A case study and practitioner perspective on the application of Radically Open Dialectical Behaviour Therapy (RO DBT)

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Abstract

Radically Open Dialectical Behaviour Therapy (RO DBT) is a new treatment for overcontrolled mental health disorders, including refractory depression. This case study provides the therapist's description of delivering RO DBT to a client who took part in a randomised controlled trial of RO DBT. It describes novel treatment strategies and their implementation. Sam attended weekly individual sessions and group skills training sessions over 7 months. The treatment involved collaboratively explaining the RO DBT model whilst linking it to Sam's history and experiences. Coping styles that served to keep Sam isolated from others were identified with a focus on social signalling. RO DBT skills were introduced to activate her social safety system and enhance connectedness. Percentage improvement in depression scores from baseline was 50% at 7 months (end of treatment) and 65% at 18 months. Sam was in full remission at 12 and 18 months. Subjective feedback from Sam was that she felt happier in her marriage, had started voluntary work and made friends locally. She reported being more compassionate to herself and having increased flexibility in adapting to situations. The therapist reported using the RO DBT skills herself and finding them useful, both in learning the new therapy and in the therapy sessions. RO DBT's focus on the overcontrolled coping style and teaching of new strategies to address social signalling and enhance connectedness is a novel treatment approach. It offers promise as an intervention for those with depression.

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Key words: cognitive behaviour therapy, RO DBT, treatment process, depression, skills, outcomes.

Sommario

Studio su caso singolo secondo la prospettiva del terapeuta nell'applicazione della Radically Open Dialectical Behavioral Therapy (RO DBT)

La Radically Open Dialectical Behaviour Therapy (RO DBT) è un nuovo trattamento per i disturbi da ipercontrollo, inclusa la depressione refrattaria. Questo caso di studio fornisce la descrizione di un intervento di RO DBT a un cliente che ha preso parte a uno studio controllato randomizzato di RO DBT. Descrive nuove strategie di trattamento e la loro attuazione. Sam ha frequentato sessioni individuali settimanali e sessioni di skills training di gruppo per 7 mesi. Il trattamento prevedeva una condivisione collaborativa del modello RO DBT, collegandolo alla storia e alle esperienze di Sam. Gli stili di *coping* che inducevano Sam a restare isolato dagli altri sono stati identificati con un *focus* specifico sulla social signalling. Le skilss di RO DBT sono state introdotte per attivare il suo sistema di sicurezza sociale e migliorare la connessione con gli altri. Il miglioramento in percentuale dei punteggi di depressione rispetto al basale è stato del 50% a 7 mesi (fine del trattamento) e del 65% a 18 mesi. Sam era ancora in piena remissione a 12 e 18 mesi. Il feedback soggettivo di Sam è stato che si sentiva più felice nel suo matrimonio, aveva iniziato a fare volontariato e aveva fatto amicizia a livello locale. Ha riferito di essere più compassionevole con se stesso e di avere una maggiore flessibilità nell'adattarsi alle situazioni. La terapeuta ha riferito di aver utilizzato lei stessa le skills della RO DBT e di averle trovate utili, sia nell'apprendimento della nuova terapia che nelle sessioni di terapia. Il *focus* della RO DBT sullo stile di *coping* ipercontrollato e l'insegnamento di nuove strategie per affrontare il social signalling e migliorare la connessione è un nuovo approccio terapeutico. Ha ad oggi riportato promettenti risultati come intervento per chi soffre di depressione.

Parole chiave: terapia cognitivo-comportamentale, RO DBT, processi terapeutici, depressione, *skills*, risultati.

Introduction

Depression can be a debilitating disorder with one third of people not responding to medication and half showing no benefit from current psychotherapies (Berlim and Turecki, 2007). For those with co-morbid diagnoses, particularly personality disorder, the prognosis can be particularly bleak. This case study describes applying a new therapy for refractory depression: Radically Open Dialectical Behaviour Therapy (RO DBT). By conceptualizing the problem as one of emotional overcontrol characterized by rigid expectations, high self criticism, lack of emotional expression and emotional loneliness, RO DBT moves away from directly targeting low

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mood and focuses on increasing psychological flexibility, enhancing emotional expressiveness and building social connections. RO DBT prioritizes improving social signalling (a broad class of behaviours encompassing verbal, non-verbal and social behaviours) as the primary mechanism of change. The therapist works with the client to reduce their social signalling deficits in order to increase connection with others, decrease emotional loneliness and replace identified maladaptive coping strategies with skills in being more open and receptive (Lynch, 2018a and b).

Underlying Treatment Principles and Structure

RO DBT describes a biosocial model in which individuals with a low reward and high threat sensitive temperament, raised in environments where performance and self-control are valued, develop an overcontrolled (OC) coping style. There is clear structure and sequence to the treatment. RO DBT includes weekly: skills classes, individual sessions and phone coaching over a period of 7 months. In individual sessions, behavioural chain analysis and rehearsal are used to identify where skills learned in class can be implemented to bring about change. Phone coaching serves to help clients put these skills into practice. The treatment promotes awareness in clients of how the over-controlled coping strategies negatively impact on others and potentially compromise their community status. The skills learned offer new ways of relating.

Therapy begins by addressing bio-temperamental biases via clients learning to change their physiology and activate their social safety system (SSS). The neuro-regulatory model of emotions (Lynch, 2018a and b) identifies 5 emotional systems, linked to the parasympathetic (PNS) and sympathetic (SNS) nervous systems that are hypothesized to be dominantly activated at any one time. These 5 systems are linked to: social safety (PNS-VVC ventral vagal complex), novelty (the PNS is suspended but the SNS is not yet activated), threat (SNS defensive arousal), reward (SNS Excitatory Approach) and feeling overwhelmed (PNS-DVC Dorsal Vagal complex). The idea is that when any one system is on; the others are, more or less, off. RO DBT orientates the client to the fact that when our threat system is active the facial expression becomes flat, frozen or masked. This signals untrustworthiness and/or lack of desire to affiliate, leading to social isolation, ostracism and thus vulnerability to emotional loneliness and depression. RO DBT targets increasing open expression (both verbally and non-verbally) enhances perceptions of trustworthiness and opportunities for intimacy and

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connections with those the client cares about in order to reduce mental health problems. The skills to activate the SSS are taught in both the skills class and individual sessions. Examples are the "Big 3 Plus 1" (eye brow wag, closed mouth co-operative smile, slow deep breath and leaning back if seated) as well as other techniques such as loving kindness meditation (see Lynch 2018b for further details).

RO DBT describes 5 themes, which are broad descriptions of behaviours that particularly pertain to the OC personality style. These themes enable the identification of specific maladaptive social signalling targets that likely serve to keep the client ostracized from their peers and thus more susceptible to emotional loneliness, disconnection and long term mental health problems. Since some of these behaviours can be quite indirect (e.g. hinting rather than asking) and subtle, the individual often doesn't receive feedback so they are less likely to learn and adapt their behaviour. The themes are;

- Aloof and distant style of relating;
- Inhibited and Disingenuous emotional expression;
- High Social Comparisons, with Envy or Bitterness;
- Rigid, Rule Governed Behaviour;
- Hyper-detail-focused, overly cautious behaviour.

To accurately target the behaviours for change, the therapist and client assess together which behaviours seem to have the greatest social impact resulting in social ostracism, thus keeping the client stuck in the presenting problem.

The role of therapists in RO DBT is to act as a guide, highlighting discrepancies in the client's reports of how they perceive themselves, others and the world. Therapists give feedback on the client's social signalling excesses and deficits whilst offering options for new behaviours. An important principle, integral to the treatment, is "Ask Don't Tell". Thus, the stance is one of curiosity and humility. It is not for therapists to tell clients how to behave. Ultimately it is for the client to choose how they want to live their life. Adherent RO DBT therapists explore with their clients what they would like to social signal, according to their values, and whether such behaviours make it more, or less likely they improve intimacy and connection with those they care about. The therapist's task is to treat their client as they would a good friend, so as to highlight behaviours that they imagine may be getting in the way of them achieving their goals with a light and easy manner (in the same way you would let a friend know they had spinach in their teeth). Part of being a friend, and part of psychological health is the art of teasing and being teased so threaded throughout the treatment is the dialectical stance between playful irreverence and

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compassionate gravity. The more maladaptive the behaviours the more playfully irreverent the therapist is. The more engaged and socially adaptive the client is (e.g. communicating directly), the more the therapist responds with compassionate gravity i.e. openness, humility, warmth and curiosity.

Given the difficulties overcontrolled clients have in forming and keeping close relationships the therapeutic alliance is a particular focus in RO DBT. Far from expecting this to always run smoothly, the relationship would likely to be seen as superficial in the absence of therapeutic ruptures and repairs. An important component of learning for overcontrolled clients is that making repairs is vital in growing and strengthening relationships. By the second phase of treatment, after approximately session 14, we would expect a number of ruptures to have been identified and addressed. Usually this has led to a good working relationship with fewer maladaptive social signals showing up in sessions. If obvious maladaptive social signals have not been targeted then this is an opportunity for the consultation team to give the therapist feedback and ask "why not?", "what is being avoided?". The team may need to help the therapist identify their own blind spots, for example their desire to avoid potential ruptures and avoid hurting their client's feelings. The therapist is encouraged to reflect on the client's behaviours and the consequences for them. The behaviour that might impact on the therapist's willingness to affiliate with the client may be the very behaviour that is keeping the client stuck in other relationships and thus, needs to be targeted for change.

This case study describes how RO DBT was delivered to a client as part of a multi-site randomised controlled trial for RO DBT, RefraMED (Refractory depression – Mechanisms & Efficacy of Radically Open Dialectical Behaviour Therapy; Lynch *et al.*, 2018). It includes the therapist's reflections of her experience of learning and delivering this new treatment. All therapists in the trial were adherent standard DBT therapists with additional training in RO DBT.

Case Study

Clinical Presentation

Sam was a woman in her forties presenting with treatment resistant depression and chronic suicidality. She had her first depressive episode in her early twenties and had suffered at least three further episodes, on average lasting between 9 months and 3 years including hospital admissions. She

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had not shown any significant improvement despite changes in anti-depressant medication and at least three different psychological therapies.

Sam described feeling isolated and depressed. With no local friends, work or children and a marriage that she experienced as cold and unloving, Sam felt lonely and unconnected with little emotional or physical intimacy.

Sam identified with the RO DBT biosocial model describing herself as a shy and timid child, who was bullied at school and always felt an outsider. Her history was characterized by an absence of tender care, play or spontaneity with a strong emphasis on performance. Her mother was reported to be angry and critical in private but always behaved impeccably when others were present. Her father often worked away from home and was quiet within the family thus appearing to be absent both physically and emotionally. Sam coped by imposing structure and routine in her life. She tried to do things perfectly, avoided making mistakes by taking fewer risks and engaged in solitary hobbies and activities to mitigate her social anxiety and to avoid her mother's criticism.

Themes

The five themes and how they related to Sam are as follows:

Aloof and Distant Style of Relating. Sam would talk at length about minutia, with minimal self-disclosure, resulting in a more superficial relationship typical of an OC coping style. Sam identified that she was keen to be liked and to please others however the pressure of having to maintain this left her anxious and avoidant of social situations. She was often late to appointments, would talk at length to avoid awkward silences, frequently communicated her physical pain and tended to prioritize task-orientated behaviours over relationships, which served to reduce intimacy.

Inhibited and Disingenuous Emotional Expression. Sam engaged in excessive head nodding, prolonged polite smiles, rarely shared her opinions, quickly agreed with the opinions of others and spoke with an exaggerated "sing-song" voice. Sam presented in this way even when discussing serious or upsetting topics, resulting in an incongruity between her verbal and non-verbal social signals. Her therapist hypothesized that this interpersonal style contributed to decreased trust and desire for affiliation within Sam's already limited social network. Sam's descriptions of uncomfortable conversations, which ended prematurely, and her observations of others avoiding her in

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social situations or not even inviting her in the first place seemed to confirm this possibility.

Frequent Social Comparisons, with Envy or Bitterness. Unable to have children and feeling that she was in a cold and unsupportive marriage, Sam frequently expressed her bitterness towards her husband and found it particularly difficult to engage with women who had children. She did not share her envy directly rather finding plausible excuses to justify why she could not meet up.

Rigid Rule Governed Behaviour. Sam's life was governed by rules of her own making relating to how she and others should behave. This caused her distress as others were unaware the rules existed and were consequently not following them. For instance Sam thought her husband should ask her how she was rather than expect her to tell him. She also felt that he should know how upset she was about not having children and should make more of an effort to support her. The rules of the overcontrolled style generally reflect rigid, rather than flexible thinking and a perception that personal change is unnecessary as it is others that need to change.

Hypervigilant and overly cautious behaviour. Sam disliked novelty as she prided herself on being prepared. She disliked ambiguity and found plausible reasons to avoid novel situations and refuse invitations unless she was confident that she knew what would be expected of her. For instance she could enjoy the choir because she could follow the music and be "conducted", but was less keen on accepting an invitation to the local sports club summer picnic as she didn't feel she had a role and couldn't prepare for what might happen.

Main Therapeutic Interventions – First phase

1. ***Address bio-temperamental biases by changing physiology.*** In skills class Sam learned about the neuro regulatory model of emotions (Lynch, 2018a). She was able to see how she was either predominantly in her SNS defensive arousal or her PNS-DVC (overwhelmed) state and rarely activated her PNS-VVC social safety system. Sam learned to activate her social safety system using strategies such as the Big 3 Plus 1 (eyebrow wag, closed mouth co-operative smile, slow deep breath, and lean back). Initially she reported feeling silly when she tried the eyebrow wag. However, she persevered and

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in the latter part of treatment would routinely access her PNS VVC through a variety of techniques. Sam practiced Loving Kindness Meditation daily, bought a puppy and was more tactile with her husband. In this way she was able to positively impact on her ability to communicate with others and increase the likelihood that others would want to affiliate with her. In the spirit of social safety activation and greater connection with others, she also joined a choir.

2. *Target social isolation by teaching social signalling skills.* The first challenge was highlighting maladaptive social targets. As well as identifying with Sam which behaviours she perceived as getting in the way of her achieving her valued goals, a good question for her therapist to ask herself was: "*Would I want to go for coffee with this person? If not, why not?*". The behaviours that might put her off are the very things that need to be targeted in the treatment.

Sam was task focused and would want to talk about problem solving to improve her ability to achieve tasks e.g. getting out of bed before midday, cleaning the house, going for solitary walks. She wanted her therapist to help her to manage practical solutions and was initially less willing to think about how her behaviour impacted on others or indeed how it may serve to keep her stuck in depression. Reflecting with Sam on the consequence of her task focus was an important step. Her desire to have closer relationships and her understanding of the positive impact of enhanced connection on her depression helped her to engage with the treatment approach focusing less on tasks and more on social connectedness.

Once Sam started talking about relationships, she reported being unsure how to start a conversation or indeed keep it going in any meaningful way, tending to speak much but reveal little. She was taught the MATCH Plus 1 skill, which helps clients enhance connection. It is a method of sharing *personal* information as a way of matching the other's disclosure and then adding more personal detail (plus one), be it a feeling, a belief, a personal experience. This skill was practiced first in class and individual therapy sessions through role-play. To assist this skill, Sam was prompted to use the awareness *continuum*. This is a practice based on Malamati sufism which encourages the participant to identify each experience they have by saying: "*I am aware of the… (thought, sensation, emotion, image..)*". This practice helped Sam establish "I" statements (as opposed to "you") to enhance her personal responsibility regarding her own reactions and reduce communicating blame. For example, rather than say "*you don't care about me*" saying: "*I really like it when we sit together and talk. I am aware of imagining that you*

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also might like some time to sit and read the daily paper but sometimes I notice that I can feel hurt and ignored". Sam practiced this with her husband, sharing with him that this was part of the treatment. She also started to practice initiating conversations with her neighbours and people at the choir she had joined.

In the skills class Sam was taught how inauthentic, frozen or masked expression leads to being perceived as untrustworthy and results in social ostracism. In contrast, open expression leads to improved trust, greater intimacy and connection resulting in improved psychological health. For Sam changing physiology before entering into social situations was integral to her progress. She practiced activating her social safety system using the big 3 plus one. The therapist noticed how Sam often had her head slightly bowed and averted eye contact and so she encouraged Sam to practice keeping her head up and improving her eye contact. Interestingly her "sing song" voice changed when she did this. She sounded more authentic and less odd. By activating her social safety system, receiving feedback on her social signalling and practicing in the session, Sam started to signal differently according to her valued goals of being more authentic, developing friendships and feeling closer to her husband. She also reduced discussing health or task related subject matters. She practiced sharing more authentically with her therapist, for example she revealed her husband had always said he didn't want children but she had thought he would change his mind. The fact this hadn't happened made her feel very sad.

3. ***Being more open and receptive to feedback in order to learn – Don't Hurt Me.*** RO DBT teaches clients how to label indirect and subtle behaviours that serve to set up conditions to make it less likely they are given feedback or have demands made of them. This can make it difficult to learn the necessary social skills, flexibly adapt and update their social repertoire whilst ultimately damaging self-respect and the quality of relationships. One of the behaviours to avoid feedback is called "Don't hurt me". It functions to shape the other person to avoid challenging them, but if called out, is subtle enough to be plausibly denied. Sam engaged in such behaviours when she phoned to say that she was not sure that she could come due to migraine, physical pain, etc. and then would come late. She also engaged in excessive sighing and over-apologising, which served to make it more likely demands from others were withdrawn. Clients typically start to own the possibility that they might signal indirectly in ways that reduce demands from others, even acknowledging intent at times. For example,

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Sam admitted, somewhat sheepishly, that sometimes she pretended to have a migraine so that her husband would take care of her and/or to avoid social interactions. As part of finding alternative ways to communicate she started to share with him how much she enjoyed his company, how she liked to hold hands and how important being cuddled was to her. He began to make small but significant changes and she was sensitive to thank him for these (rather than communicate it wasn't enough).

4. ***Introduce Self-enquiry.*** Self-enquiry is an important mindfulness skill in RO DBT informed by Malamati Sufism. It is a process of enquiring about internal experiences in response to painful or disconfirming feedback we might typically seek to avoid or regulate away from. We call this the "edge", the place where we have strong emotion and the urge to regulate the emotion down or avoid. When we are radically open we cannot be confident that we always know the truth and indeed, what that truth really is as we bring perceptual biases to any given situation. So rather than seeing the world as it is, we see it as we are. Therefore self-enquiry encourages us to approach what we wish to avoid in order for learning to occur. Using the style of self-enquiry and "ask don't tell" enabled potentially confrontational dialogue to be less threatening and yet remain curious. Such questions might be "*When you phone to let me know you are late because of pain is it possible that telling me about your pain is a way to communicate to me that I need to keep my demands low? Could this be a 'don't hurt me?'*".

5. ***Attend to Therapeutic Ruptures.*** As expected, the therapeutic relationship had tension points at times. One rupture occurred when Sam told her therapist directly that she felt the session was not relevant and she wanted to problem solve how she was going to go back to work. Her therapist thanked her for the feedback as it was helpful for Sam to express her wishes directly and they identified that Sam struggled to give her therapist feedback for fear of conflict. Her therapist followed the RO DBT rupture protocol immediately and moved to the stance of compassionate gravity, dropped the agenda, leant back in her chair and took the heat off Sam by removing her eye contact briefly. It emerged that Sam was cross with her therapist because Sam believed that her problems would be reduced if she had a job and could distract herself with work. Sam felt frustrated that her therapist would come back to social connection rather than try to work on how she could increase activities to be more productive. Up to this point her therapist had not been aware that Sam was feeling frustrated. It was helpful that Sam expressed her anger and hurt so directly,

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rather than indirectly through avoiding or being late for sessions. This was an important shift in the therapeutic relationship. The therapist summarised the difficulties that Sam was facing and validated that she understood that this seemed an obvious solution to her difficulties. The therapist used qualifiers (e.g. possibly, maybe, perhaps) to wonder, with a self-enquiry question, whether it was possible that being task orientated was part of the reason why Sam was so lonely in her relationships. Sam agreed that this might be possible and at the same time expressed anxiety about not working. They agreed to both do some self-enquiry, the therapist on whether she had missed the importance of the work and for Sam to consider whether this was another way to avoid focusing on relationships and the loneliness and isolation she experienced within them. They also agreed to spend some time at the end of each session devoted to problem solving how Sam could enhance her employment opportunities. They were able to repair and Sam said that she felt relieved to be honest. It was anticipated that Sam might leave the session and ruminate, so the therapist encouraged a renewal of Sam's agreement to come back and speak to her therapist face to face if she had the urge to drop out.

The therapist practised self-enquiry by herself and with her team. It was quite plausible that the content of the session was not as relevant as it might be and she may have been too focused on Sam's relationships not leaving enough space for Sam to think about ways to get a job. As a new therapist it was quite likely that she had overcorrected and failed to see how important this was for Sam. Self-enquiry questions were: "*Was it possible that the therapist was being arrogant thinking she knew best?*". In supervision the team worked with the therapist to notice the part that she played in this process, what there was for her to learn when getting to her edge of "*I know better*".

Through daily self-enquiry practice Sam recognized that she did feel hopeless about her relationships improving but also resentful that it was she that had to make the changes, not her husband, or indeed others. She identified that, for her, it was easier to problem solve things she felt she had control over, rather than attempt to navigate social situations, where she felt she had none. At the same time she saw this way of coping kept her stuck in the isolation and depression she experienced and she was keen to change this.

This is an example of the dialectical principle in RO DBT. Both perspectives were true. There needed to both be a greater focus on problem solving strategies for Sam returning to work and less task focus as a way to avoid intimacy in relationships. By working to understand each perspective

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and what might be helpful for each of them to learn, the relationship was enhanced. In addition, client and therapist were able to come to a position that moved forward *and* honoured both perspectives.

Second Phase of Treatment: after session 14

By this stage of Sam's therapy there had been a number of different ruptures and repairs. The therapist had the sense that they had a stronger engagement by virtue of the fact that Sam was sharing more of her vulnerabilities, was attending sessions on time, had shifted her social signalling and her voice was more musical and less falsetto. She was communicating more directly and was able to both take more responsibility for her own actions, thoughts and feelings, and let others take responsibility for theirs. The self-enquiry questions "what part do I play?" and "what is there to learn?" had particular resonance with her.

The therapy progressed to working on improving communication and intimacy with her husband and other relationships Sam was forming. This included allowing herself to feel sad for the loss of the children they may have had together. Initially Sam denied that she felt envious or bitter of others for fear that she would be judged, however, in time, she was able to express her deep loss and envy towards other women who did have children. She recognised that when around women who were mothers she would either be ingratiating to hide her envy and come across as over the top. This left her exhausted and desiring solitude. By using the skill of Flexible Mind Dares (to let go) she learned to label the emotion of envy and let go of comparing herself with others. She acted opposite to any urges to attack and revealed to her friend her wish that she too could have had children. Her friend was compassionate and Sam reported being surprised by what a positive experience sharing her emotion had been.

Sam recognised her need for intimacy and how communicating her unhappiness through bitter complaints kept her distant from others. With her therapist she looked at what she was social signalling and how she would like to social signal, according to her values. She desired to be kinder and more loving – modelling what she would like herself. So, she practiced different ways she could do this non-verbally, this included touching her husband lightly on his shoulder as she passed him, with no expectation of a response, practicing different voice tones and sharing appreciation of him when he did something that she liked. In time this made a difference and at the end of therapy she shared that he had started to hold her hand when out.

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Previously when she touched him he would flinch away from her and would want to walk separately.

Final phase of therapy

By the 20th session the end of treatment was being discussed. Future potential problem situations were identified and prepared for. In RO DBT the final session has an informal tone allowing Sam and her therapist to reminisce about notable moments and lessons learned. Her therapist encouraged Sam to keep in touch and let her know about progress and they said goodbye

Results

Clinical Outcomes

The primary outcome measure was depressive symptoms as measured by the Hamilton Rating Scale for Depression (HRSD; 1960) 12 months after randomization, that is, 5 months after RO DBT treatment had ended. Month 7 represents the end of treatment. Scores on the LIFE-RIFT (Leon, 1999), which measures functional impairment, are also reported. We defined partial remission as HRSD score below 15 and LIFE-RIFT score below 13 points; and full remission as HRSD score below 8 and LIFE-RIFT score below 13 (Lynch *et al*., in press).

Table 1 – Outcome measures

Month from randomisation	0	7	12	18
HRSD score	17	9	7	6
LIFE-RIFT score	21	13	12	12

Percentage improvement on the HRSD was 50% at 7 months (end of treatment) and 65% at 18 months (follow-up). The client was in partial remission at 7 months and full remission at 12 and 18 months.

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Participant feedback

Sam had come to treatment feeling hopeless that her whole life had been a failure and she was experiencing suicidal thoughts. During therapy, she connected with her therapist, found the skills class fun (to Sam's surprise), was no longer experiencing suicidal thoughts and was taking more steps to engage socially. She felt happier in her marriage, commenced voluntary work and made friends locally who had shared hobbies of craft making.

Sam reported that she perceived herself to be more compassionate and gentler on herself. Others observed this as well. The therapist shared that she had noticed a dramatic decline in Sam's excessive head nodding, with Sam appearing more relaxed in her seat and her smile seemed more authentic. Sam was more accepting when things did not go to plan and had a greater ability to accept what she could not change with flexibility to adapt to situations. Sam noticed a change in how she related to her husband and perceived herself as more honest with him. She remained sad about not having a child but said that she felt this was not as all encompassing as it once was. She could appreciate that her husband had always declared he did not want children and, rather than blaming him, she could identify how her desire for children was communicated in a way that was undermining of her relationship with him. More open communication was something Sam continued to work on.

Therapist style and learning

Learning a new treatment was in itself challenging and required therapists to be radically open to using the skills themselves and being open to feedback about how they could improve. For Sam's therapist the challenge was to lean back and take her time, to ask rather than tell and allow Sam to come to her own decisions. For example, the therapist learned to inhibit urges to tell Sam what to do, even when a course of action seemed obvious, and instead focus on asking Sam what she needed to do. Self-enquiry work was helpful for the therapist in recognizing the arrogance of *assuming she knew what Sam needed to do*!

In addition, the treatment requires therapists to be mindfully aware of their own signalling. Signals such as prolonged eye contact, intense looks of concern, and pressured speech may communicate to the clients they are doing something wrong or they are a problem to be solved. Instead the therapist adopts a light and easy manner, much as one would with a good friend. During

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therapy with Sam the focus on social signalling, whilst using a light and easy manner, enabled potentially confrontational dialogue to be less threatening. Such questions might be "*I know that you say that you are not avoiding the sessions, or me, but it is kind of interesting that you are frequently late for your sessions, what do you think you are socially signalling to me?*" .

An important component of the therapy was weekly meetings with other RO DBT therapists to share challenges, work on therapist skills in delivering the treatment and ensure they are keeping to the therapy protocol.

Discussion

RO DBT's focus on social signalling and enhancing connectedness provided a novel treatment approach that offers promise as an intervention for those with depression.

In contrast to previous therapies Sam had experienced, RO DBT conceptualised her difficulties as resulting from overcontrolled coping styles. By addressing the neuro-regulatory system and teaching Sam skills in activating her SSS she was able to enhance connection with others. Learning skills in being more open and accepting feedback from others were important in enabling Sam to build relationships and increase intimacy.

In a similar way, the therapist was able to use the RO DBT skills to be more open to learning and applying a new therapy. She was able to use this in the sessions to bring up challenging issues in a new way. Attendance at the weekly therapist consultation team meetings also promoted a radically open style to learning.

RO DBT's focus on social signalling and enhancing connectedness provided a novel treatment approach that offers promise as an intervention for those with depression.

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