determine whether our goal was achieved. Specifically, we compared symposia at the 2015 convention in Chicago (before the initiative was started) with the 2017* convention in San Diego (after the initiative was launched). A random 25% of symposia presenters were sampled from each of the two conventions, and we examined the percentage of Junior 1st authors (defined as non-Full members or those who are less than 10 years post terminal degree) to the percentage of Senior 1st authors (Full members or those 10+ years post terminal degree). Results (see Table) indicated that at both meetings, the majority of symposia presenters were Junior members, and furthermore, the new initiative did not lead to a reduction in junior presenters of symposia.

We will continue to monitor the composition of symposia presenters at ABCT conventions. At this time the initiative has not had an adverse influence on the inclusion of our more Junior colleagues. However, based on these results, the Board and Convention Committee will need to continue revisiting the question of how to re-engage the more senior members of our community to achieve our goal of having a full range of career levels represented at the conference.

Special thanks to Tammy Schuler, Dakota McPherson, and Barbara Mazzella for their work on data collection and analysis for this project.

ABCT in DC

52nd Annual Convention
November 15–18, 2018

	Junior 1st Author Presenters	*Senior* 1st Author Presenters
Chicago 2015	59%	41%
San Diego 2017	65%	35%

*The 50th anniversary convention in New York City in 2016 was excluded, as it was unlikely to be typical in terms of presenters.

the Behavior Therapist
Association for Behavioral
and Cognitive Therapies
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call for submissions

Graduate Student Research Grant

The ABCT Research Facilitation Committee is sponsoring a grant of up to $1000 to support graduate student research. Eligible candidates are graduate student members of ABCT seeking funding for currently unfunded thesis or dissertation research. Grant will be awarded based on a combination of merit and need.

For full information on what to submit, please go to:
http://www.abct.org/Resources/?m=mResources&fa=GraduateStudentGrant

To submit: please e-mail all required documents to Dr. Nathaniel Herr at **nherr@american.edu.**

The grant will be awarded in November 2018, with the award recipient announced and presented with the funds during the Friday evening Awards Ceremony at the November 15-18 Annual Convention in Washington, DC.

For more information on the grant and application procedures and requirements, please visit the ABCT website at www.abct.org/Awards/

▶ Applications are due April 23, 2018