EXTENDED SUMMARY:

RADICALLY OPEN -DIALECTICAL BEHAVIOR THERAPY FOR ANOREXIA NERVOSA

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Abstract

Radically Open-Dialectical Behavioral Therapy (RO-DBT) is a transdiagnostic therapy designed to address the over-control which is present in serious disorders such as Anorexia Nervosa. Over-control is a maladaptive coping mode that emerges from temperamental and social factors and has been linked to social isolation, relational deficits, hyper-perfectionism, cognitive rigidity, risk aversion and emotional inhibition. RO-DBT aims for open-experience and negative feedback as a learning chance, for the flexibility to adapt to a constantly changing environment, and for the formation of close social bonds. In this treatment pleasure, relaxation and bonding are prioritized, being the main target social-signaling deficits that perpetuate isolation. The aim of this paper is to provide an overview of the core theoretical principles and therapeutic strategies of RO-DBT and the application and usefulness in Anorexia Nervosa.

Keywords: *Anorexia Nervosa, Radical Openness, Over-Control, Dialectical Behavioral Therapy.*

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Introduction

Anorexia Nervosa (AN) is a serious chronic course mental disorder, which mainly affects women and is associated with high rates of mortality. There are few specific psychological treatments for AN and none has shown to be clearly superior. There is a lack of research, especially for those with more severe presentations, and with poor outcomes in previous treatments. Since food centric approaches often fail, clinicians need useful treatments focused on the underlying.

Dialectical Behaviour Therapy (DBT) was originally designed to address the core symptoms of Borderline Personality Disorder and has proved to be effective in conditions related to emotion dysregulation. Radically Open Dialectical Behaviour Therapy (RO DBT) is an adaptation of the standard TDC targeting disorder characterized by excessive self-control or *overcontrol (OC)*, such AN, autism spectrum disorders, chronic depression or obsessive-compulsive personality disorder. It is, therefore, a new and transdiagnostic approach. The person behind this therapy is Thomas Lynch PhD, who has written the theory and practice manuals and a growing amount of research papers.

Following the author, OC is characterized by four main deficits:

1. Low receptivity and openness.
2. Low flexible-control.
3. Pervasive inhibited emotional expression and low emotional awareness.
4. Low social connectedness and intimacy with others.

Restrictive AN is the sub-type of eating disorder that fits the most to maladaptive OC, with its characteristic obsessive, avoidant, inflexible and perfectionist personality style and its tendency to isolation. RO DBT targets OC and emotional isolation found in people suffering AN. Eating disorder symptoms, as restrictive eating, are considered another manifestation of these main deficits.

Basic postulates

the fundamental philosophical principle of treatment is *radical openness*. Radical openness represents the confluence of three factors that are necessary for emotional well-being: openness (receptivity), flexibility and social connectedness. It involves a disposition to surrender preconceptions about how the world should be in order to adapt to an ever-changing environment. Therefore, *self-inquiry* is another big principle and one of the main tools. It implies the will to challenge our nuclear beliefs and cultivate healthy doubt to learn and focus on values. At last, the belief in our *tribal nature* is other of the key aspects, since the final goal of the treatment is to *develop a life worth sharing*.

In order to explain the beginning of OC, and its impact on social relations, RO DBT presents a neurobiological theory. As the author explains, the proposed pathogenesis for OC is based on three interrelated factors: genetic and biotemperamental predisposition (the "nature" component), environmental and family influences (the "nurture" component) and the tendency to self-control (the "coping" component).

Biotemperamental predispositions manifest as heightened threat sensitivity, diminished reward sensitivity, high inhibitory control and detail-focused processing. These predispositions are inserted in a family, social and cultural environment that promotes values of perfectionism and invulnerability resulting in a type of coping style (it masks inner feelings, avoids risks, isolates from relationships…) that limits opportunities to learn new skills and create close social bonds.

Individuals suffering maladaptive OC have an important deficit in *social signaling*. They use to display incongruent or inhibited emotional expressions, and communicating warm feelings is also very difficult for them. Consequently, effective communication with others is impaired.

Overcontroled patients with AN have a neurobiological threat sensitivity, intensified by environmental feedback that leads to a difficulty to feeling safe. Self-starving is understood as a form of coping related to OC. Thus, food restriction is reinforcing because it reduces defensive arousal, that is, anxious activation, through the enervation of the dorsovagal system. Food restriction also causes the characteristically "flat face" seen in AN, which results in more social isolation and exacerbates the problem.

Treatment

rO DBT is basically structured in weekly group skills training and weekly one-hour individual psychotherapy that occur simultaneily. The treatment lasts thirty weeks.

The first phase of the treatment, *orientation and commitment*, consists in four individual sessions focused on psychoeducation and in the establishment of the alliance. In this phase the therapist will make an effort to find values and goals not directly related to the eating disorder, and different from body, food or weight recovery.

Treatment targeted in individual therapy are organise according to a hierarchy of importance:

1. Reducing live threatening behaviours.
2. Repairing alliance rupture.
3. Addressing social signaling deficit linked to common OC themes. (Table 1).

According to the author, OC typical themes that the therapists and client could work in the course of therapy are: Inhibited and disingenuous emotional expression, hyper detail focused and overly cautious behaviour, rigid rule governed behaviour, distant style of relating and high social comparisons, envy and bitterness.

Alliance ruptures management is considered a key strategy, an opportunity to improve and learn from relationships. An alliance rupture occurs, for example, when the client feels misunderstood or not engaged. There is a full protocol that the therapist applies when these ruptures are detected in the course of therapy. Sometimes, these ruptures appear in form of indirect sings like "pushback" or "don't hurt me" responses.

Life threatening behaviours refers to suicidal ideation and suicidal or parasuicidal behaviour. Self-starving, severe underweight or other eating symptoms are only considered a life threatening behaviour when the risk for life is "imminent". In fact, while working with AN, therapists avoid focusing on weight gain or showing concern about low weight.

Ideally, addressing social signaling deficits takes up most of the session time. Social signaling is "any action, regardless of form, intent or awareness that occurs in the presence of another person". Therapists and clients target carefully any relevant social signaling deficit in the course of the treatment and work together to manage it.

The skill training is carried out in groups of seven to nine participants, through thirty weekly sessions of approximately two and a half hours (Table 2). In those sessions, therapists explain and teach twenty new skills, which are identified with acronyms to facilitate learning. The main objective is to transmit new knowledge and motivate self-discovery. The methodology is explanation, experiential experimentation, worksheets and homework.

RO BDT implies the same groups of abilities that the standard DBT, with different objectives and strategies, and adds a new and specific module about radical openness skills.

In radical openness skill, the symptomatic objective is low openness, avoidance of risk and feedback, suspicion, lack of empathy and validation, and insufficient ability to forgive and show compassion. Mindfulness skills are aimed at rigid adherence to norms, the imperative of correction and compulsiveness. Emotional regulation skills are directed to the tendency to mask inner feelings, and the envy and bitterness caused by social comparisons. Distress tolerance skills point to self-care neglect and rigid needs of structure and order. Interpersonal effectiveness skills aim at isolation and fear of showing vulnerability.

Therapist style

the therapist acquires a style that models the dysfunctional behaviour of patients, who tend to "take life too seriously". Faced with this, the therapist will be teasing, close, relaxed, flexible. This "silly behaviour" is a way of signaling nondominance and friendship. The objective of this style is to activate the interpersonal safety system of patients. Therapists also employ social signaling in therapy. Signals like *eyebrow wag* or *close mouth cooperative smile* are intentionally used to communicate acceptance and warm. RO DBT also combines dialectical and behavioral strategies. Behavioral strategies are based in learning principles. Dialectical strategies imply in the integration of opposites and help patients, among other things, to improve cognitive rigidity. One of the main dialectical strategies is related to therapist style and is called "Playful Irreverence vs. Compassionate Gravity". It implies a therapist dilemma when working with OC patients: it is very important to communicate warm feelings and welcoming the patients back to the tribe, but there is also a need to challenge them and let them grown and change. Teasing and joking is a part of the style that helps

therapist to solve this dilemma.

Eficacy rechearch

The research in AN is just starting but there are already promising results. Broadly, the application of RO DBT in outpatient and inpatient programs lends to improving body mass index, main psychopathology and other relevant aspects of AN. There is, anyway, a need of randomized controlled trials in this population that can support these initial findings.

Conclusions

RO DBT is a novel proposal so it still has some limitations. Notwithstanding, we think that it is a promising alternative in treating eating disorders, particularly for the restrictive sub-type of AN, and for the chronic and serious ones. It aims at social signaling and not eating, so this could be well received by these patients that have, frequently, a large history of therapeutic failures and normally hate "eating approaches". In RO DBT client and therapist share a conceptualization of the problems and a common language, which enhances alliance. Also, repairing alliance ruptures is a key aspect, since alliance is crucial but very difficult to achieve when we are working with individuals with AN. Furthermore it is an active and structured therapy that may please this type of patients, but still models and teach flexibility, which is a big need for them. We hope this therapy, maybe with some adaptations, could be applied in the Spanish National Health System, improving the care provided to people suffering this severe eating disorder.