

Dialectical Behavior Therapy  
Primary Therapist Agreement

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 Dialectical Behavior Therapy (DBT) Program unless she/he attends weekly individual therapy sessions on an ongoing basis. I understand that DBT group therapists will not take clinical responsibility for clients outside of group itself. As per DBT protocol, group therapists will defer all risk and crisis management to the individual who maintains clinical responsibility by independently assessing for risk areas (and not depending on the group therapist to notify of or address such concerns) and by providing all crisis management either directly or via an explicit crisis plan directing the client's actions and group therapists' interventions. Finally, I agree to help my client apply DBT skills to his/her clinical problems.

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Signature of Patient

Date

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Signature of Primary Therapist

Date

Address:

Phone number:

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