

Cultural Adaptation Of Dialectical Behaviour Therapy For The Local Context: A Qualitative Study From South Asia

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Abstract

Dialectical Behavioral Therapy (DBT) is a comprehensive treatment program for individuals meeting the criteria for Borderline Personality Disorder/ emotionally unstable people. The aim of this study was to understand the views and experiences of clinical psychologists and clinical psychology students about DBT and its implementation with patients diagnosed with Borderline personality traits and to develop guidelines for culturally adapting DBT concepts and skills for borderline personality traits in Pakistan. Expert and in training therapists were recruited and semi-structured interviews were conducted with clinical psychologists (n= 9) from Islamabad, Peshawar, Lahore, Faisalabad, Karachi, and Multan. All psychologists had experience of working with patients diagnosed with Borderline personality disorder. Two focus groups were conducted with eight university students of MS clinical psychology (final year) who had seen at least two patients diagnosed with BPD. Moreover, feedback was also gathered from participants regarding the acceptable translation of terminology. Data were analyzed using thematic content analysis. The results highlighted the need to culturally adapt DBT. The participants also made useful suggestions to improve the translation and adaptation of the DBT guidelines. The participants also suggested the need to exclude certain activities from the therapy manual, which were not culturally relevant while adding more mindfulness techniques.

Key Learning Aims:

This article will enable readers to:

Understand the importance of adapting Dialectical Behavior Therapy for Borderline Personality traits and disorder.

Gain insight into the experience and views of psychologists on the method and steps necessary for said adaptation.

Identify the alterations required for effectively applying DBT on the current population

Keywords: Dialectical behaviour therapy; adapting therapies; therapy for Borderline Personality Disorder.

Introduction

Dialectical Behavioral Therapy (DBT) is a comprehensive treatment which enables the individual to gain insight about their emotional sensitivity and to enhance the ability to deal with their unstable and intense emotions in a healthy manner. It is a combination of philosophical process which is dialectics, acceptance, validation, change strategies and focuses on developing skills like mindfulness, interpersonal effectiveness, emotion regulation and, distress tolerance, which helps people to accept the life as worth living¹. DBT includes the techniques of CBT like identify negative thought patterns and to replace them with healthier responses, homework assignments in form of diary cards, assessments, appreciation of desired behaviour and, teaching social skills².

A variety of psychological interventions and psychotherapies are practiced and employed across a number of cultural and health settings, for different emotional disorders in heterogeneous groups of individuals. Several schools of psychotherapy exist and are implemented in different contexts and cultures. Nonetheless, they have been subjected to criticism for their failure to appreciate the ethnocentricity of their approaches³. However, most of the evidence-based treatments are developed and tested outside of Asian countries; notably, these interventions have been developed in North America and Europe. Subsequently, adaptation and translation of these interventions to the Asian context has received little attention.

Since there exists a difference in history, education, religion and, political system in Eastern and Western societies, therapeutic interventions originated and developed in the western world needed to be modified according to respective norms and values of Asian territories. Similarly, Dialectical Behavior therapy (DBT) developed by Linhen for the treatment of borderline patients is according to norms and values of western culture⁴. So to use this therapy for patients in Pakistan, it should be adapted and made culturally sensitive. To our knowledge, the present study is the first to explore psychologist's views on adaptation and modification of DBT in Pakistan, to make it appropriate and effective to use for the local population.

The literature search identified only one study on DBT from outside of the Western World. A study from Nepal reported that Dialectical behavior therapy (DBT) can be adapted in South Asian settings. Its concepts attributable to Asian belief systems were least comprehensible to clients. However, the 82% program completion rate suggests the utility of structured, skills-based treatment. The adaptation process informs future research regarding the effectiveness of culturally adapted DBT in South Asia⁵. It is suggested that therapies developed

in the west should be adapted for the non-white population due to the differences in culture⁶. Cultural adaptation has been defined as "the systematic modification of an evidence-based intervention protocol to consider language, culture, and the context in such a way that it is compatible with the patient's cultural patterns, meanings, and values"⁷. It is a long argument emphasized by many researchers who have pointed out the importance of cultural differences and cultural sensitivity which directly affects the process of counselling and psychotherapy^{8,9,10}. The collective knowledge shared beliefs, values, language, institutions, symbols, and images result in a shared worldview. These systems have a significant impact on psychotherapy. Their interactions are complex, and therapy will necessarily have to be tailored to the individual and their context. While the immediate subculture seems to play a prominent role in determining explanatory models of illness, many patients and relatives hold multiple causal explanatory points of view³.

Study Aim and Objectives

The overall aim of the study was to gather information from practicing clinical psychologists that could be used to culturally adapt DBT for borderline personality traits in Pakistan. Therefore, the objectives of this study were: (a) to explore the views and opinion of clinical psychologists regarding BPT and DBT to form modify and adapt DBT for the local population: (b) to develop guidelines to culturally adapt DBT skills in a standardized way to be applied/ practiced in Pakistan: (c) to seek the opinion regarding the acceptable Urdu translation of the terminologies.

Method

Research Design and Setting

A qualitative study was conducted to obtain the opinions and views of experts regarding the adapted version of DBT. An ethnographic approach was used to focus on understanding, the perspective of people participating in the study within their cultural context. In-depth semi-structured individual interviews and focus group with clinical experts were conducted to obtain their views about the adaptation of DBT and to check for the comprehensibility of the translated version. The professional clinical psychologists were belonged to different major cities of Pakistan like, Lahore, Peshawar, Islamabad, Rawalpindi, Multan and Quetta. The students of Final MS clinical psychology were from Lahore's main government universities.

Sampling Procedure

Purposive, targeted sampling was used to recruit the study participants which comprised of nine Clinical Psychologists who were asked about the treatment of borderline personality disorder, their knowledge and opinion on DBT adaptation, and then two clinical psychologists were sent the adapted version of DBT for their expert validation. Eight trainee Clinical Psychologists of MS in clinical Psychology final semester were included in the focus group. The inclusion criterion for Clinical Psychologists was at least five years of experience

along with the experience of working with borderline personality disorder/ traits patients and for MS clinical Psychology trainees was that they must have attended a workshop on DBT and had read the two main books on DBT one was Cognitive Behavior Therapy for Borderline Personality Disorder and second one is Skill Training Manual for Borderline Personality Disorder¹¹ and at least worked with one Borderline personality disorder/ traits patient. A semi-structured interview was conducted with expert Clinical Psychologists, their age range varies from 32 to 59 years, and all are females having 5 to 29 years of experience of dealing with psychiatric patients. The focus group participants gave feedback on the translated version of DBT.

Study Participants

Group 1: Students/ Trainee Clinical Psychologists

In the focus group, the students of MS Clinical Psychology (last semester) were asked to give feedback and discuss translated and modified versions of DBT to get an understanding that to which level DBT is comprehensible and consistent with our personal, religious, familial, social, and cultural values.

Group 2: Clinical Psychologists

Twelve clinical psychologists were approached for the interview in which nine clinical psychologists working in teaching hospitals of the public and private sector gave consent and were included, keeping in view their experience with DBT and patients diagnosed with BPD.

Data Collection

Participants were approached to obtain their consent for enrollment in the study. Semi-structured interviews and focus groups were conducted after assurance to participate in research. The permission for the recording of their interview and group sessions was also obtained. Field notes were also used to gather data during focus groups. Interviews conducted over the phone were also recorded for future correspondence. Location and timings of meetings and focus groups were specified beforehand and conducted at convenient places. The interview took approximately 30 minutes to complete. Two bilingual expert clinical psychologists were asked to give their feedback on the adapted DBT too.

Interview process

Seven main questions were asked from the professionals, like what they know about borderline personality traits, its prevalence, main factors, their personal reflection, treatment ways and preferred therapy/ techniques, structure of the session, prognoses.

Data Analyses

The adaptation frame work was done according to the guidelines of Barrera and Castro (2006). There are main four steps in which the first one is “information gathering” in which the DBT concepts and techniques were initially partially translated due to the difference between the Urdu and English languages (). Three bilingual MS clinical psychology students

translated the techniques and concept in Urdu language and then it was back translated by three bilingual clinical psychology MS students, as there are psychological terms which could not be literally translated and psychology students were well aware about it. Then 12 practicing Clinical Psychologists were approached, out of which nine gave time for a semi-structured interview to express their opinion and suggestions according to their knowledge, understanding and experience and the mode of therapy they used in dealing with patients suffering from BPD and suitable therapies and specially DBT. Their interviews were recorded, then transcribed and then the coding was done by two reviewers separately. The main aim of coding was to reduce the larger data in a smaller set to develop themes related to BPD, its etiology, prevalence, treatment procedures and knowledge regarding DBT.

The second step, in “preliminary adaptation design” all the information was gathered and after coding, preparing a draft based on the analyzed data and taking opinions from potential participants and experts. Unfortunately, the information which was gathered helped the researcher to shape sessions, dealing with the patients and getting information about the illness but not much about DBT in particular therefore after that few expert clinical psychologists were contacted for focus group but timings and availability was not suitable for most of the working clinical psychologists. Then a “Focus group” was planned comprising of university students to gather their views about the adaptability and suitability of language and techniques of DBT with our culture, religion and its values. Eight MS clinical psychology final semester students gave consent and joined two focus groups of 5 hours each and gave their feedback on the partially translated DBT. After incorporating their suggestions and feedback on techniques and skills training modules of DBT from its manual that how much it could be understandable and consistent with our “personal, familial, cultural and religious values”, the draft was sent to, two bilingual clinical psychologists, who were first interviewed to share their clinical experiences with BPD, were asked to give their feedback on the adapted DBT draft, these were ones who have read about (self-read) the theory and concept of DBT and have applied it practically with specifically borderline clients. The third step was “preliminary adaptation test” six case studies were conducted using the indigenous scale (for quantitative measures) and adapted DBT as pilot study to identify any ambiguity or difficulty in understanding the concepts or implementation of the therapy. The information collected through the in-depth interviews was included in psycho-education material as bibliotherapy. The feedback and effect of the treatment was evaluated.

And then at the final step “adaptation refinement” was done after evaluating the case studies (pilot studies) it was seen that the adapted therapy had a favorable outcome as the therapist as well as the patients found no difficulty in individual sessions but no one was interested for skills training group sessions, the experts and the focus group participants also suggested the same that due to the issue of stigma the patients in our culture would not favor for a group session. After this stage the main study was conducted and the 6 case studies were included in the main study.

Analysis

Thematic analysis was done to analyze the interviews conducted by clinical psychologists and then the feedback from focus group and two experts was incorporated. Interviews were analyzed using thematic content analysis. Both interviews and focus groups

were transcribed including all information irrespective of their relevance to the topic. Codes were generated from data to point out features of the data which are “the basic unit, segment or element, of the raw information that is further analyzed in a meaningful way”. In this step, data was reconsidered to generate relevant codes. All the relevant information was grouped, and unrelated information was eliminated. Through this process, data get simplified into subsets that emerged from common reporting of participants. The codes identified and obtained from the previous phase were then named according to each set of information recovered from the data. Similar information was grouped under a single theme, e.g. exclusion of words, language and, terminology leading to being misunderstood, use of culture-specific metaphors, symbols, fear of stigmatization, and removal of techniques and addition of mindfulness techniques. Through this analysis, all the information was divided into subsequent themes. During the last stage, themes revealed in the previous section were reviewed, modified, and checked what sense they make. Some of the themes were reconsidered, renamed, fused with other categories, disqualified, and split. All the information provided by each participant was also read in detail to understand underlying, covert information which was not directly said but had a deeper meaning.

Ethical Considerations

All the ethical considerations were followed while conducting the present research. The first topic was approved, and institutional permission was sought to conduct the study. All participants were given consent for their voluntary participation in the study. Permission was also sought from the author of DBT manual for its cultural adaption.

Results

The age range of the participants included in the study varied between the ages of 22 years to 59 years. The minimum education of clinical experts involved in the study was Advanced Diploma in Clinical Psychology (Post-graduation) with the maximum being PhD in Clinical Psychology. Their working experience (expert clinical psychologists) varied from 5 years to 29 years with formal training in CBT, REBT, Gestalt therapy, and Family Therapy. They had vast clinical experience in both the public and private sectors. While the students included in the sample had a minimum education of BS Honors/ MSc in Psychology with experience in dealing with psychiatric populations and had worked with at least one borderline personality disorder/ traits patient.

From in-depth interviews, some themes and sub-themes were identified which are summarized in a table given below.

Table 1: Main themes and categories

Sr#	Main Themes	Categories
1	Culture and religion	Stigmatization
		Collectivistic culture of Family

		Expression of symptoms
2	Language barriers	Communication in local language
		Use of metaphors and stories
		Educational level
3	Structure of therapy	Therapeutic relationship
		Traditional healing practices
		Beliefs about psychotherapy
4	Culturally specific techniques	Emphasis on concrete and explicit techniques
		Emphasis on mindfulness
		Removal of religiously and culturally inappropriate activities
		Modification of Homework assignments, DBT cards and, emergency help

Culture and religion

In non-western cultures, it is usually observed that culture and religion are important parts of life, so they are like guiding principles in all matters of our life. Culture and religion have a great impact on our beliefs about illness and treatment. Mental health disorders are overlooked due to stigmatization and their taboo nature. Similarly, people from different cultural groups explain their symptoms, pain and, distress quite differently. In Asian culture, there exist social shame and taboos about psychological illness and the use of mental health services.

One participant reported that “Mostly the families of the patients with borderline personality consider mental illness as a sign of insult for them, so they excessively remained concerned about the confidentiality and hide about the suffering of their patients from society. Specifically, in the case of female patients, parents got worried because diagnosis related to mental illness can affect their marriage proposals or their married life”.

Being a member of a collectivistic culture where group acceptance is crucial, stigmatisation due to mental illness leads to negative consequences on the individual and their family who are receiving treatment. Most of the time families of individuals with mental illnesses or seeking treatment risk a damaged reputation because there is still no acceptance of psychological problems in our culture. Primarily, young girls were affected more by the stigma of having a mental disorder, which may hinder their marital proposals or relationships. Participant also added that “In our society people prefer to keep concerned, within the boundary

of the family network and non-family members are usually not trusted which also leads to emotional burden”.

Participant number 3 stressed the factor of emotional suffering experienced by patients of borderline personality as “Patients usually came with too much emotional baggage that it becomes inevitable to handle their pain and sufferings in group settings. It is the need of the patient to conduct individual sessions so that catharsis could be done, and the patient felt relaxed during the session”. Hence the form and structure of the psychotherapy were modified by integrating knowledge of the unique cultural and religious values and beliefs during assessments and planning of therapy.

Language Barriers

Linguistic adaptations and modifications of terminology were carried out considering the Pakistani cultural norms and values. Clinical experts were approached to check for the comprehensibility of the initial adapted version. All the participants described the need for adaptation of terminology rather than literal translations and some changes were made according to the guidelines.

Effective communication with patients was recommended as crucial for the safety and quality of care. Barriers or hurdles to smooth communication include differences in language, comprehension of language and, cultural differences. In psychotherapy, as most of the treatment of the patient is done through dialogue, discussion and, verbal communication hence language played a key role for effective management. Participants in the study pointed that failed communication between patient and therapist increases the risk of negative consequences on patients such as they may fail to comply with instructions and did not understand their problem and prognosis.

According to the majority of participants, culturally specific terms, expressions, or metaphors were recommended to be used in the local language. After translation of into Urdu, some participants reported keeping certain words in English as their sense got changed in Urdu e.g. “love you/hate you, explore, tone and pitch” while some words were changed in Urdu as they were more elaborative and comprehensive in native language e.g.” states of mind” as “demagh ki haltein”, :wise mind” as :aqlmand demagh” and “Jago or jano” for “awareness” etc. While on the recommendation of participants few words of Urdu were changed to make them more comprehensible like word " mulakhta " was replaced with "bharpoor dimagh sey". Participants reported that translation had made therapy easy to explain and comprehend on part of both therapist and patient in our culture.

Structure of Therapy

Developing a trusting relationship with the patient during the initial session is an important task as people show compliance only to trustworthy therapists. Once patients are convinced that the therapist can heal them, they become compliant and, follow-up becomes easy. Due to this reason emphasis was laid on building a trusting relationship and restructuring beliefs about therapy and traditional healing practices. Moreover, the session structure was

modified as the standard DBT therapy, and skill training cannot be done separately. It is because groups of the borderline patient had not been conducted due to insecurity, familial and parental non-cooperation, and stigmatisation of psychiatry and, the reluctance of participants to discuss their personal experience in groups.

Exclusion of culture-specific techniques

There is a considerable difference between Western and Asian societies regarding culture, family dynamics, educational achievement, religion, political system, values so therapeutic techniques were modified for local communities. In Muslim societies, certain acts like dating, drinking, sex without marriage, open interaction with the opposite gender and independence to stay alone is considered a taboo. Due to religious beliefs and moral restrictions on people, some of the techniques involving tasks like: hanging out with opposite gender, spending time in the coffee bar, or taking a drink, or spending time on the beach, spending time alone were culturally inappropriate. Some of the participants reported that it was even difficult for them being female and as part of a developing country to do such acts so how a patient can be encouraged to do these tasks to release their anxiety. Moreover, the participant also reported replacing these techniques, to make therapy useful for patients in our culture. Hence to make DBT appropriate, relevant, and useful ethnocentrically, most of the method of skill training manual was replaced with mindfulness technique and included in every therapeutic session.

For increasing the effectiveness of DBT for borderline personality disorder patients in Pakistan, session plans and goals were modified by adding specific therapies. All the professionals in the study reported that the borderline patients, who receive psychotherapy from them were also taking medication. They used Behavior therapy and Cognitive Behavior Therapy (CBT) interventions, such as activity scheduling a safety plan, reinforcements, contingency management, verbal challenging, assertiveness training, problem-solving techniques, improving functionality, stress management, and mindfulness. They reflected that the patient usually showed more satisfaction and continued seeking treatment when cognitive work was done with them combined with behavioural or skill training in each session. Study participants also recounted that people living in Asian societies are likely to report more physical symptoms (e.g., backaches, weakness, headaches, and lethargy) rather than to present with mental health problems. They and their families usually preferred to seek help from physical health care professionals who are much more acceptable than mental health care professionals due to stigma.

Similarly, in their perception, treatment strategies only are based on dealing with cognition, and abstract thinking is not considered to be effective and they consider it as a formal discussion rather part of the management process. Concrete or tangible techniques like deep breathing, muscle relaxation, and yoga exercises are considered by patients and their families as more effective. Similarly, to keep the attrition rate low, tone down their anxieties, and make them feel better, mindfulness exercises were added. Moreover, therapy that is short-termed, Personalized, time focused, problem-solving, and based on crisis intervention approaches with limited and practical goals were recommended by professionals.

Participant 4 stated that “In our society, there is still limited awareness regarding psychotherapy. The patient usually preferred to go to a psychiatrist who can prescribe medication, while they consider therapeutic interventions as mere suggestions, advice or counselling. So in order to keep them motivated to come for sessions and to make them realize that discussions are part of interventions some behavioral and concrete techniques are mostly done with the patients along with cognitive therapies”.

In light of these suggestions, DBT was modified and mindfulness techniques from a practical guide of Tessa (2012) like mindfulness sensation, automatic pilot, what and how skills, wind down mindfulness, mindfulness breathing, mindful meal exercise, mindful body scan were included and practiced in every session to lower down anxiety and nervousness, to distract attention from negative thinking and to make them feel better.

Modification of Homework assignment, DBT cards, and emergency help

Another major adaptation in DBT was the use of homework, diary cards, and emergency help services. Participant number 7 reported that “contact timing after therapy for an emergency helps should be kept minimum and according to the ease of the therapist”. Hence the timing of telephonic contact between sessions was adjusted and kept only 4 hours from 6:00 to 9:00 pm according to the suitability of the therapist. Because patients are more likely to respond to in-session discussions and preferred to discuss their problems rather than doing homework assignments, so the use of homework was kept limited in therapy. Moreover, the use of diary cards was also kept limited and diaries were usually filled in during the session by the therapist after taking feedback of between session's events and activities.

By keeping in view all the above recommendations, the DBT was modified. The sessions were conducted individually with clients and the duration of each session was one and half an hour, comprising of standard DBT techniques along with techniques of mindfulness and skill training.

Discussion

For a cultural adaptation of DBT, guidelines were developed, and therapy was modified on recommended lines. In this regard, previous literature suggests similar guidelines for the adaptation process. It was reported that mental health therapies need to be localized to the cultural context¹². They raised the argument that effective mental health interventions in the Middle East give more consideration to family memberships, the role, and status of women, stigma associated with psychiatric illness, a preference for indigenous and religious healing methods. The major themes identified through previous literature in the adaptation of evidence-based treatments should be given importance as the effectiveness of interventions, usually depend upon specific cultural adaptations in implementation and therapeutic procedure^{13,14}.

In this study, themes and cultural contradictions identified by the professionals were considered, and DBT was translated, adapted, and modified on those lines. The understanding and incorporation of traditional and local healing methods may increase the cultural relevance of professional mental health practice¹⁵. Also, individuals in Asian societies are vigilant of

seeking treatment outside of their families or tradition, in culturally incongruent modes of care¹². Thus, an adaptation of therapy requires too much effort to incorporate and include family and societal norms actively. Gender roles among collectivistic cultural groups usually forbid females from travelling or interacting alone with non-family male members, whereas the male gender role incorporates protecting women and the provision of guidance to the family¹⁶. Thus, therapy was modified in such lines that the involvement of family will be done while respecting cultural values.

One of the significant recommendations identified by previous literature to be followed in the adaptation of therapeutic interventions within the cultural environment included efforts to increase public awareness of mental problems and indulgence of strategies to reduce the associated stigma. One way to minimize stigmatization is to integrate traditional services with evidence-based interventions developed outside the Asian cultural context. Combining mental health services into non-stigmatizing frameworks, such as general medical or established health care systems would also be beneficial¹². So in order to overcome cultural barriers, to make DBT appropriate and effective for Pakistani community, certain adaptations and modifications were done in session structure and duration i.e. sessions were done separately to keep patient at ease, to involve the family in therapy, and prevent stigmatization, language: to make therapy comprehensible for general population, skill training exercises and addition of treatment from other modalities like mindfulness techniques.

Future Implications

The present research will help us further adapt DBT according to cultural, social, and societal norms of Pakistani society. Hence in the future, this therapy can be used effectively and efficiently to treat patients with borderline personality disorders or traits. It is essential to adapt and translate interventions to the local culture and environment.

Limitations

The work in hand was my PhD work and I am very Thankful to GOD almighty who has helped me at every step of my life.

I want to say thanks to Prof. Dr. Zahid Mahmood, my supervisor in my PhD work, he is the most experienced and modest person, a teacher a guide, and a listener. I also have immense gratitude for Prof. Dr. Farooq Naeem for his continues assistance and direction necessary for this project. All clinical psychologists and students who participated in my thesis work, my class fellows for their emotional support, my loving friends, and students who remain a constant source of motivation for me.

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