Working with Overcontrolled and Rigid Behavior In Clients:

Insights From Affective Science and Radically Open Dialectical Behavior Therapy

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Financial Disclosures

Jason Luoma is CEO of Portland Psychotherapy Clinic, Research, & Training Center, a research and training clinic that provides RO DBT services and ACT services and training.

Angela Klein is Director & Founder of Centered Ground, a practice that provides RO DBT services, as well as standard DBT, CBT, and mindful eating.

Goals of this workshop

- Introduce you to the concept of overcontrol
- Show you how theory about overcontrol leads to novel interventions that are not obviously predicted by ACT
- Demonstrate some of these strategies
- Give you an overview of how overcontrol is treated from the perspective of radically open dialectical behaviour therapy (RO DBT)

How did our ancient ancestors survive without claws, horns or being thick-skinned?


PACEÑA


GAS PARA
BOLIVIANOS NO
INDUSTRIALIZANDO
SE GANARA

We are a tribal species

We evolved means to

override older 'selfish' tendencies

linked to the survival of the individual

for the survival of the tribe

A key capacity that enabled cooperation: self-control

Self-control = the ability to inhibit emotional urges, impulses, and behaviors in order to pursue long-term goals

Self-control capacities enabled a person to *not* immediately consume valuable resources and instead save for a 'rainy day'

PLUS

not acting on every impulse allowed us to work together in groups without the fear of being immediately attacked if we stepped on someone's toe

Lack of self-control is eye-catching!

Overcontrol is often not recognised

Overcontrolled people ……

Are not roaming the streets in gangs—they are not causing riots; they are not the people you see yelling at each other from across the street

They are hyper-detail-focused perfectionists who tend to see ‘mistakes’ everywhere (including in themselves)

And tend to work harder than most to prevent future problems without making a big deal out of it.

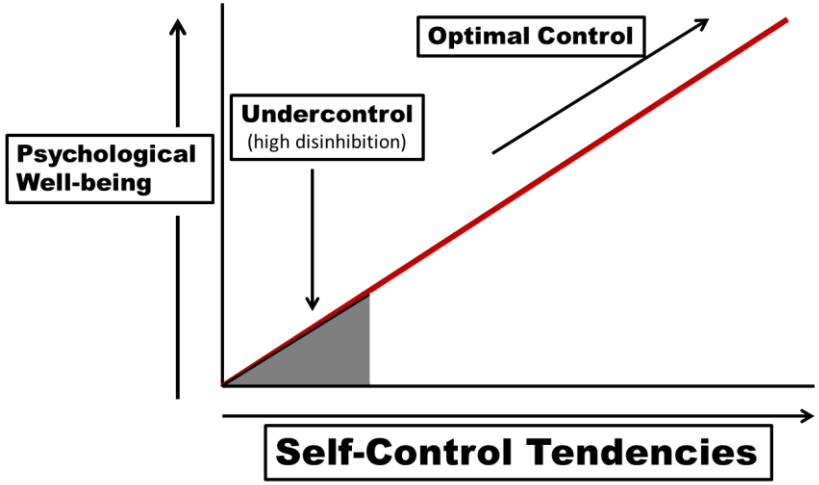
Plus, are expert at <u>not</u> appearing different on the outside (in public).

Overcontrol is Pro-Social

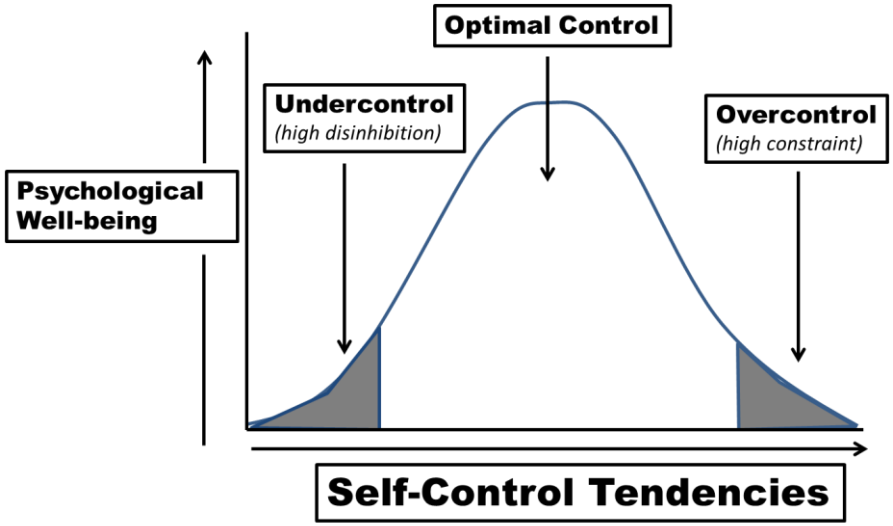
- **Desires to be correct, exceed expectations and perform well**—is essential for tribal success
- **Valuing rules and fairness** is needed in order to resist powerful yet unethical individuals or harmful societal pressures
- **Delaying gratification** saves valuable resources for less abundant times
- **Duty, obligation, and self-sacrifice** helps societies to flourish and ensures that those in need are cared for

Too much of a good thing: the problem of overcontrol

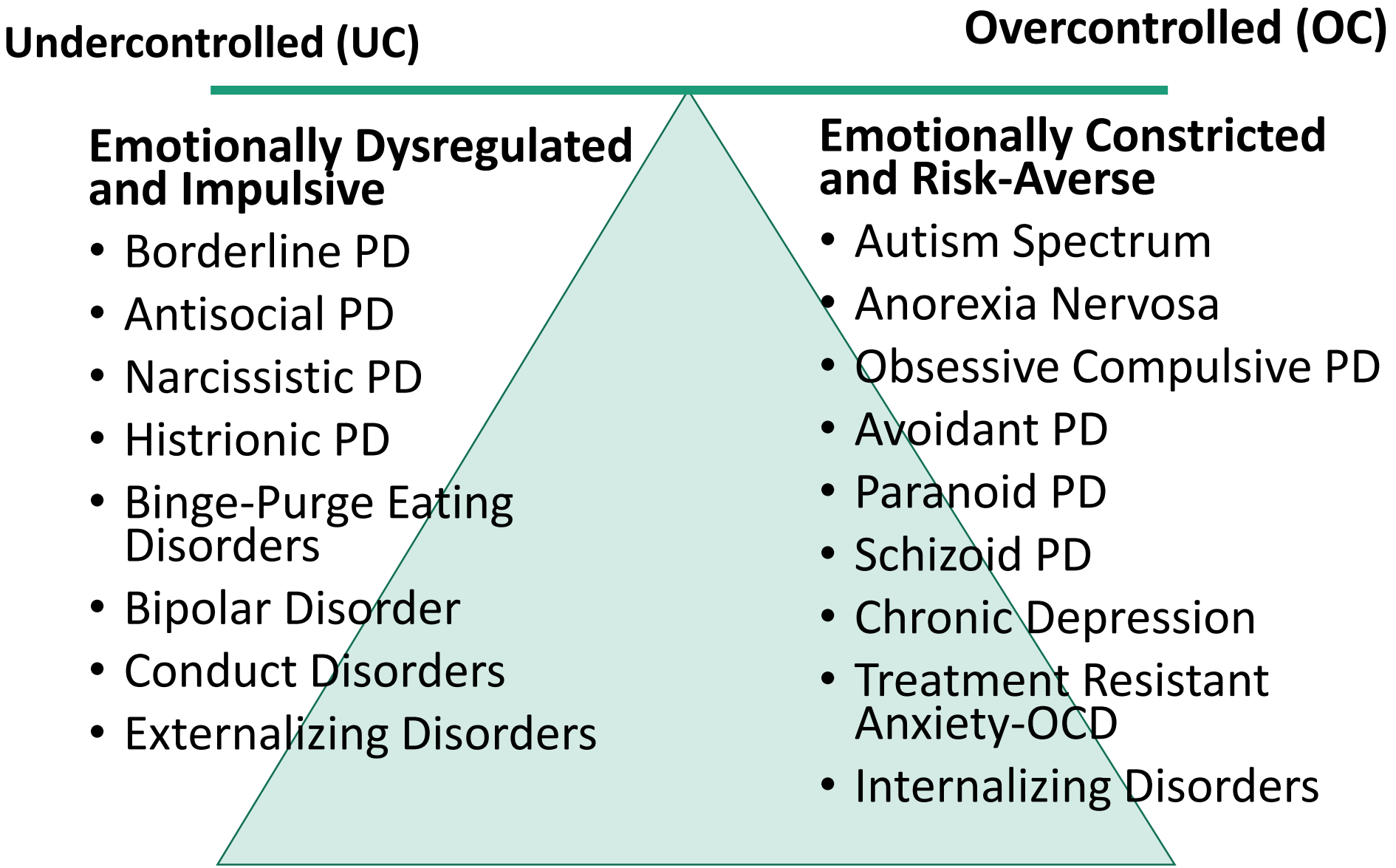
- Existing research tends to see self-control as a linear construct: more is better



- However: you can have too much of a 'good thing'



The Self-Control Dialectic



What's your style?

See next slide

Assessing Styles of Coping Word-Pair List

Circle the words or phrases that describe yourself; but only one word in each row.
Tally up the number in each column—the more you have in one column suggests your style.

A	B
Impulsive	Deliberate
Impractical	Practical
Naïve	Worldly
Vulnerable	Aloof
Risky	Prudent
Talkative	Quiet
Disobedient	Dutiful
Fanciful	Realistic
Fickle	Constant
Act without thinking	Think before acting
Animated	Restrained
Changeable Mood	Stable Mood
Haphazard	Orderly
Wasteful	Frugal
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Complaining	Uncomplaining
Reactive	Unreactive
Careless	Fastidious
Playful	Earnest

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Overcontrol is a problem of emotional loneliness

Secondary to
Low Openness
&
Social-Signaling Deficits

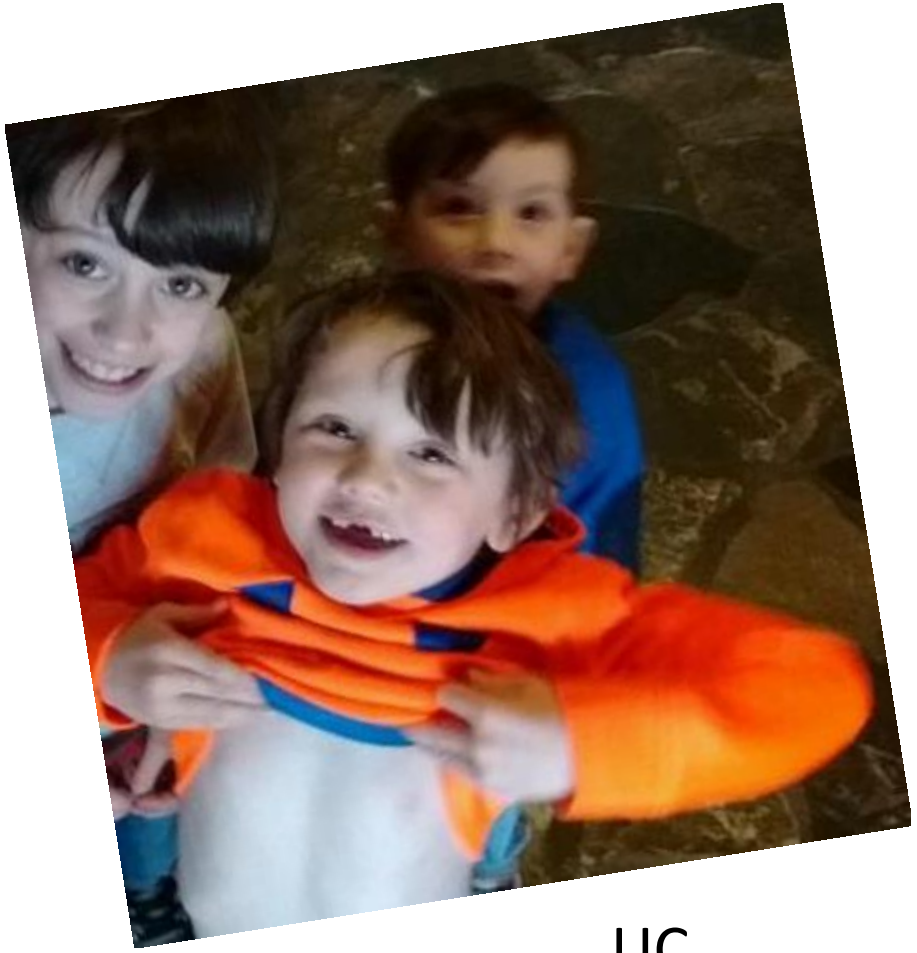
Not necessarily
lack of social contact
but
lack of social connectedness

Themes & Targets

- Behavioral themes: Social signals
  - Hyper-detail focused and overly cautious
    - Avoiding feedback and novel situations
  - Rigid and rule-governed behavior
  - Inhibited and disingenuous emotional expression
  - Aloof and distant style of relating
  - High social comparisons and envy-bitterness

- → Core RO Targets
  - Receptivity and openness
  - Flexible responding
  - Emotional expression and awareness
  - Social connectedness and intimacy

Overcontrol is a combination of biotemperament and environment



UC

OC

Environmental (e.g., family or cultural) influences:

For Undercontrolled…

The Person Learns

"If I escalate my emotional signaling—then good things may happen"

Whereas…
for Overcontrolled…

The Person Learns

"If I inhibit my emotional signalling—

then good things

may happen"

WENDY GETS PRIVACY BY CREATING HER OWN BOOK COVERS

But…when the Context Calls for Emotional Expression ….

...and Emotion is **Not** Expressed

…then signaling matters!

Emotions evolved to communicate and facilitate the formation of strong social bonds…

- **Species survival depended upon signalling cooperation.**
- **Human Facial Expressions are unconditioned stimuli, e.g. we are emotionally reacting to a facial expression at 4 milliseconds** (LaFrance, 2013)

  - *We become anxiously aroused when interacting with a non-expressive person AND we prefer not to affiliate with them* (Gross, 2002; Butler & Gross., 2003; Barnsley, Hempel, & Lynch, 2011).

  - *Open expression of emotion—even when the emotion is negative—signals trustworthiness and increases social connectedness* (Boone & Buck, 2003; Mauss et al., 2011; Feinberg, Willer, & Keltner, 2011)

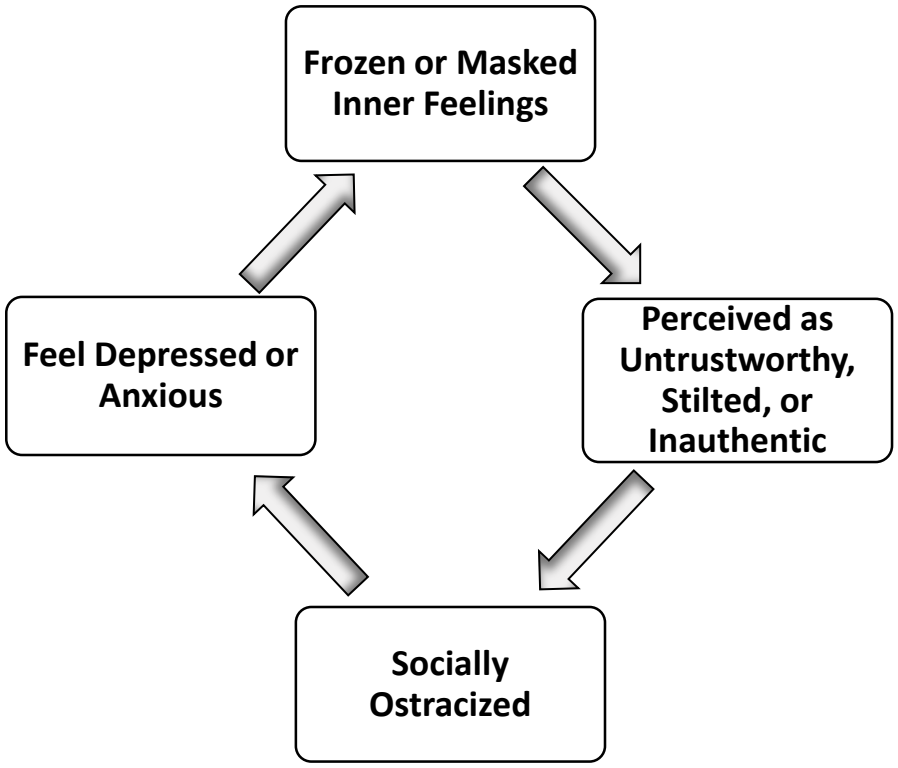
The Still Face experiment

Thus…
How we socially-signal strongly impacts our relationships

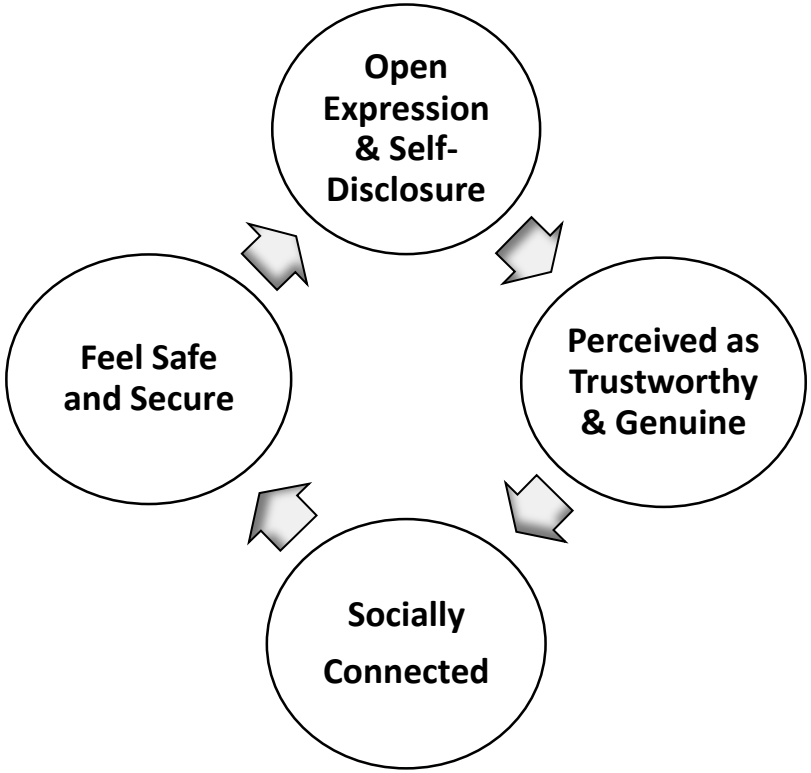
The key mechanism of change in RO DBT

Open Expression = Trust = Social Connectedness

Overcontrol



Flexible-Control



The core issue for OC individuals isn't so much how they cope with their own struggles but how they relate to others

1) **All internally focused work in RO DBT ultimately comes back to how people are social signaling and**
2) **whether that signaling brings connects them to or pushes them out of the tribe**

Note: Open expression DOES NOT mean…

simply

“Expressing emotions without Awareness or consideration”

On the contrary…. effective emotional expression is always CONTEXT dependent

RO DBT teaches there are five neural substrates of emotion

safety, novelty, reward, threat, overwhelming threat

When it comes to OC:

What's most important is the social-safety system

Social Safety System: ventral vagal complex of the parasympathetic nervous system; PNS-VVC

When our social safety system (PNS-VVC) is activated we feel calm, relaxed, and sociable. Our breathing is slow and deep and our heart rate is reduced. We are more likely to want to approach and touch others; and we can effortlessly make eye contact (without feeling self-conscious)

Our social safety system innervates muscles in our body needed to communicate and form close social bonds (Porges, 2007), including:

- **Voice-box muscles** (laryngeal and pharyngeal muscles) allowing a musical tone of voice signaling warmth and friendliness
- **Middle ear muscles** allowing us to hear human speech better
- **Facial muscles** allowing us to signal genuine friendly intentions and smiles e.g., via a genuine smile of pleasure
- **Diaphragm muscles** linked to slow and deep breathing and sighs of contentment
- **Neck muscles** allowing us to direct our gaze

Greeting Exercise

Using social safety to enhance clinical outcomes

- RO DBT teaches OC clients how to activate their social-safety system and "turn-off" bio-temperamentally heightened defensive arousal by taking advantage of neuroinhibitory relationships between the PNS and the SNS (sympathetic nervous system).

- Plus, RO DBT teaches therapists how to activate social safety in both themselves and their clients by deliberately employing gestures, postures, and facial expressions that universally signal openness, non-dominance, and friendly intentions (via mirror neuron activation and micro-mimicry).

- **So, what are some of the ways this is done?**

Talking Eyebrows

When Tension is Present…

Use the Big3 + 1!

Slow The Pace and Chill-Out

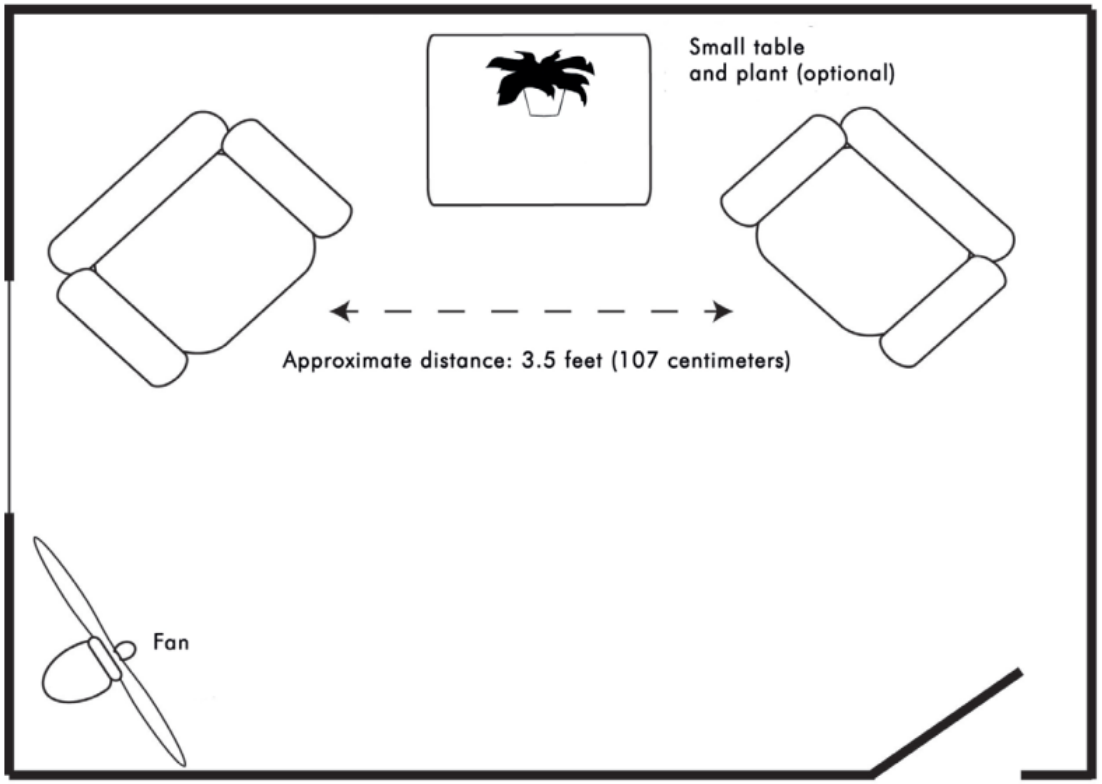
Step 1*: take a deep breath,*
Step 2*: raise your eyebrows,*
Step 3*: engage a warm closed-mouth smile; and*
(+1): *lean back in your chair (if you are sitting)*

Let's Practice

The Big Three+1

Additional strategies

- Room layout and temperature
- Taking a drink
- Loving kindness meditation



Why do you think we did that?

Chilling-Out is Therapeutic When Treating OC

Participation without planning

- **Helps OC folks overcome self-conscious self monitoring and concerns about tribal status**
- **Gives class members an experience of how uninhibitedly participating is a powerful social signal and creates a sense of tribe**
- **Gives practice in passionate participation -** OC clients often need to learn how to be more emotionally-driven, at least in some contexts.

How this relates to ACT:

- They need to learn how to chill out, relax, have fun, and party, not calmly accept their emotions and move on.

So, what is radical openness?

RO DBT considers...

Openness

a

Powerful Social-Signal

RO—Developing a passion for going opposite to where you are

- **Radical openness** is more than awareness—it is *actively seeking* the things one wants to avoid or may find uncomfortable *in order to learn*.

- It involves **purposeful self-enquiry** and cultivating a willingness to be "wrong" with an intention to change if needed.

What is Self-Enquiry?

- A mindful way of engaging with emotion and thought in order to learn from it
- A practice of asking yourself good questions in order to learn
- Different from acceptance and defusion in the goal is to learn something about yourself by inquiring into your perceptual biases
- For an outline of the basics of self-enquiry, go to: https://bit.ly/31ygQew

Self-enquiry begins by locating our “edge”

Or “personal unknown”

So...what is an Edge?

Our 'Edge' almost always pertains to actions, thoughts, feelings, images, or sensations associated with something we want to avoid, feel embarrassed about, and/or don't want to 'think' about or admit to.

Importantly, painful emotional reactions are not always "edges".

Our 'Edge' is our shadow—our dark side.

SELF-ENQUIRY— Basic Principles

- **Self-enquiry means finding a good question (or image/word) that brings you closer to 'your edge' (i.e., your personal unknown)—not a good answer.**
  - Allow yourself time to discover what you might need to learn rather than quickly search for a way to explain things away or regulate.

- **Practice being suspicious of quick answers or urges to regulate—as they may be masquerading as avoidance.**

- **Keep your self-enquiry practices short (e.g., 5 minutes in duration).**
  - Short and frequent (e.g., daily) practices—using the same question or a new question that had emerged from the previous day are usually more effective.
  - Longer practices can sometimes be secretly motived by desires to find an answer or a solution.

- **Practice frequently and keep a record of your observations in your self-enquiry journal.** Notice how your questions and practice evolve over time.

Self-enquiry practice is best done in the presence of a fellow practitioner who is willing to reflect back our blind spots

A process known as "Outing Oneself"

Two-minute silent Self-Enquiry Practice + Homework Assignment

Ask yourself silently...

- ✓ *What is the one thing I am really closed about?*
- ✓ *What is it that I don't want to admit to myself (or others)?*
- ✓ *What areas in my life do I feel secret pride about?*
- ✓ *What have caring others suggested in the past that I might need to change but have resisted?*
- ✓ *To what extent am I resisting or pretending to engage in this exercise? What might this tell me about myself, my openness, or my willingness to examine my personal reactions?*

- Begin a self-enquiry journal and record what emerges from your practice (over the next week)

RO DBT Evidence Base, Treatment Delivery, & Structure

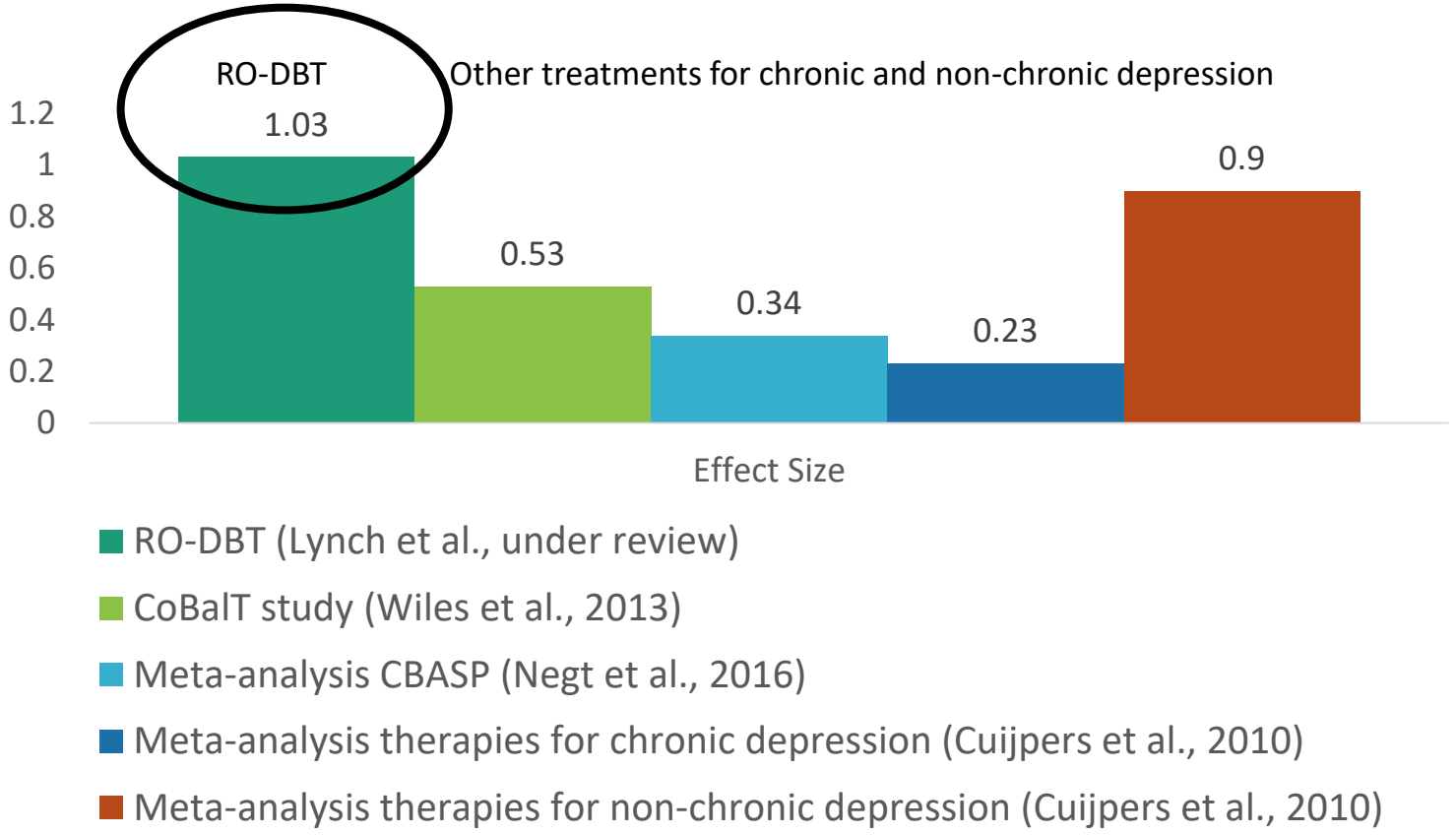
Evidence base

Three Randomized Controlled Trials for **Refractory Depression & Overcontrolled Personality disorders (n=34, n=35, and n=250)**

Three open-trials (pre-post) for adults and adolescents with **Anorexia Nervosa (n=9, n=47, n=101)**

One Non-Randomized Controlled Trial for **chronic overcontrolled personality (n=117)**

Large effect size RO DBT versus Treatment as usual



Modes for Outpatient RO DBT (~30 weeks)

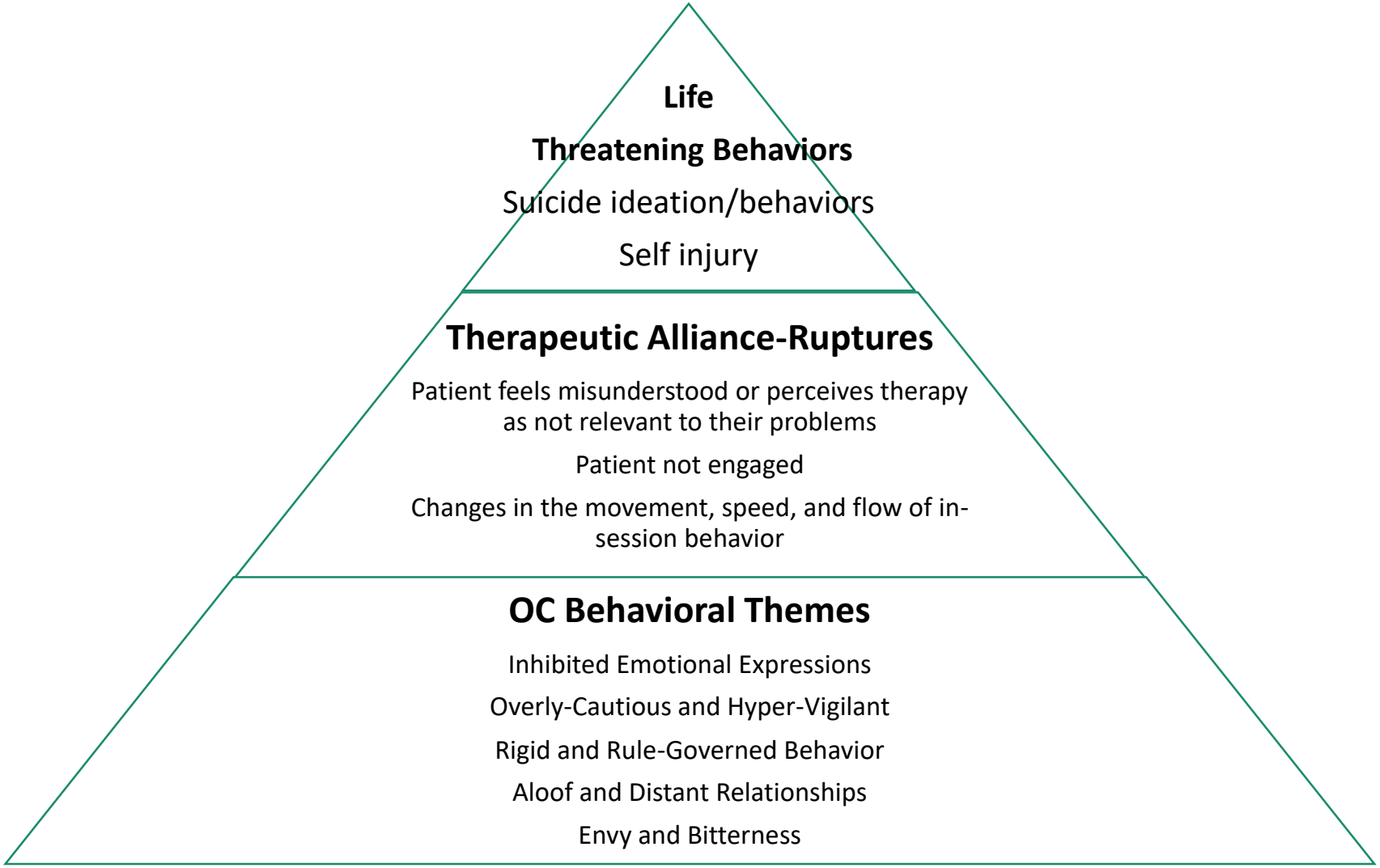
1. Outpatient **Individual Session**: 1 hour per week

2. Outpatient **Skills Training Class**: 2.5 hours per week (with 15 minute break)

3. **Telephone Consultation**: as needed (but rarely used by most OC patients)

4. **Therapists' Consultation** Meeting (optional but recommended): practicing radical openness ourselves

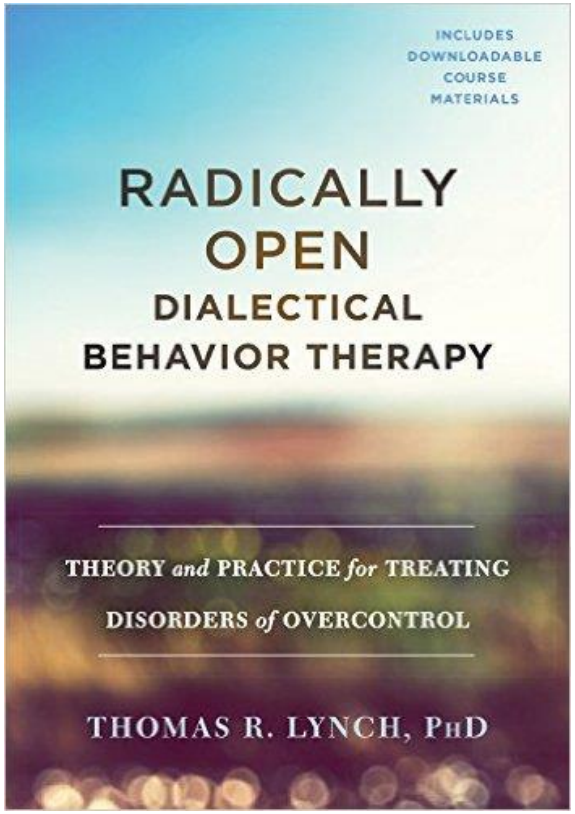
RO-DBT Individual Treatment Target Hierarchy

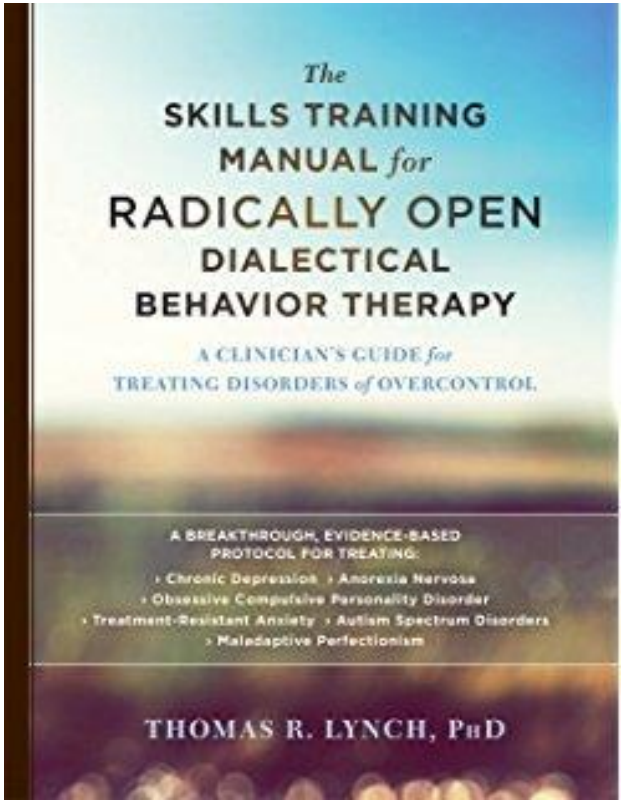


RO DBT Skills

Radical Openness Skills [circle each day of the week you practiced a particular skill]	Handout
Flexible-Mind DEF(initely): Three steps for Radically Open Living	1.B
The Big Three + 1: Activating Social Safety	3.1
Practiced Loving-Kindness Meditation: Maximizing Social Safety	4.1
Flexible-Mind VARIEs: Engaging in Novel Behavior	5.1
Flexible-Mind SAGE skills: Dealing with Shame, Embarrassment, and feeling Rejected or Excluded	8.A
Flexible-Mind is DEEP: Using Values to Guide Social-Signaling	10.2
Practiced Being Kind to Fixed-Mind	11.2
Practiced Learning from Fatalistic-Mind	11.3
Practiced Going Opposite to Fatalistic-Mind	11.B
Practiced the Awareness Continuum	12.1
Mindfulness What Skills: Observe	12.2
Mindfulness What Skills: Describe	12.2
Mindfulness What Skills: Participate without Planning	12.2
Mindfulness How Skill: Self-Enquiry	13.1
Mindfulness How Skill: Awareness of Harsh Judgments	14.1
Mindfulness How Skill: One-Mindful Awareness	14.1
Mindfulness How Skill: Effectively and with Humility	14.1
Practiced Identifying Push-Backs & Don't-Hurt-Me Responses	16.1
Flexible-Mind REVEALs: Responding with Interpersonal Integrity	16.3
Flexible-Mind ROCKs-ON: Enhancing Interpersonal Kindness	17.1
Practiced Kindness First and Foremost	17.2
Practiced Open-Minded Assertiveness: PROVE skills	18.A
Flexible-Mind Validates: Signaling Social Inclusion	19.A
Flexible-Mind ALLOWs: Enhancing Social Connectedness	21.1
Practiced MATCH +1: Establishing Intimate Relationships	21.2
Flexible-Mind ADOPTS: Being Open to Feedback	22.1
Flexible-Mind DARES: Managing Unhelpful Envy	27.A
Flexible-Mind is LIGHT: Changing Bitterness	28.A
Flexible-Mind has HEART: Learning How to Forgive	29.A

Thank you!





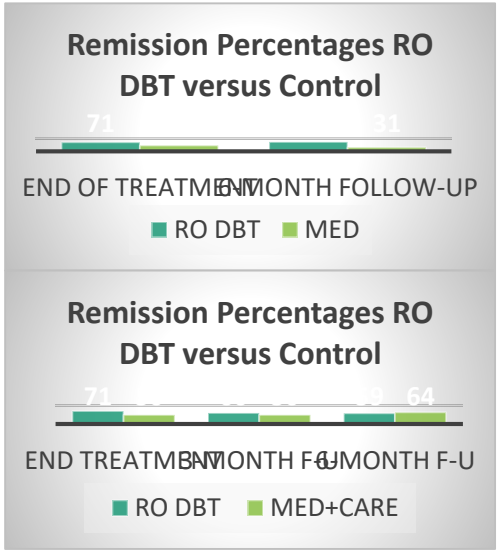
For more information on RO DBT, visit
www.radicallyopen.net

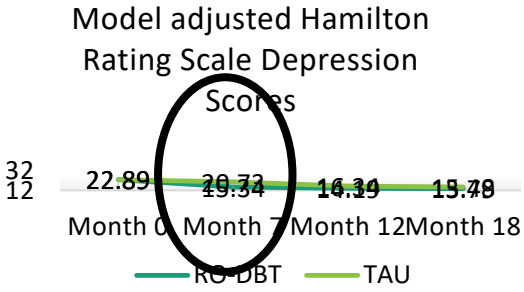
If you are receiving continuing education credits, don’t forget to sign out!

END OF TALK

Detailled RO DBT Research Slides

Three Randomized Controlled Trials for
Refractory Depression & Overcontrolled Personality disorders





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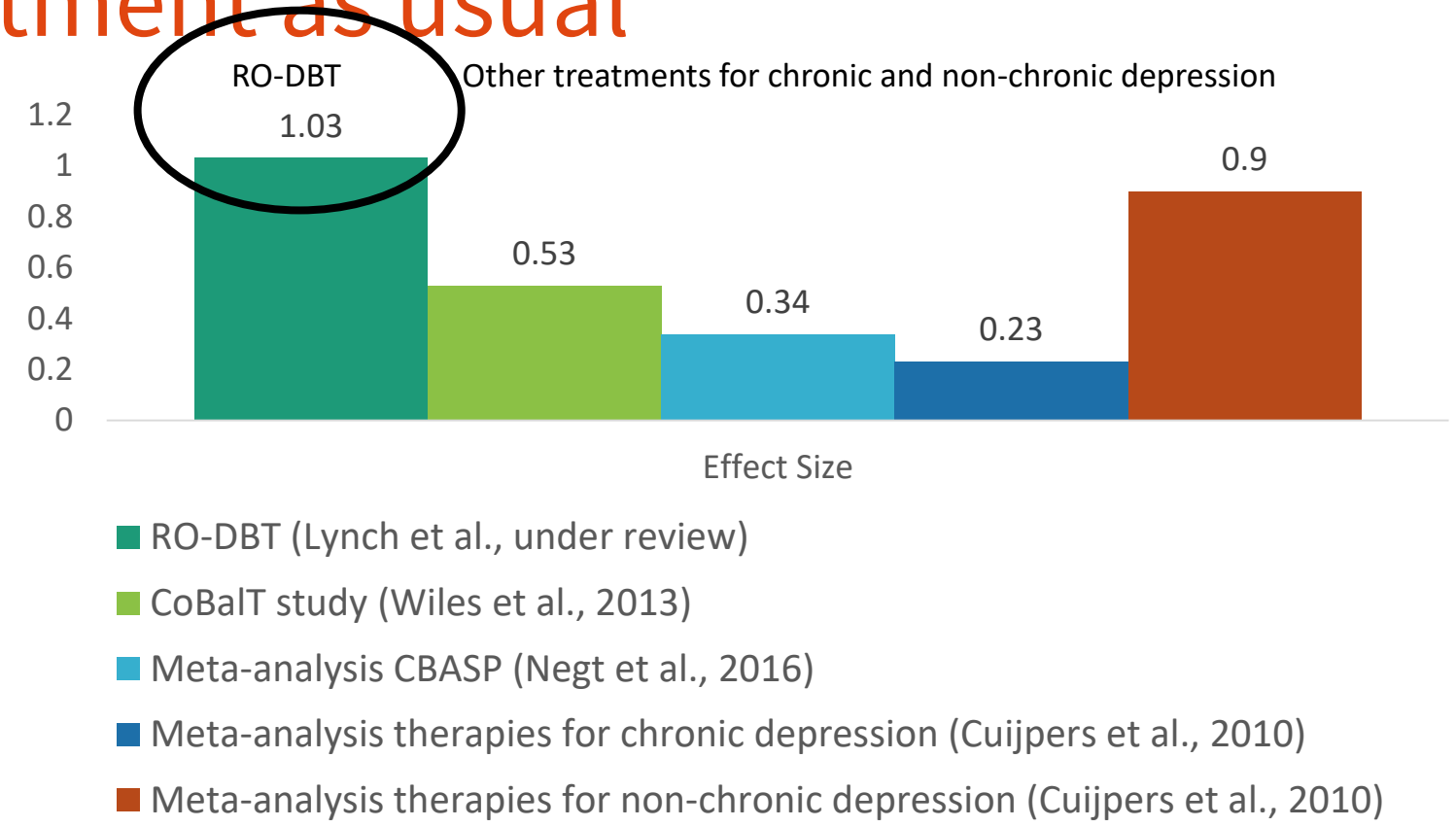
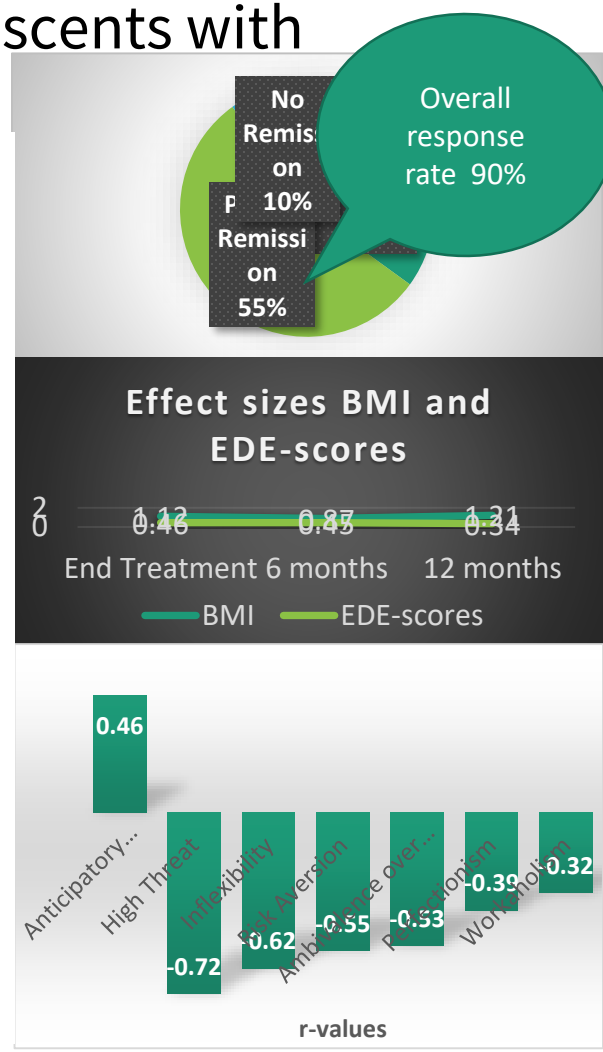


Three open-trials (pre-post) for adults and adolescents with **Anorexia Nervosa**



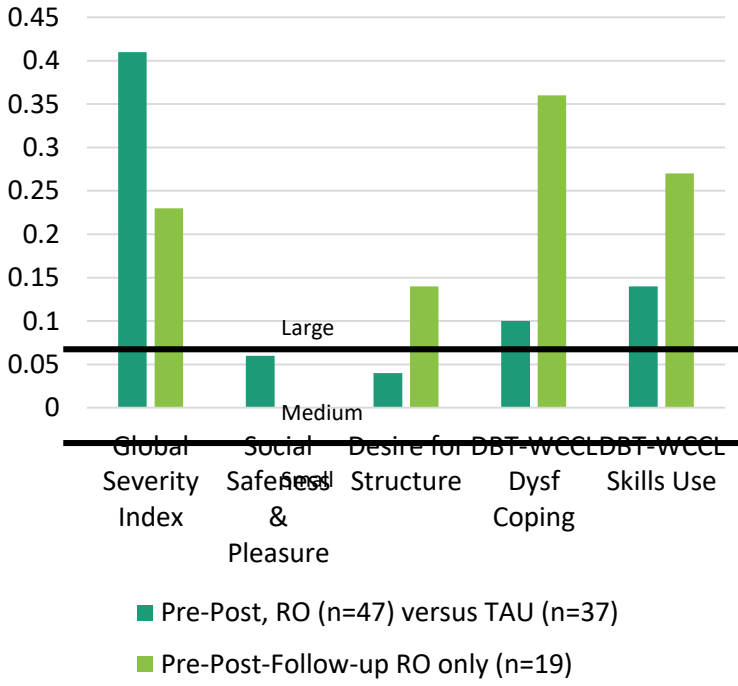
One Non-Randomized Controlled Trial for **chronic overcontrolled personality dysfunction**

Keogh et al., 2015, Journal of Practice Innovations (N = 117)

Results:

- **Post-Treatment,** RO-DBT Skills Alone compared to TAU post-treatment demonstrated significantly greater improvements in:
  - Global severity of psychological symptoms (large effect)
  - Social safeness (medium effect)
  - Rigid needs for structure (small effect)
  - Effective use of coping skills (medium to large effects DBT-WCCL scales)
- At **3-month follow-up**, the RO-DBT Skills Alone group showed significantly greater improvements in:
  - Global severity of psychological symptoms (large effect)
  - Rigid needs for structure (large effect)
  - Effective use of coping skills (large effects for both DBT-WCCL scales)

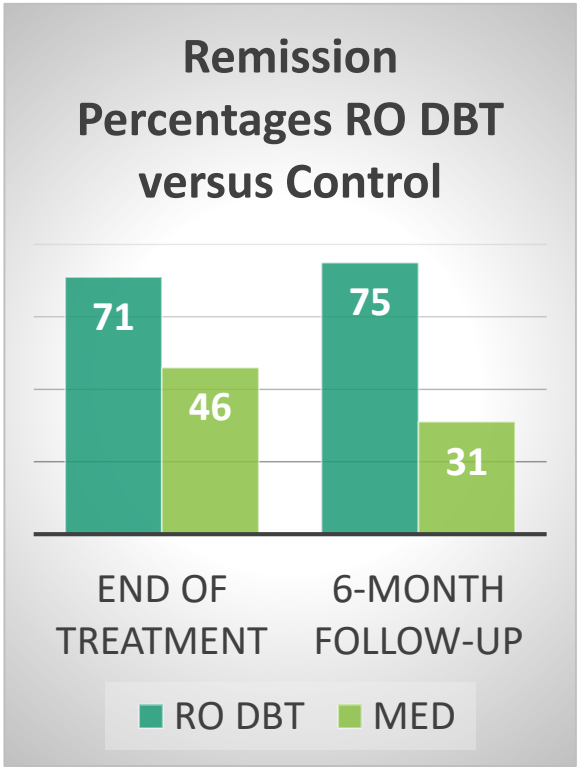
Effect Sizes (partial eta-squared) of significant findings (Keogh et al., 2015)



RCT 1: RODBT-E for Chronic Depression & Overcontrolled Personality Disorders (Lynch et al., 2003)

- Thirty-four chronically depressed individuals of 60 years or older (HAMD > 18 or BDI > 19) were randomized to
  - MED: Medication (antidepressants) alone (n=17). Percentage with at least one PD: 18%
  - RO DBT-Early + MED: Two presentations of 14 weeks of RO DBT-E & telephone contact plus antidepressants (n=17). Percentage with at least one PD: 45%

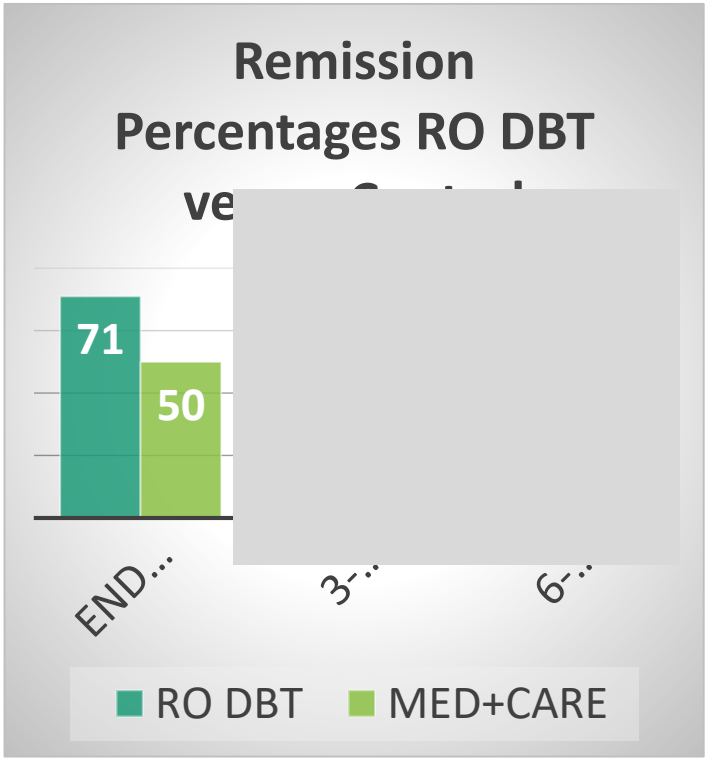
- Results: at the end of treatment, 71% of RODBT patients were in remission, in contrast to 46% of controls
  - This went up to 75% remission in RO DBT compared to 31% among controls at 6-month follow-up – a significant difference.
  - Only patients in the RO DBT group reported changes in personality style associated with fears of being liked by others and increases in adaptive coping – both maintained at 6 month follow-up



RCT2: RODBT-E2 for Chronic Depression & Overcontrolled Personality Disorders (Lynch et al., 2007)

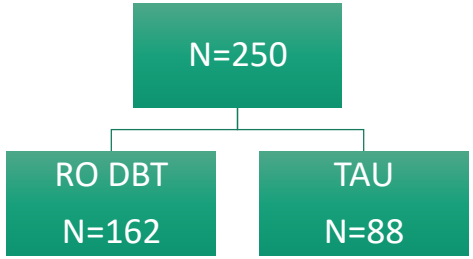
- Thirty-seven treatment resistant depressed patients (HAMD > 18) over 55 years old with comorbid PD were randomized to
  - MED + CARE: antidepressant plus general psychiatric care (n=14)
  - RODBT-E2: 24 weeks of RODBT-E2 (weekly 2-hour skills class and 1-hour individual) plus antidepressant medication (n=21)

- Results: 71% of RO-DBT recipients were in remission post-treatment compared with 50% of controls
  - This trend that was maintained at 3-month follow-up but levelled at 6-month follow-up,
  - RO DBT participants demonstrated significant improvements in personality dysfunction (interpersonal aggression, interpersonal sensitivity) compared to the control group, and these advantages were maintained at 6-month follow-up



RCT 3: REFRAMED: multi-site randomized controlled trial (Lynch et al., 2015; 2018)

- **Funded** by the National Institute for Health Research – Efficacy & Mechanisms Evaluations (NIHR-EME)
- **Aim**: Test efficacy and mechanisms of RO DBT versus Treatment as Usual (TAU) for patients with treatment resistant depression
- **Setting**: Three treatment sites in UK: Dorset, Hampshire, North Wales
- **Sample**: 250 treatment-resistant depressed patients (HAMD > 14)
  - Includes the most difficult-to-treat clients (suicidal, chronic, PD, older).
- **Treatments**: patients were randomized to
  - RO DBT (weekly individual therapy + skills class for 7 months) : n=162
  - TAU (any treatment patients were offered through the National Health Service): n=88
  - More patients were allocated to the RO DBT condition in order to study mechanisms of change



- **Assessments** at baseline, 7 months (post-treatment), and 12 and 18 months following randomization

RefraMED Study Co-Morbidity Rates

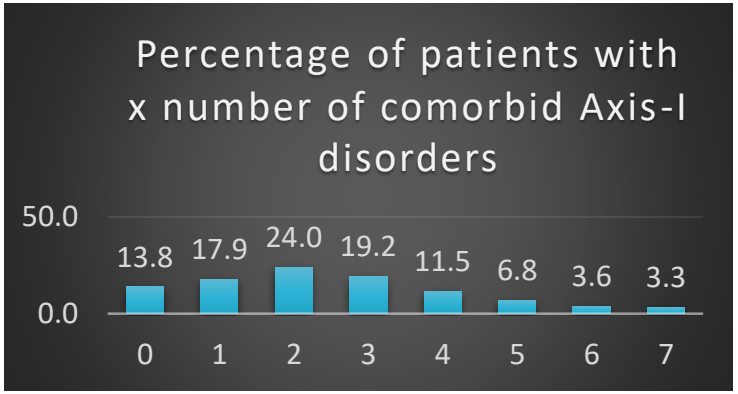
(Lynch et al., 2018)

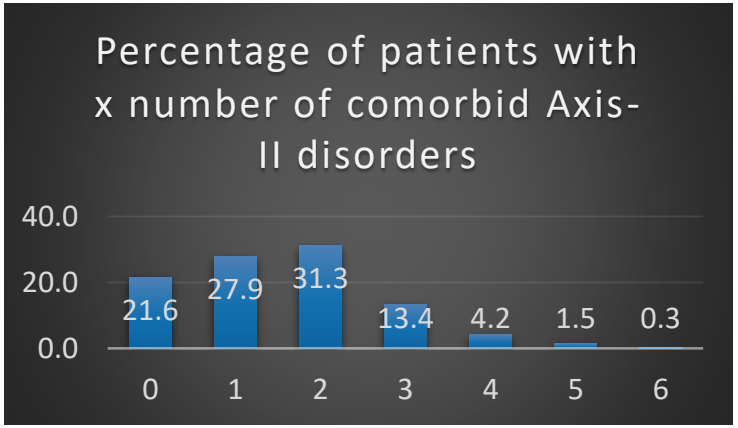
Of a sample of 250 chronically depressed patients:

- **Only 4%** of patients did not meet criteria for a comorbid mental health or personality disorder

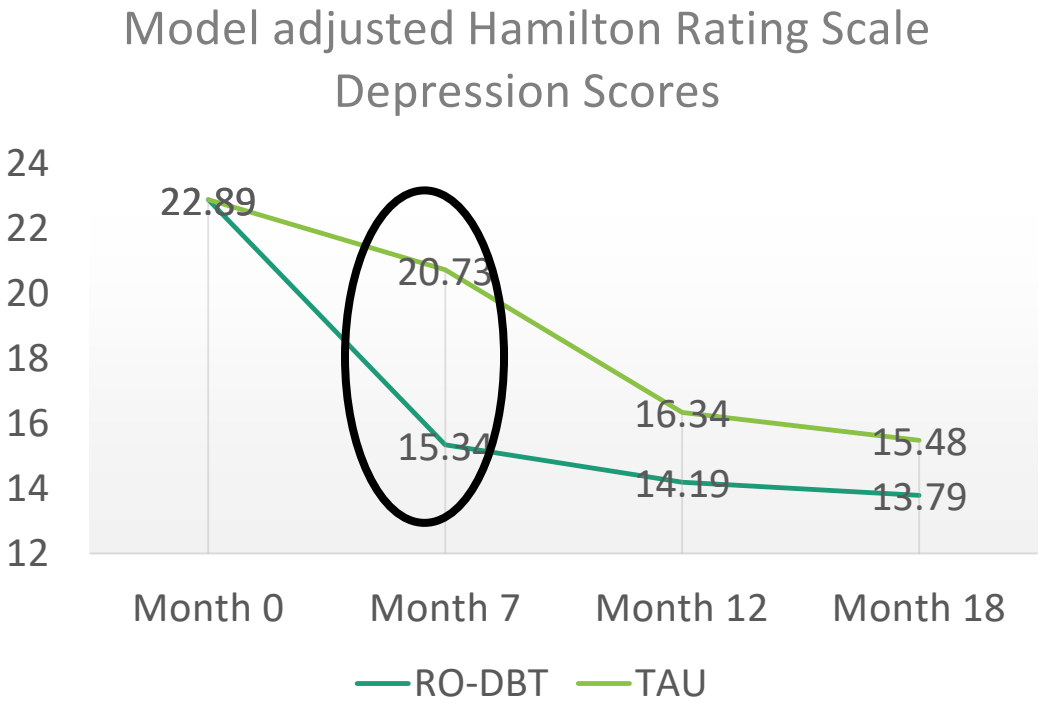
- **87% of patients** reported at least one other mental health disorder
- The two most common disorders were
  - Social phobia (80%)
  - Specific Phobia (63%)

- **79% of patients** reported at least one personality disorder
- The two most common personality disorders (PDs) were
  - Avoidant PD (54%)
  - Obsessive-compulsive PD (47%)



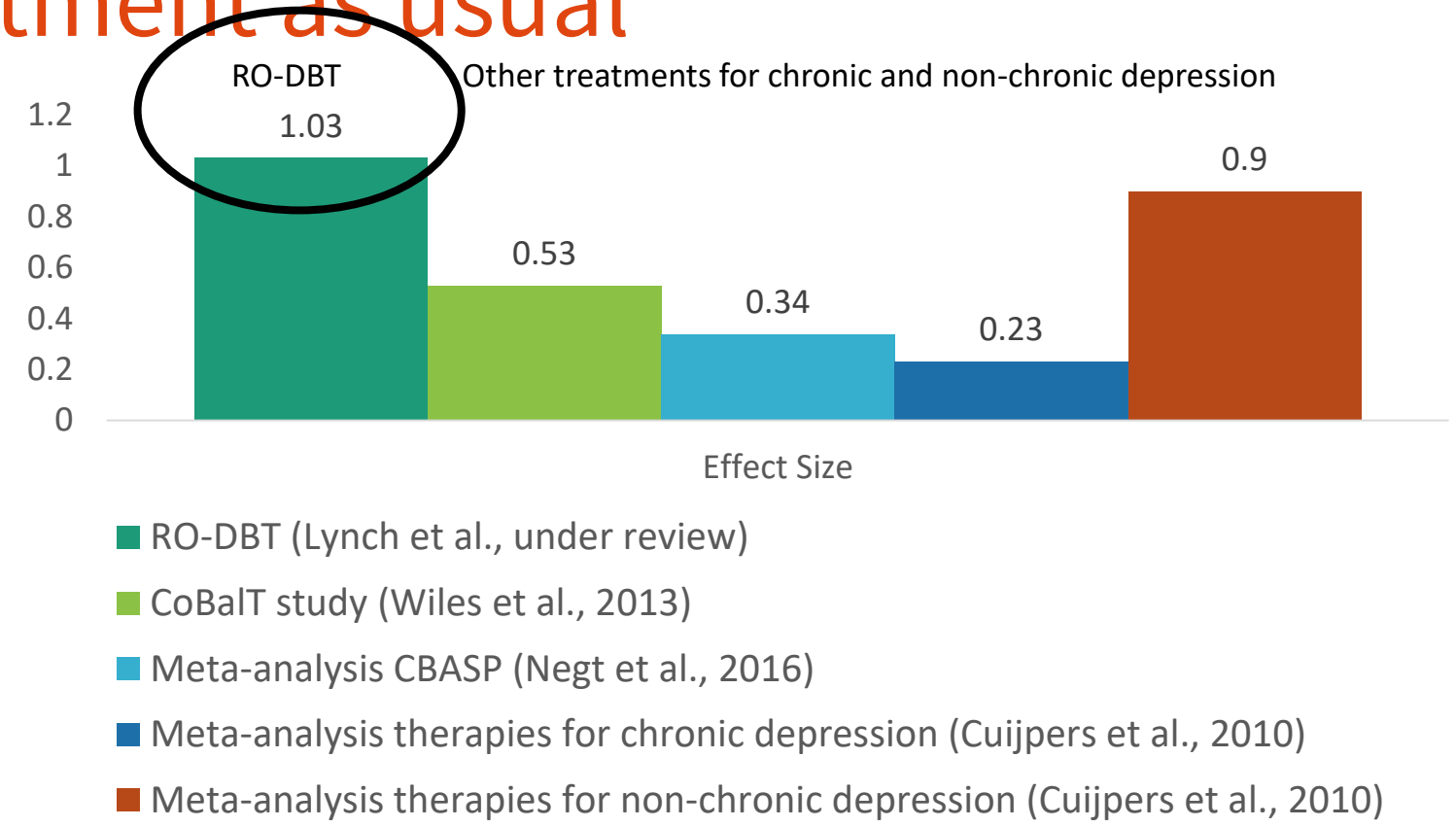


Does RO-DBT work for Refractory Depression?



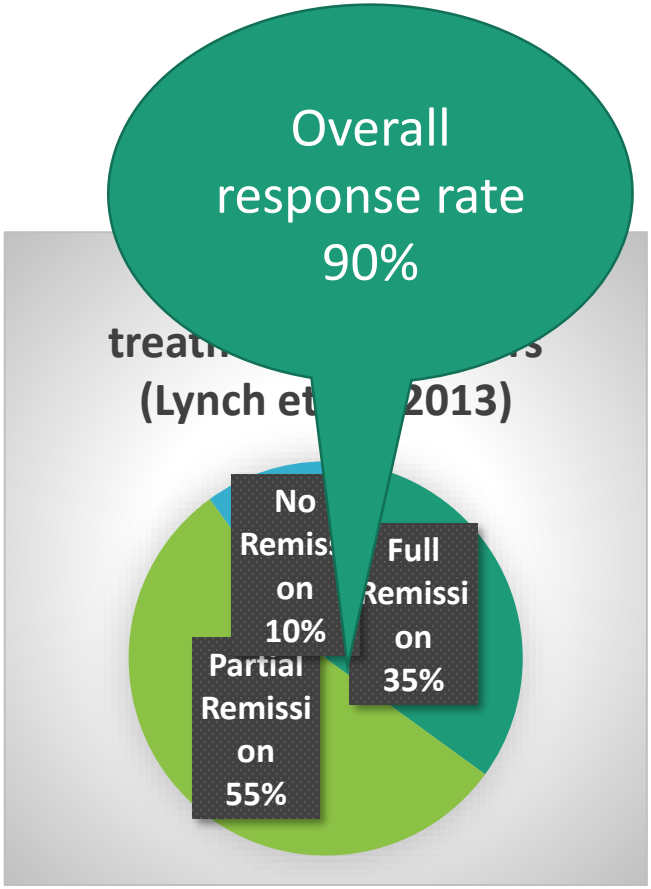
Effect sizes between group difference	
Month 7	1.03*
Month 12	0.41
Month 18	0.32

Large effect size RO DBT versus Treatment as usual



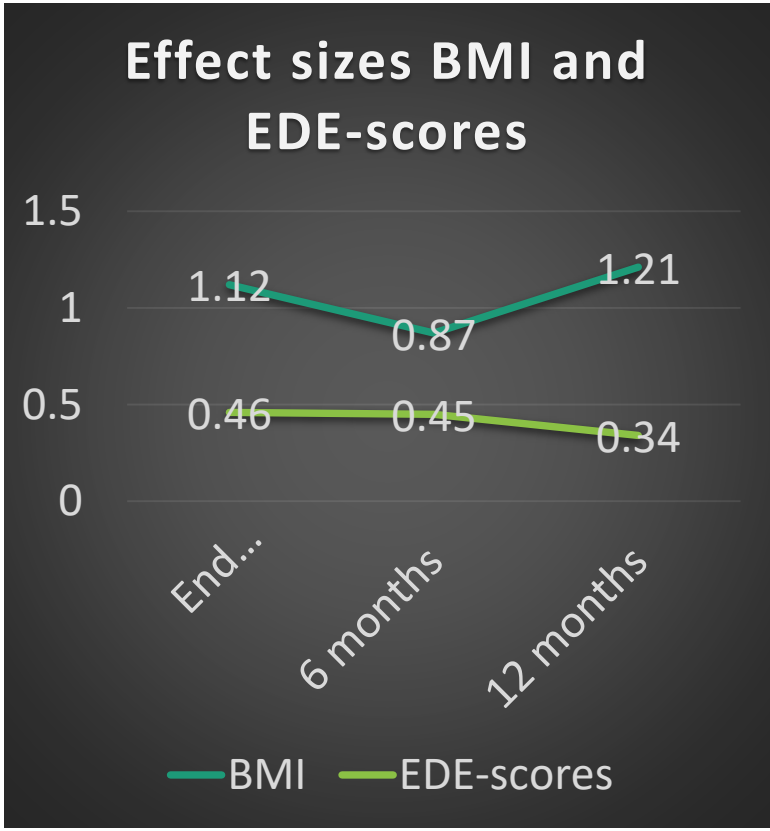
Open trial 1: RO DBT for Anorexia Nervosa (Lynch et al., 2013)

- **Sample**: 47 adults diagnosed with Anorexia Nervosa-restrictive type (mean admission BMI = 14.43) received RO DBT inpatient treatment (mean length = 21.7 weeks).
- Overall study **drop-out** = 27% (n = 13)
  - ❖ 6% dropped out of RO-DBT (n = 3)
  - ❖ 19% declined further weight restoration and left unit against medical advice (n = 9) ; 2% chose to continue weight restoration as outpatient (n = 1)
- **Results**:
  - Significant and large effect size increases in body mass index (BMI) using intent-to-treat analyses (d = 1.71) and for completers (d = 1.91).
  - Large effect size improvements in eating-disorder related psychopathology & psychological distress for treatment completers.



Open Trial 2: RO DBT for Anorexia Nervosa (Chen et al., 2014)

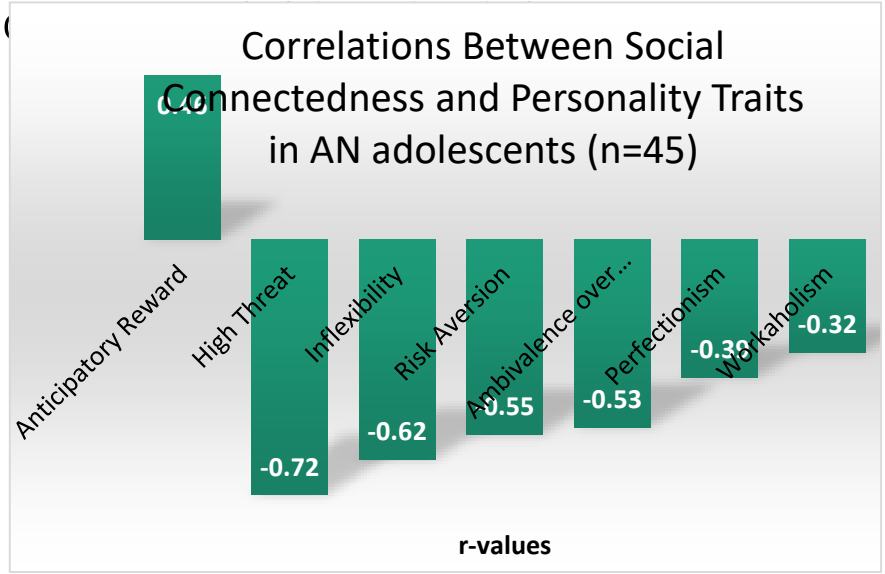
- **Sample**: 9 adult female AN patients (age range 19-51 years). At baseline:
  - Average BMI of 18.7
  - 75% met subclinical or full criteria for binge-purge AN
  - 88% had at least one comorbid Axis-I DSM-IV disorder (e.g. depression); 63% had at least one comorbid Axis-II DSM-IV disorder (e.g. obsessive-compulsive PD)
  - 25% reported histories of suicidal or non-suicidal self-injury
- **Treatment**: Standard Individual DBT + 32 weeks Radical Openness Skills classes (mean months of treatment = 8). **Treatment dropout** = 1 (11%)
- **Results**
  - Intention-to-treat analyses showed significant increases in weight gain and menses resumption for 62% of the sample at the end of treatment.
  - Large effect sizes for BMI; medium effect sizes EDE (graph)



Open Trial 3: RO DBT for Adolescent Anorexia Nervosa

(South London and Maudsley NHS Foundati
Eating Disorder Service)

1. **Feasibility Study** (Simic et al., 2016; Astrachan-Fletcher, Giblin, Simic, Gorder, 2018)
   - Sample: 45 adolescent AN patients
   - Social connectedness was significantly
     - positively related to high anticipatory reward; and
     - negatively related to high threat, ambivalence over emotional expression, inflexibility, risk aversion, perfectionism, and workaholism (*see graph)*
   - Social connectedness and reward responsiveness were negatively correlated with all composites of the **Eating Disorders Inventory-3**, i.e. with more severe eating disorder psychopathology.

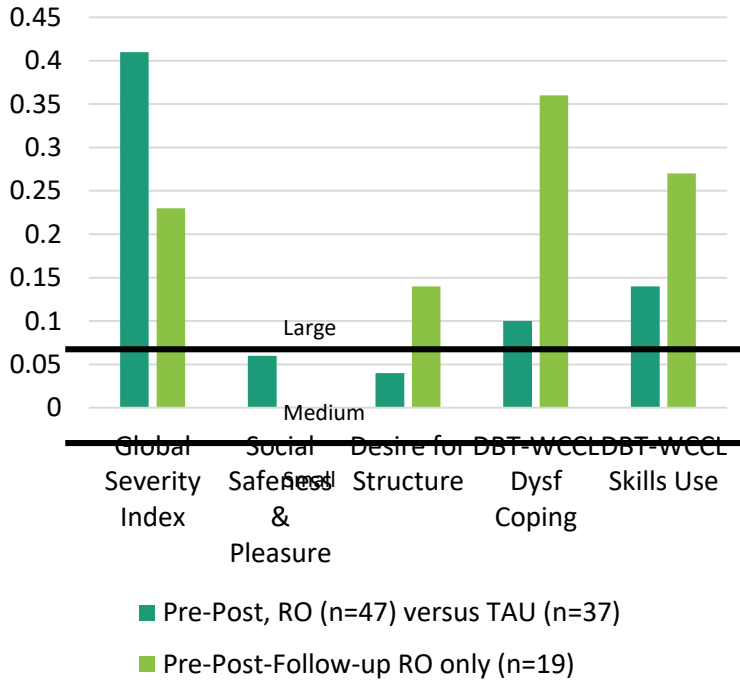


2. **Open Trial** (Simic et al., 2017; Astrachan-Fletcher, Giblin, Simic, Gorder, 2018)
   - Sample: 56 adolescent AN patients
   - Patients received outpatient or day treatment RO DBT
   - At the end of treatment:
     - Significant ***improvements*** in social connectedness (d=0.60) and consummation of pleasure (d=0.53)
     - Significant ***decreases*** in withdrawal (d=0.69), perfectionism (d=0.44) and negative temperament (d=0.34)

Non-Randomised Controlled Trial: RO DBT Skills Only for treatment resistant over-controlled adults (Keogh et al., 2015)

- **Design:** RO-DBT Skills Group Alone (n = 58) compared to Treatment-As-Usual wait-list (n = 59). The RO group was followed-up after 3 months (n=19)
- **Treatment**: RO skills class consisted of twice weekly three-hour classes over a period of nine weeks (group closed; total classes = 18).
- **Results**:
  - 10% (n = 6) **drop-out rate** for RO-skills group; no significant differences between drop-outs and treatment completers
  - **Post-Treatment,** RO-DBT Skills Alone compared to TAU post-treatment demonstrated significantly greater improvements in:
    - Global severity of psychological symptoms (large effect)
    - Social safeness (medium effect)
    - Rigid needs for structure (small effect)
    - Effective use of coping skills (medium to large effects DBT-WCCL scales)
  - At **3-month follow-up**, the RO-DBT Skills Alone group showed significantly greater improvements in:
    - Global severity of psychological symptoms (large effect)
    - Rigid needs for structure (large effect)
    - Effective use of coping skills (large effects for both DBT-WCCL scales)

Effect Sizes (partial eta-squared) of significant findings (Keogh et al., 2015)



About me, Angela Klein, Ph.D.

- Clinical psychologist in private practice
  - Ph.D. in clinical psychology, University of Missouri-Columbia, 2009
  - Centered Ground, San Diego & Carlsbad, North County, since 2014
  - CBT and DBT treatment, including standard DBT, RO, and DBT-based mindful eating for adolescents, families, and adults
  - Intensively trained in RO as of January 2015
  - Author of “Mindful Eating from the Dialectical Perspective: Research and Application” (Routledge, 2016), as well as peer-reviewed eating disorder research
  - Extensive previous experience developing, implementing, and researching DBT-based approaches across varied levels of care, specializing in eating disorders

Self-inquiry practice

- Person outing themselves: Tell your partner about an emotional event, without justifying, defending, or rationalizing
- Listener to person outing themselves:
  - After 1-2 minutes, ask: “Are you at your edge?”
    - If not, then: “What do need to do to get there?”
  - Then, whether the person has found their edge or not: “What is it that you might need to learn from this situation?” AND/OR “What question might you need to ask yourself in order to learn?”
  - Every 30 seconds, “Are you still at your edge, or have you regulated?”
    - If regulated, “Then what question do you need to ask to get back there?”