DBT-Informed Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



DBT-Informed Practice

Chain analysis, validation under fire, and bringing DBT's structure into ordinary clinical settings.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the DBT-Informed Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 9 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Full-programme DBT is a team treatment, but its structures and stance can transform ordinary clinical work when borrowed with discipline. This course teaches exactly that: DBT's working machinery for practitioners bringing it into individual therapy, community teams and settings without a full programme.

The first module teaches the structures. You will learn chain analysis done properly, the forensic, collaborative reconstruction of one episode of target behaviour that locates every point where a skill could have changed the ending, and the discipline that surrounds it: the target hierarchy that decides what gets session time, and diary cards that make a week visible at a glance. The second module teaches the stance under fire: the six levels of validation and how to hold them with a client in extremis, balancing acceptance and change moment by moment, and an honest reckoning with what DBT-informed practice can and cannot claim relative to the full evidence-based programme.

Substantial written lessons with key points and clinically demanding practice tasks, with a study tutor throughout. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the

conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Deliver skills teaching in the emotion regulation module, from naming emotions to opposite action
- Coach interpersonal effectiveness skills, including DEAR MAN, GIVE and FAST, with rehearsal
- Conduct a chain analysis of a problem behaviour and build a solution analysis onto it
- Use validation strategically, at the right level, as the acceptance side of the dialectic
- Apply DBT-informed structure, including diary cards and skills coaching, in individual work
- Hold the hierarchy of treatment targets when sessions pull in every direction

PART 1

Diary Cards for Functional Analysis

This module explores using the DBT diary card for chain analysis, session planning, and skill generalization.

CHAPTER 1

Chain analysis that changes behaviour

The chain analysis that changes behaviour sits at the heart of Dialectical Behaviour Therapy (DBT) as conceived by Marsha Linehan, and it is the instrument through which the therapist translates a client's chaotic episode into a map of causality that can be altered. In a DBT-informed practice the analyst does not approach the episode as a police interrogation but as a joint inquiry, a shared curiosity about the way the mind, body and environment conspired to produce a target behaviour. The process unfolds in two distinct passes: the first pass is a forensic walk through the chain, identifying the vulnerability factors, the prompting event, each link of thought, feeling, sensation, urge and action, and finally the consequences; the second pass revisits the same chain and inserts concrete solutions at every weak link, thereby converting the episode from a story of inevitability into a series of doors that can be closed.

The first pass begins with the vulnerability factors, the background conditions that render the client's emotional system more fragile on a particular day. These are not abstract risk factors but the concrete, lived experiences that have accumulated in the hours preceding the target behaviour. Missed sleep, an unbalanced meal, a recent interpersonal conflict, the presence of alcohol or other substances, hormonal fluctuations, or even a weather change can all increase emotional reactivity. The therapist asks the client, with gentle curiosity, "What was happening in your life that day that might have made you more vulnerable?" The answer is recorded verbatim, because the specificity of the description is what later allows the therapist to target the vulnerability with a skill such as PLEASE, the emotion regulation skills that reduce physical vulnerability.

Having established the vulnerability, the analyst then locates the prompting event, the external or internal cue that set the chain in motion. Precision is essential: the prompt is not a vague feeling of "being upset" but a discrete occurrence, for example "at 9.40 p.m. I saw a text message from my partner that said 'I need space' and she did not reply". The therapist frames the question as "What exactly happened that seemed to trigger the next step?" This avoids the client's tendency to collapse the prompt into a generalised

judgement and preserves the chain's temporal fidelity.

The chain itself is then walked link by link, moving through both the verbal and non-verbal channels. Each link is explored in the order of thoughts, emotions, bodily sensations, urges and actions, and the analyst asks for the client's description of each component in the moment it occurred. For instance, after the prompt the client might report a thought such as "She has finally given up on me", a feeling of intense anxiety, a sensation of heat rising in the chest, an urge to send another message, and an action of reaching for the phone. The analyst records each link as it is narrated, then asks "What happened next?" and "And then?" This iterative questioning continues until the target behaviour – the act that the therapist and client have identified as problematic, such as self-harm, substance use, or an impulsive outburst – is reached. The final segment of the first pass records the immediate consequences (for example, a brief sense of relief, a numbing of emotional pain) and the delayed consequences (such as shame, guilt, or damage to relationships). By laying out the chain in this way the client sees that the behaviour was not a mysterious, unstoppable force but a sequence of understandable steps.

The second pass is where the therapeutic power of the chain analysis is realised. The analyst returns to the same chain and, with the client, inserts a skill or environmental modification at each point where the chain could have been interrupted. At the level of vulnerability, the therapist may suggest a PLEASE intervention: protecting sleep by establishing a wind-down routine, ensuring regular meals, or limiting alcohol intake. At the prompt, a stimulus-control strategy might be introduced, such as moving the phone to another room after a certain hour or setting a notification filter, thereby reducing the likelihood that the client will be exposed to the triggering cue. When the chain reaches the surge of emotion, the therapist may propose a TIPP (Temperature, Intense exercise, Paced breathing, Paired muscle relaxation) response to the bodily sensation of heat, thereby diffusing the physiological arousal before it fuels the urge. If the urge to act is identified, the therapist can suggest opposite action, a core DBT skill, or a specific behavioural alternative that aligns with the client's values. Finally, at the consequence stage, the therapist may plan a contingency repair, such as arranging a brief check-in with a support person or using a diary card to monitor post-behaviour mood, thereby reducing the reinforcing value of the immediate relief.

Throughout both passes the tone remains one of collaborative curiosity. The therapist refrains from asking “Why did you do that?” and instead asks “What was happening for you at that moment?” This subtle shift transforms the worksheet from a punitive audit into a shared map, and clients often report that the moment the analysis is conducted with curiosity rather than accusation, the chaos of their experience begins to feel ordered. The client learns that each link in the chain is a potential point of control, not a fixed destiny.

To illustrate the process in concrete terms, consider the case of Maya, a 28-year-old woman who presents with recurrent episodes of self-harm by cutting. Maya reports that on a particular evening she cut her forearm. The therapist begins the first pass by asking about vulnerability factors. Maya describes that she had slept only four hours, had skipped dinner due to a busy work deadline, and had consumed two glasses of wine after a heated argument with a colleague earlier that day. The therapist records these details and notes them as physiological and interpersonal vulnerabilities.

Next, the therapist asks Maya to identify the prompt. Maya recalls that at 10.15 p.m. she received a text from her mother saying, “I’m worried about you, you haven’t called for days”. The prompt is thus the receipt of a caring yet anxiety-inducing message. The chain is then walked: Maya’s thought was “She thinks I’m a failure”, her feeling was a surge of panic, her bodily sensation was a tightness in the throat and a burning in the chest, her urge was to “escape the feeling” and her action was to retrieve a razor blade from the bathroom drawer. The immediate consequence was a sharp sense of relief, while the delayed consequence was shame and the need to hide the wound from her partner.

In the second pass, the therapist and Maya revisit each link. For the vulnerability, they agree on a PLEASE plan that includes a regular sleep schedule, a balanced snack before late-night work, and limiting alcohol to one glass on stressful days. For the prompt, they devise a stimulus-control rule: Maya will set her phone to “Do Not Disturb” after 10 p.m. on work nights, and will respond to parental messages the following morning, thereby reducing the immediate emotional impact. At the point of the emotional surge, they rehearse a TIPP sequence: Maya will splash cold water on her face, do a brief set of jumping jacks, and practice paced breathing until the chest tightness eases. When the urge to cut emerges, they identify opposite

action – in this case, calling a trusted friend and holding a stress ball – as a concrete alternative. Finally, they plan the response to any lapse: after an episode of self-harm, Maya will complete a diary card and bring the episode to her next session for a chain analysis. In standard DBT the therapist does not take coaching calls in the 24 hours after self-harm, so that contact does not reinforce the behaviour, and Maya agrees instead to call for coaching before acting on an urge.

Maya's experience of the chain analysis illustrates how the process transforms a seemingly inexplicable act into a series of modifiable steps. She reports that the analysis felt like "seeing the whole night laid out on a table" and that the insertion of skills made her feel "more in control of the doors that open and close". The collaborative curiosity of the therapist, rather than a interrogative stance, allowed Maya to engage openly with the material and to accept the proposed interventions as logical extensions of her own experience.

The chain analysis, when used in this DBT-informed manner, also dovetails with the missing-links analysis, a complementary instrument that examines why a known skill was not employed at a particular link. The missing-links analysis, as Linehan (2015) sets it out, asks four questions in turn: whether the client knew what effective behaviour was needed; if so, whether they were willing to do it; if so, whether the thought of doing it ever entered their mind; and if so, what got in the way of doing it right away. Each answer points to a different remedy: not knowing what was needed calls for teaching or clarifying the skill, unwillingness for work on commitment and willingness, a skill that never came to mind for cues and rehearsal, and an obstacle in the moment for problem solving. By integrating both analyses, the therapist converts each difficult week from evidence of hopelessness into a curriculum of learning, which is precisely DBT's working definition of treatment.

In summary, the chain analysis that changes behaviour is a two-stage, collaborative process that begins with a meticulous forensic walk through the vulnerability, prompt, links, behaviour and consequences, and then proceeds to a second pass that strategically inserts skills and environmental modifications at every weak point. The technique rests on a stance of curiosity rather than interrogation, fostering a therapeutic alliance in which the client feels validated and empowered. Through concrete worked

examples such as Maya's case, the learner can see how the abstract principles translate into everyday clinical practice, and how the systematic use of DBT skills and strategies – PLEASE, TIPP, opposite action, stimulus control and contingency repair – can convert chaotic episodes into opportunities for change. The ultimate aim of the chain analysis is not merely to understand why a behaviour occurred, but to demonstrate unequivocally that the behaviour was a sequence of modifiable events, thereby giving the client a roadmap for future self-regulation and a sense of agency that lies at the core of DBT-informed practice.

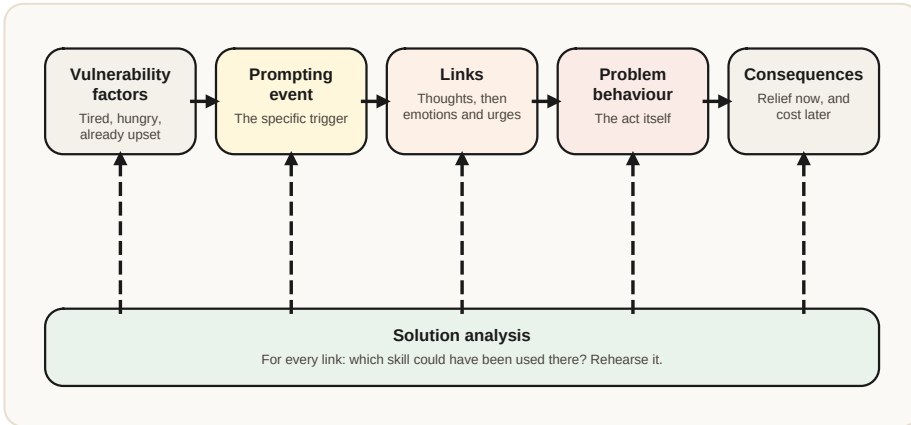


FIGURE 1.1 Chain analysis of a problem behaviour

Behaviour makes sense when its chain is laid out: vulnerability factors set the stage, a prompting event fires, links of thought, feeling and urge follow one another, the behaviour occurs, and its consequences (often short-term relief) reinforce the whole chain. Solutions are inserted link by link.

Points worth keeping

- Walk the chain: vulnerabilities, prompt, links, behaviour, consequences
- Then re-walk it inserting solutions at every weak link
- Tone is technique: curiosity, never interrogation

PRACTICE TASK

Chain-analyse a minor lapse of your own (late-night doomscrolling will do), and insert two solutions at named links.

CHAPTER 2

Hierarchy, diary cards and session discipline

The practice of Dialectical Behaviour Therapy (DBT) is built upon a series of structural safeguards that were originally devised for a population whose lives were literally at risk of self-destruction. Marsha Linehan's (1993) seminal work described a hierarchy of target behaviours that guides every therapeutic decision, and this hierarchy remains the backbone of DBT-informed practice even when the full programme is not available. The hierarchy is ordered from the most urgent to the least urgent: Life-threatening behaviour, Therapy-interfering behaviour, and Quality-of-life interfering behaviour. Skills acquisition is not a separate rung but the primary method used to address these targets. Each target has a precise definition, a set of assessment tools, and a protocol for how it shapes the agenda of each session. The diary card functions as the sensory organ of this hierarchy, translating the client's week into objective data that can be examined without the distortion of the most dramatic narrative. Together, hierarchy, diary card, and session discipline create a predictable therapeutic environment that can be transferred to any clinical setting, providing safety for clients whose emotional regulation is otherwise chaotic.

Life-threatening behaviour occupies the apex of the hierarchy. It includes suicide attempts, self-harm, serious threats of suicide, and any concrete plan that indicates imminent danger. In DBT this behaviour is never bypassed or minimised; it triggers an immediate chain analysis, a safety plan, and often a brief crisis intervention that supersedes all other work (Linehan, 1993). The therapist's first responsibility is to ensure physical safety, which may involve contacting emergency services, arranging a hospital admission, or mobilising a support network. Only after the client's safety is secured does the therapist return to the regular session structure, and even then the hierarchy dictates that the remainder of the session be devoted to reviewing the chain of events that led to the crisis, identifying vulnerabilities, and reinforcing any skills that were successfully employed.

The second rung, Therapy-interfering behaviour, is the structural innovation

that distinguishes DBT from many other modalities. It encompasses any action that undermines the treatment itself: missed appointments, chronic lateness, refusal to complete diary cards, persistent hostility towards the therapist, or any pattern that prevents the therapeutic work from proceeding (Linehan, 1993). Importantly, the therapist's own interfering behaviours are also included in this category; the therapist must model accountability by naming and analysing any lapse in adherence to the agreed-upon structure. When a client repeatedly arrives twenty minutes late, for example, the therapist does not simply express irritation. Instead, the therapist frames the lateness as a behaviour that is currently winning against the therapeutic alliance, invites the client to walk the chain of antecedents and consequences, and negotiates a concrete plan to restore punctuality. This approach prevents the erosion of the therapeutic contract and maintains the integrity of the treatment.

Quality-of-life interfering behaviour occupies the third level of the hierarchy. These are behaviours that, while not immediately life-threatening, significantly diminish the client's overall functioning and wellbeing. Examples include substance misuse, chaotic interpersonal relationships, financial instability, and chronic health neglect (Linehan, 1993). The focus on quality of life reflects DBT's commitment to building a life worth living, a principle pursued through the quality-of-life targets of the treatment hierarchy rather than through a module of its own. In an intermediate, DBT-informed context, the therapist still attends to these behaviours, but only after the higher-order targets have been addressed. The hierarchy ensures that a client who is, for instance, drinking heavily will not be allowed to bypass a recent self-harm episode; the self-harm will be the priority, and only once stability is achieved will the therapist shift attention to the substance use.

Skills acquisition forms the core methodology of DBT. The acquisition and generalisation of DBT skills—mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness—are woven throughout the hierarchy. Skills are taught continuously, but their practice is prioritised according to the client's current hierarchy status. When a client is in the midst of a Life-threatening crisis, the therapist may focus on the specific distress tolerance skill of "TIP" (temperature, intense exercise, paced breathing) to stabilise the client, whereas during a Quality-of-life focus the therapist may explore interpersonal effectiveness strategies to negotiate a

healthier living arrangement. Thus, skills are not a separate module but a thread that runs through every level of the hierarchy.

The diary card is the instrument that makes the hierarchy operational on a day-to-day basis. It is a simple, daily log that records urges, actions, emotions, skill utilisation, medication adherence, and sleep quality. Whether completed on paper or via a secure app, the diary card provides a concrete snapshot of the client's week, allowing the therapist to see patterns that would otherwise be hidden behind the most dramatic story the client chooses to tell. For example, a client may report that the week was "fine" because the most salient event was a heated argument with a partner, yet the diary card may reveal that the client experienced three intense urges to self-harm, used the "wise mind" skill twice, and slept only four hours each night. By reviewing the diary card at the start of each session, the therapist lets the data, rather than the loudest narrative, set the agenda. The hierarchy then determines which data point takes precedence: a self-harm urge recorded on Tuesday will automatically move the session to address the Life-threatening rung, even if the client wishes to spend the time discussing a work problem.

Non-completion of the diary card is often treated as a Therapy-interfering behaviour if it is chronic or hostile, but it can also be addressed as a skills target. It is addressed with the same systematic curiosity as any other interfering pattern. The therapist asks the client what prevented the card from being filled out, explores the function of avoidance, and collaboratively develops a plan to ensure future completion. This approach teaches, more efficiently than any verbal instruction, that the structural elements of therapy are load-bearing and non-negotiable. The client learns that the therapist's commitment to the hierarchy is matched by an equal commitment to the client's adherence to the agreed-upon tools.

Session discipline emerges from the combined application of hierarchy and diary card. The session begins with a brief review of the diary card, during which the therapist identifies the highest-priority target behaviour for that week. The therapist then explicitly states the agenda, linking it to the hierarchy: "Because you recorded a self-harm urge on Tuesday, we will start by reviewing that chain before moving on to any other topics." This transparency removes ambiguity and reinforces the predictability that is essential for clients whose emotional experience is otherwise volatile.

Predictability is not bureaucratic rigidity; it is a therapeutic safety net that allows the client to feel that the therapist's responses are reliable, not subject to the client's mood swings.

The transferability of these structures to ordinary clinical settings is one of the most valuable aspects of DBT-informed practice. Even when a full DBT programme is unavailable, the therapist can implement a simplified diary card that tracks three target behaviours, urges, actions, two core emotions, and skill use. The hierarchy can be co-constructed with the client, written on a visible poster in the therapy room, and referred to explicitly at each session. The category of Therapy-interfering behaviour can be incorporated into the treatment contract, ensuring that both therapist and client are accountable for maintaining the therapeutic frame. By embedding these structural elements, the therapist creates a micro-environment of safety that mirrors the larger DBT system, and this environment can be the catalyst for change in any therapeutic context.

A concrete worked example illustrates the integration of hierarchy, diary card, and session discipline. Sam, a 28-year-old client referred for chronic self-harm and alcohol misuse, was engaged in a community mental health service that did not offer a full DBT programme. The therapist introduced a three-column diary card: Column 1 recorded urges to self-harm (rated 0-100), Column 2 recorded actual self-harm actions (yes/no), and Column 3 recorded alcohol consumption (units). Two emotion items—"anxiety" and "sadness"—were also rated on a 0-10 scale, and a checklist of DBT skills used that day was included. Together, Sam and the therapist co-created a hierarchy written on a laminated sheet: Life-threatening behaviour (self-harm), Therapy-interfering behaviour (missed appointments, diary-card non-completion), and Quality-of-life interfering behaviour (excessive drinking), with skills acquisition as the underlying method.

During the first week, Sam completed the diary card consistently. On Tuesday, he recorded an urge to self-harm of 85, but no action, and noted that he had consumed six units of alcohol. On Thursday, he missed his scheduled session, arriving twenty-five minutes late. At the start of the next session, the therapist reviewed the diary card, noting the high self-harm urge and the missed appointment. Applying the hierarchy, the therapist said, "Because the diary card shows a strong self-harm urge on Tuesday and you were late for our last session, we will first explore the chain that led to the

urge, then discuss what made you late, and finally look at your drinking." The therapist guided Sam through a chain analysis of the Tuesday urge, identifying a triggering interpersonal conflict, an emotional cascade, and a lapse in using the "TIP" skill. The therapist then examined the lateness, discovering that Sam had been anxious about the possibility of discussing his self-harm, which functioned as a Therapy-interfering behaviour. Together they negotiated a concrete plan: Sam would set an alarm, and the therapist would send a brief reminder text the evening before each session. Finally, the therapist praised Sam for using the "wise mind" skill on Tuesday, reinforcing skill acquisition.

Over the next four weeks, Sam's diary cards showed a gradual reduction in self-harm urges (averaging 45 by week four) and a consistent pattern of punctual attendance. His alcohol consumption decreased from an average of eight units per day to three units, and he began to tick the "opposite action" skill more frequently. The hierarchy and diary card had provided a transparent framework that allowed Sam to see his progress in concrete terms, while the session discipline ensured that each session addressed the most pressing target behaviour first. Sam later described the experience as "finally having someone hold the other end of the rope," encapsulating the core message that structural predictability, not rigidity, is the conduit for therapeutic change.

In summary, the hierarchy of target behaviours, the diary card, and the disciplined session structure constitute the essential scaffolding of DBT-informed practice. By adhering to the hierarchy—Life-threatening, Therapy-interfering, and Quality-of-life—therapists ensure that the most urgent risks are addressed first, that the therapeutic frame is protected, and that skill development proceeds in a safe context. The diary card translates the client's week into objective data, allowing the hierarchy, rather than the most dramatic story, to dictate the session agenda. Session discipline, grounded in transparency and predictability, transforms the therapeutic environment into a reliable source of safety that clients can rely upon even when external circumstances are chaotic. These structures are not confined to comprehensive DBT programmes; they can be adopted in any therapeutic setting, offering a portable set of tools that preserve the integrity of the treatment and promote lasting change.

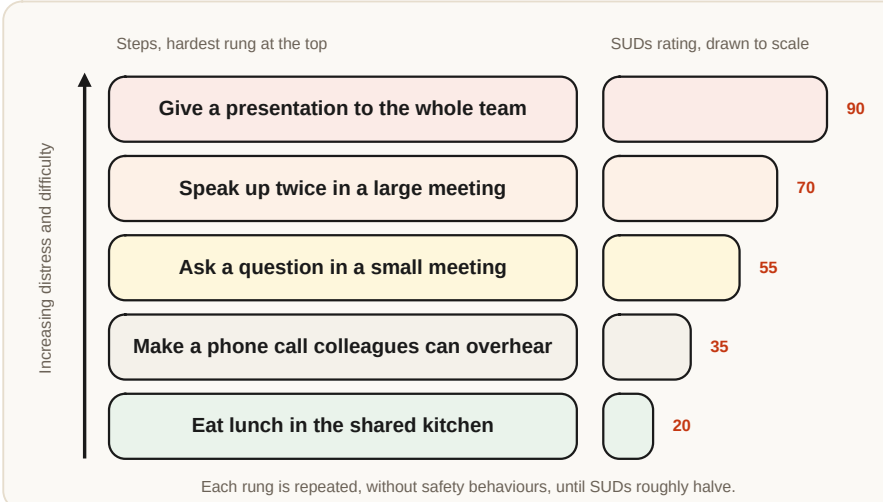


FIGURE 2.1 A graded exposure hierarchy

Fear is approached as a ladder, not a leap. Each rung is faced repeatedly, without safety behaviours, until anxiety falls and the prediction is disconfirmed, then the next rung begins. Subjective Units of Distress (SUDs) keep the grading honest.

Points worth keeping

- Hierarchy: life-threatening, therapy-interfering, quality-of-life, skills
- The diary card lets the week, not the loudest story, set the agenda
- Structure is safety, and transfers to ordinary settings

PRACTICE TASK

Design a seven-column diary card for one client you know of, choosing what genuinely needs daily tracking.