Dr. Katie Flanagan, Psy.D. &
Dr. Jessica Flynn, Ph.D., C. Psych.

DIALECTICAL BEHAVIOR THERAPY VS. RADICALLY OPEN DIALECTICAL BEHAVIOR THERAPY

Accuracy, Utility, and Risks Statement

This presentation discusses clinical intervention principles based on the most recent research and clinical experience of the presenters. As with all clinical interventions, attendees should be thoughtful about applying these skills and strategies without appropriate training and supervision.

Additionally, neither Dr. Katie Flanagan nor Dr. Jessica Flynn are certified trainers of the therapy modalities discussed and this material cannot be considered part of training towards becoming an official RODBT practitioner or a certified DBT clinician.

Program Notices

Conflicts of Interest:

None known.

Commercial Support:

None.

AGENDA

- Introduction
- Background of DBT and RODBT
- Exercise: Skill Practice
- Similarities and Differences
- Exercise: Case Presentation
- Questions

INTRODUCTIONS

Katie Flanagan, Psy.D.

Clinical Psychologist + RODBT coordinator at UCEBT

RODBT Practitioner, Level 3 trained

Jessica Flynn, Ph.D., C. Psych

She/Her

Clinical Lead DBT Program, Sageview Health, Canada

Private Telehealth Practice in Utah

PRIMARY GOALS

DBT VS RODBT

- Identify differences
- Decision making

A SHARED HISTORY

- A significant percentage of individuals with certain personality styles do not improve in existing therapy models
  - DBT = Borderline Personality Disorder
  - RODBT = Obsessive Compulsive Personality Disorder
- Addressing personality matters!
  - 10% of individuals in our communities meet criteria for a personality disorder (Fok et al., 2012)

THEORY: TWO OVERARCHING PERSONALITY STYLES

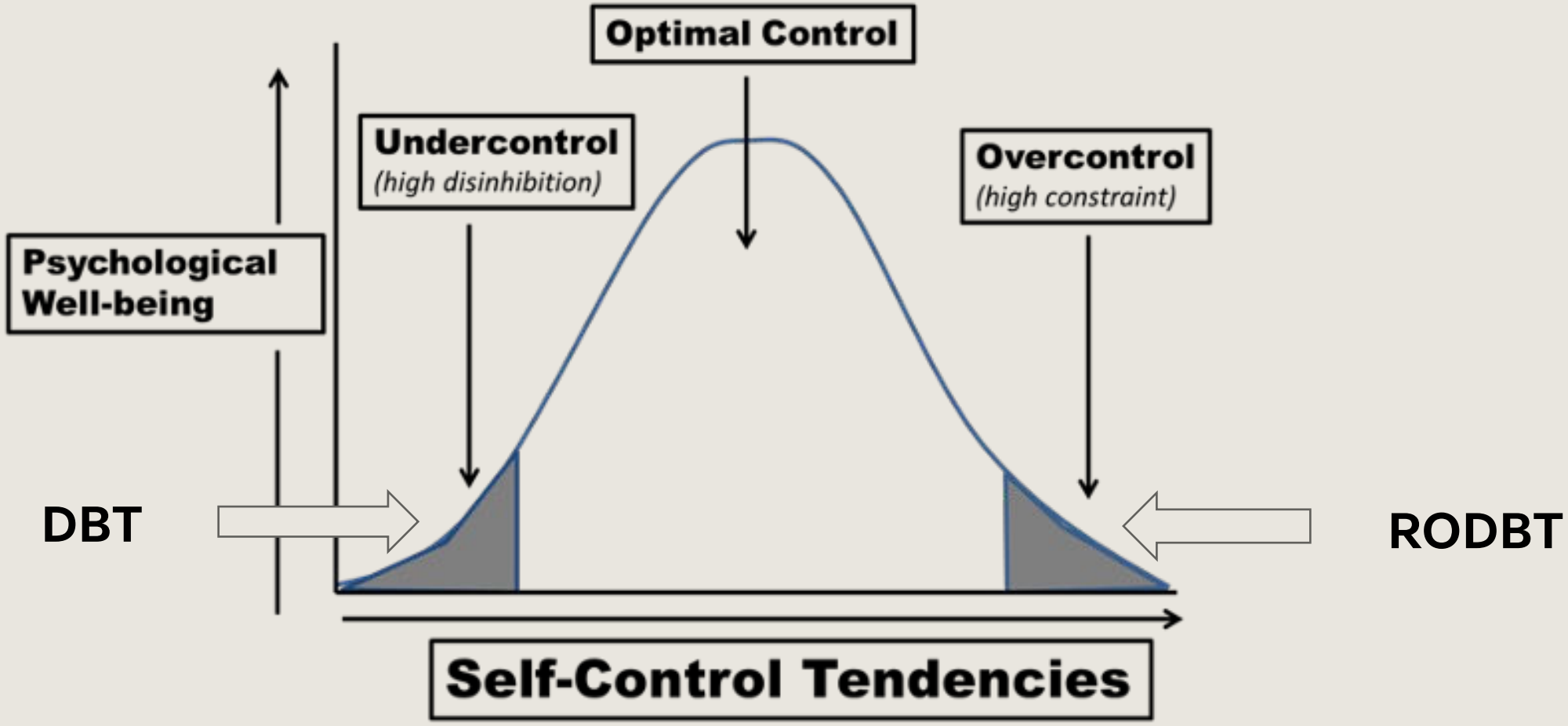
Multiple studies exploring factors that underlie co-morbidity have found results indicating the presence of two overarching personality styles (Clark, 2005; Kendler et al, 2003; Krueger, 1999; Krueger et al, 1998; Vollebergh et al, 2001)

Undercontrolled: impulsive, dramatic, emotionally expressive, more likely to develop externalizing disorders

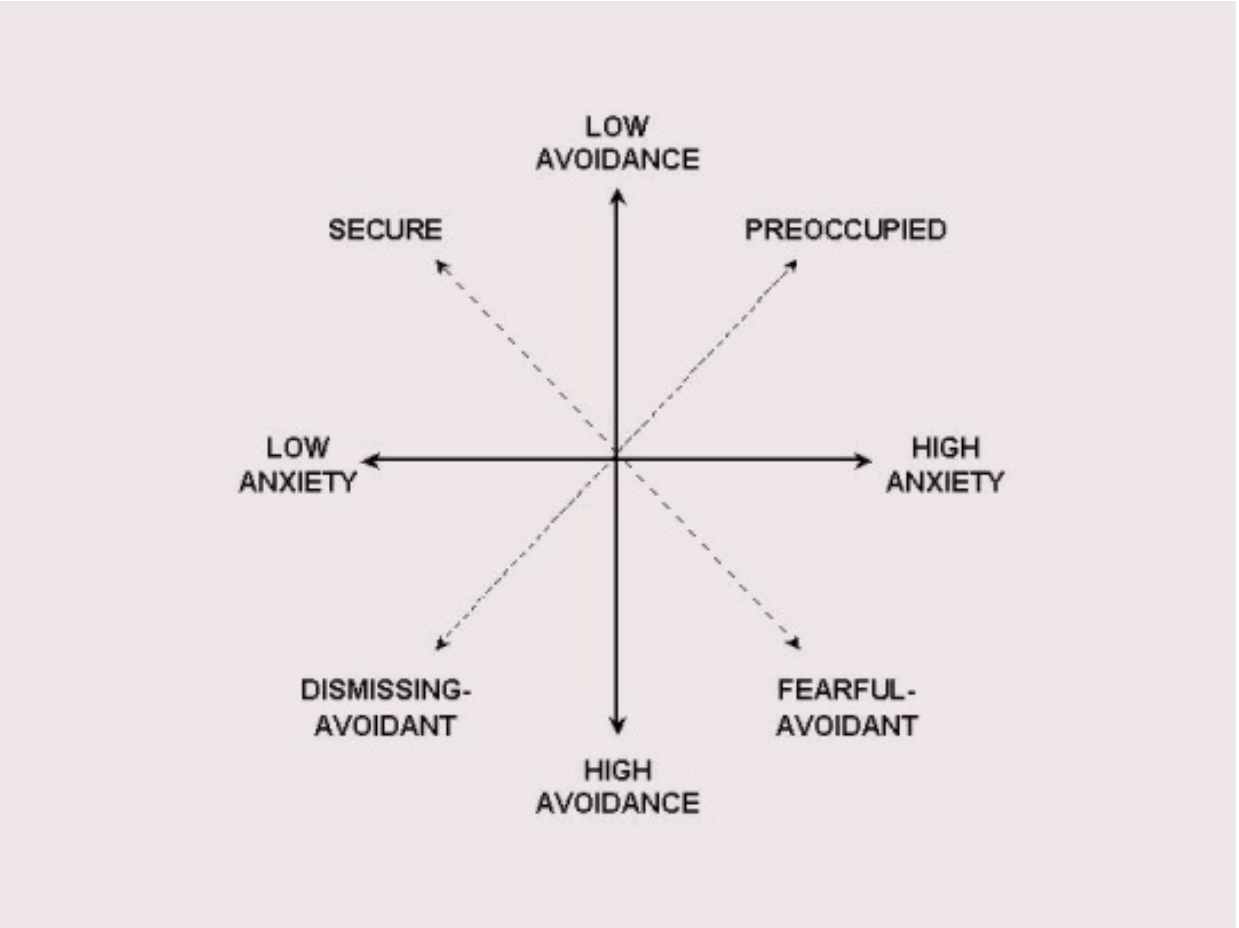
Overcontrolled: emotionally constricted, shy, risk averse, more likely to develop internalizing disorders

WHICH CHILD IS UC VS OC?

SELF CONTROL



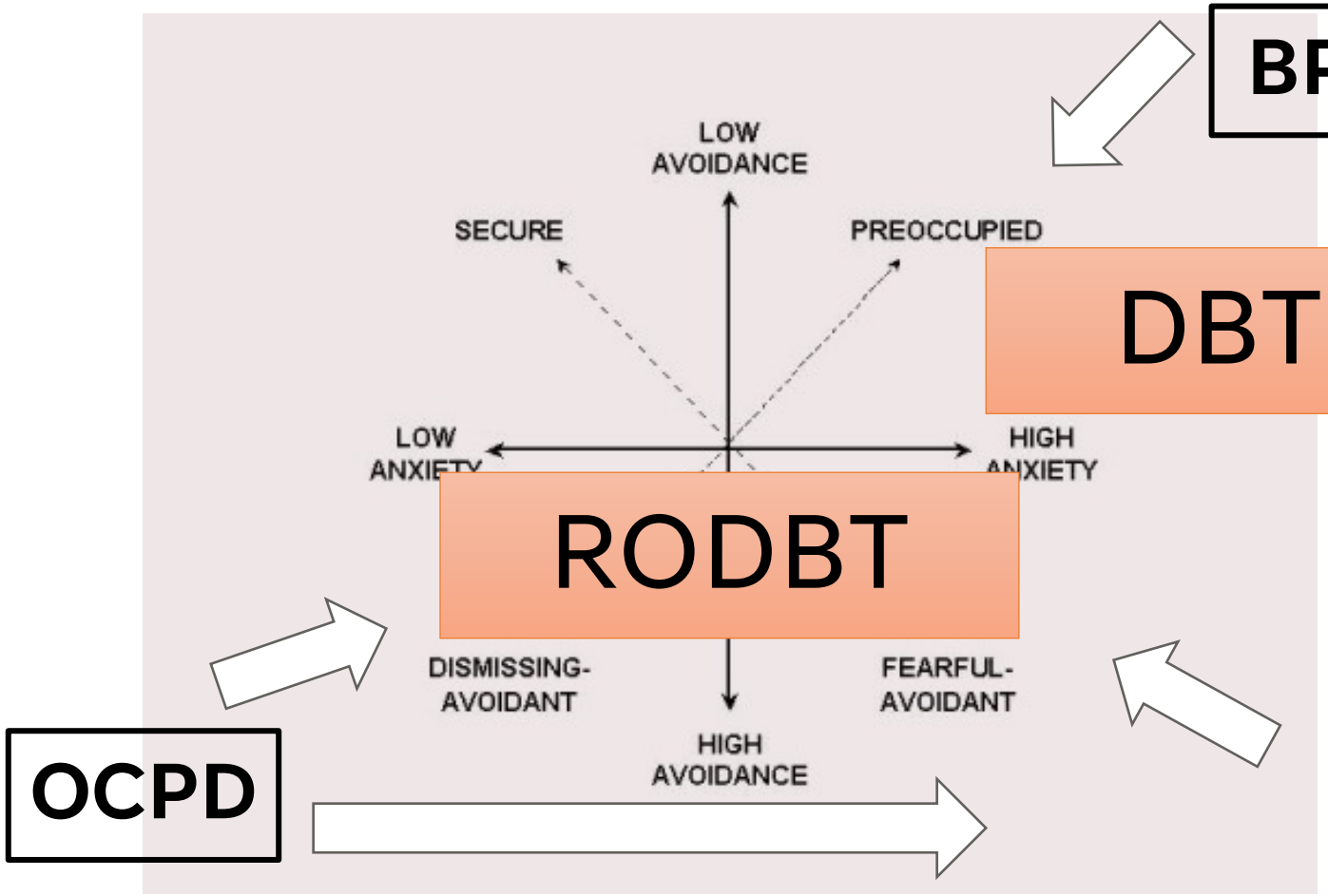
THEORY: ATTACHMENT STYLES



Additional category: Unresolved

Bartholomew and Horowitz(1991) & Brennan et al. (1998)

THEORY: ATTACHMENT STYLES



BPD

DBT

Fifth category: Unresolved

RODBT

OCPD

AVPD

Bartholomew and Horowitz(1991) & Brennan et al. (1998)

INTRODUCTION TO DBT

Jessica Flynn, Ph.D., C. Psych.

DIALECTICAL BEHAVIOR THERAPY (DBT)

- Treatment developer: Marsha Linehan, Ph.D.
- Developed to treat parasuicidal/suicidal women with BPD
- Rigorously studied for 30+ years
- Empirically supported treatment for BPD
- Adapted for other populations and treatment problems

THE PROBLEM OF UNDERCONTROL

- Self-control is important to overall success
- BPD is characterized by difficulty modulating affect
  - Emotions and behavior "out of control"
  - Quickly changing emotions
  - Reasoning overwhelmed

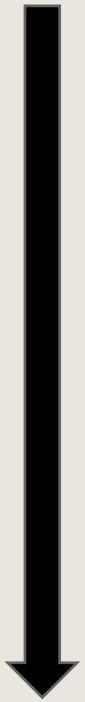
BIOSOCIAL THEORY

Emotional Sensitivity
Emotional Reactivity
Slow Return to Baseline

Indiscriminately Rejects
Intermittently Reinforces
Oversimplifies

Disconnected from Private Experiences
Oscillate between Extreme Emotion & Inhibited Emotion
Look to Others to Regulate
Forms Unrealistic Standards

CREATING SAFETY, STABILITY & REGULATION



- Risk for Suicide and Self Harm
- Behaviors that Interfere with Therapy
- Emotional & Behavioral Dysregulation

- Commitment
- Skill use:
  - Mindfulness
  - Distress Tolerance
  - Emotion Regulation
  - Interpersonal Effectiveness

CREATING SAFETY, STABILITY & REGULATION

CURRENT EVIDENCE BASE OF DBT

HTTPS://BEHAVIORALTECH.ORG/RESOURCES/

DBT MODES	POPULATION	CITATION
12-mos standard	BPD; Age 18-45	Linehan et al., 1991
6-mos standard	Veterans; BPD; Age 21-46	Koons et al., 2001
12-mos standard	BPD (53% SUD); Age 18-70	Verheul et al., 2003
6-mos standard	BPD & NSSI; Age 18-65	Carter et al., 2010
12-mos standard	Cluster B PD (93% BPD); Age 18-65	Feigenbaum et al., 2011
12-mos standard	BPD & NSSI/SA; Age 18-60	McMain et al., 2009
6-mos standard	BPD & NSSI; Age 18-65	Carter et al., 2010
12-mos standard	BPD & SSI; Age 18-45	Linehan et al., 2006

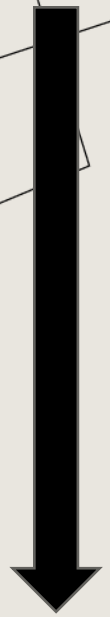
CURRENT EVIDENCE BASE OF DBT

HTTPS://BEHAVIORALTECH.ORG/RESOURCES/

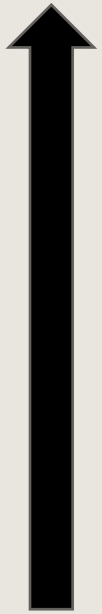
DBT MODES	POPULATION	CITATION
12-mos standard	ED & SUD; Age 18+	Courbasson et al., 2012
12-mos standard	Cluster B PD (93% BPD); Age 18-65	Feigenbaum et al., 2011
12-mos standard	PD & NSSI; Age 16+	Priebe et al., 2012
12-wk modified	PTSD (45% BPD); Age 17-65	Bohus et al., 2013
19-wk comp	BPD Traits & NSSI/SA; Age 12-18	Mehlum et al., 2014
13-wk mod. skills	BPD; Age 18-45	Soler et al., 2009
14-wk mod. skills	ADHD; Age 18+	Hirvikoski et al., 2011
12-wk mod. skills	Bipolar I or II; Age 18+	Van Dijk et al., 2013
16-wk comp	BPD traits & recent SA	Andreeasson et al., 2016

DBT EFFECTIVENESS & CONDITIONS

Evidence-based treatment for borderline personality disorder



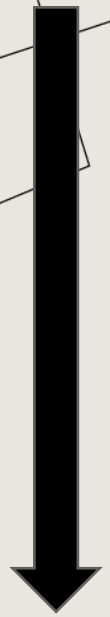
- Suicide Attempts
- Non-suicidal Self Injury (NSSI)
- Depression
- Hopelessness
- Anger
- Substance Dependence
- Impulsiveness



- Adjustment (general & social)
- Positive Self-Esteem

DBT EFFECTIVENESS & CONDITIONS

Evidence-based treatment for suicidal behaviors



- Suicide attempts (by 50%)
- Fewer ER visits for suicidality (by 53%
- Fewer psychiatric hospitalizations for suicidality

DBT SKILLS TRAINING EFFECTIVENESS

More effective than waitlists, standard group therapy, support group and medication only

- Emotion dysregulation
- Binge eating and binge/purge episodes
- Eating and weight related concerns
- Depression
- Anxiety
- ADHD behaviors
- General distress

ADAPTATIONS

- BPD with co-occurring:
  - PTSD
  - Substance use disorder
  - High irritability
- Cluster B Personality Disorders
- Self-harming individuals with personality disorders
- Attention-deficit hyperactivity disorder (ADHD)
- Posttraumatic stress disorder (PTSD; childhood sexual abuse)
- Bipolar disorder
- Bulimia nervosa
- Major Depression
  - Treatment resistant
  - Older adults with chronic depression & 1+ PD
- Suicidal and self-harming adolescents
- Pre-adolescent children with severe emotional & behavioral dysregulation
- Transdiagnostic emotion dsyregulation
- Binge eating disorder

MECHANISMS OF CHANGE

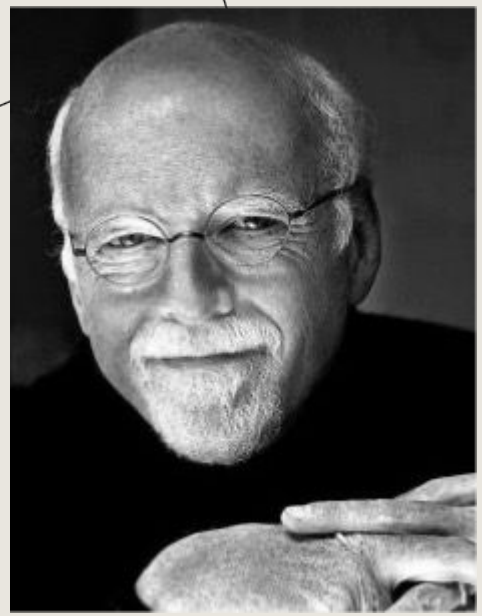
*REVIEW BY RUDGE ET AL., 2017

- Emotion Regulation/Self-Control
- Skills Use
- Alliance/Investment in Treatment

INTRODUCTION TO RODBT

Katie Flanagan, Psy.D.

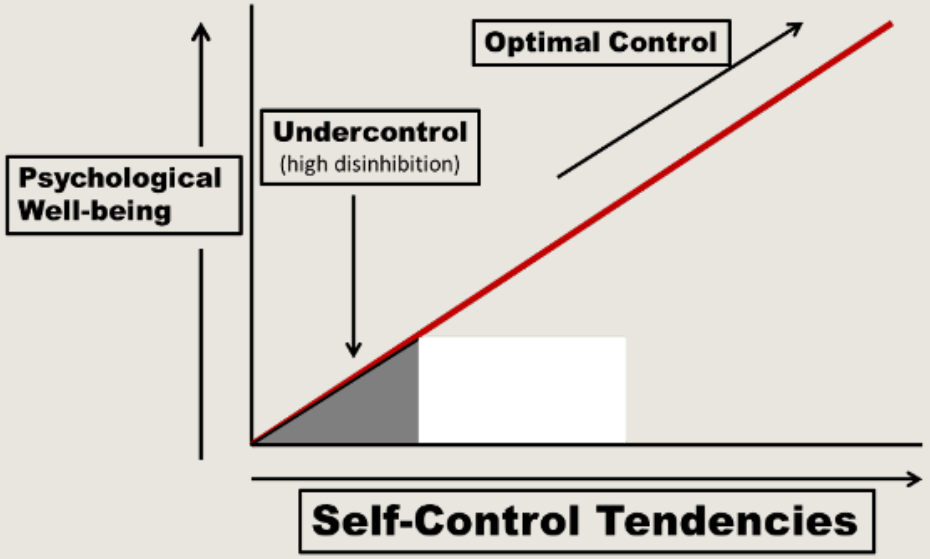
RADICALLY OPEN DIALECTICAL BEHAVIOR THERAPY (RODBT)



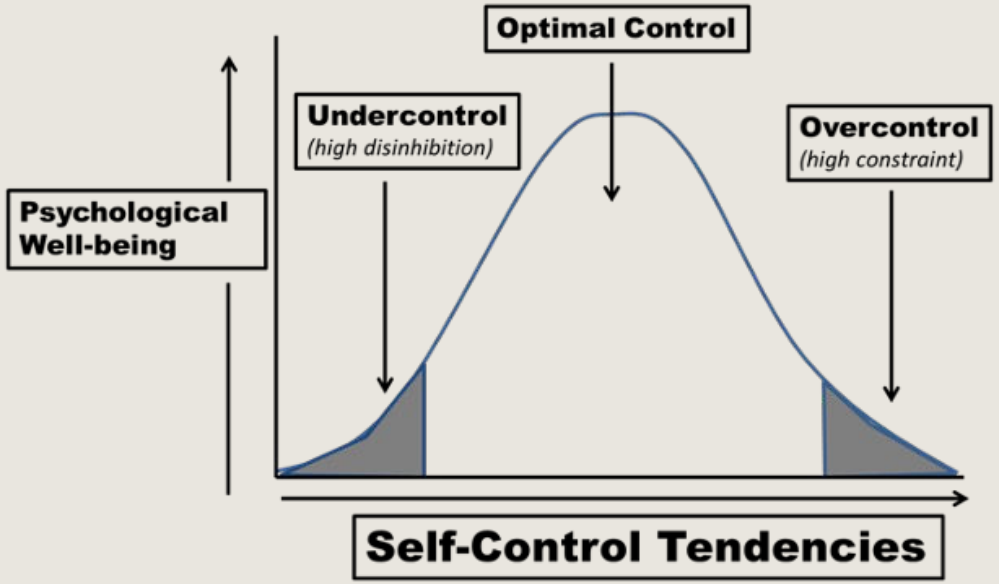
- RO DBT is informed by 30+ years of translational treatment development research
- Evidence-based behavioral treatment for individuals who cope with their emotions by engaging in excessive self-control
- Treatment developer: Thomas R. Lynch, PhD FBPsS

THE PROBLEM OF OVERCONTROL

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



But maybe you can have too much of a 'good thing'



BIOSOCIAL THEORY OF OVERCONTROL

Low Reward Sensitivity
High Threat Sensitivity
High Inhibitory Control
High Attention to Details

Mistakes are Intolerable
Never Appear Vulnerable
Structure & Control Essential
Winning Imperative

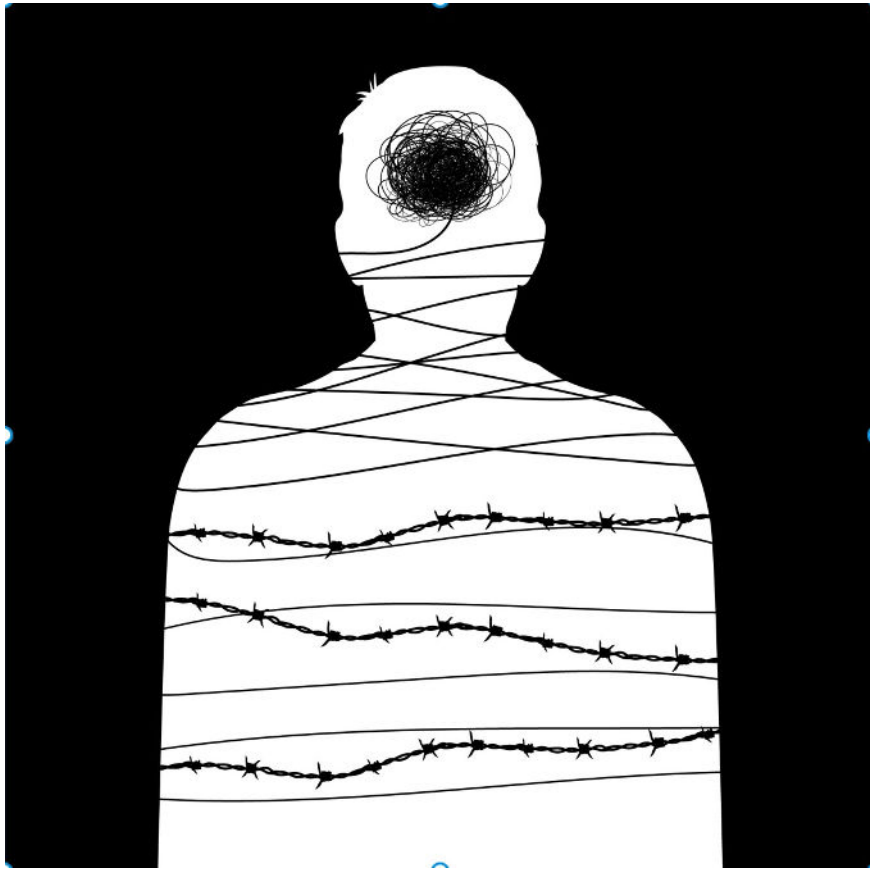
Mask Inner Feelings
Avoid Risk
Dislike Being the 'Center of Attention'
Aloof and Distant

FOUR CORE DEFICITS OF OVERCONTROL

1. **Lack Receptivity and Openness**, e.g. avoiding feedback and novel situations
2. **Lack Flexible Responding**, e.g. compulsive need for structure, rigid responding
3. **Lack Emotional Expression and Awareness**, e.g. inhibited or disingenuous expressions
4. **Lack Social Connectedness and Intimacy**, e.g. aloof and distant relationships

Emotional loneliness

BIO-TEMPERAMENTAL PREDISPOSITION



It is powerful because it impacts perception and regulation at the sensory-receptor or **preconscious level** (milliseconds)!

When a client's biotemperamental predisposition is high it creates more rigid response styles. Whereas clients with fewer biotemperamental biases can be more flexible in their response style to fit the context they are in.

- Meaning: They usually can't talk their way out of their rigidity!

Example: An OC client will feel and appear uptight at work, at home, at the gym and at a party,

CREATING SOCIAL SAFETY

RO DBT teaches OC clients skills for how to activate their social-safety system and “turn-off” bio-temperamentally heightened defensive arousal in order to be open, have vulnerable expression of emotion and connect with others.

RO DBT also 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).

CURRENT EVIDENCE BASE OF RODBT

- Three Randomized Controlled Trials (RCTs) for **Refractory Depression & Overcontrolled Personality disorders**—funded by NIMH, NIHR-EME, & NHS in (older) adults
  - *Lynch et al., 2003, International Journal of Geriatric Psychiatry (N = 34), outpatient older adult sample (>60)*
  - *Lynch et al., 2007, American Journal of Geriatric Psychiatry (N = 35), outpatient older adult sample (>55)*
  - *Lynch et al., 2020, British Journal of Psychiatry (N = 250), outpatient adult sample*
- Five open-trials (pre-post) for adults and adolescents with **Anorexia Nervosa and restrictive eating disorders**
  - *Lynch et al., 2013, BMC Psychiatry (N = 47), inpatient adult sample*
  - *Chen et al., 2015, International Journal of Eating Disorders (N = 9), outpatient adult sample*
  - *Baudinet et al. 2020, Journal of Eating Disorders (N= 131), IOP (Maudsley) adolescent sample*
  - *Isaksson et al., 2021, Journal of Behavior Therapy and Experimental Psychiatry (N = 13), outpatient adult sample*
  - *Baudinet et al., 2021, BMC Psychiatry (N=28), case series, transdiagnostic adolescent sample, mostly ED*
- Three non-randomized controlled trials for adults and adolescents that used a **skills-only approach**
  - *Keogh et al., 2016, Journal of Practice Innovations (N = 117), outpatient adults with chronic overcontrolled personality dysfunction*
  - *Cini et al., 2018, International Conference for Eating Disorders (N = 38), inpatient adolescents with AN*
  - *Cornwall et al., 2021, BJPsych Bulletin (N = 23), outpatient adults with Autism Spectrum Disorder*

ADDITIONAL STUDIES ON OVERCONTROL & MECHANISM OF CHANGE

- Two studies on overcontrol in children
  - *Gilbert et al., 2020, Journal of Anxiety Disorders (N = 69), children 8-12 years of age with pediatric anxiety disorder*
  - *Gilbert et al. 2022, Research on Child and Adolescent Psychopathology (N=126), 5–6-year-old children*
- Mechanisms of change in RO DBT
  - *Gilbert et al., 2023, Journal of Consulting and Clinical Psychology (N=250), outpatient adult sample*
- Implementation Study
  - *Johnson et al., 2023, Journal of College Student Psychotherapy: implementation of RO DBT in a University or College Counseling Setting*

For more research papers on RO DBT: https://www.radicallyopen.net/research-on-ro-dbt/

EXERCISE: SKILLS PRACTICE

RO DBT SKILL: BIG 3+1

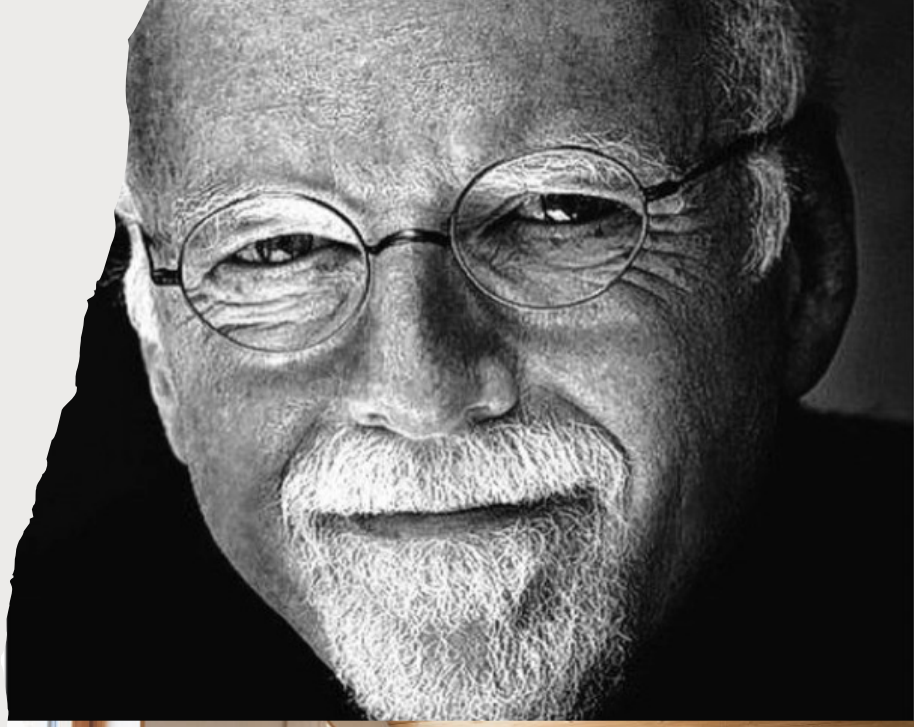
Goal: Activate social safety to increase social connectedness

If you are sitting down, start with the (+ 1)

(+1) Lean back in your chair

Next, engage the Big 3

1. Take a slow deep breath
2. Make a closed-mouth smile
3. Use an eyebrow wag



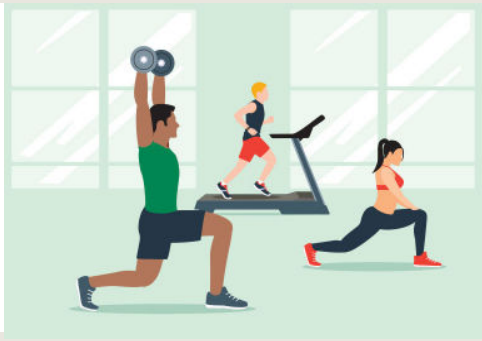
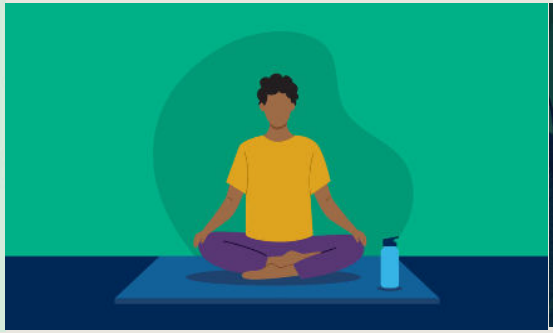
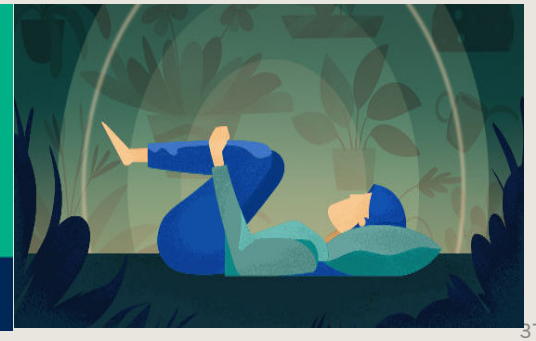
DBT SKILL: TIPP

T – Temperature

I – Intense Exercise

P – Paced Breathing

P – Paired Muscle Relaxation

SIMILARITIES

Treatment Components

Behavioral Principles

Dialectical Philosophy

Client Presentation

TREATMENT COMPONENTS

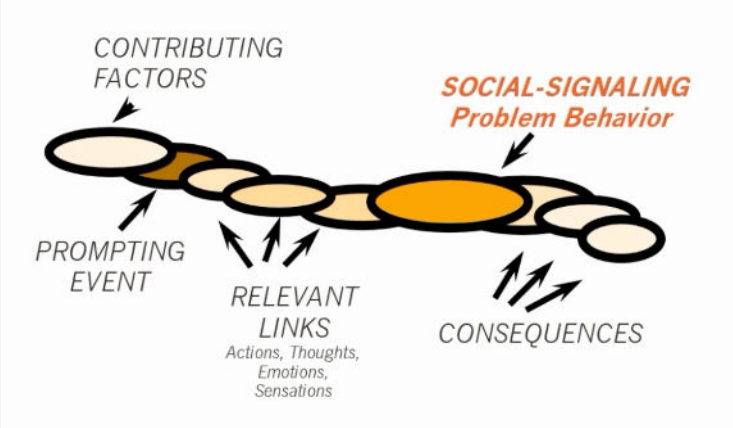
Individual Sessions – Pre-Treatment

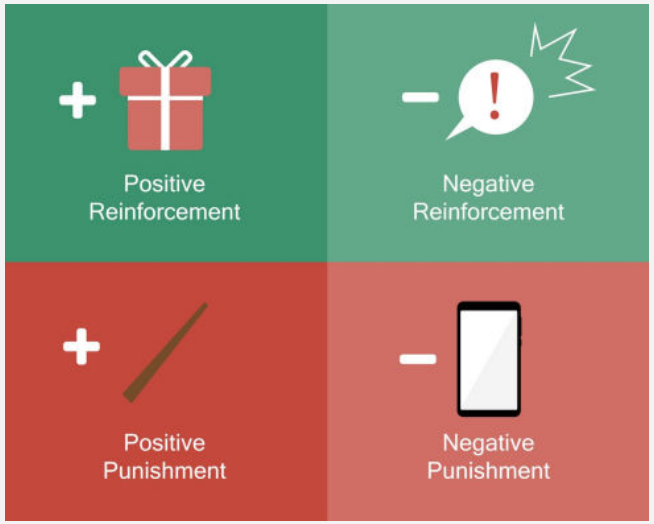
Individual Sessions – Treatment

Group Skills Training

Phone Coaching

Consultation Team





BEHAVIORAL PRINCIPLES

- Problem assessment
- Behavior chain analysis
- Shaping
- Reinforcement (positive or negative, natural or arbitrary, fixed or variable schedule)
- Punishment
- Extinction and Extinction Burst
- Contingency Management
- Exposure

DIALECTICAL PHILOSOPHY

- Dialectical = a synthesis or integration of opposites

- DBT:
  - Acceptance & Change
  - Reciprocal & Irreverence

- RODBT
  - Nonmoving Centeredness & Acquiescent Letting Go
  - Playful irreverence & Compassio nate Gravity

CLIENT PRESENTATION

- Treatment Resistant
- High rates of suicide and self-harm acts
- Skills Deficits

DIFFERENCES

Therapeutic Stance

Primary Focus

Skills Focus

Client Presentation

THERAPEUTIC STANCE

DBT	RODBT
Directive stance	Less Directive
Dialectical challenge: acceptance and change	Encourages independence of action and opinion
High level of daily involvement	Focuses on self-discovery and self-enquiry
Watches carefully for therapist burn-out	Celebrates vulnerable and unplanned expression of emotion
Celebrates willingness to control behavior	Supports the client in letting go of always trying harder

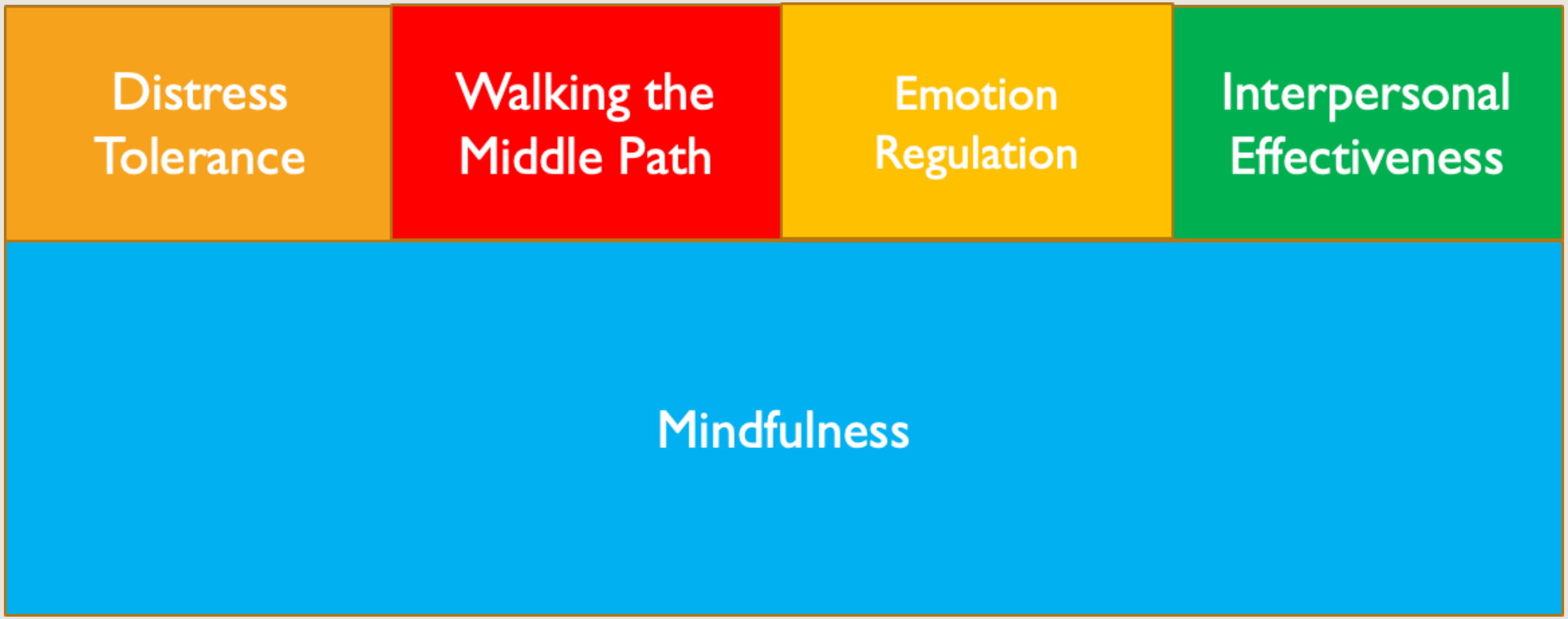
PRIMARY FOCUS

DBT	RODBT
Manage risk for suicide	Address any imminent life-threatening behaviors
Focuses on gaining behavioral control, especially during crisis	Manage therapeutic alliance ruptures
Encourages development of strategies to avoid conflict, organize, restrain impulses, and delay gratification	Decrease severe behavioral overcontrol and aloofness/distance which lead to emotional loneliness
Focuses on non-mood dependent responses	Increase behavioral flexibility, openness, and vulnerable expression of emotion to enhance socially connectedness

SKILLS FOCUS

DBT	RODBT
Tolerate distress & manage crisis	Increase openness to new information or disconfirming feedback in order to learn
Prevent vulnerability to emotion and change difficult emotion	Learn how to activate social safety
Increase non-judgmental awareness	Enhance social connectedness and intimacy
Learn how to get needs met, how to maintain self-respect and how to maintain relationship	Increase vulnerable expression of emotion
	Improve ability to flexibly respond to each situation

DBT SKILLS


Distress Tolerance
Walking the Middle Path
Emotion Regulation
Interpersonal Effectiveness
Mindfulness

SKILLS FOCUS

DBT	RODBT
Increase non-judgmental awareness	Increase openness to new information or disconfirming feedback in order to learn
Tolerate distress & manage crisis	Learn how to activate social safety
Prevent vulnerability to emotion and change difficult emotion	Enhance social connectedness and intimacy
Learn how to get needs met, how to maintain self-respect and how to maintain relationship	Increase vulnerable expression of emotion
Adolescents: find ways to think dialectically in the caregiver-child relationship	Improve ability to flexibly respond to each situation

CLIENT PRESENTATION

DBT	RODBT
Externalizing problems	Internalizing problems
Cluster B personality disorders	Cluster A & C personality disorders e.g. avoidant, obsessive compulsive, paranoid, and schizoid PDs
Problems that are often linked to difficulties with self-control including conduct disorders, illegal substance misuse, bulimia, binge eating	Chronic depression, treatment resistant anxiety, autism spectrum disorder, and anorexia nervosa
Unplanned, impulsive and/or mood dependent suicide/self-harm behavior	Planned, usually well-kept secret, and more likely to be rule-governed suicide/self-harm behavior

UNDERCONTROLLED (UC)

Emotionally Dysregulated and Impulsive

- Borderline PD
- Antisocial PD
- Narcissistic PD
- Histrionic PD
- Binge-Purge Eating Disorders*
- Conduct Disorders
- Bipolar Disorder
- Externalizing Disorders

OVERCONTROLLED (OC)

Emotionally Constricted and Risk-Averse

- Obsessive Compulsive PD
- Paranoid PD
- Avoidant PD
- Schizoid PD
- Anorexia Nervosa
- Chronic Depression
- Autism Spectrum Disorders
- Treatment Resistant Anxiety-OCD
- Internalizing Disorders

*B-P ED – there may be OC and UC versions


ASSESSMENT

DBT ASSESSMENT MEASURES - BY UNIVERSITY OF WASHINGTON

COMPREHENSIVE INTAKE: SCID + IN-DEPTH HISTORY

DEMOGRAPHIC DATA SCALE (DDS) LINEHAN, 1982

BORDERLINE SYMPTOM LIST (BSL) Bohus et al.. 2007

DBT- WAYS OF COPING SCALE (DBT-WCCL SCALE) Neacsiu, et al., 2010

REASONS FOR LIVING SCALE (RFL) Linehan, et al., 1983

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) **Kroenke et al., 2001**

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SUICIDE ATTEMPT SELF-INJURY INTERVIEW (SASII) Linehan, et al. 2006

LINEHAN RISK ASSESSMENT & MANAGEMENT PROTOCOL (LRAMP) Linehan, M.M. (2009) & Ward-Ciesielski (2012)

http://depts.washington.edu/uwbrtc/resources/assessment-instruments/

RODBT ASSESSMENT MEASURES - BY RO-DBT RESEARCH GROUP

- **Styles of Coping word-pairs**
  - Self-report scale that can be used in treatment as a way to help the client self-identify as more OC or UC
- **OC Trait Rating Scale**
  - Self-report scale to see how well a client matches OC traits
- **Clinician Rated OC Trait Rating Scale**
  - Scale designed to be completed by the clinician to see how well a client matches OC traits
- **Clinician Rated OC Prototype Rating Scale**
  - Scale designed to be completed by the clinician to assess how closely the client matches the prototype for OC

Access: See the RO DBT Textbook and 'Downloadable Resources – Assessment Materials' within the RO DBT Online Support Course

RODBT ASSESSMENT MEASURES – BY OTHER AUTHORS

- **Distress Overtolerance Scale** (Gorey et al., 2016): the distress overtolerance scale is based on Lynch's theory and has a two-factor structure (i.e., Capacity for Harm and Fear of Negative Evaluation)
- **Schedule for Nonadaptive and Adaptive Personality—2nd Edition (SNAP2)[1] or SNAP-Y for adolescents[2]:** Recommended subscales: Negative Temperament (high scores) and Disinhibition (low scores)
- **Temporal Experience of Pleasure Scale (TEPS):** OC clients are expected to score low on both anticipatory and consummatory pleasure scales
- **Five-Factor Obsessive–Compulsive Inventory (FFOCI):** Recommended subscales (OC clients are expected to score high on all): Inflexibility, Risk-aversion, Perfectionism, Punctiliousness, Workaholism
- **Social Connectedness Scale-revised (SCS-r):** OC Clients are expected to have low scores on this measure
- **Ambivalence of Emotional Expressiveness Questionnaire (AEQ):** OC Clients are expected to have high scores on this measure
- **Acceptance and Action Questionnaire (AAQ-II):** measures psychological inflexibility

CASE EXAMPLE

The client is a 30-year-old, heterosexual, cisgender female. She was born in Utah and values her middle eastern heritage. She is a practicing Muslim. She is divorced, has one child, and works full-time as a lawyer. She is seeking treatment to address ongoing and increasing social anxiety and worsening procrastination behaviors at work. She reported a history of disordered eating though denies any current behaviors. She endorsed current SI and self-harm behaviors.

POLL

QUESTIONS

15 minutes

RESOURCES FOR FURTHER TRAINING

Training, Support and Supervision for Mental Health Professionals

RODBT: https://www.radicallyopen.net/

DBT: https://behavioraltech.org/

THANK YOU

Jessica Flynn, Ph.D., C. Psych.

jess.flynn@gmail.com

Sageviewhealth.ca

Katie Flanagan, PsyD

Kaitlin.flanagan@ucebt.com

www.ucebt.com

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