A Big Rock means the problem behaviour has crossed the line and can't be ignored. Hawton suggests you can summarise most unacceptable behaviours into three Big Rocks: 'speaking or acting rudely'; 'hurting anyone'; and 'wrecking stuff'. I think he's absolutely right!

So if the problem behaviour is indeed a Big Rock, the next step is to use counting to three as a signalling system to give the child a chance to revise their choice of behaviour. This is designed to encourage the child to toggle between the old brain's impulsivity and desire to go with the emotions versus the new brain's more rational and reasonable capability to choose a behaviour that will have a better outcome. So the parent is instructed to calmly and slowly count to three—and if they get to three, then a consequence is given. Children quickly learn with practice that they need to get on top of their emotions and choose what's in their interest rather than get to the count of three (hence the name 1 2 3 Magic).

I must admit though, I immediately wondered when I heard this if that meant that you could hit your brother twice and get away with it as long as you didn't go a third. But it turns out that parents (who have to explain all of this to their children prior to starting the new system) have the option to go straight to a three if the behaviour was bad enough to warrant that. For example, 'Sam, you hit your brother. That's a three straight away, and now you have seven minutes of *Time Out*' (*Time Out* is the usual one minute per year of life up to a maximum of 10 minutes).

I really recommend the program as I have found parents to be very responsive to it (both within a group context and in single client sessions) and it is very easy and practical to deliver from a clinician's point of view. There is also research to support this program's effectiveness *(e.g., Bradley, S. J., Jadaa, D., Brody, J., Landy, S., Tallett, S. E., Watson, W., Shea, B. & Stephens, D. (2003). Brief psychoeducational parenting program: An evaluation and 1-year follow-up. Journal of the American Academy of Child & Adolescent Psychiatry, 42, 1171 – 1178).*

Anoushka Houseman, BSc(Adv)(Hons) MPsychClin

Clinical Psychologist, K-12 Behaviour Team, Catholic Education Office, Diocese of Parramatta

Radically Open Dialectical Behaviour Therapy (RO-DBT): A mouthful that's worth tasting!

Recollections from the APA, New York, 2014.

Most of us are now familiar with DBT. Developed by Marsha Linehan, it has given hope to patients (and clinicians) by providing useful tools that assist those diagnosed with borderline personality disorder or similar conditions where emotional dysregulation is an issue. Inability to manage impulses or delay gratification can make a person vulnerable to substance abuse, behavioural addictions, aggressive behaviour, and associated legal, relationship and financial problems. Alternatively, a high level of self control seems to be associated with success occupationally, financially, and relationally, and is probably present in many of us. But can we have too much of a good thing, and could there be distress and impairment behind all of that restraint?

Dr Thomas Lynch presented a coherent and eloquent workshop suggesting that was exactly the case. He believes that 'overcontrol' may underlie numerous disorders including anorexia nervosa, some chronic depressive illnesses, obsessive-compulsive personality disorder and perhaps hoarding. It is a trans-diagnostic concept, and when present at pathological levels involves deficits in three key areas: openness to novel stimuli (required for change or learning), flexibility to adapt appropriately to different environments, and social connectedness to form relationships that allow us to have intimacy.

The concept was developed in a biosocial framework. It has its roots in temperament, with individuals vulnerable to disorders of overcontrol being shy, emotionally constricted and risk averse. They have a high level of threat sensitivity with easy activation of parts of the sympathetic nervous system. This 'turns off' the parasympathetic system which innervates the facial muscles to allow full, free facial expression, and the larynx and pharynx to speak calmly and warmly. Dr Lynch noted that the open expression of emotion signals trustworthiness and increases social connectedness. If others can't read our real emotional state, they are likely to feel anxious around us and even avoid us. To demonstrate: ask someone you know well to greet you warmly and share their day, without moving their eyebrows. then repeat with normal movement. Disturbing isn't it! This may be the same feeling over controlled individuals are invoking in others, and rather than challenging them when they say people avoid them and don't like them, we might need to look at the signals they are sending out.

What about social influences on overcontrol? Families may have a role here. If the stated or underlying message is that mistakes are intolerable, and displays of strong emotion are punished, ignored or invalidated, it is easy to see how a young person might inhibit emotion, curtail spontaneity, strive for perfection and deny their own personal needs. Society then provides a further tailwind by rewarding external achievements, and the way it treats those who 'break the rules'. So what then is the cost? Because overcontrol is not flexible, individuals are unable to relax enough to truly join others socially, and can't experience a full range of emotions including joy, excitement, and even real grief. By creating plausible deniability for any emotional state, they are never really known by others, and emotional isolation and loneliness may follow, even for those married or in close relationships. They can become trapped in a bind of empty productivity, and are vulnerable to the resentment of others through unexpressed anger. They may have outbursts of rage, also known as 'emotional leakage', which they are ashamed of, or a secret life of addictions or aberrant behaviour behind their mask. In short, there is no positive risk, no learning, no change and no growth. They tend to present in mid life, often after a personal crisis such as marriage breakdown, or as they reassess their life at age milestones.

While a full description of treatment was beyond the scope of the workshop, I will highlight a few key concepts. Standard caveats apply, such as biological treatment for depression where relevant, and addressing nutritional issues in eating disorders. Patients are taught to regulate their own physiology, using meditation to enhance parasympathetic activity. With an understanding of basic facial signalling and the importance of mirroring, they try to create a safe social system using improved facial movement to engage with others. Improvement in a relationship with even one other person may generalise in a type of virtuous cycle. The therapist assumes the role of the 'tribal ambassador', welcoming them back into the social system with a stance of kindness and acceptance rather than fixing or correcting, which only triggers the pathological urge to strive. Modes include individual and group outpatient work, with telephone support and therapist group discussion.

The concept of radical openness is in contrast to the radical acceptance of standard DBT. It is not uncontained emotional expression, but a move beyond awareness to seek the areas of our life or ourselves that we may prefer to avoid or find uncomfortable. It acknowledges and challenges the biases assumed to be present in both therapist and patient. Self-enquiry is encouraged by the therapist, in a healthy environment of doubt regarding previous perceptions and actions, without being overly harsh. It starts with, but is more than self-awareness, and moves to an understanding of previous automatic reactions, towards flexible responding. This is modelled by the therapist in a willingness to admit therapeutic mistakes, re-examine hypotheses, and experientially by the therapist in discussion groups. It is reflective and not understood purely intellectually, and requires ongoing practice.

RO-DBT gives some useful perspectives on clinical scenarios. The impact of the depressed mother on the developing infant can be understood better by the facial signalling and mirroring concepts, which we can experience ourselves in the 'eyebrows' exercise. How about the impact of thousands of hours of dynamic therapy where the patient never saw the face of the therapist, or was met simply with the 'blank slate'. Even a way to understand why we feel uncomfortable looking at faces where cosmetic botox has been used—iatrogenic signalling and mirroring impairment raising our sympathetic nervous activity!

It also made me think about us as clinicians, often with overcontrol tendencies and being high achievers. Or roles we have that demand that we inhibit our feelings to remain the calmest person in the room, when we may feel anything but. It would seem crucial that we practice some radical openness with someone in our life to promote our own emotional health. Dr Lynch has a book coming soon and the website www.radical-openness.com has more information, including training opportunities. I think RO-DBT may help a select number of patients in my practice, and I'm guessing it might be the same for you. Are you open to it?

Mark Sanbrook FRANZCP

Senior Staff Specialist Psychiatrist, Hornsby Mental Health Service

Private Practice, St Leonards Specialist Clinic