NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

Comparative Effectiveness Research Series

Dialectical Behavior Therapy

An Informational Resource

2012

This document is part of a series discussing evidence-based practices evaluated in comparative effectiveness research studies. The information is designed to inform practitioners and other decisionmakers considering the adoption of evidence-based practices in their organization. This document in the series provides general information about Dialectical Behavior Therapy (DBT), along with results of studies assessing DBT's efficacy, details about cost, and examples of DBT-based interventions for implementation in primary care and behavioral health settings. The decision to adopt and implement evidence-based practices is guided by many factors that may not be covered here. The authors hope this information can assist in making an informed decision on the implementation of this treatment model.

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Table

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment program developed by Marsha Linehan, Ph.D., in the early 1980s. Originally developed to treat chronically suicidal patients, DBT evolved into a treatment for suicidal individuals with borderline personality disorder (BPD). It has since been adapted for individuals with a wide range of psychiatric and substance use disorders. The term dialectical conveys the multiple tensions patients experience during therapy and the importance of enhancing dialectical thinking patterns to replace rigid thinking. DBT requires the therapist to balance strategies to maintain therapeutic progress for patients who at various moments may fluctuate between a suicidal crisis, rigid refusal to collaborate, rapid emotional escalation—or the beginning of successful collaboration.[1]

The Practice

The central dialectic in this therapeutic approach is the balance between acceptance and change, while working toward the client's goals. The DBT therapist balances change techniques (e.g., problem solving) with acceptance strategies (e.g., validation). Acceptance procedures also include mindfulness and maintaining a nonjudgmental stance. The DBT approach includes five core strategies in its application:

- Dialectics
- Problem solving (e.g., behavior therapy)
- Acceptance (e.g., validation)
- Case management strategies
- Communication strategies

Standard outpatient DBT treatment consists of modes:[2,3]

- **Individual therapy**
- **Skills training group**
- **Telephone consultation**
- **Clinical treatment team meeting**

Core Components and Understanding the DBT Approach

DBT is a comprehensive treatment with four standard components in an outpatient setting: (1) individual therapy; (2) skills training; (3) clinician-client telephone consultation between sessions; and (4) weekly meetings for the clinical team to provide support for one another to decrease staff burnout, process therapeutic challenges, and promote adherence to the treatment model.

The five functions[4] of treatment determine the modalities of treatment delivery:

1. Enhancing and maintaining client motivation (individual therapy, skills training, coaching)
2. Increasing client capabilities (skills training, individual therapy, coaching)
3. Ensuring generalization to the natural environment (telephone or in-person consultation)

4. Structuring the environment (telephone consultation, case management strategies)
5. Enhancing the motivation and capabilities of treatment providers (DBT team meetings)

Goals of Individual Therapy

DBT individual therapy aims to help the client progress through four main treatment stages, each with defined goals and targets (see Table 1). This organization assists in first addressing issues that are life threatening, prevent effective treatment, or prevent a reasonable quality of life.

Table 1.The Four Stages of DBT Individual Therapy

Stage I: Moving From Being Out of Control of One's Behavior to Being in Control	Stage II: Moving From Being Emotionally Shut Down to Experiencing Emotions Fully	Stage III: Building an Ordinary Life, Solving Ordinary Life Problems	Stage IV: Moving From Incompleteness to Completeness/ Connection
▪ Goal: Keep client alive, improve functioning ▪ Targets: Address life-threatening behaviors and those that interfere with effective treatment and may destroy quality of life ▪ Increase behavioral skills	▪ Goal: Help client experience emotions ▪ Target: Increase emotional experiencing; decrease emotional suffering	▪ Goal: Help client deal with problems of everyday living ▪ Target: Focus on management of aspects of daily living (e.g., marital conflict, job dissatisfaction)	▪ Goal: Help client move toward a life that involves an ongoing capacity for experiences of joy and freedom ▪ Target: Focus on helping client reach a sense of connectedness to a greater whole

Skills Training

- ***Core mindfulness*** (focusing skills): Mindfulness skills as specific behaviors that together make up the basics of focusing the mind in the present moment, without judgment and without attachment to the moment
- ***Distress tolerance*** (crisis survival and reality acceptance skills): Recognizing negative situations and their effects, managing extreme emotions and resisting urges to engage in dysfunctional coping; practicing accepting circumstances or situations that are painful or unwanted

- ***Emotion regulation*** (de-escalation skills): Learning to deal with emotions by identifying and labeling emotions, reducing vulnerability, increasing skills aimed at changing emotions (checking the facts, opposite action, problem solving, building mastery, coping ahead), and increasing mindfulness to current emotions
- ***Interpersonal effectiveness*** (people skills): Teaching communication strategies that include asking for what one needs, saying no, and coping with interpersonal conflict; building and maintaining relationships; walking a middle path (avoiding extremes)

Why DBT Is an Evidence-Based Program

- Theoretically based
- Scientifically evaluated through rigorous research
- Found effective in achieving positive results as intended
- Evaluation results have been subjected to peer review
- Recognized by Federal or other types of organizations as an evidence-based program

The use of acronyms to teach communication skills is a technique used in DBT. For example, the acronym ***DEARMAN*** is used to help clients communicate what they want so they can get it (interpersonal effectiveness).

D Describe your situation.

E Express why there is an issue and how you feel about it.

A Assert yourself by asking clearly for what you want.

R Reinforce your position by offering a positive consequence if you were to get what you want.

M Mindful of the situation by focusing on what you want and ignoring distractions and attacks.

A Appear confident even if you do not feel confident.

N Negotiate with a hesitant person and come to a comfortable compromise on your request.

Telephone consultations by the individual therapist (if different from the group facilitator) can be effective between sessions to assist in the generalization of new skills being learned. Initiated by the client, telephone consultations are optional and last about 10–15 minutes.

Weekly DBT team meetings are essential for the DBT treatment team to address any problems or issues that arise in the delivery of treatment and to assist with reorienting clinicians to the DBT framework. The DBT team provides consultation, support, and solutions for each therapist.

What the Evidence Tells Us About DBT's Effectiveness

One of the first DBT articles authored by Dr. Linehan was published in 1987 in the *Bulletin of the Menninger Clinic.*[5] Since then, DBT evaluation studies conducted by Dr. Linehan and her colleagues have been published in dozens of scientific journals, including 29 randomized clinical trials conducted across 21 independent research teams.[1] There are extensive data for the efficacy of DBT or DBT adaptations in treating suicidal behaviors and disorders characterized by pervasive and difficult-to-manage emotion dysregulation. DBT is an evidence-based program recognized by the American Psychiatric Association as a recommended treatment for BPD.[6] DBT has also been reviewed by the U.K. National Institute for Health and Clinical Excellence as an evidence-based approach for BPD.[7] DBT has been included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices since 2006.[8]

Comparative Effectiveness Research and Systematic Reviews

In addition to outcome trials, DBT has been systematically reviewed and compared to other psychotherapeutic approaches in comparative effectiveness research (CER) studies, which compare the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor community health and the nation's health care system. The Agency for Healthcare Research and Quality defines CER as a way to develop, expand, and use a variety of data sources and methods to conduct research and disseminate results in a form that is quickly usable by clinicians, clients, policymakers, and health plans and other payers.[9] Notably, the vast majority of DBT outcome studies have been CER trials since the evaluations took place in settings where clients were already receiving treatment. The superiority of DBT over other commonly used approaches, such as CBT, psychotherapy, and group therapy, have been found in several studies.[10–16] Findings are summarized below:

- Reductions in suicide attempts and nonsuicidal self-injury
- Fewer psychiatric inpatient days and fewer emergency room visits
- Treatment completion
- Increases in binge abstinence and reductions in binge frequency
- Fewer dropouts from treatment
- Decreased depression and anxiety
- Decreased substance use

Systematic reviews on the effectiveness of different psychotherapeutic approaches in the treatment of BPD find the strongest evidence from clinical trials favoring DBT. A meta-analysis of 26 DBT studies for BPD[17] found moderate effect sizes when DBT was compared to treatment as usual, and findings support DBT as effective in clinical practice.

DBT Adaptations for Implementation in Real-World Settings

To meet the specific needs of health care settings and the clients they serve, DBT adaptations have been evaluated in specific populations, settings, and delivery systems. The effectiveness of DBT has been evaluated in the treatment of—

- Adult patients with BPD and co-occurring substance abuse
- Patients with eating disorders (binge eating, anorexia, bulimia)
- Adults and older adults with depression and bipolar disorder
- Individuals with trichotillomania
- Individuals who are developmentally delayed
- Individuals with attention deficit disorder
- Individuals who stalk
- HIV patients
- Domestic violence victims

DBT has been implemented worldwide in multiple treatment settings, ranging from outpatient practices to secure residential and inpatient facilities. Specific sites include—

- Private practices
- University outpatient clinics
- College counseling centers
- Schools
- Forensic settings (prisons, detention centers)
- Intensive outpatient programs
- Community mental health centers
- Residential programs
- Psychiatric inpatient units

Behavioral Tech, LLC[18] (http://behavioraltech.org/), and Behavioral Research and Therapy Clinics[19] (http://blogs.uw.edu/brtc/), founded by Dr. Linehan and the University of Washington, provide training to mental health care providers and treatment teams. According to Behavioral Tech, there are currently more than 180 sites throughout the United States with providers trained in DBT. Innovative approaches to deliver DBT include incorporating family therapy, brief psychoeducation prevention intervention, and an interactive mobile phone application.

Example of a DBT-Adapted Intervention

Dialectical Behavior Therapy for Adolescents (DBT-A)[20] is a 12–25 week program based on the clinical reality that most adolescent suicide attempters fail to attend or complete therapy. The shorter length of treatment encourages treatment completion. The program includes a skills training group with parent participation to enhance maintenance of skills by teaching family members who can serve as coaches and help improve the home environment. Parents or other family members are also encouraged to attend individual therapy sessions to work on family dynamics. DBT-A reduces suicide attempts, nonsuicidal self-injuries, and depression, and it increases treatment completion rates.

Example of Real-World Implementation

DBT in a Routine Public Mental Health Clinic. An evaluation of DBT integrated into a routine public mental health clinic in Australia was assessed for efficacy and cost-effectiveness.[21] The usual treatment for BPD in this setting is a clinical case management approach. The DBT program was delivered over 6 months and consisted of weekly 1-hour individual therapy sessions, 2-hour weekly group skills training, access to phone coaching between sessions, and 90-minute weekly DBT team consultation meetings. Existing clinical staff consisted of master's-level psychologists and social workers, nurses, occupational therapists, and psychiatrists. DBT therapists received intensive DBT training from Behavioral Tech and basic training from experienced DBT trainers.

There are several factors to consider when an organization is deciding whether to adopt a new practice. Implementing organizational change can be challenging, but there are tools available to facilitate the process.

The evaluation demonstrated that providing DBT for BPD patients with minimal modifications in a routine clinical setting was more effective and cost-effective than treatment as usual:

- Patients receiving DBT for 6 months had reduced suicide attempts, nonsuicidal self-injury, inpatient hospital stays, and emergency room visits.
- Treatment costs per patient were significantly less for DBT patients than treatment as usual patients, with an average savings of $5,927 (Australian dollars) per patient during the 6 months of treatment.

Organizational Readiness To Adopt DBT

DBT organizational readiness tools have not been developed to date; however, several resources are provided during DBT trainings to assess readiness to adopt DBT[1]:

Individual Therapy Survey. The Individual Therapy Survey asks individuals to provide information regarding their education, years of experience, and current work.

DBT Provider Questionnaire. This measure identifies how much reading about DBT subjects have done and their participation in various study groups, consultation teams, and previous trainings. The information sheds light on individual ability to administer DBT. The questions also address how many times subjects have been the primary DBT therapist, backup therapist, pharmacotherapist, or skills leader prior to attending training.

The Institute of Behavioral Research at Texas Christian University. This institute has identified five broad categories of organizational readiness for change based on extensive research findings related to technology transfer and the adoption of EBPs (http://www.ibr.tcu.edu/evidence/evi-orc.html).

Barriers to Implementation. This measure documents what each team member believes are barriers to implementing DBT.

Copenhagen Burnout Scale. This measure is a self-administered questionnaire containing 19 Likert-rated, closed-ended items. It assesses burnout in three domains: work, client, and personal.

Evidence-Based Practice Attitude Scale. This is a self-administered questionnaire containing 15 Likert-rated, closed-ended items that assesses therapists' feelings about using new types of therapy, interventions, and treatments.

Team Needs Assessment. Individuals rate their team functioning on five scales (team cohesion, dialectical mission, needs met, team leadership, personal efficacy). After completing the ratings, they use the instrument as a point of discussion on how their team is functioning.

University of Washington Clinical Influence Scale. This inventory assessing social influence in clinical settings addresses the assumption that DBT training is provided to opinion leaders. The idea is that the opinion leaders will influence other providers in their communities to move toward more effective treatments.

Dissemination and Implementation Resources

The main vehicle for DBT training dissemination is the Behavioral Tech Web site.[18] Those interested in learning more about DBT can readily access information on the history of the practice, training opportunities, didactic resources, and a directory of DBT therapists and DBT internship sites.

Implementation Materials

The DBT treatment manual *Cognitive Behavioral Therapy for Borderline Personality Disorder* and the accompanying *Skills Training Manual for Treating Borderline Personality Disorder* provide the foundations of the practice along with the dialectical and biosocial theory of BPD. The skills training manual, a supplemental text to the treatment manual, provides step-by-step instruction on formatting DBT therapy groups and teaching skills training in weekly or biweekly sessions. Homework and handouts are also provided in the manual. A resource for specific applications of DBT in a variety of settings and with different populations is also available (*Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*). Details about these three publications follow:

1. Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. NY: Guilford Press.
2. Linehan, M. M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. NY: Guilford Press.
3. Dimeff, L. A., & Koerner, K. (2007). *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*. NY: Guilford Press.

Dialectical Behavior Therapy with Suicidal Adolescents (see publication details below) adapts the proven techniques of DBT to treatment of multiproblem adolescents at highest risk for suicidal behavior and self-injury:

4. Miller, A. L., Rathus, J. H., & Linehan, M. (2007). *Dialectical Behavior Therapy With Suicidal Adolescents*. NY: Guilford Press.

Dialectical Behaviour Therapy: Distinctive Features (publication details below) highlights 30 distinctive features of the treatment and uses extensive clinical examples to demonstrate how the theory translates into practice:

5. Swales, M. A., & Heard, H. L. (2009). *Dialectical Behaviour Therapy: Distinctive Features*. London: Routledge.

Doing Dialectical Behavior Therapy: A Practical Guide (publication details below) offers an introduction to DBT and demonstrates the nuts and bolts of implementation. This book guides therapists on how to integrate the concepts and techniques of DBT into their work with emotionally dysregulated clients:

6. Koerner, K. (2012). *Doing Dialectical Behavior Therapy: A Practical Guide*. NY: Guilford Press.

In addition to the references above, there are many other books and resources that specifically address what the founder of DBT deems necessary reading to learn about the basics of DBT. These are available on the Behavioral Tech Web site at http://behavioraltech.org/downloads/dbtReadingList.pdf. Additional resources are available at http://behavioraltech.org/products/list.cfm?category=Books

Training Resources for Providers

DBT can be provided by a wide range of health care professionals, and the treatment does not require delivery by any particular discipline. Therefore, a range of training resources are available based on individual and agency needs. While DBT is designed to be implemented as a team-based treatment (minimum of three, maximum of eight professionals), there are ample individual training opportunities through workshops and online training modules available at http://behavioraltech.org/training/

DBT for Beginners

- Individuals new to DBT and contemplating starting a new DBT team or wishing to learn more about DBT can participate in an online learning system, attend a variety of 2-day workshops, or view a series of training videos that provide a brief overview of DBT skills and components.
- New members of a team who have been previously trained are encouraged to participate in a 5-day foundational DBT training and the 10-day intensive training required for all DBT teams. This training is offered at various locations throughout the country.
- The University of Washington Behavioral Research and Therapy Clinics[19] provides skills training and intensive training through their experimental training program. University faculty trained by Dr. Linehan provide training through various university programs (e.g., University of Nevada, Reno; Alliant University, San Diego; Columbia University Schools of Social Work and Medicine, New York).
- For those interested in forming a new DBT team, Behavioral Tech sponsors three to five intensive 10-day trainings each year. If a larger mental health system or a large number of clinicians are interested in the 10-day intensive training course, Behavioral Tech is able to host trainings onsite at individual agencies.

DBT for Experienced Users

- Advanced Intensive Training in Dialectical Behavior Therapy, a 5-day training, is designed for clinicians and researchers who have been actively practicing DBT for at least a year. This training focuses on frequent problem areas in DBT individual therapy (e.g., handling in-

session, severe emotional dysregulation; conducting a truly competent behavioral analysis; how to talk with clients about problematic phone calls; more indepth teaching on mindfulness; review of how to teach the most difficult-to-teach skills). Enrollment is limited and the course is offered only once every 2 years.

- Clinical case and program consultation is offered through Behavioral Tech. Case consultation is available for both teams and individuals seeking to build clinical skills or receive assistance with specific case difficulties. Program consultation aims to assist in designing a program specific to the setting and addressing issues that arise during implementation. Consultations may be provided onsite and/or via telephone.

Resources for Agency Directors

Behavioral Tech has experience in many program implementations, each tailored to the needs of the individual agency. Costs are tied to specific training days and are scalable based on the number to be trained. Behavioral Tech suggests that the model of implementation start with orientation training, followed by indepth intensive training, then a further 2-day training focused on specific topic areas determined by agency staff. It is strongly recommended that providers receive consultation throughout the training process to support the information acquired and to strengthen the understanding and commitment to the treatment protocols.

Useful resources include training facilities; a devoted internal program manager; administrative staff to support trainings; the ability to produce training materials for program participants; and administrative support for scheduling training, elements of treatment, continuing education of staff, and the DBT consultation team.

DBT is a highly structured and intensive model requiring organizational support. The benefits of implementation include better clinical outcomes and treatment engagement and ongoing professional support for providers dealing with a challenging population.

Costs

The costs of implementing DBT can vary widely and are affected by the size of the organization, number and educational background of staff, number of facilities, and devotion of managerial resources to the effort. Training costs through Behavioral Tech can range from $1,300 to $2,400 per person, and workshop costs range from $260 to $349. The option to lower costs can be negotiated when training large groups. One way to accomplish this is to have a team of up to eight individuals willing to recruit other trainees and host trainings. These groups ordinarily pay little to nothing for trainings for their own staff.

References Cited

[1] Personal communications with developer

[2]Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. NY: Guilford Press.

[3]Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. NY: Guilford Press.

[4] Swales, M. A. (2010). Implementing dialectical behavior therapy: Organizational pre-treatment. *The Cognitive Behavior Therapist, 3*(4), 145–157.

[5]Linehan, M. M. (1987). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic, 51*(3), 261–276.

[6] American Psychiatric Association. (2001). Practice guideline for the treatment of patients with borderline personality disorder. *Am J Psychiatry 158*, 1–52.

[7] National Institute for Health and Clinical Excellence. (2009, January). *Borderline personality disorder: Treatment and management*. Retrieved from http://www.nice.org.uk/nicemedia/pdf/CG78NICEGuideline.pdf

[8] Substance Abuse and Mental Health Services Administration. (2006, October). *Dialectical behavior therapy*. Retrieved from the National Registry of Evidence-based Programs and Practices, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36

[9] Agency for Healthcare Research and Quality. (n.d.). *What is comparative effectiveness research?* Retrieved from http://www.effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1

[10]Linehan, M. M., Armstrong, H. E., & Suarez, A. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064.

[11]Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., & Kivlanhan, D. R. (2002). Dialectical behavioral therapy versus comprehensive validation plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*, 13–26.

[12]Lynch, T. R., Morse, J. Q., Mendelson, T., & Robins, C. J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry, 11*, 33–45.

[13]Lynch, T. R., Trost, W. T., Salsman, N., & Linehan, M. M. (2007). Dialectical behavior therapy for borderline personality disorder. *Annual Review of Clinical Psychology, 3*, 181–205.

[14]McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized clinical trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1365–1374.

[15]Paris, J. (2010). Effectiveness of different psychotherapy approaches in the treatment of borderline personality disorder. *Current Psychiatry Reports, 12*(1), 56–60.

[16]Telch, C. F., Agras, W. S., & Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 6*9, 1061–1065.

[17]Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting Clinical Psychology, 78*(6), 936–951.

[18] Behavioral Tech Web site http://behavioraltech.org

[19] University of Washington Behavioral Research and Therapy Clinics Web site http://blogs.uw.edu/brtc/

[20]Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide and Life Threatening Behaviors, 32*(2), 146–157.

[21]Pasieczny, N., & Connor, J. (2011).The effectiveness of dialectical behaviour therapy in routine public mental health settings: An Australian controlled trial. *Behaviour Research and Therapy, 49*(1), 4–10.

Other References

Berzins, L. C., & Trestman, R. L. (2004). The development and implementation of dialectical behavior therapy in forensic settings. *International Journal of Forensic Mental Health, 3*, 93–103.

Blennerhassett, R. C., & O'Raghallaigh, J. W. (2005). Dialectical behaviour therapy in the treatment of borderline personality disorder. *British Journal Psychiatry, 186*, 278–280.

Bradley, R. G., & Follingstad, D. R. (2003). Group therapy for incarcerated women who experienced interpersonal violence: A pilot study. *Journal of Traumatic Stress, 16*(4), 337–340.

Cavanaugh, M. M., Solomon, P., & Gelles, R. J. (2011). The Dialectical Psychoeducational Workshop (DPEW): The conceptual framework and curriculum for a preventative intervention for males at risk for IPV. *Violence Against Women, 17*(8), 970–989.

Cuny, S. M., Huser, M., Small, S., & O'Connor, C. (2007). What is an evidence-based practice? *Evidence-based programs: An overview*. University of Wisconsin-Madison and University of Wisconsin-Extension. Accessed at http://www.uwex.edu/ces/flp/families/whatworks_06.pdf

Fleischhaker, C., Böhme, R., Sixt, B., Brück, C., Schneider, C., & Schulz, E. (2011). Dialectical Behavioral Therapy for Adolescents (DBT-A): A clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a one-year follow-up. *Child and Adolescence Psychiatry and Mental Health, 5*(1), 3.

Hill, D. M., Craighead, L. W., & Safer, D. L. (2011). Appetite-focused dialectical behavior therapy for the treatment of binge eating with purging: A preliminary trial. *The International Journal of Eating Disorders, 44*(3), 249–261.

Hirvikoski, T., Waaler, E., Alfredsson, J., Pihlgren, C., Holmström, A., Johnson, A., … Nordström, A.-L. (2011). Reduced ADHD symptoms in adults with ADHD after structured skills training group: Results from a randomized controlled trial. *Behaviour Research and Therapy, 49*(3), 175–185.

Keuthen, N. J., Rothbaum, B. O., Fama, J., Altenburger, E., Falkenstein, M. J., Sprich, M., … Welch, S. S. (2012). DBT-enhanced cognitive-behavioral treatment for trichotillomania: A randomized controlled trial. *Psychology and Psychiatry, 1*(3), 106–114.

Pistorello, J., Fruzzetti, A. E., MacLane, C., Gallop, R., & Iverson, K. M. (2012). Dialectical behavior therapy (DBT) applied to college students: A randomized clinical trial. *Journal of Consulting and Clinical Psychology* (epub ahead of print 25 June 2012).

Rizvi, S. L., & Linehan, M. M. (2001). Dialectical behavior therapy for personality disorders. *Current Psychiatry Reports, 3*, 64–69.

Rizvi, S. L., Dimeff, L. A., Skutch, J., Carroll, D., & Linehan, M. M. (2011). A pilot study of the DBT coach: An interactive mobile phone application for individuals with borderline personality disorder and substance use disorder. *Behavior Therapy, 42*(4), 589–600.

Safer, D. L., Lively, T. J., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry, 58*, 632–634.

Swenson, C. R., Torrey, W. C., & Koerner, K. (2002). Implementing dialectical behavior therapy. *Psychiatry Services, 53*, 171–178.

Glossary

Adaptation: A modest to significant modification of an intervention to meet the needs of different people, situations, or settings.

CER (comparativeness effectiveness research): The Federal Coordinating Council on Comparative Effectiveness Research defines CER, in part, as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, delivery system strategies) to prevent, diagnose, treat, and monitor health conditions in real-world settings.

Comparison group: A group of individuals that serves as the basis for comparison when assessing the effects of an intervention on a treatment group. A comparison group typically receives some treatment other than what they would normally receive and is therefore distinguished from a control group, which often receives no treatment or "usual" treatment. To make the comparison valid, the composition and characteristics of the comparison group should resemble the treatment group as closely as possible. Some studies use a control group in addition to a comparison group.

Core components: The most essential and indispensable components of an intervention (core intervention components) or the most essential and indispensable components of an implementation program (core implementation components).

Dialectical behavior therapy: A system of therapy originally developed to treat people with borderline personality disorder and now including treatment of people who self-harm and abuse substances. DBT consists of the combination of cognitive behavioral therapy and mindfulness techniques.

Dissemination: The targeted distribution of program information and materials to a specific audience. The intent is to spread knowledge about the program and encourage its use.

Evidence-based practices: Programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the persons receiving the services.

Implementation: The use of a prevention or treatment intervention in a specific community-based or clinical practice setting with a particular target audience.

Intervention: A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention), or alter the course of an existing condition (treatment intervention).

Additional Resources

International Society for the Improvement and Teaching of Dialectical Behavior Therapy Web site http://isitdbt.net/

The Treatment and Research Advancements National Association for Personality Disorder Web site http://www.tara4bpd.org

American Psychological Association Guide to Beneficial Psychotherapy Web site http://www.apa.org/divisions/div12/cppi.html

Linehan Institute Web site http://www.marieinstitute.org/

Behavioral Tech Research, Inc., Web site http://www.btechresearch.com/
Site focuses on researching information technology and e-learning to develop innovative methods of training and fidelity assessment