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Dialectical behavior therapy for children: A pilot study of skills training groups for parents

Marit Coldevin[1], Maia Daasvand Skyberg[1], Solveig M. Kirchhofer[1 2],
Per Martin Løken[1], Synne Jenssen[1], Jan Stubberud[2 3]

Summary

Background:Dialectical behavior therapy for children (DBT-C) has been developed to treat children with severe emotion regulation disorder, and the interventions are aimed at both children and parents. We wanted to look at how parents reported treatment outcomes for their child's behavioral difficulties after participating in parenting skills training groups in DBT-C. To the best of our knowledge, no studies, either international or national, have previously explored treatment outcomes after DBT-C parenting group intervention.

Method and results:The sample in this within-group study was parents of 23 children aged 8–14 years (*Mdn*= 11 years, 74% boys) under treatment in mental health care for children and young people (BUP). The pilot was part of a larger quality development project in an outpatient clinic. The outcome measures were the Eyberg Child Behavior Inventory (ECBI), where we compared parent-reported behavioral symptoms in the child before and after the intervention, in addition to the extent to which the parents experienced the behavior as problematic. In addition, the parents answered a questionnaire that measured the perceived benefit of the intervention. The results showed a reduction in the frequency of behavioral difficulties in the child ($t(21) = 5.127, p < .001$) and the parents experienced the behavioral difficulties as a problem to a lesser extent ($t(19) = 2.714, p = .014$).

Conclusion:Subject to the small sample size and the lack of a control group, the pilot study gives an indication that DBT-C parenting skills groups can reduce behavioral difficulties in children with emotion regulation disorder. There are few studies on DBT-C, and our results pave the way for further research into the treatment method. Future studies should ensure the possibility of evaluation of high internal and external validity, emphasize evaluation of effect with several measuring instruments from several peers and monitor change targets along the way. In addition, surrounding factors, such as previous and other parallel treatment or follow-up, should be checked for.

*Keywords:*DBT-C, emotion regulation disorder, parenting skills training, behavioral difficulties

[1] Nic Waals Institute, Lovisenberg Diakonale Hospital (LDS)
[2] Department of Psychology, University of Oslo
[3] Research department, LDS

CONTACT
mmc@lds.no

NOTICE
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PEER REVIEWED

Children with severe emotional dysregulation in the form of frequent outbursts of anger and persistent irritability struggle to a great extent psychologically, socially and functionally (Copeland et al., 2013). When the anger and irritability cannot be understood as an expression of unsustainable life conditions or developmental disorders, the children have traditionally been understood diagnostically as suffering from behavioral disorders (Leibenluft, 2017). Data from patient registers show that behavioral disorders are one of the most frequently diagnosed diagnoses in the age group 7–12 years in Norway (Health Directorate, 2022). Recent years of research have provided the basis for differentiating the children who struggle with behavioral disorders into several symptom subgroups, mainly 1) irritable, 2) headstrong/defiant or 3) hostile/ insensitive (see
e.g. Stringaris & Goodman, 2009). In DSM-5, the development is taken into account through the establishment of the diagnosis Disruptive Mood Dysregulation Disorder (DMDD) (American Psychiatric Association, 2013). DMDD is characterized by two primary symptoms: "chronic" irritability (daily irritation, > 1 year) and severe anger outbursts (≥ 3 times per week, > 1 year) in two or more arenas. Several studies have shown that there is a developmental connection between severe irritability in childhood and later affective disorders, anxiety disorders, personality disorders, suicidal acts/intentions and substance abuse (Althoff et al., 2010; Stringaris et al., 2009). Such connections emphasize how important it is to explore interventions that are specifically aimed at severe emotional dysregulation in children.

DBT for children

Emotion regulation can be defined as an individual's ability to adapt or modulate which emotions one has at which times, and how one experiences and expresses them (Gross, 2014). Emotional dysregulation, which contrasts with adaptive emotion regulation, is thought to be the core difficulty in DMDD (Brotman et al., 2017). There are currently very few evidence-based treatment programs for DMDD, but dialectical behavior therapy for children (DBT-C) has shown promising results (Perepletchikova et al., 2017).

DBT-C is ordinary DBT adapted according to age for children with severe emotional dysregulation and their caregivers. DBT-C is based on standard DBT in content and didactics. In addition, it includes parenting guidance and elements of parenting interventions based on social learning theory that have been shown to be effective for behavioral difficulties, such as Parent Management Training (PMT) (Forgatch & Patterson, 2010).

DBT is a complex treatment model where emphasis is placed on skills training, cognitive restructuring ture, affect exposure and contingency management. The treatment emphasizes both acceptance and validation of what is, and the need for change, and it can be described as a synthesis of three paradigms: behavioral psychology to promote change, mindfulness to promote presence and acceptance, and dialectics to balance change and acceptance (Linehan, 1993).

The overarching goal of DBT is to treat severe impairments in emotion regulation. The starting point is a theory that emotional dysregulation arises and is maintained by a mutual influence between an innate emotional sensitivity/reactivity in the child and the environment's invalidation of this reactivity (Linehan, 1993). By invalidation is meant serious and/or long-lasting negative responses to the child's emotional expression, which is believed to lead to a lack of understanding of one's own emotions and inappropriate coping strategies for self-regulation in the child. When this pattern is repeated over time, various forms of psychopathology can arise, such as emotionally unstable personality disorder, which is traditionally the target group for the intervention (Linehan, 1993).

A basic principle in DBT-C is that the child *not* is actively involved in the therapy before the parent can demonstrate basic understanding and appropriate behavior in order to be able to support the child in its process of change. In particular, the parents must acquire an increased degree of validating attitude and behavior towards the child (Perepletchikova et al., 2017).

As far as we know, DBT-C has only been evaluated in one efficacy study (Perepletchtikova et al., 2017), and there is a need for further exploration of the treatment method. The assumption in DBT-C that the child should not be involved until the parent has acquired emotion regulation skills provides a basis for exploring whether the parent group intervention in itself can contribute to reducing the child's symptoms. No one has investigated this before. In addition, it is important to examine the extent to which the parents find the method useful.

The overall aim of the pilot study was to obtain knowledge about treatment outcomes after the parenting skills training group in DBT-C. The research questions were:

1. Do the parents report a change in the children's degree of behavioral difficulties before and after the parenting group?
2. Do parents report their children's behavioral difficulties as less problematic from before to after the parenting group?
3. In what way do parents experience the group intervention as meaningful, including its usefulness for them as parents, the child and the interaction between child and parent?

Method

Design

The pilot study is an exploratory study with a within-group design. It is part of an ongoing professional development project that aims to describe and ensure the quality of the therapy offer DBT-C at the Nic Waals Institute, an outpatient clinic in mental health care for children and young people (BUP) that belongs to Lovisenberg Diakonale Hospital. The study has been recommended by the data protection officer at Lovisenberg Diakonale Sykehus.

Procedure

The participants were recruited in connection with their children being examined and treated at the outpatient clinic. The recruitment period was autumn 2019–spring 2021. Parents of children who were assessed by the responsible therapist and the consultation team to be in the target group for DBT-C, took part beforehand in an orientation and commitment interview (see figure 1). Before the group started, the parents received a written invitation to participate in the professional development project of which the study is a part. The parents filled in the Eyberg Child Behavior Inventory (ECBI) questionnaire at the first and last skills training group, about four months apart. An evaluation form was filled in during the last group lesson. We and the Data Protection Commissioner at the hospital considered the project to be a quality assurance project since it was a review of data for the control and evaluation of an existing treatment that has been offered since 2018 at the Nic Waals Institute. All parents participated according to the terms of informed consent. Data was de-identified and stored securely on Lovisenberg's research server.

Participants

All parents who were offered a skills training group agreed to participate in the study (n = 36 children; *n*=72 parents). What the children had in common was that they struggled with severe emotional dysregulation according to the criteria for DMDD according to the DSM-5, and the children were between 6 and 13 years old. Of the 72 parents who agreed to participate, 49 submitted a parent evaluation form after completing the group. This sample consisted of 31 fathers (63.3%), 13 mothers (26.5%) and 5 people (10.2%) who did not report gender. There were 23 parents who scored the ECBI before and after the group. The sample here consisted of 23 children, among them 6 girls (26.1%) and 17 boys (73.9%) aged 8–13 years (median = 11, IQR = 3). The informants on the ECBI were 16 mothers (69.6%), 5 fathers (21.7%) and in two cases the parents reported together (8.7%).

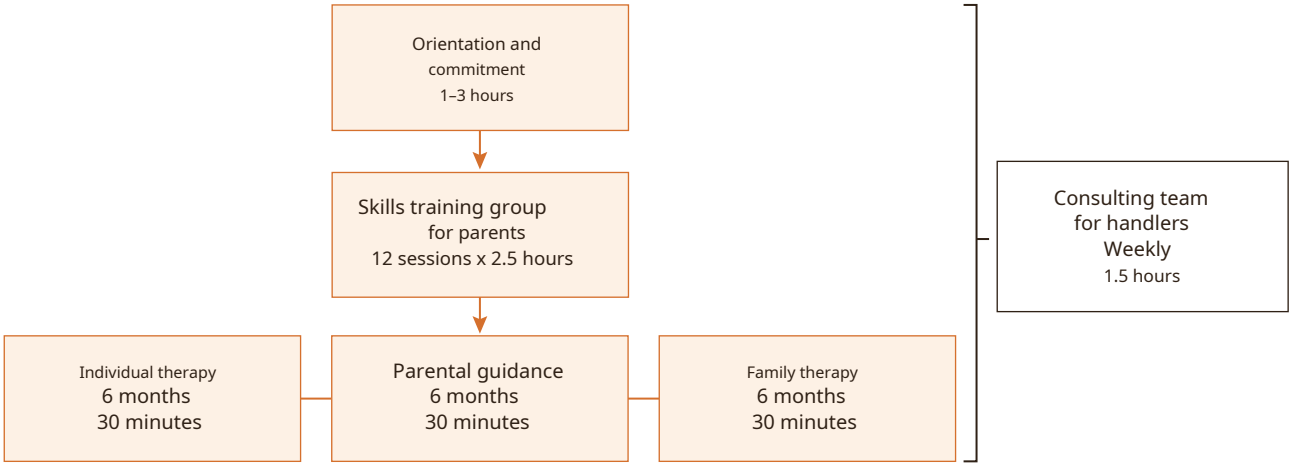
DBT-C

DBT-C as a whole consists of four modules. In this study, we have focused on the skills training group for parents.

Skills training for parents deals with four main themes that are repeated in individual and family therapy, illustrated in Figure 2. In the skills training group, which has a total of 12 sessions, the skills are presented, and they are linked to the parents' issues, both through role plays and exercises and through reflection

Figure 1

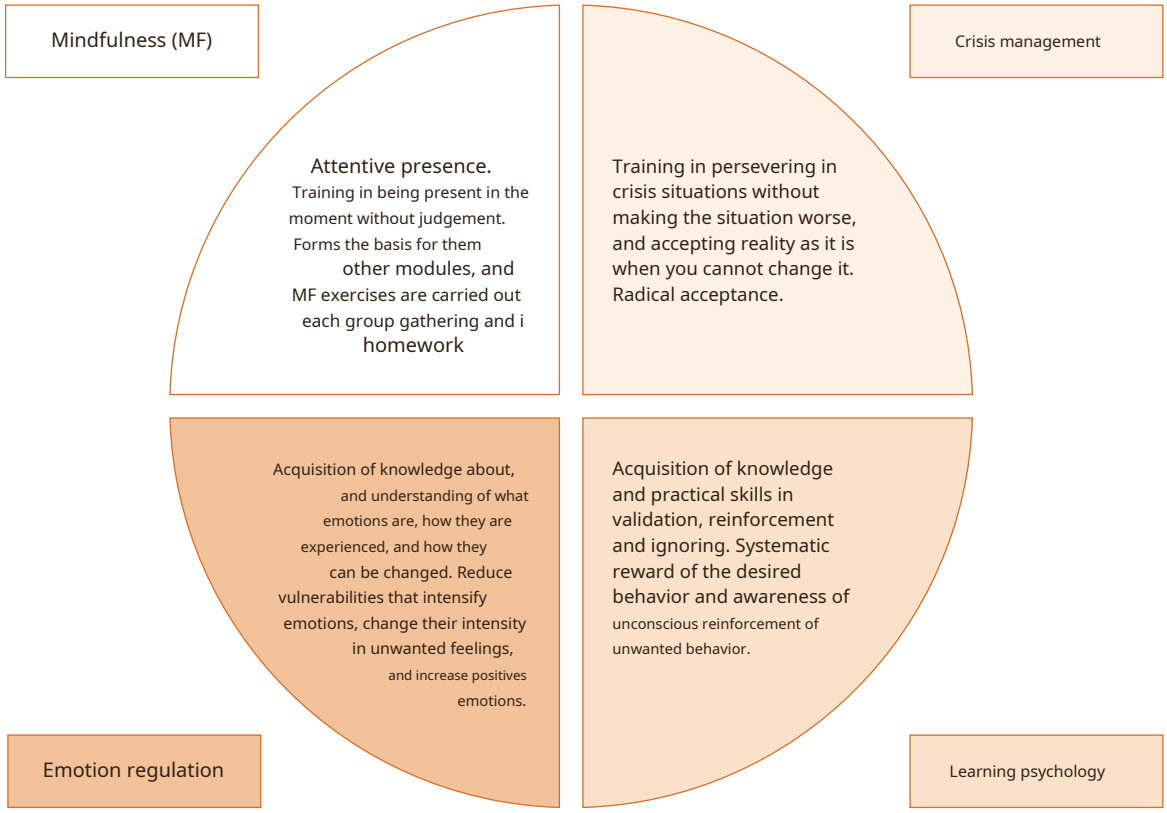
Dialectical behavior therapy for children at Nic Waal's institute



*Notice.*Individual therapy, parental guidance and family therapy take place in a 90-minute session.

Figure 2

Topics in DBT-C skill groups for parents



*Notice.*Self-constructed figure that gives an overview of the main themes in the skill groups as described in DBT-C.

in plenary and smaller groups. The parents are given homework in connection with the topics reviewed in the groups. The skills training follows a set sequence. It starts with information on the treatment model and its application (one collection), followed by mindfulness (one collection), crisis management (two collections), dialectics and validation (three collections), behavior and behavior change (two collections), emotion regulation (two collections) and summary/conclusion (one collection).

All the therapists who held groups are trained psychologists or psychiatrists and certified DBT therapists with training from the National Center for Suicide Research and Prevention (NSSF). Three of the therapists are certified DBT-C therapists after training with Dr. Perepletchikova.

Measuring instruments

Eyberg Child Behavior Inventory

The ECBI (Eyberg & Ross, 1978) is a parent-report instrument developed to survey behavioral problems in children aged 2–16 years. The instrument consists of the two subscales Intensity and Problem. The intensity scale is a seven-point Likert scale that measures the frequency of problem behaviour, for example "hits others" or "does not follow instructions" (1 = Never, 7 = Always). The problem scale is dichotomous (yes/no) and indicates the parents' assessment of the behavior as problematic or not. T-score ≥ 60 indicates clinical level. The ECBI is standardized and validated (Boggs et al., 1990) and considered to have good psychometric properties, also in a Norwegian population (Intensity: α = .82–0.93; Problem: α = .84–.96) (Reedtz & Martinussen, 2011).

Evaluation form

The evaluation form consists of a total of nine questions related to the perceived usefulness and effect of participating in the skills training group (see supplementary material). Five questions are answered on a four-point scale (not at all, to a small extent, to a large extent, to a very large extent), three questions ask for descriptive answers, and one question is an assessment of which skills the parent

lived as most and least useful (mindfulness, crisis management, dialectics, validation, learning psychology, emotion regulation). The evaluation form was prepared by the authors Løken and Coldevin in 2019 according to guidelines developed by Bradburn et al. (2004).

Statistical analyses

Initial analyzes were conducted to explore normality, outliers and missing values. Assessment of skewness and kurtosis substantiated the assumption of normality, with the exception of T-scores for the Problem variable, which had skewness > –1.96, indicating deviation from normal (p < .05). Missing values (4) were investigated with frequency tables and Little's MCARtest. Descriptive statistics were used to examine mean scores for the ECBI and the evaluation form. Inferential analyses, including parametric and non-parametric tests of group differences, were conducted: Paired T-test was done to explore difference in mean values, and Wilcoxon Signed-Ranks were performed before and after skill training group to investigate whether there was a difference in mean rank. Effect sizes (Cohen's d) were calculated to assess the size of any differences between the time points. We carried out correlation analyzes to see if there was a relationship between scores before and after the skills training group on the EBCI scales Intensity and Problem. In all analyses, raw scores were used in favor of T-scores. Expected probability was set to $p < .05$.

Results

The child's symptom score and the parents' problem score before and after skills training

There was a statistically significant difference between the pre- and post-group in Intensity scores ($t(21) = 5.127, p < .001$, Cohen's d = 1.1, 95% CI [.55, 1.62]) and Problem scores ($t(19) = 2.714, p = .014$, Cohen's d = 0.6, 95% CI [.12, 1.08]), see Table 1.

The pre-scores for Intensity and Problem were highly correlated ($r = .759, p < .01$). This indicates that higher scores on the Problem measure are associated with higher scores on the Intensity measure. For post-scores we found a moderate correlation ($r = .630, p < .01$). T-scores above/equal to 60 indicate clinical level (pre-score Problem: M = 66.4 and Intensity: M = 64.6, post-score Problem: M = 61.1 and Intensity M = 59.3).

Since the sample was small, a non-parametric test was also carried out to examine group differences in Intensity and Problem before and after group. The Wilcoxon Signed-Ranks test indicated that Intensity in the post-group (mean rank = 12.68) was significantly lower than Intensity in the pre-group (mean rank = 4), Z = –3.718, $p < .001$. Correspondingly, Problem in the post-group (mean rank = 9.29) was significantly lower than in the pre-group (mean rank = 6.13), Z = –2.252, $p < .001$.

Descriptive analyzes of evaluation forms

Figure 3 presents the parents' assessment of positive change in the child, in the parent themselves and in the interaction in the family as a result of participation in the parent group.

The parents (n=49) evaluated validation as the most useful parenting skill (87%). It's also the only one of the skills that no one has rated as least useful. The skill that is highlighted as least useful is learning psychology (24.5%). Furthermore, a total of 93.8% reported that they and their family had benefited from the offer to a large (57.1%) or very large (36.7%) extent. A total of 95.9% would recommend the offer to other parents in the same situation as themselves to a large (22.4%) or very large (73.5%) extent.

Discussion

We found a reduction in both the child's degree of difficulties and the parents' reported degree of problems in handling the child's difficulties after the intervention with the DBT-C skills group. Furthermore, the parents reported that they found the method useful for themselves, for the interaction within the family and for the child. Despite the small sample size, the results suggest

Table 1

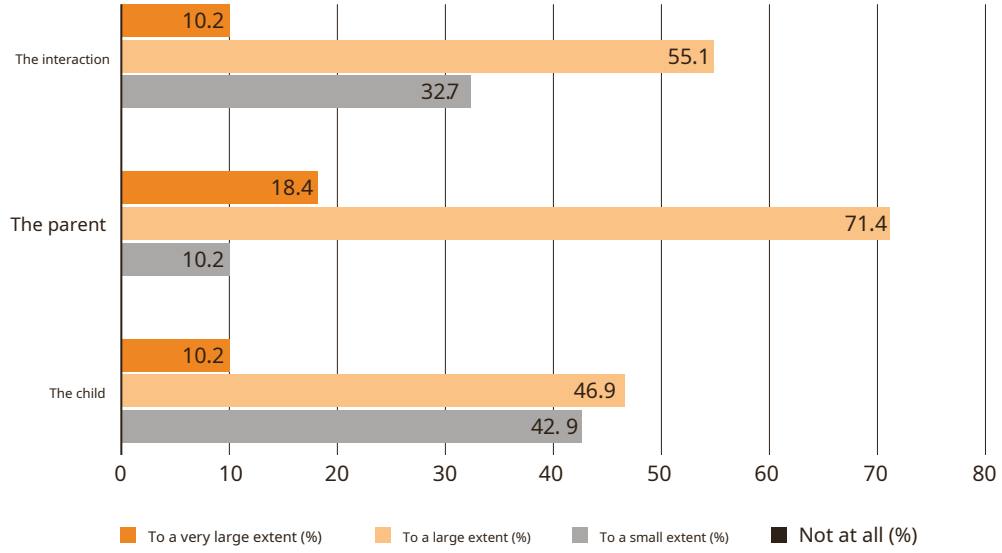
Differences between groups before and after intervention on problem and intensity scores reported by parents

Goal	Pre-group				Mail group					
	M(SD)	***Mdn***	**Range**	**IQR**	***M(SD)***	***Mdn***	**Range**	**IQR**	***t***	***p***
ECBI-I (n=22)	148.78 (21.17)	146	107–207	22	131.36 (28.38)	129	89–190	30	5.127	<.001**
ECBI-P (n=20)	19.14 (4.90)	20	7–28	7	15.24 (7.16)	16	1–25	11	2,714	. 014*

Notice. ECBI-I = ECBI Intensity, ECBI-P = ECBI Problem. Higher ECBI scores indicate more difficulties. IQR = interquartile range.
* = $p < .05$. ** = $p < .001$

Figure 3

Degree of positive change reported by parents as a result of participation in group (n = 48–49)



*Notice.*One missing value for assessment of Positive change in the interaction.

tates, in line with the theory behind the treatment intervention DBT-C, that psychoeducation and skills training can contribute to symptom relief in the children. In addition, the parents felt that the parenting role was less problematic or more manageable. As we do not have a control group, it must be taken into account that the change before and after the group may be due to other factors, such as regression towards the average and natural change over time. A possible factor for change in light of this is that the parents meet other parents in a similar situation, which can normalize the child's difficulties and their own difficulties in dealing with them. Normalization is also considered to be a central group process (Finucane & Mercer, 2006) which in itself can be an important change mechanism. Furthermore, it can give hope to experience support, to be part of a treatment program that is highlighted as effective, and to meet health personnel, which has been shown to be significant for change (Wampold & Imel, 2011).

Our findings are consistent with those of Perepletchikova et al. (2017), who found a reduction in children's behavioral problems after DBT-C. Similar positive effects (e.g. reduction in self-harm and suicidal behavior) after DBT have also been seen in other child and adolescent populations (Kothgassner et al., 2021; Mehlum et al., 2014), which provides support for using DBT -C as a method for children with DMDD. The results from our study suggested mild symptoms in the children, without the children themselves having received treatment. This suggests that fer-

strength group for parents alone can help create change in children in some families, and that it is not always necessary to involve the child in the treatment. Our findings also open up a possible differentiation and adaptation of measures, where the children are involved in the treatment based on results according to the skill group for parents. In the future, this should be investigated with control groups and a wider sample.

The parents generally reported great utility from the intervention, and they experienced the greatest degree of change in themselves (70% "to a large extent"). This is also the purpose of the first part of the DBT-C intervention. However, there was no percentage difference in parents who reported "a large degree of change in the child" and "a small degree of change in the child". The results from the evaluation form for the 49 parents differed from the significant reduction in ECBI intensity scores. It is very unclear what weight the discrepancy should be given, given that the evaluation form was filled out anonymously and the results cannot therefore be compared on an individual level. One can speculate whether the parents who do not report a large degree of change in the ECBI, and who need more help, are the same ones who report that their child's difficulties have changed to a small extent.

The parents emphasized that validation was a particularly effective skill in the evaluation. It is possible that acquisition of this skill is reflected in the reduction in ECBI problem scores. The theoretical framework

to DBT starts from invalidation as something that particularly maintains dysregulation in the child (Linehan, 1993). From a theoretical point of view, we can expect that skills that address validation will be extra potent in terms of change in the child. There is empirical support for this in studies on treatment interventions for parents with a focus on validation. These have also shown an effect on children's symptoms, for example emotion-focused therapy for parents (EFT; Ansar et al., 2022). It is natural to believe that validation as a skill is awareness-raising and gives an increased understanding that one's own and others' emotional expressions are meaningful. In the extension of such awareness, the behavior may become easier to accept or be perceived as less serious by the parents. One question is whether the parents have experienced the child's behavior as less problematic after validation training, and thus have reported problem behavior as lower.

It is interesting that the parents highlighted learning psychology (positive and negative reinforcement) as at least useful. There may be several reasons. As DMDD is believed to be an emotion regulation disorder rather than a behavioral disorder, behavioral psychology principles may fall short. Another explanation could be that this is an extensive topic with exercises that require more individual adaptation and follow-up than what group courses over two sessions can cover. The principles require direct involvement of the child (systematic rewards and boundary setting must be introduced to the child), with the adaptations that are appropriate for the individual family. When this is not feasible in the group format, it can be perceived as a less useful skill.

Parent training programs for children with behavioral difficulties that are largely based on learning theoretical principles have been shown to be effective over a long period of time (e.g. Ogden & Hagen, 2008; Patterson & Fleischman, 1979), and are described as the gold standard in the treatment of such difficulties in children. Therefore, one would think that learning theoretical principles are also important for change in the relevant target group. A possible adjustment based on the feedback about learning psychology as the least useful from the parents is to deepen the topic further in the skills training, as well as ensure enough time to work with behavioral psychology principles in the individual follow-up.

Limitations and further research

This is a pilot study with several limitations, and the results must be interpreted with caution. The study has a small sample size, and no power or number calculations were carried out. In further studies, the sample size must be increased so that sufficient statistical power is ensured, and there is an opportunity to identify systematics differences within a sample. The study did not include a control group, and therefore we could not draw causal inferences about the effects of the intervention. Furthermore, it is important to point out that there is no comparative information beyond the parents' reporting on the children's symptom change before and after the group. Future studies should ensure that it is possible to evaluate high internal and external validity. For example, one can evaluate the effect using several measuring instruments and compare information from arenas outside the home and the clinic, e.g. teachers, both after completed skills training for parents and after completion of the entire DBT-C treatment. In addition, change targets should be monitored along the way. Surrounding factors, such as previous and other parallel treatment or follow-up, should be checked for. Finally, the therapist's adherence to the method should be measured to ensure that it is the relevant method that is offered and measured.

Conclusion

The results from our pilot study, despite the limitations, provide evidence that children who struggle with emotional and behavioral clinical dysregulation can benefit from the parents being trained in skills that are central to influencing regulation difficulties and interaction with the child. This is the purpose of the skills training group for parents in DBT-C. The parental feedback further suggests that the change largely occurs in the parents' way of meeting the child. Validation is highlighted as a particularly useful skill. The study shows promising results for DBT-C, including a skills training group for parents, and provides a basis for further exploration of the method.

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