



# The Roles of the DBT Individual Therapist

Stephanie Vaughn, PsyD

## Navigator

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- DBT individual therapists must be well grounded in the theory and practices of DBT
- They must be navigators in the beginning and throughout the process
- This can make the difference between a patient staying in therapy and dropping out

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The roles and activities of a DBT therapist are many. DBT individual therapists must be well grounded in the theory and practices of DBT as a whole. They have a variety of roles including being a navigator to the process of DBT. DBT can be experienced as something foreign even to those who have been in therapy for many years and there are many facets of DBT that are new. To be a navigator in the beginning and throughout the process so that the patient doesn't feel like they're thrown into the deep waters of the unknown can make the difference between a patient staying in therapy and dropping out.



The DBT individual therapist must also be a motivating cheerleader. So motivating the client for change is important. Part of our role as individual therapists in DBT is to cheerlead and to remind the patient that they have access to skills and resources and that basically they can do it. Of course, we want to balance that with validating that the patient's situation is in fact a terrible situation or that it is unbearable as it is currently being experienced. So an important role of the DBT therapist is to stay dialectic. So we do both and we want to be both centered and flexible. We want to be both nurturing and demanding. And we want to focus on accepting the patient as they are, the acceptance piece, while at the same time being oriented to change and motivating them to change.

## Collaborator



- DBT therapists are collaborators in the process of change
- They believe in the autonomy of the client
- The relationship between the therapist and the patient is a real relationship between equals
- Clients must be aware that the therapist self-discloses as part of that relationship

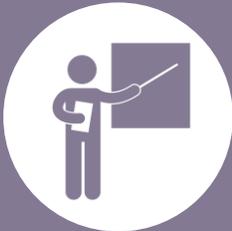
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So we're a collaborator with the patient in the process of change. The DBT therapist believes deeply in the autonomy of the client, that the client is their own individual separate entity with their own wise mind and they have an innate right to make their own decisions in the world. As a collaborator, the DBT theory is that the relationship between the therapist and the patient is a real relationship between equals, not some sort of false alternative universe sort of relationship. It is a real relationship. Both parties find out information about one another. They see each other in a real setting, in a couch, in a couple of chairs that they develop a real relationship and DBT acknowledges that is the case. The therapist does self-disclose more in DBT perhaps than in other therapies. And part of the orientation for clients who have been in other types of therapy involves making sure that they are aware that the DBT therapist self-discloses as part of that real relationship and partly as a contingency management strategy at times.

## Teacher

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- They need to be well versed in skills, behavioral principles and cognitive theory
  - DBT is a model of change
- We want the patient to be their own therapist, using the learned skills and continuing education on their own
- DBT therapists need to practice mindfulness strategies and be well versed in its principles

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The DBT individual therapist is also a teacher. So they must be well grounded in the skills that they teach and are continuously practicing them on their own. They need to be well versed in behavioral principles and can use behavioral language. We want to try to teach the patient to be ultimately their own therapist and to use the very skills that we learned in school and in continuing education on themselves and change their environment as is possible and radically accept when it's not possible. So cognitive theory is also extremely important in DBT and we want to teach all those cognitive principles to our patients. So the DBT therapist also needs to be grounded in cognitive theory and any other methods of change because ultimately as we've referenced before DBT is a model of change and that change is what is going to be the most helpful for patients to create their life worth living. We're teaching the practice of mindfulness. So the DBT therapist needs to practice their own mindfulness strategies and to be well versed in the principles of mindfulness and how to apply it in any given moment so having a repertoire of mindfulness activities to fall back on.

## Juggler

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- The individual therapist is the juggler of all of the problems their patient brings into session
- They need to be able to use target hierarchy
- They have to prioritize the time in session
- Life-threatening behavior discussion is a priority

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The individual therapist is really the juggler also of all of the problems their patient brings in to session. They need to be able to use the target hierarchy that we'll be discussing in another module. And they need to be able to prioritize the time in session to utilize the diary card to determine which topics to cover first, for how long and at what intensity and all within a 45-minute or a 60-minute session getting in all of the important and essential discussions particularly those involving life-threatening behavior even when the patient is insistent that other topics take priority. So the DBT therapist is the juggler of all of the problems within a session.

## Validator



- They need to move very quickly from change strategies to acceptance-validation strategies
- Understanding the six levels of validation is important
  - *Which level am I validating at right now?*
  - Recognizing if validation is going to be helpful for the long-term

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They are also the validator. They need to be able to fall back to validation when the change strategies become too aversive. The individual DBT therapist needs to be able to move very quickly from change strategies to acceptance-validation strategies sometimes within a minute. They may move from change to acceptance from session to session but need to be able to have that flexibility in responding. So understanding the six levels of validation is important and to keep that label in mind, “which level am I validating at right now?” and recognizing whether validation is going to be helpful for the long-term from one moment to the next. More on validation strategies in another recording.

- DBT therapists need to keep DBT theories in mind
- They have to stay dialectic

Follow the letter of the law  
↓  
Theory

← AND →

Follow the spirit of the law  
↓  
What makes sense

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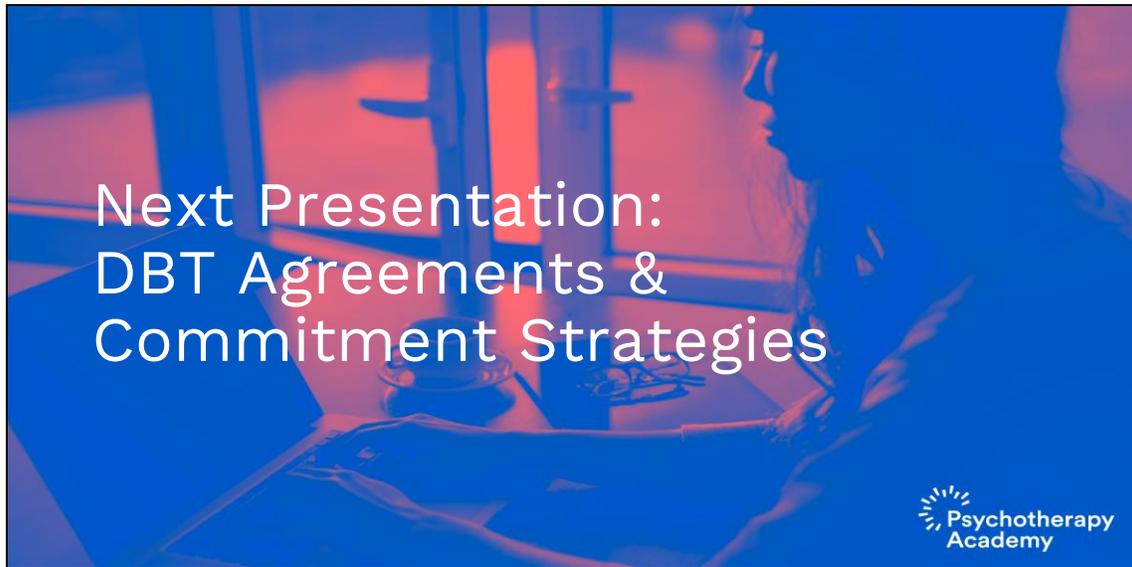
The DBT therapist needs to keep the overarching DBT theories in mind and let that flavor their interventions. In any given session, in any given moment, there may be a variety of and often multiple paths to take in decision making of how to respond to a patient. But all of those need to go back to some sort of DBT principle or idea. And so we are looking in DBT following the spirit of the law rather than the letter of the law at all times. And the dialectic there being of course we want to follow the letter of the law in DBT and at the same time, not but, and at the same time when those letters of the law don't fit, we need to be able to go back to the spirit of the law and make our critical decisions based on theory and just what makes sense and wise mind.

## Key Points

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- A primary goal for DBT individual therapists is to help **motivate** clients.
- The relationship between therapist and client in DBT is considered to be a **real relationship** between **equals**, involves mutual self-disclosure and is **collaborative**.

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Next Presentation:  
DBT Agreements &  
Commitment Strategies



# DBT Agreements & Commitment Strategies

Stephanie Vaughn, PsyD

## DBT Agreements & Commitment Strategies



- All patients begin in pre-treatment
  - The individual therapist discusses the DBT agreements and assesses the motivation for commitment
- Involvement in DBT must be voluntary, and individuals must have the option of choosing a non-DBT therapy
- Agreements can be verbal, but optimally will be written

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All patients begin in pre-treatment. This is when the individual therapist discusses the DBT agreements and assesses the motivation for commitment. Individuals involved in DBT must be voluntary. DBT expressly prohibits involuntary treatment. And thus, in the case that treatment is not voluntary, the patient should have the option of choosing an alternate non-DBT therapy. So in DBT, there are patient agreements and therapist agreements. These can be verbal but optimally will be written and referred back to in case that they are needed in the future.

# Patient Agreements



Patient agrees to:

- “Gentleman’s agreement”:
  - 1-year commitment to DBT
  - Not legally binding and no financial obligation

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The patient agrees to a one-year, what we refer to as a gentleman’s agreement. So this is a one-year commitment to DBT as a whole. This is a renewable agreement so that when the year is up patient and therapist can go back and examine the progress that’s been made and determine whether a new contract should be made. This is a gentleman’s agreement in that it is not legally binding and there is not necessarily a financial obligation which goes along with it but it’s similar to a handshake in that one can agree today and change their mind tomorrow but optimally that wouldn’t happen.

# Patient Agreements

Patients agree to:



- Attend weekly sessions and weekly skills training
- Work on life-threatening behaviors & therapy-interfering behaviors
- Provide the payment necessary, if payment is required

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The patient also agrees to attend weekly sessions and weekly skills training. They agree to work on eliminating life-threatening behaviors which include suicidal behaviors and self-harm behaviors. They also agree to work on any behaviors which interfere with therapy referred to as therapy-interfering behaviors. And if payment is received by the therapist, they agree to provide the payment necessary.

# Therapist Agreements



Therapists agree to:

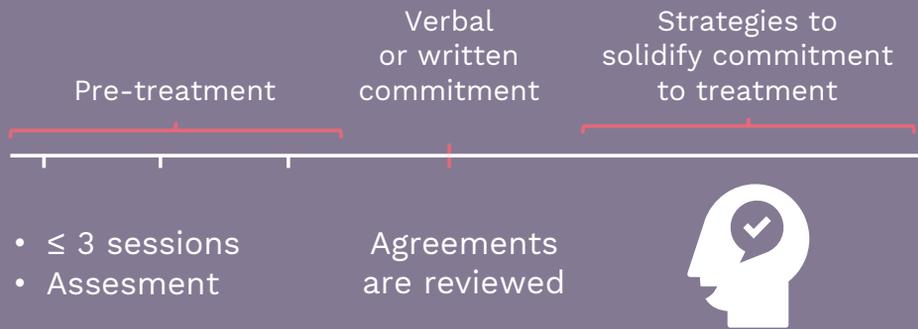
- Maintain standard ethics and confidentiality
- Make every reasonable effort to conduct therapy as competently as possible
- Attend peer consultation team meetings
- Provide reasonable intersession contact in the form of telephone coaching
- Treat the patient with respect and work on their own therapy-interfering behaviors

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The therapist agrees beyond the standard ethics and confidentiality requirements of the profession to make what is referred to as every reasonable effort to conduct therapy as competently as possible and to attend peer consultation team meetings. The individual therapist also agrees to provide reasonable intersession contact in the form of telephone coaching. And they agree to treat the patient with respect and work on their own therapy-interfering behaviors that might arise.

# Commitment Strategies



Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Until the patient and therapist both agree to the way that treatment will proceed, the methods and the goals, the patient is not involved in DBT but rather is in pre-treatment. Pre-treatment should last typically no more than three sessions, during which time a typical assessment occurs that is not unlike any other form of psychotherapy. The agreements are reviewed and the therapist begins implementing the commitment strategies in order to solidify the patient's commitment to treatment.

# When To Use Commitment Strategies

In pre-treatment and throughout the year, when:



Life-threatening behaviors arise



Patient threatens to quit therapy



Patient is resistant to implementing new change procedures

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Individual therapists use commitment strategies in pre-treatment but also throughout the year when behaviors such as life-threatening behavior, threats of quitting therapy or seeming resistance to implementing new change procedures arise.

# Commitment Strategies



## Devil's advocate

- The therapist will argue for the side of not committing to treatment
- Helps to reinforce the patient's sense of choice and autonomy

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Some of the strategies are the devil's advocate technique in which the therapist will argue for the side of not committing to treatment. This helps to reinforce the patient's sense of choice and autonomy.

# Commitment Strategies

## Assessing the Pros and Cons

Highlight the differences between DBT vs. other modes of therapy



- DBT requires more of a time commitment than CBT
- The therapist is committed to managing and responding to issues according to the DBT target hierarchies

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Also making a smooth segue into another commitment strategy, which is assessing the pros and cons of entering into DBT. It's important to be genuine in highlighting the differences between DBT versus other modes of therapy and that includes the cons of entering into treatment. DBT requires more of a time commitment than CBT considering the individual therapy, group skills training and intersession contact components which occur weekly. In addition, rather than focusing on the crisis of the week, the therapist is committed to managing and responding to issues according to the DBT target hierarchies. So rather than engaging in heart-to-heart or venting sessions, a therapist may repeatedly redirect a patient back to discussing life-threatening behavior from the previous week. This can be aversive to some patients and thus, it is important to highlight this as a potential downside of treatment.

# Commitment Strategies



## Foot in the Door

- Easy first request
- Increases the likelihood the patient will agree to another request

## Door in the Face

- Asking for something larger than expected, followed by a less intense request

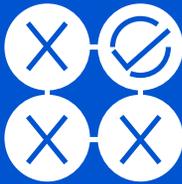
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Another commitment strategy is referred to as foot in the door. And very similar to foot in the door is what is referred to as door in the face. So foot in the door is when a therapist may ask for an easy first request putting the foot in the door which then widens the opportunity for compliance and increases the likelihood the patient will agree to another request. The door in the face technique would be to ask for something larger than expected, being told no by the patient and then thus making it more likely they will agree to a less intense request. So when considering homework, for example, if we were using door in the face technique, we might ask for a new skill to be practiced every day and this may be too much of a commitment for a new patient learning the skill so we could back off and ask for three times per week.

# Commitment Strategies

Highlighting the freedom to choose and absence of alternatives



- Particularly important in pre-treatment
- Freedom to choose to engage in DBT
- Lack of alternatives that would be beneficial

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Another commitment strategy that is important particularly in pre-treatment is highlighting the freedom to choose and the absence of alternatives, so the freedom to choose to engage in DBT treatment while at the same time highlighting that there seems to be a lack of alternatives that would be beneficial.



The therapist and the patient agree to the way that therapy will proceed



The therapist assesses there is adequate commitment and progression of treatment will be voluntary

Stage 1

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So the commitment strategies are not something that's simply done in the very beginning of treatment. This is something that a therapist would go back to time and time again when commitment seems to waver, when a self-harm episode occurred, when a patient's suicidal urges have intensified and when they are potentially considering dropping out of treatment. The way that the therapist goes back to these can vary based on style. They may pull out the written commitments or may simply refer back to the verbal commitment to work on therapy-interfering behaviors or life-threatening behaviors saying something like "but you promised in the beginning that you wouldn't drop out of treatment." Once the therapist and the patient agree to the way that therapy will proceed and the therapist assesses that there is adequate commitment and that progression of treatment will be voluntary, then we can move into stage 1 of the DBT.

## Key Points

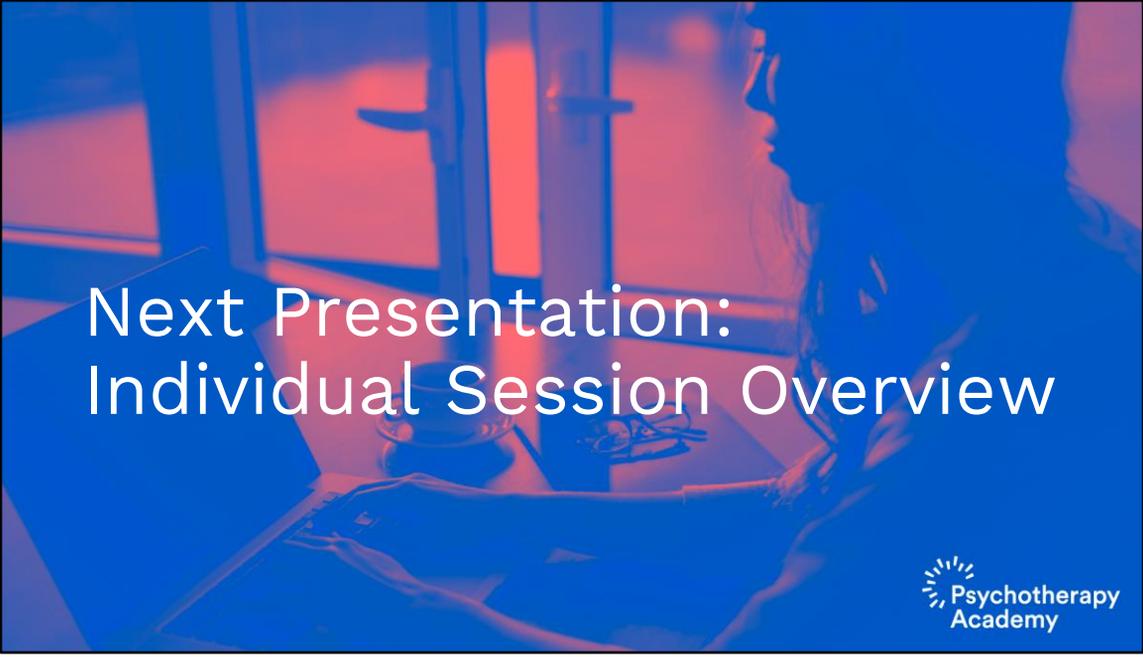
- There are specific **Patient and Therapist Agreements** that must be consented to before beginning DBT, a vital one being the patient's agreement to work on eliminating life-threatening behavior.
- **Adults** in DBT are typically asked to commit to therapy for at least 1 year.
- If **involuntary treatment** is required, patients must be allowed to choose a **non-DBT alternative**, as involuntary treatment is not permitted.



There are specific patient and therapist agreements which must be consented to before beginning DBT, a vital one being the patient's agreement to work on eliminating life-threatening behavior.

Adults in DBT are typically asked to commit to therapy for at least one year.

If involuntary treatment is required, patients must be allowed to choose a non-DBT alternative, as involuntary treatment is not permitted.

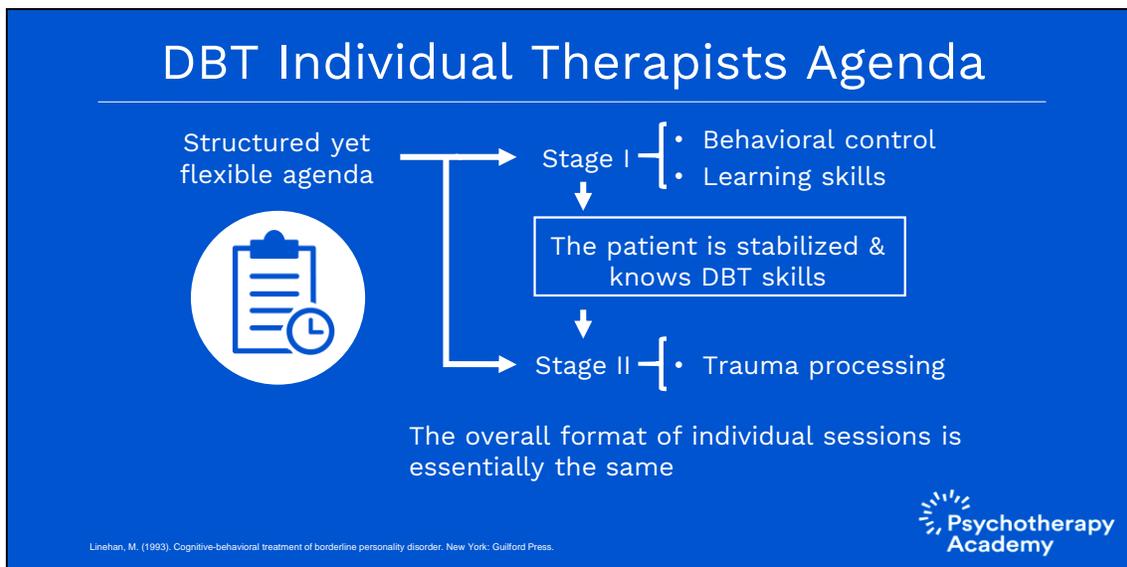


# Next Presentation: Individual Session Overview



# Individual Session Overview

Stephanie Vaughn, PsyD



DBT individual therapists stick to a \*structured yet flexible agenda \*in stages 1 and 2. In stage 1, \*improving behavioral control and learning skills is essential. \*Once the patient is stabilized and has acquired a working knowledge of the DBT skills, more emotionally intense work such as \*trauma processing can be initiated in stage 2. Regardless of whether the patient is in stage 1 or stage 2, \*the overall format of individual sessions is essentially the same.

# 1. Mindfulness Activity



- Lasts from 1 to 5 minutes
- It is important not to skip it
- Being fully present in the moment
  - Minimum required foundation to practice skills
- Mindfulness activity at the beginning and end of session

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



All sessions begin with a \*mindfulness activity. This can last anywhere \*between one and five minutes. It \*is important not to skip the mindfulness activity as it implies that it's not important. In DBT, being \*present, fully present in the moment is the minimum required foundation of being able to practice skills. \*Conducting a mindfulness activity at the beginning and end of session further reinforces this idea

## 2. Review Diary Card & Homework

In the beginning of session:



Diary card

- Mandatory in stages I and II
- Self-monitoring of emotions, targets and urges, and actions to engage in problem behavior

Homework

Any barriers to completion of the diary card or homework are therapy-interfering behaviors

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



\*In the beginning of session, the individual therapist will \*review the diary card and any homework that was assigned. The \*diary card is mandatory in stages 1 and 2 and involves patient \*self-monitoring of emotions and targets as well as urges and actions to engage in problem behavior. There are different forms of the diary card. And the diary card can be covered in more depth in a future discussion. Compliance with homework, adherence to recommendations can be discussed as well. \*Any barriers to completion of the diary card or homework are considered to be therapy-interfering behaviors. More discussion about therapy-interfering behaviors in another module.

JR4

### 3. Target-Based Agenda - Stage I



Increasing skills use + behavioral control

- 1) Eliminating life-threatening behavior
- 2) Reducing therapy-interfering behavior
- 3) Reducing quality-of-life-interfering behavior

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The agenda for session is set in the beginning much like CBT and follows the direction of the \*DBT target priorities. With DBT's target-based agenda in stage 1, patients will be working\* on increasing skills use and attaining some behavioral control, the \*first goal being eliminating life-threatening behavior, the second\* being reducing therapy-interfering behavior and the third \*being reducing any behavior that interferes with the patient's quality of life. Although it is tempting to get off track and easy to become distracted, it is essential that a DBT individual therapist stick with these target priorities.

This doesn't mean that they must be addressed in this order in session. It means that they must be addressed with the intensity graduating according to the goal.

JRS

### 3. Target-Based Agenda - Stage I



- The primary goal is to keep the patient alive and in therapy in order to work on other behaviors
- Reinforcing increasing use of skills
  - Referencing skills that the patient is learning in group

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



In other words, if patients kill themselves, \*then there is no work that can be done on therapy-interfering behaviors or quality-of-life-interfering behaviors. If the patient drops out of therapy, there can be no work done on any other behavior. And so the therapist must keep in mind that the primary goal is to keep the patient alive and to keep them in therapy in order to work on the other quality-of-life-interfering behaviors such as substance abuse, eating disorders, problematic relationships and the like.

The target-based agenda also include \*further reinforcing increasing skills use. So the DBT individual therapist will often reference \*skills that the patient is learning in group as a way of coping with a situation that's brought up in therapy.

JR6

## 3. Target-Based Agenda - Stage II



Reducing post-traumatic stress  
+  
Processing invalidating histories

- At minimum, the patient will have experiences with an invalidating environment

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



\*If the patient is in stage 2, then the target-based agenda \*remains the same. However, this is the stage in which the goal is to\* reduce posttraumatic stress \*and where the patient will process invalidating histories. Although not all DBT patients will have a history of posttraumatic stress, when considering the biosocial model and the idea that emotion dysregulation plus an invalidating environment equals the distress that we see for patients in DBT, we can presume that\* at minimum the patient will have experiences with an invalidating environment of some sort.

JR7

### 3. Target-Based Agenda - Stage II



- Processing can cause intense increases in emotional distress
- Do not to begin stage II until some level of behavioral control has been attained
- The process of exposure may be started and stopped repeatedly

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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This processing \*can cause intense increases in emotional distress and thus, it is essential \*not to begin stage 2 processing until there is some level of behavioral control attained. The process of exposure which occurs in stage 2 may be\* started and stopped repeatedly depending upon whether the patient maintains that behavioral control. It is not uncommon for a patient to enter stage 1, progress to stage 2 and then go back to stage 1, moving again to stage 2 and back to stage 1 again and again as they repeatedly stop and start the process of exposure

## 4. Behavioral Chain Analysis

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Stage I:  
The majority of session includes  
behavioral chain analysis

↓

Snapshot of a single behavior that occurred over  
the past week, related to the target priorities

↓

Followed by collaborating together  
and generating solutions



Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



All behaviors in DBT in stage 1 and stage 2 are addressed to some degree using what is referred to as a \*behavioral chain analysis. So the majority of session in \*stage 1 includes conducting a behavioral chain analysis which \*is a snapshot of a single behavior that has occurred over the past week that is related to the target priorities. So the majority of session is dedicated to assessing these behaviors using behavioral chain analysis \*and then collaborating together and generating solutions. More on behavioral chain analysis in future discussions.

## 4. Exposure-Based Interventions



- Stage II:
  - The length of session will be extended to fully process post-traumatic memories and regulate emotions
  - DBT's exposure treatment of choice is prolonged exposure

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

If a patient is in \*stage 2, the \*length of session will be extended in order to fully process posttraumatic stress memories and to allow the patient the time needed to regulate prior to ending session. \*DBT's exposure treatment of choice is what is referred to as prolonged exposure.

## 5. New Homework

- Once behavioral chain analyses have been completed (Stage I) or exposure processing has occurred (Stage II)

## 6. Mindfulness Activity

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



When \*behavioral chain analyses have been completed and/or stage 2 when exposure processing has occurred, the therapist will then\* assign new homework. This homework may be in addition to the homework which is assigned in DBT group or could be an extension of the homework assigned. After assigning new homework, the therapist will again engage the patient \*in another brief mindfulness activity.

## Background Tasks



- Motivate the patient
- Keep in mind dialectical dilemmas and strategies
- Tie in what is being asked of the patient into life-worth-living goals
- Juggle the targets → Finesse and flexibility

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



While this is a structured agenda and it is important to hit each point along the way, there is also room for flexibility. The individual therapist needs to keep in mind that there are \*background tasks associated with doing DBT. These background tasks flavor the therapy and drive the style. The individual therapist needs to remember that \*motivating the patient is essential. The therapist must \*keep in mind the dialectical dilemmas and strategies which are covered in later discussions. The therapist needs to keep in mind that the patient is working toward\* creating a life worth living and to that end, the therapist needs to be able to tie in whatever is being asked of the patient in individual therapy into the patient's life worth living goals. It's difficult for patients to engage in anything that they cannot see would be beneficial to them personally. The individual therapist is often required to use finesse \*in juggling the targets in therapy as patients will at times punish the therapist for attempts to stay within the agenda.\* So some degree of finesse and flexibility is required.

## Key Points

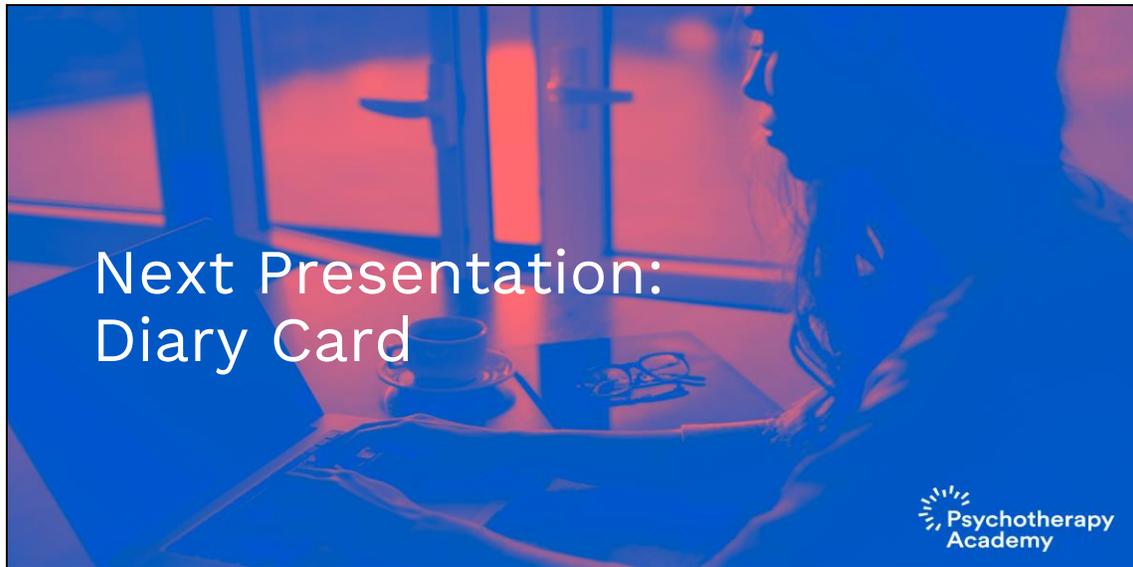
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- Begin all individual sessions in DBT Stages I & II with a **mindfulness activity** and review of the **diary card**.
- A primary change intervention in DBT stage I is **Behavioral Chain Analysis** while Stage II focuses on **exposure-based interventions** for trauma and histories of invalidation.
- Within each session, DBT individual therapists prioritize **targets** to address in session and help the patient see how working on these will help them achieve their life-worth-living goals.



### Key Points :

- Begin all individual sessions in DBT Stages I & II with a mindfulness activity and review of the diary card from the previous week.
- A primary change intervention in DBT stage I is Behavioral Chain Analysis while Stage II focuses on exposure based interventions for trauma and histories of invalidation.
- Within each session, DBT individual therapists prioritize targets to address in session and help the patient see how working on these will help them achieve their “life worth living” goals.





# Diary Card

Stephanie Vaughn, PsyD

# Diary Card

One of the individual therapist's best tools



Completed daily and presented just before or at the start of session

Failure to complete → Therapy-interfering behavior

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



A thoroughly completed diary card is one of the individual therapist's best tools. The diary card is completed by the patient daily and presented to the therapist just before or at the start of session. Failure to complete a diary card is considered to be a therapy-interfering behavior. How to address this therapy-interfering behavior is covered in more detail in the module on therapy-interfering behaviors as a whole. We will be covering the basics of a DBT diary card.

### What It Looks Like

Front Side
Targets
Data driven

Dialectical Behavior Therapy Diary Card		Initials		ID#		Filled out in session? Y N		How often did you fill out this side? Daily 2-3x Once			Date Started						
Day & Date	Us e 0-5	Suicid e 0-5	S-H 0-5	Pa n 0-5	Sa d 0-5	Sham e 0-5	Ang er 0-5	Fea r 0-5	Illic it # Specif y	ETO H # Specif y	Prescri p # Specif y	OTC # Specif y	S-H Y/N	Lying #	Joy 0-5	Skill 5 0-7	R ✓
Mon																	
Tue																	
Wed																	
Thu																	
Fri																	
Sat																	
Sun																	

**Notes**

\*USED  
 1 = Thought about or used  
 2 = Thought about, not used, didn't want to  
 3 = Thought about, not used, wanted to  
 4 = Tried, could do them, but they didn't help  
 5 = Tried, could use them, helped  
 6 = Didn't try, used them, didn't help  
 7 = Didn't try, used them, helped

	Before	After	Belief in control of Emotions:	Before	After
Urge to use (0-5):			Behaviors:		
Urge to quit therapy (0-5):			Thoughts:		
Urge to harm (0-5):					

BRTC Diary Card  
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Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

So what a \*diary card looks like is it's similar to a \*spreadsheet. There are two sides to the diary card typically. On the\* front side which is used in individual therapy, it looks like a spreadsheet with the \*days of the week separated by rows and the \*targets which are being addressed separated by columns. There is a \*section for the patient to take note on specific days at the bottom but this is a really short condensed version of the patient's day. This is \*not a diary in the sense of a log of all of the thoughts, emotions and experiences of the patient. This is more data driven.

Back

### What It Looks Like

Days of the week

Dialectical Behavior Therapy Diary Card	Instructions: Circle the days you worked on each skill							Filled out in session? Y N			How often did you fill out this side? Daily 2-3x Once		
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday						
1. Wise mind													
2. Observe just notice (Rise Surfing)													
3. Describe out words on													
4. Participle: enter into the experience													
5. Nonjudgmental stance													
6. One - mindful: in-the-moment													
7. Effectiveness: focus on what works													
8. Oblective effectiveness: DEAR MAN													
9. Relationship effectiveness: GIVE													
10. Self-respect effectiveness: FAST													
11. Reduce vulnerability: PLEASE													
12. Build MASTERY													
13. Build positive experiences													
14. Opposite-to-emotion action (Alt. Rebellion)													
15. Distract (Adaptive Denial)													
16. Self-soothe													
17. Improve the moment													
18. Pros and cons													
19. Radical Acceptance													
20. Building Structure // Work													
21. Building Structure // Love													
22. Building Structure // Time													
23. Building Structure // Place													
Urge to use (0-5):	Before therapy session: _____		After therapy session: _____								BRTC Diary Card		
Urge to quit therapy (0-5):	Before therapy session: _____		After therapy session: _____								Copyright 1999 Marsha M. Linehan, Ph.D.		

DBT Skills


  
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Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

So on the \*back of the diary card is a thorough \*list of the DBT skills and the \*days of the week are also separated so that the patient can \*mark whether or not they completed the practice of that skill for that particular day. So at a glance, we should be able to look at the diary card and get a summary of how the patient's week has gone and how much skills practice they have participated in.

## Where to Find Examples

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- Search engines: “DBT diary card”
- Linehan’s original text and workbooks
- You can create your own but there are specific targets that need to be measured

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Examples of how to lay out a diary card are easily found. If you go to any search engine and type in DBT diary card, you will see multiple images. You can also find them in Linehan’s text, both the original text and her workbooks. You can create your own but there are specific targets that need to be measured in order to be DBT adherent as much as possible.

Front Side

Targets

Blank sections

Dialectical Behavior Therapy Diary Card		Initials	ID#	Filled out in session? Y N	How often did you fill out this side? Daily 2-3x Once		Date Started								
Day & Date	Us 0-5	Suicid 0-5	S- H 0-5	Pai 0-5	Joy 0-5	Sa 0-5	Sham 0-5	Ang 0-5	Fea 0-5	Illic # Specif y	ETO # Specif y	Prescri # Specif y	OTC # Specif y	S-H Y/N	Suicida Y/N
Mon															
Tue															
Wed															
Thu															
Fri															
Sat															
Sun															
Notes										*USED #MINUS thought about or used		4 = Tried, could do them, but they didn't help			
										1 = Thought about, not used, didn't want to		5 = Tried, could use them, helped			
										2 = Thought about, not used, wanted to		6 = Didn't try, used them, didn't help			
										3 = Tried but couldn't use them		7 = Didn't try, used them, helped			
		Before	After	Belief in control of...		Before	After								
Urge to use (0-5):				Emotions:											
Urge to quit therapy (0-5):				Behaviors:											
Urge to harm (0-5):				Thoughts:											

BRTC Diary Card  
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Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

So what is measured on the \*front side of the card, that front portion where the \*days are separated by rows and the \*targets are separated by columns and the patient is going through and marking what they've experienced each day? So \*self-harm urges and suicidal urges are both \*rated on a 0 to 5 scale. So this is not something that would be a yes or a no. We want to know the \*intensity of the urge. So a self-harm urge may be at a 1. A suicidal urge could be at a 0 or a suicidal urge could be at a 4. But the scale is from 0 to 5. That's on rating urge only.

There is also a column for rating \*acts, that's actions. And actions are either a \*yes or a no. So we want to know did the person \*self-harm. We don't want to measure the intensity of the self-harm. We want to measure whether it occurred or not. We risk invalidating the experience of the patient if we start to try to measure the severity of the self-harm. We just want to know whether it occurred or not. Actions of \*suicidal behavior are also marked as a yes or a no. And while that may seem to be a fruitless pursuit to get a patient to mark whether or not they engaged in suicidal behavior because it may seem like if they had engaged in suicidal behavior they would be in a hospital, that's not always the case. And in fact, you may and I have on more than one occasion gotten a diary card back that said the patient had engaged in suicidal behavior, did not go to the hospital and showed up in my office. And that was either in the form of an overdose that obviously did not lead to death or serious harm or having put a bag over their head or done some other type of ligature that didn't work out so that they would mark that yes, they had engaged in suicidal act.

There is a section for marking \*emotions. There are a variety\* of emotions which are listed on the diary card and you can choose those. They're primary emotions. You can add your own. You can play around with those a little bit. There's a little more freedom in the measure of emotions. And that's \*also on a 0 to 5 scale. There is a section for \*substance use, a section for whether or not the patient took their medications as prescribed. The substance use section will measure whether or not they\* used alcohol or drugs, recreational drugs. Other pertinent behavioral targets are also listed. So we have a diary card that contains \*blank sections that the therapist can jot down whatever target is being worked on that week. And so it's an easy quick go to. If we've changed the target for the week, we can just jot down a new one. Other pertinent behavioral targets which might not apply to everyone in your population would include things like bingeing and purging, shutting down. And it is common place for us to use euphemisms that the patient uses such as shutting

down or there are other euphemisms for avoidance or keeping the doors to suicide open, euphemisms like playing around.

I had a client who would refer to an interpersonal behavior that she would engage in with her partner as playing around. And we knew, she and I both understood what that meant. It was a precursor to an argument or a conflict that they might get into. It was basically a provocation that the patient would deliberately do in order to get the partner to respond. So you can use euphemisms of the patient. And the good thing about euphemisms is the patient understands what they are but anyone else looking at them besides you would not necessarily know what that was.



- Discuss with the patient about how to keep the diary card safe and private
- Be flexible

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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So it's important when you're presenting the diary card to have the discussion with the patient about how to keep the diary card safe and how to keep it private. You can use a paper diary card. You can use an actual card and have the targets printed on the card. There are multiple apps that you can use. The patient may have their own way of sending you the data. So you want to be a bit flexible with that.

Back

### What It Looks Like

Days of the week

Dialectical Behavior Therapy Diary Card	Instructions: Circle the days you worked on each skill	Filled out in session? Y	How often did you fill out this side?			
			Daily	2-3x	Once	
1. Wise						
2. Observe (without overreacting)						
3. Describe the words on						
4. Practice the words on						
5. Nonjudgmental stance						
6. Effectiveness: GIVE						
7. Effectiveness: TAKE						
8. Objective effectiveness: FEEL-FOCUS						
9. Relationship effectiveness: GIVE						
10. Self-respect effectiveness: FAST						
11. Reduce vulnerability: PLEASE						
12. Build MASTERY						
13. Build positive experiences						
14. Practice the words on						
15. Distract (Adaptive Denial)						
17. Improve the moment						
18. Pros and cons						
19. Radical Acceptance						
20. Building Structure // Work						
21. Building Structure // Love						
22. Building Structure // Time						
23. Building Structure // Place						

DBT Skills

Urge to use (0-5): Before therapy session: \_\_\_\_\_ After therapy session: \_\_\_\_\_  
 Urge to quit therapy (0-5): Before therapy session: \_\_\_\_\_ After therapy session: \_\_\_\_\_

BRTC Diary Card  
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Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

\*On the \*back side again are the skills that are being practiced in DBT. The card itself can be overwhelming upon first presentation. And so you may want to take a highlighter or a pen and circle a few targets to hit in the beginning or a few sections that the patient can fill out but then leave the rest for later. And so then we shape the patient into filling out the entire diary card.

## Functions

The therapist can see the daily behavior at a glance and prioritize



- How we align priorities is dictated by the DBT hierarchy
- A large portion of session is driven by the diary card

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The purpose of the diary card, the function is so that the individual therapist can see the daily behavior of the patient over the past week at a glance and prioritize. So the diary card drives the session. At least, a large portion of session is driven by the diary card. So if we look over the diary card and we see that the patient has had suicidal urges consistently over the past week, then we're going to definitely discuss that. If they've had a self-harm act, we absolutely need to address that. How we align those priorities is dictated by the DBT hierarchy which we will cover in a later module.

## Functions



- Life-threatening behavior
  - Self-harm acts, suicidal acts, and urges need to be addressed
  - There is a hierarchy that we need to follow

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So life-threatening behavior. When you look over the diary card and you see that any life-threatening behavior has occurred, this is never overlooked. So self-harm acts, suicidal acts, urges, these need to be addressed. The intensity and duration of how you address this is partially up to the discretion of the individual therapist but with the underpinning of DBT theory that there is a hierarchy that we need to follow in order to fully address problems and to minimize the risk to the patient and make sure that we're moving forward. So we again want to refer back to that priority list.

## Functions



- Differentiate between urges and actions
- Increase awareness
  - Emotions, urges, thoughts, behaviors
- Reminder for using skills

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So another function of the diary card is to differentiate between urges and actions. We want to see urges occur without actions obviously. But if we're trying to extinguish a behavior that has been conditioned over time and has been reinforced, then we're going to be looking for high urges and no actions until they top out, until the patient tops out at a 5 and then habituates and then the urge comes down. So that's something that we would be monitoring with the diary card. We want to increase the patient's awareness of these urges, of their emotions, of their behavior, of what constitutes a behavior versus an urge, a thought versus an emotion. So this is another way to increase awareness. It's also a reminder for using DBT skills. It prompts the patient. In theory, it's impossible if you're doing a diary card to go through an entire day and not think about skills, even if you think about skills in retrospect because you're filling out the diary card at the end of the day. Still, it's a prompter for the idea that there is another possibility for managing strong emotions other than falling back on life-threatening behavior. So it's a reminder for using skills.

## Functions

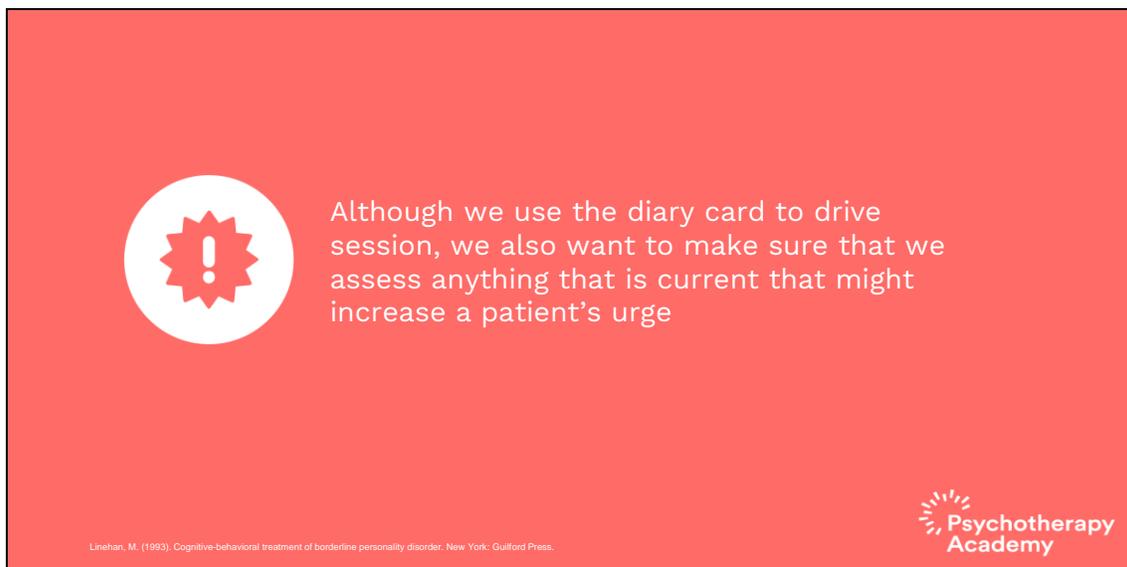


- Assist in behavioral chain analysis
- Tracking progress over time

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The diary card assists, it drives behavioral chain analysis which is a primary intervention in stage 1 individual therapy of DBT. So we go over behavioral chain analysis in more detail in another section. But if we don't have the diary card, it can be extremely difficult, if not impossible, to do behavioral chain analysis because we select an instance of the behavior typically from the diary card and then proceed with the behavioral chain analysis. In addition to assisting with behavioral chain analysis and differentiating between urges and actions, we also can track progress over time. So if we have a diary card that's being filled out every week, we can see over the course of weeks or months whether the behavior is getting better, worse, staying the same. And this is essential in DBT as a whole because we don't want to be treating the patient with anything that's not helping them to improve. And so when the year of DBT therapy is up and we are looking back on progress and we're looking back to see whether or not DBT should continue, this is an important tool to go back to and assess the progress.



Although we use the diary card to drive session, we also want to make sure that we assess anything that is current that might increase a patient's urge

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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So although we use the diary card to drive session, we also want to make sure that we assess anything that is current or upcoming that might increase a patient's urge. And that's just a teaser for another discussion that we are going to have in another module in which we discuss the priorities and target hierarchy of what we address. And so if we're looking at a diary card and we see that the patient has had a suicidal act from the past week, we might be automatically driven to begin chain analysis on that event. However, if there is enough urge in the present moment and there is a plan for additional life-threatening behavior, it would make sense and behoove us to put that aside, put that diary card data aside and proceed with assessing the current problem first. But again, this is something that we discuss in further detail in another module.

## Key Points

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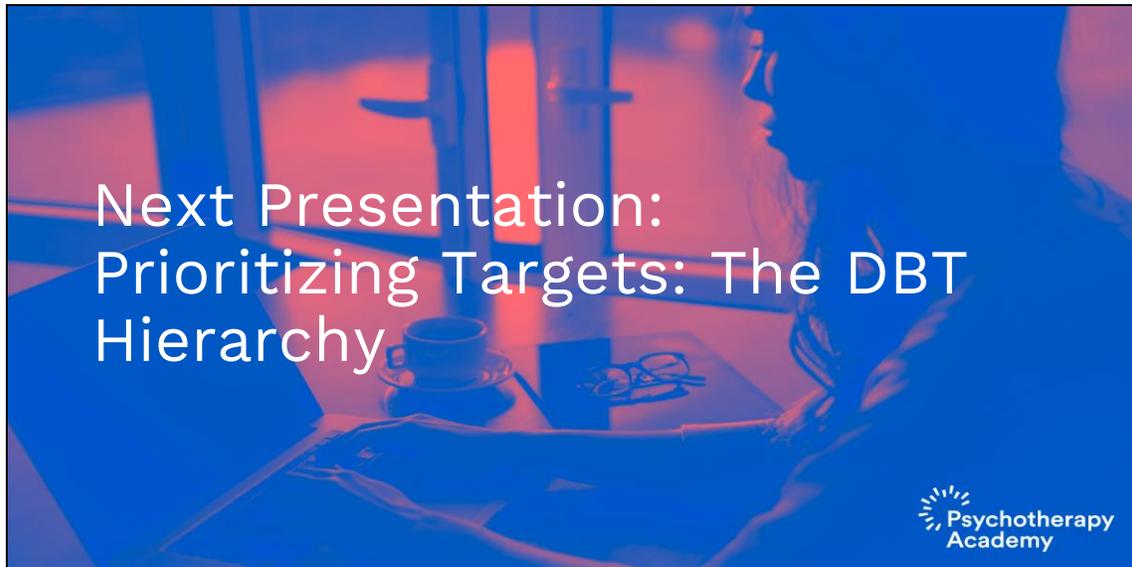
- The **diary card** is a weekly self-monitoring tool with multiple functions including assisting the therapist in prioritizing targets for session
- Failure to complete the diary card is considered a **therapy-interfering behavior**



### Key Points

The diary card is a weekly self-monitoring tool with multiple functions including assisting the therapist in prioritizing targets for session.

Failure to complete the diary card is considered to be a therapy interfering behavior.



Next Presentation:  
Prioritizing Targets: The DBT  
Hierarchy



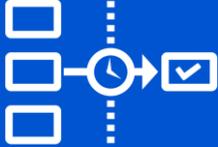
# Prioritizing Targets: The DBT Hierarchy

Stephanie Vaughn, PsyD

Prioritizing targets.

## Prioritizing Targets

Prioritize



Manage the time according to DBT's hierarchy of targets



Diary card



Helps determine what should be addressed first, for what amount of time, at what intensity

Not the only tool



Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Before beginning a behavioral chain analysis in individual DBT, the therapist will need to prioritize which targets to address and manage the time according to DBT's hierarchy of targets. It's not uncommon for multiple issues to exist in any individual session and it can become difficult for a therapist to decide where to start especially when emotions run high. The diary card is an excellent resource for determining what should be addressed first and for what amount of time, at what intensity. However, you don't want to necessarily fall back on the diary card as your only tool for determining what you should talk about. And that's because the diary card is a record of what has transpired up to now. There are times that the thing that's on fire so to speak is actually happening in the present moment or is upcoming.

# 1. Life-Threatening Behavior



*Is there anything that's upcoming that might increase your urges or your risk for suicide or self-harm?*

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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So one of the questions that I have figured out is an excellent one to ask at the beginning of a DBT session once you have the diary card in hand is, is there anything that's upcoming or that's happening now that's likely to increase your risk for self-harm or to increase your risk for unskillful behavior as a whole? So that will hopefully guide you in terms of whether you should address life-threatening behavior that's happened over the past week or something that's happening right now. And there's nothing worse than finishing up a session and you feel really great about having done an excellent behavioral chain analysis on something that happened last Tuesday and the patient starts to walk out the door and says, oh, by the way and then we know that the dreaded door knob statement as they call it is about to happen. And they say, oh, by the way, my rapist was released from prison. And you as the therapist are aware that the patient has said before that she would kill herself if he ever got out because she couldn't live with the symptoms of PTSD that she was experiencing. So that would be an example of something that could have been prevented if we would have asked the question in the beginning. Is there anything that's upcoming that might increase your urges or your risk for suicide or self-harm?

# 1. Life-Threatening Behavior



Life-threatening behavior takes priority  
↓  
Increases the patient's imminent risk for death

- ✔ Self-harm is considered life-threatening
- ✘ Drug or alcohol use is not

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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So if you haven't figured it out already, life-threatening behavior definitely takes priority in a DBT session. Life-threatening behavior would be anything that increases the patient's imminent risk for death. Also any self-harm behavior. So that is subsumed under life-threatening behavior. Determining whether a behavior is life-threatening or not can be confusing to some therapists who are new at learning DBT. We wouldn't characterize drug use or alcohol use as a life-threatening behavior even though perhaps the patient is using to the point that it is risking their health. That's a more long-term life-threatening behavior. We only categorize something as a life-threatening behavior once it is imminently risking a patient's life.

# 1. Life-Threatening Behavior



- Actions
- Current and future experiences



- Urges
- Past experiences

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So urges and actions are differentiated in DBT and actions will take precedence. They take priority over the discussion of urges.

o if we're still talking about the category of life-threatening behavior, thinking about or having urges to kill yourself over the past week, that is an important discussion to have. And on the diary card, a therapist can at a glance see at what intensity the patient experiences that. However, if at a glance the therapist also sees that the patient has had a life-threatening act, perhaps they self-harmed or they put a yes under suicidal behavior, meaning that they did some sort of suicidal act, that would take precedence. The discussion of that would be essential. We'd need to tease that apart, ask questions about it, determine exactly what happened prior to assessing any of the urges that had happened outside of that. And again, the current experience and future experiences even take precedence.

# 1. Life-Threatening Behavior



Wise mind

↓

Keep target priorities in working memory

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So some of these are going to be determined by wise mind. If I'm sitting in a session and I'm looking at a diary card, there is a self-harm act that's occurred over the past week, there is a yes under suicidal behavior that it has happened in some shape, form or fashion, I'm still going to ask the question of "is there anything upcoming that's going to put you at risk?" because yes, the person may have attempted on Tuesday but if they're planning on attempting tomorrow or after they leave session, I'm going to need to spend the bulk of session assessing that. So sometimes, most often actually, they all tie in together. So it's a matter of keeping those target priorities in your working memory so that you don't let anything fall through the cracks. It is a lot like juggling.

# 1. Life-Threatening Behavior



Formal suicide assessment tool

↓

Linehan's Risk Assessment and Management Protocol (LRAMP)

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



The formal suicide assessment tool that's recommended in DBT is Linehan's Risk Assessment and Management Protocol that is referred to as the LRAMP. And you can find that online at the University of Washington's website. And it's a basic tool. It can take a little time to fill out. There's an abbreviated version and a more extended version. But we want to use that anytime that we're doing a formal suicide assessment. And we can discuss that in further detail in another video.

## Other categories of behavior



Juggle and address them to some degree

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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So if life-threatening behavior takes priority, that doesn't mean that our other categories of behavior are ignored. Again, we need to make sure that we are able to juggle each of these and address them to some degree.

## 2. Therapy-Interfering Behavior



Missing or arriving late to sessions



Misuse of inter-session contact



Failure to complete the diary card



Interpersonal dynamics

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So if we also have therapy-interfering behavior going on, let's say that the same patient also arrived extremely late to session, 30 minutes late for that matter and you're trying to juggle all these targets and keep your hierarchy and therefore address life-threatening behavior, it's going to be very difficult for you to address the fact that the patient arrived late to session. However, that's an important topic to address. And so more discussion about how to address therapy-interfering behaviors is in another module as well. Therapy-interfering behaviors are a whole other category and there are multiple ways of addressing those. But some of the examples are the misuse of intersession contact. So maybe the patient is calling more frequently than the therapist is okay with, //failure to complete the diary card at all. So not only might the patient arrive to session late but then we don't even have a diary card filled out that we can look at and then even begin to come up with our target hierarchy. Interpersonal //dynamics between the therapist and the patient in session such as a patient arguing incessantly or saying I don't know, withdrawing emotionally, those are the types of things that can interfere with therapy. So these are things that both interfere directly with therapy as in the patient is not even there or they're not conscious in session, maybe they're sleeping or something and then also things that are likely to lead to premature termination either by the therapist or from the patient themselves. So that's the second most important thing to address.

### 3. Quality-of-Life-Interfering Behavior

Drug use

Binge eating

Failure to take prescribed medication

Legal problems

Relationship problems

High risk sexual behavior

Job loss

Financial issues

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

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The third is quality-of-life-interfering behavior. So that's a catch-all for most everything else and that includes things like drug use, binge eating, failure to take prescribed medication, legal problems, high risk sexual behavior, relationship problems, the loss of a job, financial issues. It's everything else. So if it's not imminently life threatening, then it most likely falls into this category.

### 3. Quality-of-Life-Interfering Behavior

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More interesting and easier to discuss



Address anything that risks their life before moving on

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Therapists can get easily distracted into focusing on quality-of-life-interfering behavior over life-threatening behavior because it tends to be the more interesting at times. I mean, to discuss relationship problems can be far more interesting than discussing a self-harm act that occurred last Tuesday. And it may seem like old news to the patient. The patient often can reinforce the therapist inadvertently to moving away from discussing life-threatening behavior. And so it's just easier to discuss quality-of-life-interfering behavior. But as Linehan says, we can't do therapy if the patient is dead. And so we have to make sure to fully address anything that risks their life before we're able to move on to the quality-of-life-interfering behavior.

## Differentiating Behaviors

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- Repeated psychiatric hospitalizations:  
Quality-of-life or therapy-interfering behavior?



- High risk sexual behavior:  
Quality-of-life or life-threatening behavior?

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



So sometimes, it's hard to differentiate between these different categories. For example, a patient who might seek repeated psychiatric hospitalizations, so they are taking themselves to the psychiatric hospital, attempting to be admitted, perhaps being admitted on multiple occasions, this could be a quality-of-life-interfering behavior because, I mean, for obvious reasons it's getting in the way of them being able to have a life worth living, to have relationships to sustain, employment. And so it could be considered a quality-of-life-interfering behavior. However, it could also be considered a therapy-interfering behavior if their hospitalization prevents them from attending therapy. So other examples of how a behavior might fall into multiple categories. High risk sexual behavior. So if a patient is engaging in high risk sexual behavior, we would qualify it as a quality-of-life-interfering behavior. However, if that happens to be a, let's say that they have a history of sexual trauma and we know from having spent enough sessions and done enough behavioral chain analyses with them that every time that they engage in high risk sexual behavior, that leads to suicidal urges or self-harm urges and it's so conditioned that we're 99% sure that it's going to lead to that, then it becomes a precipitating event for life-threatening behavior, essentially being the same as life-threatening behavior. So we would want to definitely address that as a life-threatening behavior as well.

## Differentiating Behaviors

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- Drug use & bingeing and purging:  
Quality-of-life or life-threatening behavior?

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



Drug use can be one of those more precarious situations and also bingeing and purging can be one of those precarious situations that we're not sure whether to categorize it as life threatening or quality of life interfering.

## Differentiating Behaviors



- Don't get caught up in semantics or the details  
*Is this imminently threatening the patient's life now?*
- Use wise mind when considering where something falls on the hierarchy.

The important thing is don't get caught up in semantics or the details of things. What you really want to do is fall back on wise mind and we're really using this to determine how much time we dedicate, we devote to addressing this, at what intensity. And so this is the question, is this imminently threatening the patient's life now? Then we absolutely need to address it and hit it hard. Otherwise, we may need to put it aside to focus on other topics like therapy-interfering behavior because if the patient is not in therapy, you're not going to be able to address the drug use anyway. So we definitely want to use wise mind when considering where something falls on the hierarchy.

## Key Points

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- In DBT there are **3 categories of targets**:
  1. Life-threatening behavior
  2. Therapy-interfering behavior
  3. Quality-of-life-interfering behavior
- **Imminent and upcoming risk** takes precedence for discussion over past patient behavior and urges

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.



### Key Points

In DBT there are 3 categories of targets to which are prioritized respectively: Life threatening behavior, therapy interfering behavior, and quality of life interfering behavior. Imminent and upcoming risk takes precedence for discussion over past patient behavior and urges.