

# Primary Individual Therapist Statement

## DBT Skills Training Program

Dialectical Behavioral Therapy Center of San Diego (DBTCSD)  
9666 Businesspark Ave., Suite 105, San Diego 92131 (619) 602-0726  
(619) 609-0707 /fax

Client Name: \_\_\_\_\_ Therapist Name: \_\_\_\_\_

I am the primary individual psychotherapist for the client referred to above. I understand that my client will not be eligible to participate in the DBT Skills Training Group at DBTCSD unless s/he attends weekly individual counseling sessions on an ongoing basis. Furthermore, I understand that in order to maintain clarity of roles and decrease confusion about who is the primary therapist in charge of treatment planning and implementation, DBT skills trainers will not provide telephone skills coaching and they will defer all suicide risk assessment and crisis management tasks to me or my clinical back-up both during skills training session times and outside of skills training session times.

In line with these understandings, I agree to the following:

1. To schedule regular weekly individual therapy sessions with my client while s/he is participating in the DBT Skills Training Group at DBTCSD,
2. To help my client apply DBT skills to his/her clinical problems,
3. To promptly provide to the DBT Skills Training group leaders updated emergency information for me or back-up mental health professional, such as changes in our phone numbers.
4. To notify the skills trainers and maintain transitional clinical coverage if my client decides to change primary therapists while in the DBT Skills Training Group at DBTCSD. If this is not possible, I will immediately notify the DBT Skills Training group leaders at DBTCSD.

No Yes Has your client ever engaged in suicidal behavior or intentional self-injury, or ever had strong and/or persistent suicide ideation? (circle Yes or No)  
If so, we ask you to agree to the following:

If at any point my client has engaged in suicidal behavior or intentional self-injury, or has had strong and/or persistent suicide ideation, I understand and agree to the following:

5. To maintain overall clinical responsibility for my client and to maintain an explicit written crisis plan directing the client's actions and skills trainers' intervention during a crisis,
6. To be sure that either I or a back-up mental health professional trained in suicide-risk assessment and intervention are available at all times to independently assess for risk areas (not depending on the skills trainers to notify of or address such concerns) and manage the care of the client in a crisis,
7. To notify skills trainers when I am on vacation and arrange for a mental health professional trained in suicide assessment and intervention to manage the care of my client in a crisis.

I understand that if the crisis plans are found to not work as intended if my client ever becomes suicidal, the DBTCSD will notify me. If my client has a suicide crisis at the DBT skills group and I and my back-up mental health professional are not available to assess and manage the imminent risk, skills training with my client will be terminated. If other problems arise with the crisis plan that we cannot mutually correct, skills training with my client will be terminated.

\_\_\_\_\_  
Signature of Primary Therapist

\_\_\_\_\_  
Date

therapyagreement.rtf