The patient was a 30-year-old female from a large family of origin in which she said she always felt like the “black sheep.” She had a sensitive temperament and difficulty fitting in with her parents, who placed high expectations on their children. She experienced ongoing invalidation from her parents and siblings. This invalidation impacted her self-esteem, a likely contributor to her overall vulnerability and experience of being sexually abused as a teenager by a member of her extended family. Her family did not believe her and blamed her for the shame her allegation brought to the family. This solidified her reported self-view as a person who did not deserve anything positive in life.

Although she was academically capable of higher achievement, her high-school grades were barely above passing. She had a series of unfulfilling minimum-wage jobs and minimal positive social interactions. She married in her mid 20s in order to leave her family home. She again experienced invalidation, this time in the form of emotional and physical abuse from her husband. She reported chronic depressive symptoms and using superficial cutting, both as a way to deal with her intense experiences of dysphoria and to punish herself for how her life was turning out.

In the midst of this abusive relationship, she began to experience intense feelings of hopelessness.

Laurence Y. Katz, MD, FRCPC, is Associate Professor of Psychiatry, and Program Director, Child and Adolescent Psychiatry, Department of Psychiatry, University of Manitoba. Sarah A. Fotti, MD, FRCPC, is Assistant Professor of Psychiatry, Section of Child and Adolescent Psychiatry, Department of Psychiatry, University of Manitoba.

Address correspondence to: Laurence Y. Katz, MD, FRCPC, Department of Psychiatry, University of Manitoba, PZ-162, 771 Bannatyne Avenue, Winnipeg, MB, Canada R3E 3N4; email: lkatz@hsu.mb.ca.

Disclosure: The authors have no relevant financial relationships to disclose.
and persistent thinking that her life would never get better. She made an unsuccessful attempt at suicide, after which she sought medical help.

The patient was admitted to an in-patient psychiatric unit for 2 weeks and diagnosed with dysthymia and borderline personality disorder (BPD). She was treated with antidepressant medication and a sedative/hypnotic for sleep. She did well in groups on the ward and appeared to have some insight into her difficulties with emotional regulation, interpersonal relationships, and impulsive self-harm behaviors. She also decided to leave her marriage.

After discharge from the hospital, she was referred to an outpatient program for Dialectical Behavior Therapy (DBT). A senior psychiatric resident, supervised by a psychiatrist with an active practice using DBT, provided her individual DBT therapy, including the use of DBT diary cards and 24-hour coaching calls. The resident had previous DBT experience from a rotation on an adolescent inpatient unit that provided comprehensive DBT. There, the resident had participated in DBT skills training groups and observed individual DBT therapy sessions. The resident also had didactic teaching of DBT as part of the seminar series provided to all residents.

The patient did not have any further inpatient admissions during the course of her treatment. She had excellent attendance at both the skills group and individual therapy appointments. She was an active participant in the group and was quite supportive and encouraging to other group members. The patient regularly completed her homework for group and diary cards for individual therapy. She formed a strong positive relationship with the treating psychiatric resident and used coaching calls appropriately.

Life-threatening behaviors, including suicidal ideation and cutting, were the treatment targets for the first year. After a year of supervision, the resident completed training, the resident completed training and remained in this relationship.

Over the course of her therapy, she was able to return to the work force.

DISCUSSION

Developing models for psychiatric residency training programs that are in the best interest of both the patients and the residents has been a challenge in both the US and in Canada. It is difficult to prepare a trainee to work with someone at the level of acute crisis and disorder most DBT patients are in when they enter treatment. Canadian psychiatry residents will have had exposure to DBT in seminars and rounds presentations, but will not have had anything resembling the intensive model of training for clinicians, developed by Marsha M. Linehan, PhD.

The model that has worked best in this residency-training program is to put senior residents who wish to have a level of training that will allow them to practice DBT on a 6-month clinical rotation on a service that has an active DBT program. They are then gradually integrated into the skills training groups and provided didactic teaching and readings. Participants may then be able to observe a DBT therapist conducting individual DBT therapy. When ready, residents on rotation can begin individual treatment with their own patient and then carry that patient with them as part of their longitudinal psychotherapy experience for a period of at least 1 year thereafter, with supervision from an experienced DBT therapist.

This model allows for residents to continue individual DBT with diary cards, 24-hour coaching calls, and the availability of supervision. If there are multiple residents participating, then supervision can be accomplished in a group simulating DBT consultation team practice.
In this case, the patient attended skills training group in the adult outpatient program and individual therapy with the resident. The patient did not attend the adult program DBT consultation team meetings because the resident treating her did not have time allocated for this particular meeting; however, the resident’s supervisor was a part of the consultation team and served as a liaison when necessary.

Recently, the Royal College of Physicians and Surgeons in Canada has required that all psychiatry residents have “working knowledge” of DBT. This means that all residents must have observed or participated in a course of treatment in the specified psychotherapeutic modality. Thus, the next generation of Canadian psychiatrists will be able to facilitate delivery of DBT by its treatment teams, either by supporting its use in treatment, or by pursuing further training and becoming certified DBT therapists themselves.

The supervisor in this case first became interested in DBT while doing child and adolescent psychiatry subspecialty training in the US in 1996. At that time, a clinic for the treatment of depressed adolescents had begun implementing DBT as a treatment option for multiproblem suicidal adolescents. The DBT program was a training program for psychology trainees and welcomed other trainees to gain exposure. Up to this point, the supervisor had experienced these adolescents as particularly difficult to treat; in contrast, the American clinic was making significant treatment gains using DBT in a 12-week treatment program. The clinic’s results were supported by data gathered as part of the program and later published.¹

Although both the supervisor and the resident/psychiatrist were child and adolescent psychiatrists, in Canada all child and adolescent psychiatrists are certified as general adult psychiatrists first and many provide some treatment to adults in addition to their primarily child and adolescent practices. Our 30-year-old patient was chosen, as at the time there was no adolescent DBT outpatient program at this site (the child and adolescent program was an inpatient one), but there was an adult outpatient program and the resident required exposure to outpatient DBT to round out her training.

The experience and learning gained in the practice of DBT has impacted the supervisor’s formulation of many patients, and the DBT skill set required to treat multiproblem suicidal adolescents in DBT (skills training, exposure therapy, cognitive therapy, contingency management) has been invaluable in the general practice and teaching of psychiatry.

With the supervisor’s training in DBT, when formulating the case described above, the patient’s level of disorder involving life-threatening behavior, numerous quality-of-life interfering behaviors, apparent skills deficits, and presence of DBT secondary targets, led to the supervisor recognizing that DBT was the treatment of choice for this patient.

The patient had multiple diagnoses and multiple problem behaviors that make treatment in other psychotherapeutic models challenging but for which DBT was specifically designed. Given the research that existed at the time of this treatment, DBT was the only one with significant evidence of benefit for a patient with this presentation.

The supervisor in this case has generally been the prescriber for both his patients and other patients in the DBT program who are treated by nonphysicians. On occasion where the medication management has been so complicated as to interfere with the goals of individual therapy, arrangements have been made for another psychiatrist to manage the medications. This has only happened with adult DBT patients and has not been necessary with adolescents.

In this case, the resident was able to oversee the medication management without it interfering with the individual therapy. The regimen involved an antidepressant and a hypnotic to help with sleep, and as the patient improved during treatment it was primarily maintenance medication management.

**REFERENCE**