The beginning of our year-long course in Dialectical Behavior Therapy (DBT) training consisted of a comprehensive didactic course summarizing the theoretical foundations and interventions of DBT. We learned how the role of a DBT therapist differed from clinicians practicing other forms of psychotherapy. We were encouraged to be more directive in sessions, whereas our earlier psychodynamic training had taught us to follow the patient’s lead regarding significant themes. This challenged us to think about how and when to choose different therapeutic stances with our patients. We learned to prioritize patient behaviors that might interfere with their safety and treatment before moving on to discussing patient-generated issues.

An important advantage of learning DBT in residency was our increased comfort and confidence in treating suicidal and high-risk patients. We learned to speak frankly with patients about suicidal and self-injurious behaviors, to collaborate with them in assessing acuity, and to share responsibility for their safety. We also learned the value of collaborating with a team of peer supervisors and group leaders in working with high-risk patients. DBT training deepened our understanding of the roles and responsibilities of both people within the doctor-patient relationship.

Our ability to tolerate strong affects was significantly strengthened in learning DBT. We found ourselves becoming better attuned to alliance-building because ruptures were readily noted and addressed by our patients. Thus, we became comfortable with conversing about the patient’s experience of the therapeutic relationship.

Aerin M. Hyun, MD, PhD, is a psychiatrist in private practice in New York, NY. She was a Fellow in the Women’s Mental Health program at Columbia University. Emily Gastelum, MD, is a psychiatrist in private practice in New York, NY. She was a Fellow in the Psychosomatic Medicine program at Columbia University. Beth S. Brodsky, PhD, is Associate Clinical Professor of Medical Psychology in Psychiatry at Columbia University; and Research Scientist in the Silvio O. Conte Center for the Neurobiology of Mental Disorders, at the New York State Psychiatric Institute, Department of Molecular Imaging and Neuropathology.

Address correspondence to: Beth S. Brodsky, PhD, NYS Psychiatric Institute, Room 42, 1051 Riverside Drive, New York, NY 10032; email: bsb21@columbia.edu.


doi:10.3928/00485713-20130403-08
Although safety and treatment-interfering behaviors take top priority in any modality, DBT was our first experience working psychotherapeutically with chronically suicidal and self-injuring outpatients. Our DBT course provided us with clear techniques for prioritizing and attending to the safety of this patient population within a psychotherapeutic framework.

We studied the specific tasks employed in DBT sessions, such as setting agendas and prioritizing topics with the patients. We became familiar with diary cards, a unique feature of DBT where the patient records daily every thought that precedes each significant behavior or action, for self-monitoring emotions and behaviors. We also learned about behavioral chain analyses, the specific breakdown of events, thoughts, and feelings leading to specific unhealthy behaviors, for addressing problematic behaviors. By practicing these tasks with one another in the beginning of the course, we became more confident teaching our patients about the usefulness of these skills.

**DBT AND PSYCHOPHARMACOLOGY COMBINED**

Combined therapy/medication-management sessions are often a challenge within any treatment paradigm, but we found that prescribing medications posed particular difficulties with patients undergoing DBT in whom therapy-interfering behavior could arise due to medications, either as a vehicle for self-harm (ie, overdosing) or noncompliance. Working with our assigned patients, we learned how to navigate these complications, while also reviewing their homework each session, reviewing DBT skill sets (eg, specific exercises related to helping regulate emotions, improve distress tolerance, etc), and addressing their recent life events, all within a single weekly 45-minute session.

When patients came late and/or missed sessions, making it difficult to cover all the necessary components of the structured appointment, we found it helpful to “observe limits” and then later, to restructure sessions if needed. Therefore we firmly tried to maintain a predictable frame for the sessions, but also remain open-minded and flexible about changing the structure of the frame if needed (ie, if after a certain amount of time it became clear that the drawbacks of the current frame outweighed the benefits, we would consider revising it to better meet treatment needs and goals).

We began by devoting one-third of the session to medications and two-thirds to homework/skills, adhering to this structure even if the patient was late. A contingency for lateness was that the patient might not get his or her “take-as-needed” prescriptions filled that day, or be able to discuss her week. However, as in any combined treatment with a challenging patient population, it was difficult to manage. In retrospect, we might have considered starting off by incorporating one or more of the following within the treatment frame for some of our more challenging patients: 1) split treatment; 2) incorporating medications into the skills and integrating them more fluidly into sessions; or 3) twice weekly sessions.

**PEER SUPERVISION AND LEARNING**

The consultation team approach, a required component of DBT treatment that includes peer supervision, was nicely modeled in our curriculum. For 90 minutes per week residents met with the class instructor, Beth S. Brodsky, PhD, for group supervision. This was optimal for in-depth discussions of cases, trouble-shooting, and collegial support for those having experienced difficulties with patients that week. The group gave us the opportunity to hear about a variety of cases and vicariously to gain exposure to different levels of pathology, illness course, and outcomes. This broad perspective would not have been possible with just individual supervision, where we might have only had exposure to one or two cases over the course of a year.

Supervision was conducted via case discussion and by viewing videotapes of individual sessions (with patient consent). This helped us to better identify how and when to implement DBT interventions, such as increased validation, balancing validation with change, and taking more directive stances to maintain session agendas. Furthermore, group supervision acquainted us with one another’s patients, which proved useful when leading the DBT skills group or providing coverage. When patients faced difficulties, because we already were familiar with their situation, we could better address their needs and respond in a nuanced and clinically effective manner.

Residents who opted to take the DBT elective within our training
program garnered support from one another in treating severe Axis II psychopathology. We learned from one another, co-led groups, and informally consulted with each other throughout the year. The team-based approach made us feel supported and increased our confidence that we were providing meaningful and high-quality outpatient care.

**PHONE COACHING**

Learning to coach patients between appointments was another skill acquired through DBT training. Before enrolling in the DBT course, we had checked our messages during business hours or perhaps once during the evening and on weekends. Phone coaching patients demanded that we adhere to a central principle of DBT teachings: to evaluate, recognize, and respect our own limits while also (dialektically speaking) challenging ourselves to do more than we originally had thought possible. Thus, we incorporated DBT principles into our own lives and modeled these principles for our patients. Practically, it meant offering our patients a time frame in which they could call us and expect to hear back within a reasonable amount of time (generally an hour or so). This challenged us to become more flexible with our own busy work schedules and personal time.

Interacting with patients in times of crisis taught us much about their coping skills and limitations. Between-session availability for coaching required that we become more active and deliberate in our interventions rather than relying on empathy and listening skills as had been the case with other psychotherapy modalities.

Offering coaching sessions between appointments raised concerns that patients might take advantage of and overwhelm what precious free time we had outside of residency. In reality, we were surprised by how infrequent the phone calls were. We learned to view coaching calls as time-limited, problem-solving sessions rather than as extensions of therapy sessions. Fielding these calls increased our confidence in handling between-session issues with non-DBT patients, and extinguished fears that patients might abuse these opportunities.

**DBT PEER LEADERSHIP**

Leading DBT groups was crucial for consolidating our first-hand knowledge of DBT skills. We became better between-session coaches after we learned, and then taught, our patients in the group. In addition to learning the skills more thoroughly, co-leading the group helped us incorporate alternative styles of group facilitation and to diffuse some of the intense affect overtaking the group at times. If one patient needed to step out and receive individual attention, the group could continue and not be as disrupted. Having two leaders meant greater flexibility in teaching and conceptualizing skills, which was educational for both patients and trainees.

**DBT IN CLINICAL PRACTICES**

DBT training has provided us with a deeper understanding of associated therapeutic principles, such as affect tolerance, alliance building, setting frameworks, developing treatment plans, and clarifying therapists’ roles.

Learning another therapeutic modality increased our flexibility in conceptualizing patients and providing treatment. We gained conviction in the value and effectiveness of DBT as we observed safety issues and treatment-interfering behaviors diminish in patients, giving way instead to patients focusing on quality-of-life concerns and life goals as they became better able to tolerate their affects and navigate life’s difficulties. We learned to recognize and prioritize treatment goals, regardless of therapeutic modality, both within sessions and from a longer-term treatment perspective.

Learning the difference between our own anxieties vs. those generated by emergent situations was key for us. We learned to differentiate situations that required immediate action from those that could be managed by containing our patients’ and our own anxieties. We learned to differentiate acute risk that placed patients in imminent danger from chronic risks that could be handled by taking a long-term approach (ie, that these were risks that could be addressed over a longer period of time) about the types of treatment they require. We found that in modeling anxiety tolerance and mindful action for our patients, they could then learn and practice this for themselves.

In summary, we consider our participation in the DBT curriculum to have been a special highlight of residency training and crucially important to our development as psychiatrists. We strongly believe that residency training programs would benefit from integrating DBT into their curricula.