

# DBT Therapist Rating and Feedback Form

Alan E. Fruzzetti, 2010, 2011, 2012

This DBT Therapist Rating and Feedback Form was developed to help DBT supervisors (either formal supervisors or peer supervisors) enhance and structure the feedback they give to DBT therapists on DBT consultation teams, which in turn may lead to improved treatment delivery (greater DBT treatment skills) and high and sustained motivation to use comprehensive DBT (more availability to clients, reduced burnout).

On this rating form:

- **Required** means that this would be expected in all DBT sessions occurring in Stage 1; note that this may be a bit different in the Pre-Treatment stage, in which what is required varies somewhat
- **If needed** means that in some sessions, given the situation (client presentation/behavior), this intervention would be required, while in other situations it might not be required (but would be OK) and in still other situations this intervention would be a poor choice

Rating options for each item (for *this session* only):

1. Therapist's handling of this intervention was **very effective** – sufficient in frequency, timing good, very competently delivered; needs no improvement at all to be good DBT; in this session the intervention was at expert or almost-expert level (note: does not need to be perfect...just very good/very effective)
2. Therapist's handling of this intervention was **effective** enough given the client's presentation – sufficient in frequency (neither way too many times nor way too few), and sufficiently competent (just "good enough" to be considered DBT, but not at expert-level in this session)
3. Therapist's handling of this intervention was **mixed** – done well enough in one or more instances, but either overdone (too many times) or not done enough (too few) or not done very well at another time when needed (note: if done well enough when needed, but not so well in a situation in which it was not required, give the therapist a rating of "effective" – think of it as good enough given what was needed)
4. Therapist's handling of this intervention was **ineffective** – needs some improvement: either needs to do this a little better (more competently) or more frequently (or both); therapist clearly tried to do this, it was needed, but either the timing, frequency or quality of the intervention needed to be better in this session; however, there was some foundation of this intervention present to work on and improve
5. Therapist's handling of this intervention was **very ineffective** – needs significant improvement, either to learn this intervention from the beginning (it was not close to competent in this session) or to understand the timing of the intervention much differently (timing was off enough to make the intervention ineffective or even counter-productive); bigger miss than a 4, either because the strategy was more poorly executed or because it was more acutely needed in this session
6. Intervention strategy **not needed and not delivered** in this session

Note:

- Ratings should not be affected by how well interventions work, but instead on how well they were delivered; think, "delivered effectively/ineffectively" rather than "did it work?"
- For feedback purposes, be clear with the therapist what part(s) of the session you observed directly; if you did not observe the entire session, be mindful that you may have missed important examples of either better or worse interventions
- Make a hierarchy of feedback items, ranking from most important (needed the most improvement for the session to have been "good enough" DBT or to have been "very effective" DBT) to less important problems; typically start with problems in structure and work forward
- Be sure to include well-executed interventions in your feedback as well; consult with your team regarding how to give feedback constructively

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

## Session Structure

---

- \_\_\_\_\_ 1. Diary card review or problem solve missing/incomplete diary card - (Required)  
*The diary card functions to keep targets clear and salient on a daily basis. It also provides ongoing assessment. For example, it helps to monitor therapy progress on primary and secondary targets as well as on the use of skillful alternatives to problematic behaviors. It is used in session to help set the agenda (below) and to improve chain analyses by helping with recall/providing details. The diary card acts as a reminder to practice skills, and helps block avoidance and escape. It facilitates improvement through self-monitoring. It thus provides a basic structure of treatment.*
- \_\_\_\_\_ 2. Set agenda from diary card - (Required)  
*The diary card functions to keep targets clear and salient on a daily basis, and thus allows a quick way to organize the previous week's targets on the treatment target hierarchy (below). Thus, it is a key element of structure, allowing the therapist efficiently to understand the client's prior week a little bit, set the agenda, check in on other modes of treatment, and assess current dysfunctional urges (such as to quit treatment, use substances, or make a suicide attempt).*
- \_\_\_\_\_ 3. Agenda reflected treatment target hierarchy (primary targets) - (Required)  
Stage One  
*Suicidal Behavior*  
*a) Suicide crisis behavior, b) Self injury acts, c) Significantly increased suicidal ideation and suicidal communication, d) Significantly "worse" Self injury or suicide-related expectancies and beliefs, e) Significantly increased suicide-related affect, f) Aggression and/or violence (as perpetrator or victim), g) Child abuse or neglect (as perpetrator or victim)*  
*Therapy Interfering Behaviors*  
*a) Of the client, b) Of the therapist*  
*Quality of Life Interfering Behaviors*  
*a) All behaviors that significantly contribute directly to severe problems in current quality of life (safety and stability), including skills deficits. These also are prioritized, in collaboration with the client*  
Stage Two  
*a) Trauma/PTSD and/or b) Problems with experiencing emotion (including cues, if known) or severe misery/distress or Axis I disorders*
- \_\_\_\_\_ 4. Kept agenda - (Required)  
*The therapist kept returning to the agenda (based on the treatment target hierarchy) even as she or he addressed in-session behaviors. This is different from whether the therapist completed the agenda (not necessary)*
- \_\_\_\_\_ 5. Checked in on group, pager/telephone, family interventions, and other treatment modes - (Required)  
*Did client attend skills training group, is she or he actively participating in group, does she or he have questions about homework, or are there other problems related to skills training group? Did client call pager or speak with the therapist on-call during the week? If there was a family session, did it need debriefing or follow-up? Were there any crises, or any brief in-patient admissions or ER visits since the last session? Note: sometimes this information is available to the therapist in other ways; however, base ratings on what you observe. On a team you can follow up with questions for the therapist.*
- *Targets for skills training group: Decrease behaviors likely to destroy therapy if not managed immediately. Increase skill acquisition (teaching). Decrease therapy-interfering behaviors.*
  - *Targets for telephone calls with primary DBT therapist or DBT on-call crisis service provider: Decrease crisis behavior, increase generalization of skills, and maintain/improve relationship. With skills trainer: Decrease therapy interfering/destroying behavior. Refer client back to primary therapist.*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

- *Targets for brief in-patient admission: Reduce immediate crisis behavior and problems that led to admission. Limit new problem behaviors that could maintain or prolong hospitalization. Develop appropriate discharge plan including a. Out-patient DBT program or services, b. Safe living situation. Orient and connect to outpatient DBT. Discharge.*

\_\_\_\_\_ 6. Therapist consistently paid attention to client emotion (Required)

*Therapist identified emotion and highlighted relevance of emotion across situations (e.g., in the session, on any chain, in ordinary discussions). Therapist also helped client discriminate between primary and secondary emotions, the linkage of judgments to secondary emotions, helped client observe and label emotion accurately, and managed emotion in session (with coaching as needed).*

\_\_\_\_\_ 7. Attended to client's dysfunctional current urges in the session - (If needed)

*Structured session according to treatment target hierarchy. Also paid attention to client urges (e.g. cutting, using drugs, quitting therapy) both immediately before and during the session.*

\_\_\_\_\_ 8. Sufficient attention (e.g., orienting, commitment) to safety plan - (If needed)

*If there were current or recent urges to harm (or suicide, aggression, or vulnerability to being assaulted) therapist helped develop and/or got ongoing commitment to a safety plan.*

\_\_\_\_\_ 9. Wind-down, wrap-up, and attention to effective transition out of session - (Required)

*If the client had high arousal during the session, therapist paid sufficient attention to helping him or her bring arousal down prior to the end of session and/or helped client to develop a plan for managing arousal following the end of the session.*

## Acceptance Strategies

---

\_\_\_\_\_ 10. Validation level 1 - (Required)

*Stayed awake, paid attention to client & his/her experience: unbiased (mindful) listening and observing.*

\_\_\_\_\_ 11. Validation level 2 - (Required)

*Accurate reflection (verbal and non-verbal); non-interpretative acknowledgement of emotional experience.*

\_\_\_\_\_ 12. Validation level 3 - (Required)

*Articulated the patient's un-verbalized emotions, thoughts, or behavior pattern; "mind reading."*

\_\_\_\_\_ 13. Validation level 4 - (If needed)

*Validated in terms of previous learning or biological dysfunction.*

\_\_\_\_\_ 14. Validation level 5 - (Required)

*Validated in the present context: normalized the normative experiences of the client (e.g., "it makes perfect sense" or "of course, anyone would feel/think X in that situation"). Therapist found the normative elements in the client's experience (e.g., primary emotion or other "normal" responses).*

\_\_\_\_\_ 15. Validation level 6 - (Required)

*Radical genuineness: patient is not fragile; dysfunctional behaviors are addressed directly and respectfully, and the client's experiences can be experienced directly and genuinely by the therapist.*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

\_\_\_\_\_ 16. Reciprocal communication – (Required)

*The therapist was genuinely engaged with the client as a person, using warmth, self-disclosure (self-involving or personal), minimizing arbitrary power differences due to role, SES, etc. (i.e., is an equal human being).*

\_\_\_\_\_ 17. Cheerleading - (If needed)

*Gave encouragement when client was dealing with problems; believed in the client's ability to change and have a better life, more skills, etc.*

\_\_\_\_\_ 18. Functional validation - (If needed)

*Therapist was responsive to the client's needs and experience. This goes beyond verbal validation to a more action-oriented response that conveyed that the therapist understood the client and her or his situation. For example, if a client is particularly concerned about an upcoming event the therapist would put this on the agenda and work hard to help the client come up with an effective plan for handling the event, thereby taking the situation seriously.*

\_\_\_\_\_ 19. Therapist did not invalidate client - (Required)

*Therapist did not invalidate client, including attributing normative experiences to pathology and dysfunction or simply failing to try to understand the way(s) in which the client's experiences (however dysfunctional) are legitimate. Invalidation here includes either invalidation of something valid or validating something invalid.*

## Change Strategies

---

\_\_\_\_\_ 20. Chain analysis of primary target - (Required)

*Identified at least one primary target and completed a chain analysis of a specific instance of the primary target or picked up on a previous chain and continued. Generated effective description, reasonable hypotheses about potential missing links (not remembered or experienced by client at the time).*

\_\_\_\_\_ 21. Identified precipitating or prompting event on the chain - (Required)

*Therapist tried to identify one (or more) prompting events, or "triggers," even if the client claimed the change in arousal or emotion or a dysfunctional behavior came "out of the blue." This is important because it is very difficult to identify the accurate emotion (e.g., primary vs. secondary) without identifying the prompting event(s) specifically on the chain.*

\_\_\_\_\_ 22. Attention to emotion on the chain - (Required)

*While doing the chain analysis the therapist and client identified important emotion links on the chain. The therapist made accurate distinctions between primary and secondary emotions on the chain.*

\_\_\_\_\_ 23. Attention to vulnerabilities on the chain - (Required)

*Therapist or client identified factors that increased vulnerability with regard to the specific primary target. These could include but are not limited to physical illness, lack of sleep, too little nutrition, too much caffeine or other mood related substances, or other inattention to self-care. Other factors that impact emotion sensitivity and reactivity, such as temperament or history, may also be included here.*

\_\_\_\_\_ 24. Attention to secondary targets on chain and throughout session - (Required)

*Identify secondary targets leading to primary targets:*

*a) Emotion dysregulation (increase emotion modulation).*

*b) Self invalidation (increase self-validation).*

*c) Active passivity - instead of working to solve her own problems, the client works to try to get others including the therapist to solve her problems for her (increase active problem-solving).*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

- d) Apparent competence (increase accurate expression).  
e) Crisis-generating behavior (increase mindfulness & realistic judgment).  
f) Inhibited grieving/emotional experiencing (increase emotional experiencing).

\_\_\_\_\_ 25. Wove in skills as solutions - (Required)

*Therapist and client choose at least one link from the chain analysis and problem solve how to use a specific DBT skill in that situation instead of the behavior associated with the problem link. More than one solution per link and more than one link may be considered/discussed.*

\_\_\_\_\_ 26. Solutions developed collaboratively - (Required)

*Therapist and client worked together. Therapist did not work unilaterally. Even if the client was difficult, the therapist tried hard to “drag” some collaborative agreement/solution out of the client.*

\_\_\_\_\_ 27. Taught something relevant to facilitate problem-solving (may be skills or other relevant teaching or psychoeducation, e.g., about emotion) - (If needed)

*When a skill is needed to solve a problem and the client has not learned that skill, the therapist needs to orient to and teach that skill in the session. Similarly, if misinformation or a lack of understanding contributes to a problem, the therapist needs to provide accurate information (or consult to the patient on how to find accurate information).*

\_\_\_\_\_ 28. Got commitment to solutions - (Required)

*Therapist must get client’s commitment to at least one skillful solution to at least one problematic link on the chain: therapist ensured that the client was oriented to the solution, that the client understood the solution, and that client was willing to do the new behavior. This may also include coaching skills as solutions in and out of the session.*

\_\_\_\_\_ 29. Troubleshooting solution - (Required)

*Troubleshooting involves the therapist and client considering potential roadblocks that might interfere with the success of the solution. They may discuss how solutions can generalize to different situations. Following the identification of a solution, the therapist anticipates and helps the client anticipate potential barriers to successful implementation. The therapist addresses: “What might get in the way of you doing X?” and helps reduce or eliminate these potential barriers with successful planning, coaching, and further problem-solving as needed.*

\_\_\_\_\_ 30. Connected current solutions to previous solutions - (If needed)

*Therapist and client built on previous successful solutions. Therapist may have used previous successes to enhance motivation for using a new skill.*

\_\_\_\_\_ 31. Irreverent communication - (If needed)

*Therapist confronted client in a way that got the client’s attention and slowed/stopped dysfunctional talk (or action); or, therapist responded in an unorthodox manner (e.g., humor where serious discourse was more expected, or a serious response when client likely was not taking the situation seriously), discussed dysfunction in a “matter-of-fact” way, etc.*

\_\_\_\_\_ 32. Used other behavior therapy strategies as needed: Contingency management - (If needed)

*The therapist highlighted or used contingency management. This may have included reducing or removing reinforcers for the problem behavior (a primary or secondary target), or adding new reinforcers to encourage the use of skillful alternatives. In addition this may have included mindfulness or enhanced awareness of naturally occurring short and long-term positive consequences of the skillful behavior and/or mindfulness of the longer-term negative consequences of the problem behavior. Contingency management may include using short-term therapist attention or warmth as a reinforcer for client improvements.*

<b>1. Very effective</b>	<b>2. Effective</b>	<b>3. Mixed</b>	<b>4. Ineffective</b>	<b>5. Very ineffective</b>	<b>6. Not needed &amp; Not delivered</b>
--------------------------	---------------------	-----------------	-----------------------	----------------------------	--

\_\_\_\_\_ 33. Used other behavior therapy strategies: Stimulus control - (If needed)

*Therapist highlighted or used stimulus control. This may include any conditioning or reconditioning of emotional responding to any stimulus (e.g. certain words, situations, or specific tangible stimuli). Typically this will involve some kind of formal classical conditioning (or reconditioning or deconditioning), and may include very brief exposure. If the exposure is clearly systematic (e.g., several presentations), include it in #35, Exposure and Response Prevention, below.*

\_\_\_\_\_ 34. Used other behavior therapy strategies: Skill training - (If needed)

*Therapist taught a needed skill from the DBT skill manual, or possibly another skill if needed (one not in the manual).*

\_\_\_\_\_ 35. Used other behavior therapy strategies: Exposure and response prevention - (If needed)

*Therapist explicitly re-presented a stimulus more than one time in order to achieve habituation, or to achieve a significantly smaller emotional response from the client when facing the stimulus. Thus, exposure here may be formal or informal.*

\_\_\_\_\_ 36. Used other behavior therapy strategies as needed: Cognitive modification - (If needed)

*This may include formal cognitive restructuring or more informal cognitive interventions (e.g., specific reappraisals).*

\_\_\_\_\_ 37. In-session coaching and feedback (If needed)

*If client exhibited a significant problem or dysfunctional behavior in the session, the therapist used coaching and feedback to help the client increase his or her efficacy with skills and increase self-management. This is both a skill strengthening and a skill generalization opportunity. This is in contrast to the therapist "regulating" the client (which may be easier or have a bigger immediate impact, but which may reinforce client passivity and decrease self-management).*

\_\_\_\_\_ 38. Pushed enough (Required)

*Therapist maintained a steady focus on change throughout the session (including sufficiently clear targets, pushing for skill use both in and out of the session, confrontation around dysfunction, dragging out new behaviors in the session, etc.).*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

## Dialectical Strategies

---

\_\_\_\_\_ 39. Balanced acceptance and change in session overall - (Required)

*The therapist was balanced in employing both acceptance and change interventions over the course of the session (i.e. therapist provided both validation/acceptance and problem-solving/change interventions).*

\_\_\_\_\_ 40. Balanced acceptance and change skills as solutions - (Required)

*The therapist used both acceptance and change-oriented skills as solutions on the chain or in other parts of the session. It is important to remember that in most situations either an acceptance skill or a change skill will provide an effective alternative to the problem behavior or problematic link on the chain.*

\_\_\_\_\_ 41. Balanced reciprocal and irreverent communication - (Required)

*Therapist balanced warmth and vulnerability (reciprocal communication) with matter of fact, unexpected or unorthodox, or irreverent communication (also code reciprocal and irreverent communication separately, in the "Acceptance" and "Change strategies" sections, respectively).*

\_\_\_\_\_ 42. Balanced consult-to-the-patient with environmental intervention - (If needed)

*If needed, therapist balanced helping the client solve the problem him- or herself (consultation to the patient) with actually solving the problem or part of the problem for the client (environmental intervention). Balance in this case does not necessarily mean 50/50. Rather, the therapist leans toward consultation to the patient as the default position and makes exceptions (environmental intervention) only when needed. Environmental intervention may be necessary in a life or death situation, when the client is skillful but the social environment is powerful and intransigent (and the outcome is very important), or in other situations in which the costs of intervening (short and long term learning) are smaller than the gains. This includes on the one hand being available for consultation and support and problem-solving while on the other hand requiring that the client engage in active problem-solving as much as possible prior to the therapist intervening (e.g., not having the patient call the therapist to solve a problem, but for coaching, especially after the client has already engaged in some active self-management).*

*Note regarding calling the therapist as a "solution" to a crisis: Calling the therapist is not a solution to a crisis per se. However, calling the therapist for coaching and help in implementing a crisis plan may aid the solution. What is required is a legitimate plan for handling the crisis, which may or may not include calling the therapist (or other mental health professional). Ideally, calling the therapist occurs clearly as generalization (including managing a crisis), and occurs following a client's attempts to use skills (therapist can then reinforce skill use when effective or even when not very effective yet, and can coach on additional skills). At times this could involve working to get the client to call the therapist (if this seems like an important piece of a potential solution), and at other times working to get the client to forestall calling the client until the client has made multiple attempts at skillful self-management. Thus, calling the therapist should be balanced: not too soon or frequent, not too distant/infrequent, to be effective (of course, balancing therapist limits in the process with client safety and skill generalization).*

\_\_\_\_\_ 43. Balanced intensity, speed, movement, and flow - (Required)

*DBT is a therapy that puts no premium on neutrality. Instead effective progress is believed to result from a dialectical balance that includes varying intensity of the therapist, varying speed, varying movement, and a natural flow.*

\_\_\_\_\_ 44. Dialectical communication - (Required)

*Used metaphors, stories, similes and analogies as examples or models of the dialectic of acceptance and change.*

\_\_\_\_\_ 45. Targeted wise mind - (Required)

*Because wise mind is a dialectical synthesis of logical and emotional mind, helping the client get to wise mind always provides at least temporary dialectical balance.*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

## In-Session Behavior Management

---

- \_\_\_\_\_ 46. Paid attention to initial mood, improving or deteriorating mood/emotion expression – (If needed)  
*This is important when the client's emotion is negative, cascading down, or otherwise may lead to (or already has led to) interference in the session. The therapist did not try to use logical solutions to emotional problems. Rather, the therapist tried to help the client bring his or her emotional arousal down before engaging in logical problem solving.*
- \_\_\_\_\_ 47. Managed client passivity - (If needed)  
*If the client displayed significant passivity, therapist not only did not reinforce the passivity but engaged in one or more therapeutic interventions to block the passivity and/or elicit and reinforce greater client activity. This may include, for example, benevolently demanding that the client do something before the therapist jumps in with assistance, skill coaching, dialectically balancing validating the client's current emotion (e.g., fear, sadness) with a push for him or her to engage in effective in-session work anyway (and providing help to do so).*
- \_\_\_\_\_ 48. Managed client escalation - (If needed)  
*If the client showed significantly escalated emotional arousal that could or did interfere with the session's progress, the therapist intervened to help the client de-escalate. This includes the therapist not reinforcing the client's escalation and instead blocking the escalation and coaching the client in what skills to use and how to use them. Contingency management may also be used but typically would be used in conjunction with skill coaching. It is also important that the therapist reinforce the client for de-escalation.*
- \_\_\_\_\_ 49. Reinforced improvement and/or de-escalation - (If needed)  
*Therapist discriminated even small improvements in client behavior (including reductions in client suffering, negative emotional arousal, etc.) and highlighted them (attention). In addition, the therapist may have specifically used those opportunities to reinforce socially or tangibly (e.g., with appreciation, validation, planning a specific way to celebrate an achievement), as well as use contingency clarification (e.g., "if you continue to do X and it helps Y, imagine how much better you'll feel and be able to get what you want").*
- \_\_\_\_\_ 50. Managed (including the use of blocking) client other escape behaviors - (If needed)  
*If the client engaged in behaviors that could have or did interfere with the session's progress, the therapist intervened to help block and/or redirect the client. This includes the therapist not reinforcing the client's escape behaviors. Contingency management may also be used but typically would be used in conjunction with skill coaching. It is also important that the therapist reinforce the client for stopping the behavior.*
- \_\_\_\_\_ 51. Therapist did not reinforce dysfunctional client behaviors - (Required)  
*Therapist did not reinforce dysfunctional client behaviors. Instead, the therapist blocked or purposefully ignored the dysfunction.*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

## Mindfulness

---

\_\_\_\_\_ 52. Stayed non-judgmental of client - (Required)

*Therapist at all times behaved in a non-judgmental fashion toward client (even when the client appears to be acting ineffectively, or judgmentally) as evidenced by body language, tone, and verbal behavior (descriptive, non-judgmental). Therapist never appeared off-balance (i.e. therapist was able to keep in mind the context of and what is valid about the client's behavior, and was aware of his or her own reactions such that these enhanced rather than undermined the session).*

\_\_\_\_\_ 53. Stayed non-judgmental of self - (Required)

*Therapist at all times behaved in a non-judgmental fashion toward him- or herself, even when the therapist may have made a mistake, been invalidating, etc. It is essential to model self-validation, especially when making mistakes or doing things less than perfectly. Of course, this does not preclude validating the client, apologizing for mistakes, etc., just self-judgments and self-invalidation.*

\_\_\_\_\_ 54. Stayed non-judgmental of others - (Required)

*Therapist at all times behaved in a non-judgmental fashion toward others, including family and friends of the client, other professionals both on and off the DBT team, and others in the therapist's life.*

\_\_\_\_\_ 55. Present focus in session - (Required)

*Therapist appeared to be paying attention to the client and the content of the session at all times. Therapist did not appear to be distracted, or not to be paying attention, etc.*

\_\_\_\_\_ 56. Liked client - (Required)

*Therapist appeared to like client. This does not preclude the therapist from exhibiting frustration, but rather requires that the therapist return to a baseline quickly and not appear burdened by the client, his or her dysfunctional behavior, or suffering, and seeing the whole client as a person.*

\_\_\_\_\_ 57. Enjoyed doing DBT - (Required)

*Therapist appeared to enjoy doing DBT, did not appear be burned out, did not apologize for implementing aspects of the treatment that were difficult (although the therapist may have acknowledged any negative impact on the client, etc.).*

1. Very effective	2. Effective	3. Mixed	4. Ineffective	5. Very ineffective	6. Not needed & Not delivered
-------------------	--------------	----------	----------------	---------------------	-------------------------------

Crisis emerges in the session or session is in middle of a crisis – not rated otherwise

---

\_\_\_\_\_ 58. Did not reinforce crisis escalation or dysfunction - (If needed)

*If there was a crisis in session, which could be a recent, ongoing or pending crisis, the therapist did not reinforce crisis behaviors either by changing the topic, avoiding a topic, failing to address the client's role in the crisis, or otherwise "reinforcing the tantrum" of escalation (metaphorically). Rather, therapist attempted to block escalation or dysfunction, coached skills, etc.*

\_\_\_\_\_ 59. Validated valid targets - (If needed)

*The therapist helped clarify targets that would legitimately or realistically alleviate the crisis, rather than apparent solutions that would not likely genuinely alleviate the crisis. For example, the client going into hospital is unlikely to solve an ongoing interpersonal or financial crisis. Similarly, the therapist validated the client's valid (primary) emotions in clear ways (e.g., V5) and helped client discriminate away from secondary emotions.*

\_\_\_\_\_ 60. Coached skills as solutions - (If needed)

*The therapist coached skills as solutions rather than either solving the problem him/herself or encouraging the client to use other passive solutions.*

\_\_\_\_\_ 61. Attended to affect and problem-solved after regulating emotion - (If needed)

*The therapist did not try to use logical solutions to emotional problems. Rather, the therapist tried to help the client bring his or her emotional arousal down before engaging in logical problem solving.*

\_\_\_\_\_ 62. Crisis recurrence plan - (If needed)

*The therapist and client discussed possible reoccurrence of the crisis and both how to prevent reoccurrence and how to respond to reoccurrence safely and with minimal escalation.*

\_\_\_\_\_ 63. Balanced therapist availability as solution - (If needed)

*Calling the therapist is not a solution to a crisis per se. However, calling the therapist for coaching and help in implementing a crisis plan may aid the solution. What is required is a legitimate plan for handling the crisis, which may or may not include calling the therapist (or other mental health professional). Ideally, calling the therapist occurs clearly as generalization (including managing a crisis), and occurs following a client's attempts to use skills (therapist can then reinforce skill use when effective or even when not very effective yet, and can coach on additional skills). At times this could involve working to get the client to call the therapist (if this seems like an important piece of a potential solution), and at other times working to get the client to forestall calling the client until the client has made multiple attempts at skillful self-management. Thus, calling the therapist should be balanced: not too soon or frequent, not too distant/infrequent, to be effective (of course, balancing therapist limits in the process with client safety and skill generalization).*

Most important therapist strategies & interventions done well:

Most important therapist targets for supervision and consultation (typically 1 to 3 items):