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Cultural Adaptations of Dialectical Behavior Therapy: A Systematic Review

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Objective: Adapting mental health-care interventions to the race, ethnicity, or culture of the target group can enhance the acceptance and effectiveness of the treatment. Dialectical behavior therapy (DBT) is an evidence-based treatment that is principle-driven, rendering it well-suited for adaptations across cultural contexts. This article conducts a systematic review of the literature to determine the nature and extent of cultural adaptations of DBT to date. ***Method:*** We searched databases for original articles describing cultural adaptations of DBT, as applied to both (a) people of color within Western countries and (b) populations within non-Western countries. Consistent with the focus on descriptively characterizing extant DBT cultural adaptations, we included both published and nonpublished studies, as well as both observational and experimental studies. ***Results:*** Our search yielded 18 articles that met inclusion criteria. Of these articles, half described adaptations made with people and communities of color within the U.S. Most adaptations involved modifications to language, metaphors, methods, and context. ***Conclusions:*** Culturally adapted DBT has been implemented and accepted among several racial, ethnic, and cultural groups, although there is insufficient evidence to determine whether culturally adapted DBT is more efficacious than nonadapted DBT. We conclude with recommendations for best practices for DBT researchers and clinicians, and situate our findings among larger efforts to render existing evidence-based psychotherapies more optimal for people of color and people from non-Western countries.

What is the public health significance of this article?
Dialectical behavior therapy (DBT) may require cultural adaptation to be efficacious and accepted by all racial, ethnic, and cultural groups. The studies reviewed detail a number of cultural adaptations of DBT, most commonly in terms of language translation and addition of culturally congruent metaphors and sayings. The field must continue to both train culturally competent DBT clinicians and further adapt DBT to different cultural contexts.

Keywords: dialectical behavior therapy, cultural adaptations, systematic review, people of color

Increasingly, the field has recognized the need for more culturally responsive interventions (Rathod et al., 2018). Systematic modification of evidence-based treatments (EBTs) to clients' cultural contexts is known as *cultural adaptations of EBTs* (Bernal et al., 2009). Clients' cultural contexts include the language, customs, practices, and value and belief systems that are shared among the client's social group (Causadias et al., 2018). Culture influences therapeutic processes and adaptations can affect effectiveness (Huey et al., 2014). A 2016 meta-analysis found that these cultural adaptations were almost five times more likely to produce remission from psychopathology than control conditions (e.g., no intervention or other interventions; Hall et al., 2016). A recent meta-analysis of

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Stephanie L. Haft played lead role in conceptualization and equal role in data curation, formal analysis, methodology, writing of original draft, and writing of review and editing. Sinclaire M. O'Grady played an equal role in conceptualization, data curation, methodology, writing of original draft, and writing of review and editing. Esme A. L. Shaller played supporting role in conceptualization, supervision, writing of original draft, and writing of review and editing. Nancy H. Liu played lead role in supervision and supporting role in conceptualization, writing of original draft, and writing of review and editing.

The protocol for the study, search terms, and associated materials are publicly available on Open Science Framework: https://osf.io/bswk9.

The data and information reported in this article have not been previously published, nor is this work currently under consideration for publication elsewhere. This work was registered on Open Science Framework, and materials associated with this systematic review are publicly available online. The articles reviewed in the present article are cited and listed in the references section.

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randomized controlled trials found that Black and ethnically diverse groups experienced greater symptom improvements from culturally adapted interventions as compared to nonadapted active interventions (Arundell et al., 2021). A growing number of systematic reviews and meta-analyses similarly find moderate to large effects for culturally adapted EBTs (see Rathod et al., 2018, for a review of meta-analyses).

Recent research has highlighted the need to examine the nature of cultural adaptations separately by intervention subtype (Heim & Kohrt, 2019; Rathod et al., 2018), which can identify intervention-specific components that may require tailoring to fit a client's cultural context. Understanding intervention-specific cultural adaptations has practical implications for clinicians, and can inform future research directions (e.g., specific mechanisms of change in psychotherapy). Cultural adaptations have been comprehensively examined and summarized for cognitive behavioral therapy; CBT (Naeem, 2019), trauma-focused therapies (Ennis et al., 2020; Wright et al., 2020), parent training (Baumann et al., 2015), mindfulness- and meditation-based interventions (DeLuca et al., 2018), and couples therapy (Mikle & Gilbert, 2019). However, no systematic examination of cultural adaptations of dialectical behavior therapy (DBT) has been conducted to date, even though DBT has been widely disseminated due to its strong evidence base (Panos et al., 2014).

DBT

DBT was developed by Dr. Marsha Linehan to treat chronically suicidal individuals, and was later found to be especially effective for individuals who met criteria for borderline personality disorder (BPD; Ward-Ciesielski et al., 2020). Over 30 years later, DBT has been applied to many conditions (e.g., BPD, mood disorders, eating disorders, attention deficit hyperactivity disorder [ADHD], and post traumatic stress disorder [PTSD]), bolstering its established efficacy for treating transdiagnostic emotion dysregulation. DBT has been implemented across treatment settings (e.g., Linehan, 2014; Neacsiu et al., 2014) and adapted to treat adolescents (Rathus & Miller, 2015). DBT's biosocial theory posits that transactions between biological predisposition to emotional vulnerability and/or impulsivity and environmental invalidation contribute to emotion dysregulation (Crowell et al., 2009). Given individuals' histories of invalidation, DBT emphasizes accepting clients as they are *and* simultaneously pushing them to change, representing the therapy's core philosophy of *dialectics* (balancing opposites). To address emotion dysregulation and associated problems, DBT includes four skills modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Linehan, 2014). Comprehensive DBT includes four treatment components: individual therapy, group skills training, between-session phone coaching, and a therapist consultation team. There is also some evidence that DBT skills training alone can be effective (Neacsiu et al., 2014). DBT employs a variety of stylistic strategies and assumptions across several treatment stages which are summarized elsewhere (Linehan, 1993, 2018; Ward-Ciesielski et al., 2020).

Why Might DBT Need to Be Culturally Adapted?

Although some scholars assert cultural adaptations may not be required for behavioral, idiographic treatments since they are inherently culturally responsive (O'Donohue, 2005; Patterson, 2004), there is growing recognition that such interventions were developed within a Western, educated, industrialized, rich, democratic (WEIRD; Henrich et al., 2010) context. As a result, they may not be responsive to or culturally consistent with all cross-cultural or racial and ethnic groups. Indeed, many racial and ethnic groups were not included in the original studies of DBT (Koons et al., 2001; Linehan et al., 1999; Springer et al., 1996). Alarmingly, the Center for Disease Control and Prevention highlights that suicide rates differ by race and ethnicity (Curtin & Hedegaard, 2019; Forte et al., 2018). Given particularly high rates in some groups (e.g., American Indian/Alaskan Native; Curtin & Hedegaard, 2019), suicide risk factors and intervention needs likely differ by race and ethnicity. Therefore, there is an urgent need to examine the utility of DBT across different cultural groups.

DBT appears well-suited to cultural adaptations. First, as a principle-based treatment, it requires flexibility within fidelity across different clients and settings (Hayes et al., 2011). Relatedly, the dialectical philosophy draws from Eastern philosophy and aligns with the goal of cultural adaptations to balance fidelity to the treatment and fit with client cultural backgrounds (Domenech Rodríguez & Bernal, 2012; Koerner et al., 2007). Second, DBT has a built-in pretreatment phase, which prioritizes a thorough assessment of cultural values and beliefs (Linehan, 2014). Third, DBT integrates components from Zen Buddhism and similar contemplative practices, such as mindfulness, which have historical roots in both Eastern meditative and Christian contemplative traditions (Dimidjian & Linehan, 2003). Fourth, DBT is idiographic. In chain analysis, for example, the clinician and client continually and iteratively identify together how cultural contexts influence treatment (Bolden et al., 2020; Rizvi & Ritschel, 2014). Taken together, this idiographic, principles-based nature of DBT requires a thorough assessment and in-depth knowledge of the client's environment, which includes cultural context. Cultural context is often associated with race, ethnicity, or country of origin, although this can overlap and vary within groups, families, and even individuals (Patterson, 2004). Therefore, the idiographic nature of DBT is suited to detect and acknowledge within-group cultural differences, which may contrast with some protocol-based treatments that prescribe broad approaches for single cultural groups. The inclusion of Zen Buddhism may be consistent with collectivist cultures, which emphasizes the relatedness of an individual to other people and the broader environment (as opposed to individualist cultures which highlight the uniqueness and independence of a person; Mesquita, 2001). This element may signal that DBT can be inclusive of practices from a non-WEIRD context. Nevertheless, despite the above, it remains unclear whether aspects of DBT may be ethnocentric and require adaptation. Therefore, a thorough review of cultural adaptations to DBT is needed to fully understand its strengths and limitations.

Defining Cultural Adaptations and the Ecological Validity Framework

A clear definition of *cultural adaptation*, as well as its distinction from related terms, is ambiguous in the literature (Benuto et al., 2021; Huey et al., 2014). The construction of the term *cultural adaptations* drew upon concepts of *cultural competence* and *cultural sensitivity*, which heavily emphasize clinician awareness and knowledge of cultural factors and cultural groups (Benuto et al., 2021). However,

awareness refers to a cognitive task, whereas delivery of culturally adapted psychotherapy—especially DBT—is largely behavioral in nature (Benuto et al., 2021). Therefore, a conceptualization of *cultural adaptations* that incorporates behavioral elements of treatment delivery (e.g., assigning skills to practice, psychoeducation, clinician–client interactions) in addition to cognitive elements (e.g., case formulations, clinician cultural knowledge) is likely to be the most useful to the field. One commonly used definition of *cultural adaptation* is "the systematic modification of an evidence-based treatment (EBT) or intervention (EBI) protocol to consider language, culture, and context in such a way that is compatible with the individual's cultural patterns, meanings, and values" (Bernal et al., 2009, p. 362). Still, this definition is vague about what constitutes a "modification"—this could range from those that are superficial (e.g., using quotes from culturally relevant figures) to deep (e.g., removing entire DBT skills to be more congruent with a client's cultural context). Recently, a typology of cultural adaptations was proposed based on meta-analyses of therapies adapted for people of color (Arundell et al., 2021). In this framework, cultural adaptations are classified as either therapist related (e.g., ethnic matching, therapist training, provider language), content related (e.g., use of religious texts, materials translation, culturally sensitive terms), or organization specific (e.g., location of treatment, length of intervention, method of access). Further refining the conceptualization of cultural adaptations will help the field more clearly gauge the extent to which certain treatments are adapted, which is currently difficult to determine. In the present review, we considered any tailoring of treatment that fits into one of the dimensions of the ecological validity framework (EVF) as a cultural adaptation.

The EVF (Bernal et al., 2009) considers cultural adaptations as occurring in eight possible overlapping dimensions—language, persons, metaphors, content, concepts, goals, and methods (see Table 1 footnote for descriptions). It categorizes efforts of both *cultural adaptations* and *cultural sensitivity*, terms that are often used interchangeably in the literature (Huey et al., 2014). As these concepts share an emphasis on tailoring treatment to cultural contexts, we use the term *cultural adaptations* throughout this review for simplicity.

Present Systematic Review

The present investigation systematically reviews the literature on cultural adaptations of DBT with cross-cultural and racial and ethnic groups. Our goal is to understand themes in culturally adapting DBT, review preliminary data on outcomes and efficacy, and summarize common challenges to adapting DBT. This work will inform the best practices for implementing DBT among cross-cultural or racial and ethnic groups and inform future research efforts on the effectiveness of DBT for non-WEIRD populations.

Method

Protocol and Registration

This systematic review followed the 2020 preferred reporting items for systematic reviews and meta-analyses (PRISMA; Page et al., 2021) guidelines. The protocol was prospectively registered using the Inclusive Systematic Review Registration Form v0.92 (Van den Akker et al., 2020). Associated materials are publicly available on Open Science Framework: https://osf.io/bswk9.

Search Strategy

We searched PubMed, PsycINFO, Embase, Web of Science, Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), China National Knowledge Infrastructure (CNKI), and Scientific Electronic Library Online (SciELO) for relevant articles from January 1, 1991 to June 1, 2021. Search terms combined those related to cultural adaptations and DBT using the "AND" Boolean operator. Terms included controlled vocabulary from databases (e.g., MeSH terms) in combination with keywords found in the title and/or abstract fields of citation records. Exact search terms are available in the Open Science Framework repository. Each search included a date filter limiting results to articles that were published in 1991 or later to reflect the timing of DBT's first implementation (Linehan et al., 1991). Bibliographies of relevant articles were searched ("back searching") and the "cited by" feature of relevant articles was used to obtain additional articles ("forward searching"). The first and second authors imported articles into Covidence (Veritas Health Organization, 2021) and completed the following stages: title/abstract screening, full-text screening, and data extraction. For title/abstract and full-text screening, each article was independently reviewed, and the first authors resolved inclusion decision discrepancies through discussion until consensus was reached. For articles that presented duplicated analyses (e.g., a dissertation and a peer-reviewed published article on the same topic), the peer-reviewed or more recent version of the study was included in the present review.

Inclusion and Exclusion Criteria

We included studies that (a) administered comprehensive or components of DBT, (b) comprised a sample where the majority were people of color within a Western country, or a cross-cultural group in a non-Western country, and (c) explicitly mentioned a cultural adaptation and/or culturally sensitive treatment implementation that fit within at least one dimension of the EVF (Bernal et al., 2009). Studies could include participants of any age, and could be of any study design (e.g., case study, randomized controlled trial, cohort study) as long as other inclusion criteria were met. Dissertations and theses as well as articles published in other languages were included. Studies were excluded if they were conference abstracts or review articles that did not present original data. If studies included a sample of predominantly people of color or cross-cultural group, but did not explicitly mention a cultural adaptation, we contacted study authors to confirm whether cultural adaptations were made. In total we contacted six authors, received two responses, and included one article that met these criteria.

Data Extraction

The first and second authors independently extracted the following data from included articles: study aims, name of adapted intervention, dimensions of Bernal's framework that were adapted, whether adaptation was surface versus deep, treatment setting, DBT components, treatment length, therapist experience level, number of DBT intervention participants, comparison group type, outcome measures, effect sizes, key findings, challenges, and the following characteristics of participants: country, race/ethnicity, age, and diagnoses. We calculated and verified effect sizes when possible

Table 1
Cultural Adaptations Implemented Using the Ecological Validity Framework (Bernal et al., 2009)

Author	Language	Persons	Metaphors	Content	Concepts	Goals	Methods	Context
Arunagiri (2021)	+	−	+	+	−	−	+	+
Beckstead et al. (2015)	−	+	−	+	−	−	+	−
Butt et al. (2020)	−	−	−	−	−	−	+	+
Cancian et al. (2019)	+	−	+	−	+	−	−	−
Chang et al. (2022)	+	−	−	−	−	−	−	−
Cheng and Merrick (2017)	+	+	−	+	+	+	−	+
Fan and Leung (2015)	+	+	−	−	−	−	−	+
Gomez et al. (2017)	+	−	−	−	−	−	−	−
Kamody et al. (2020)	−	−	+	−	−	−	+	+
Kinsey (2014)	+	+	+	+	+	−	+	+
Kohrt et al. (2017)	+	−	+	+	+	−	+	+
McFarr et al. (2014)	+	+	+	+	+	−	+	+
Mercado and Hinojosa (2017)	+	+	+	+	+	−	+	+
Montero Fernández et al. (2013)	+	−	−	−	−	−	−	−
Moritz et al. (2021)	+	−	−	−	−	−	−	−
Padilla Torres et al. (2017)	+	−	−	−	−	−	−	−
Ramaiya et al. (2018)	+	+	+	+	+	+	+	+
Yang et al. (2020)	+	−	+	−	+	−	−	−

Note. *Language*: translations of materials, delivery of psychotherapy in non-English language, matching materials to literacy level and dialect of clients. *Persons*: acknowledgment of cultural similarities and differences, therapist–client ethnic matching, incorporation of community stakeholders. *Metaphors*: use of sayings, expressions, metaphors, idioms, and visual images common to the culture of the client. *Content*: adding/removing skills or materials from the standard treatment to be more congruent with the clients' cultural context. *Concepts*: relating theoretical constructs presented in the treatment to concepts, beliefs, and values that are common in the client's culture. *Goals*: efforts to obtain client-derived intervention goals beyond symptom reduction that are based on or congruent with client cultural values. *Methods*: altering the format and activities used to achieve intervention goals to reflect traditions in the client's culture. *Context*: consideration of acculturation, socioeconomic background, systematic barriers, cultural norms, as well as where/how treatment is delivered.

using data reported in the article. For pre–post/treatment-control designs, effect size was calculated as the mean pre–post intervention change in the treatment group minus the mean pre–post change in the control group divided by the pooled pretest standard deviation (d_s; Lakens, 2013; Morris, 2008). For pre–post/within-group designs, effect size was calculated as the difference in pre–post scores divided by the average of the pre- and postintervention standard deviations (d_{av}; Lakens, 2013). Discrepancies were resolved in extracted data through discussion. Efforts were made to contact study authors to obtain missing data not reported in articles—of the three authors contacted, one responded and provided data at the time of the present article submission.

Quality Assessment

Given the mixed study designs used in included articles, the quality assessment with diverse studies (QuADS) tool was used to evaluate overall study quality (Harrison et al., 2021). The QuADS tool is an updated version of the widely used quality assessment tool for studies with diverse designs (QATSDD; Sirriyeh et al., 2012). The QuADS tool outlines 13 criteria on which to rate studies using a 4-point scale from 0 to 3, where higher scores represent better quality. The first and second authors independently rated studies using the QuADS tool and resolved discrepancies through discussion until consensus was reached.

Data Synthesis

To synthesize quantitative and qualitative information extracted from included studies, we first summarized the characteristics of included studies. Next, we used the EVF (Bernal et al., 2009) to organize results on the nature of cultural adaptations made in each dimension. Third, we summarized results from outcomes and effect sizes reported in the studies. Fourth, we report the QuADS tool ratings of quality assessment. Finally, we narratively integrate information on common challenges encountered across studies.

Results

Study Selection

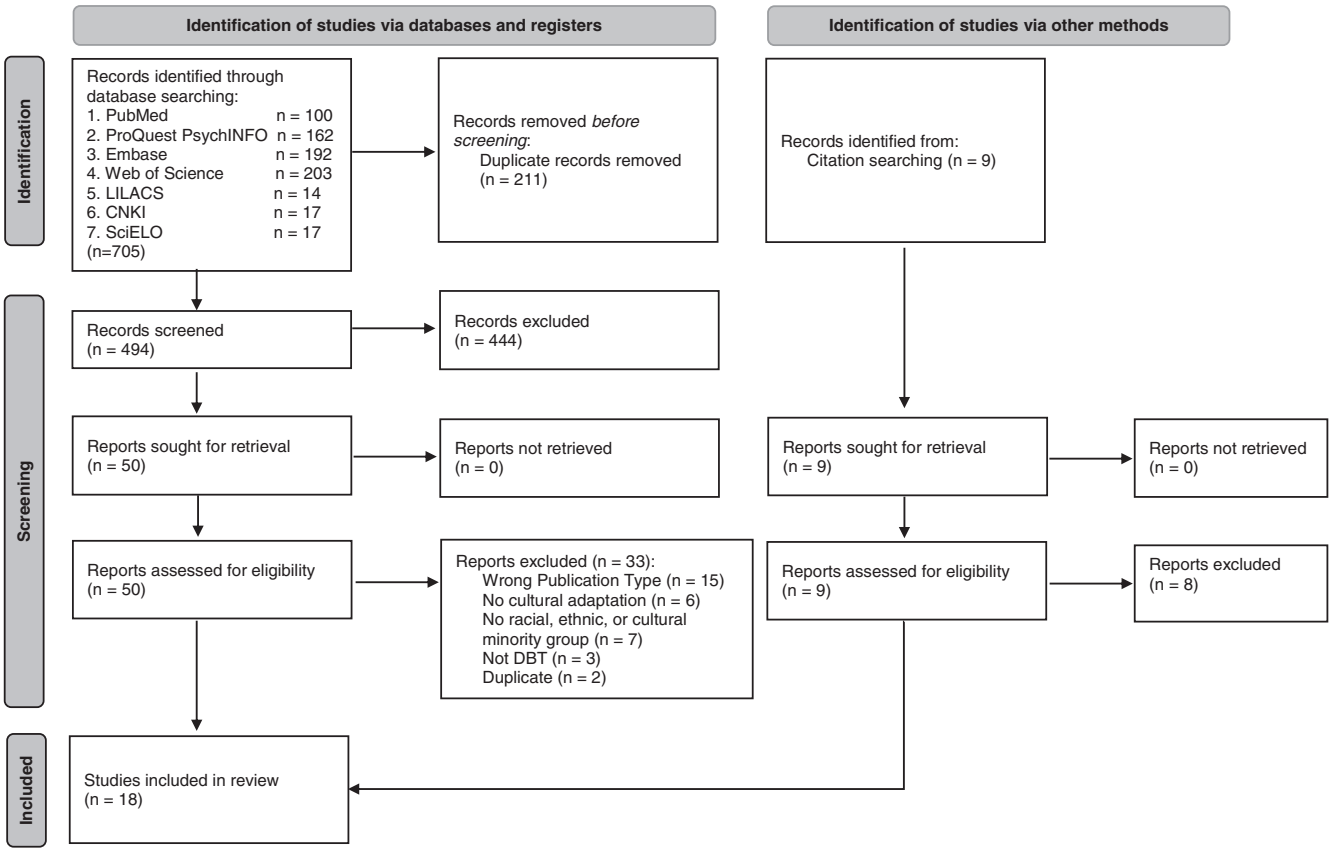
Our database search yielded a total of 705 articles (494 after duplicate removal), 17 of which were ultimately included. Forward and backward searching resulted in the screening of nine additional articles, one of which met inclusion criteria, resulting in 18 total included articles. The PRISMA diagram depicting the study selection and reasons for exclusion is presented in Figure 1.

Study Characteristics

The characteristics of the 18 included studies are summarized in Table 2. Two of the articles were published in Spanish. All of the studies were published within the last 7 years, with 38.9% ($k = 7$) published in the last 2 years. A third of the included articles ($k = 6$) were case studies, a third ($k = 6$) used a within-group pre–post design, four used a between-group treatment-control design, one consisted solely of qualitative interviews, and one was a small cohort study. One study focused on young children, seven studies focused on adolescents or young adults, while the others included a broader age range of adults ($k = 7$) or ages were not reported ($k = 3$). Half of the studies ($k = 9$) were conducted in the USA, and the rest were conducted in Brazil, Pakistan, Taiwan, China, Spain, and Nepal. Five of the studies implemented comprehensive DBT with all of its components (skills group, individual therapy, phone

Figure 1

PRISMA Flow Diagram of the Study Search and Selection Process



Note. PRISMA = preferred reporting items for systematic reviews and meta-analyses; LILACS = Literatura Latino-Americana e do Caribe em Ciências da Saúde; CNKI = China National Knowledge Infrastructure; SciELO = Scientific Electronic Library Online.

coaching, consultation) while the rest used only certain DBT components (and therefore could more accurately describe as DBT-informed treatment). Of the studies where attrition rate was relevant and reported ($k = 9$), it ranged from 0% to 50%. Treatment length ranged from 4 to 40 weeks, with an average treatment length calculated across 16 studies of 14.5 weeks. Of the studies that described the treatment setting ($k = 16$), treatment settings ranged from community centers ($k = 1$), residential treatment centers ($k = 1$), universities ($k = 1$), a preschool ($k = 1$), university counseling centers ($k = 1$), hospitals ($k = 8$), and community clinics ($k = 3$).

Cultural Adaptations

Language

The *language* dimension was the most common cultural adaptation reported, with 15 (83%) studies adapting this dimension. Studies reported translating DBT handouts and materials and delivering therapy in Portuguese (Cancian et al., 2019; Moritz et al., 2021), Mandarin (Cheng & Merrick, 2017; Yang et al., 2020), Cantonese (Fan & Leung, 2015), Spanish (Gomez et al., 2017; McFarr et al., 2014; Mercado & Hinojosa, 2017; Montero Fernández et al., 2013; Padilla Torres et al., 2017), and Nepali (Ramaiya et al., 2018). One study specified that language translation included conducting DBT consultation group fully in Spanish (Mercado & Hinojosa, 2017). In the translation process, one study noted that the DBT term of "self-respect" had to be removed, as this had no direct correlate in Nepali (Ramaiya et al., 2018)—instead, materials referenced respect for others (*aruharulaai adhaar garne*) which was deemed more culturally relevant. Overall, few studies specified the processes used in translating DBT materials—one exception indicated that translation into Portuguese was done by three judges with official DBT training (Cancian et al., 2019).

In some studies, the language was mixed—for example, one study delivered individual therapy in Mandarin, while group skills training was delivered in English (Cheng & Merrick, 2017). Other studies delivered therapy in English, but included certain terms from Suquamish (Kinsey, 2014) and Navajo (Kohrt et al., 2017). Two studies conducted treatment in English but strategically renamed DBT groups to "Chai and Chat" (Arunagiri, 2021) and "Healthy and Whole" (Kinsey, 2014) to reduce the stigma of attending.

Persons

Seven studies (38.9%) described adaptations to the *persons* dimension. Three studies trained counselors who were members

Table 2

Characteristics of Included Studies (k = 18) Reporting Cultural Adaptations of Dialectical Behavior Therapy

Author	Country	Sample size of tx group (*N*)	Age	Racial, Ethnic, Cultural group	Diagnoses	DBT components	Attrition Rate	Tx setting	Tx length (weeks)	Comparison condition	Outcomes and effect Size
Arunagiri (2021)	USA	7	?	72% Bangladeshi, 14% Pakistani, 14% Nepali	MDD, PTSD, panic disorder, agoraphobia, binge-eating disorder, GAD	Skills group	13.0%	Community center	5	Within group; pre–post	Depressive Sx ($d_{av} = -0.21$)[b]; suicidality($d_{av} = -0.30$)[b]; emotion regulation ($d_{av} = -0.55$)[b]
Beckstead et al. (2015)	USA	229	12–18 years	100% American Indian/Alaska Native	SUD (77%), mood disorder (49%), ADHD (19%), eating disorder (4%), psychotic disorder (4%)	Skills group; individual; phone coaching; consultation	?	Residential treatment center	17	Within group; pre-post	General distress ($d_{av} = 1.32$)
Butt et al. (2020)	Pakistan	34	18–45 years	100% Pakistani	?	Individual; phone coaching; consultation	?	?	17	Between group; TAU control	Borderline personality disorder traits ($d_s = 1.82$)[b]
Cancian et al. (2019)	Brazil	37	*M* = 39 years	?	?	Skills group; consultation	44.0%	University	10	Between group; WL control	Emotion regulation ($d_s = 0.74$)[b]; depression ($d_s = 0.50$)[b]; anxiety ($d_s = 0.21$)[b]; stress ($d_s = 0.66$)[b]; emotional eating ($d_s = 0.30$)[b]; binge eating ($d_s = 0.99$)[b]; intuitive eating ($d_s = 1.00$)[b]; Mindful eating ($d_s = -0.56$)[b]
Chang et al. (2022)	Taiwan	18	21–46 years	100% Chinese	BPD (100%), mood disorder (88.9%), SUD (38.9%)	Skills group; individual; phone coaching; consultation	16.7%	Hospital	52	Within group; pre–post	Borderline Sx ($d_z = 1.15$); parasuicides ($d_z = 0.83$); Suicide ideation ($d_z = 0.71$); depression ($d_z = 0.80$); hopelessness ($d_z = 0.35$); general activities ($d_z = 0.34$)
Cheng and Merrick (2017)	USA	1	24 years	Chinese	Anorexia Nervosa, Binge eating/ purging type	Skills group; individual; phone coaching; consultation	—	University Counseling Center	40	—	Symptomatic distress; interpersonal relations; social role
Fan and Leung (2015)	China	32	5–6 years	100% Chinese	Externalizing problems (100%)	Skills group	0.0%	Preschool	8–10	Between group; WL control	Externalizing behaviors ($d_s = 0.58$)[b, c]; soothability ($d_s = 0.25$)[b, c]; impulsivity ($d_s = 0.13$)[b, c]; inhibitory control ($d_s = 0.33$)[b, c]
Gomez et al. (2017)	USA	1	21 years	Latino	?	Individual[a]	—	Hospital	4	—	DBT diary card; PTSD symptoms; mindfulness acceptance
Kamody et al. (2020)	USA	30	14–18 years	100% Black	?	Skills group[a]	50.0%	Hospital	10	Within group; pre–post	Distress tolerance ($d_{av} = 0.12$); cognitive reappraisal ($d_{av} = 0.38$); executive suppression ($d_{av} = 0.27$)

(*table continues*)

Table 2 (*continued*)

Author	Country	Sample size of tx group (*N*)	Age	Racial, Ethnic, Cultural group	Diagnoses	DBT components	Attrition Rate	Tx setting	Tx length (weeks)	Comparison condition	Outcomes and effect Size
Kinsey (2014)	USA	2	?	100% Native American	?	Skills group; individual	?	Community clinic	?	—	—
Kohrt et al. (2017)	USA	1	14 years	American Indian/ Alaska Native	MDD, other specified anxiety disorder, disruption of family by separation or divorce	Skills group; individual; phone coaching; consultation	—	Hospital	7	—	DBT diary card; suicide probability; suicide risk; reasons for living
McFarr et al. (2014)	USA	1	41 years	Mexican	MDD, GAD, BPD	Skills group; individual; phone coaching; consultation	—	Hospital	?	—	—
Mercado and Hinojosa (2017)	USA	1	45 years	Latina	GAD, dysthymic disorder	Skills group	—	Community clinic	17	—	Depression; anxiety; hopelessness; personality; DBT study questionnaire
Montero Fernández et al. (2013)	Spain	1	32 years	Spanish	BPD, SUD	Skills group; individual[a]	—	Hospital	6	—	—
Moritz et al. (2021)	Brazil	16	?	?	ADHD (100%), current depressive episode (67.74%)	Skills group[a]	18.75%	Hospital	12	Between group; TAU control	ADHD inattention ($d_s = 0.22$)[b]; ADHD hyperactivity ($d_s = 0.31$)[b]
Padilla Torres et al. (2017)	Spain	4	13–17 years	Spanish	MDD (25%), BPD (50%), eating disorder (50%)	Skills group[a]	0.0%	Hospital	16	Within group; pre–post	Anxiety; experiential avoidance; depression symptoms; emotional tolerance
Ramaiya et al. (2018)	Nepal	10	19–47 years	100% Nepali	Depression (100%), anxiety (100%), PTSD (100%)	Skills group	18.0%	Community clinic	10	Within group; pre–post	Suicidal ideation ($d_{av} = 4.49$)[b]; emotion regulation ($d_{av} = 2.92$)[b]; coping skills ($d_{av} = 3.69$)[b]; depression symptoms ($d_{av} = 3.29$)[b]; anxiety ($d_{av} = 0.57$)[b]; resilience ($d_{av} = 4.41$)[b]
Yang et al. (2020)	China	33	17–21 years	100% Chinese	?	Skills group; phone coaching	15.2%	?	12	Between group; SG therapy control and WL control	Suicidal Bx ($d_s = 0.09$-SG; $d_s = 0.39$-WL)[b]; hopelessness ($d_s = 0.15$-SG; $d_s = 0.42$-WL)[b]; psychological distress ($d_s = 0.32$-SG; $d_s = 0.47$-WL)[b]; psychopathology ($d_s = 0.05$-SG; $d_s = 0.27$-WL)[b]

Note. MDD = major depressive disorder; GAD = generalized anxiety disorder; PTSD = posttraumatic stress disorder; BPD = borderline personality disorder; SUD = substance use disorder; ADHD = attention deficit hyperactivity disorder; SG = Supportive group; WL = waitlist; d_s = mean pre–post change in tx group minus mean pre–post change in control group divided by the pooled pretest standard deviation; d_{av} = pre–post change in tx group divided by the average pre- and poststandard deviation; d_z= pre–post change in tx group divided by the standard deviation of the difference scores. Positive values indicate changes in the direction of more positive adjustment and/or symptom reduction.

[a] Indicates when dialectical behavior therapy (DBT) treatment was combined with elements from other modalities (e.g., cognitive behavioral therapy, acceptance and commitment therapy, substance use treatment). [b] Indicates an effect size that was calculated by the authors using values reported in the article. [c] Effect size represents the average between parent- and teacher-report of the construct.

of the community on the implementation of DBT, including counselors who were members of local tribes (Beckstead et al., 2015; Kinsey, 2014), and local Nepali mental health professionals (Ramaiya et al., 2018). One study trained local preschool teachers as coleaders of skills groups (Fan & Leung, 2015). One study explicitly acknowledged intentional therapist–client ethnic and language matching (Mercado & Hinojosa, 2017). Two studies described therapists' choices to self-disclose relevant to the client's cultural background. Of these, one emphasized therapist self-disclosure of shared cultural background (i.e., as an international student) as highly validating to the client (Cheng & Merrick, 2017). Another study described the therapist's choice to self-disclose hobbies, children, and other personal aspects of the therapist's life to align with the Latino value of *personalísmo*, which emphasizes the importance of personal relationships and treating people with respect (McFarr et al., 2014). No studies mentioned an acknowledgment of cultural, linguistic, racial, or ethnic *differences* between therapists and clients in treatment.

Metaphors

Overall, nine (60%) studies adapted the *metaphors* domain. Two studies including South Asian samples used the mythology of the tortoise and the hare to explain distress tolerance (Arunagiri, 2021; Ramaiya et al., 2018). Another study presented familiar aphorisms from Confucius and other prominent historical Chinese figures to illustrate distress tolerance (e.g., "a little impatience spoils great plans"; Yang et al., 2020). Two studies with Spanish-speaking clients used culturally familiar sayings and stories *(dichos* and *cuentos)* to build therapeutic rapport and explain concepts (McFarr et al., 2014; Mercado & Hinojosa, 2017). Two studies added visual images of individuals from the clients' cultures onto handouts (Arunagiri, 2021; Kamody et al., 2020). Two studies described keeping metaphors from the natural world at the forefront to be more consistent with the Native American worldview (e.g., breathing with the rhythm of wind through the trees; Kinsey, 2014; Kohrt et al., 2017). Another study indicated adopting metaphors that were relevant to Brazilian culture, but did not give specific examples (Cancian et al., 2019).

Content

Eight studies (53%) described adaptations to the *content* dimension. Several studies added content based on cultural knowledge and values. For example, Beckstead et al. (2015) consulted with tribal leaders and added a treatment component that included a credentialed medicine man/spiritual counselor from the local tribe who provided traditional tribal practices of weekly sweat lodge ceremonies, smudging ceremonies, and talking circles (Beckstead et al., 2015). Similarly, in another study participants underwent a traditional healing ceremony (Kohrt et al., 2017). One study added an additional skill of "meaning making" where participants created new meanings through living one's values, engaging in mentorship and civic duty, and processing intergenerational trauma (Kinsey, 2014). McFarr et al. (2014) emphasized adding proverbs *(dichos)* and short stories *(cuentos*; McFarr et al., 2014). One study incorporated content to have an emphasis on spirituality (e.g., added "it's in God's hand" and "this is a test of God") in line with the cultural belief of *fatalismo,* which ascribes life events to "fate" and the notion that they are meant to happen. This emphasis improved understanding of the concepts of radical acceptance and reducing emotional suffering (Mercado & Hinojosa, 2017). Another study adapted the interpersonal effectiveness module to discuss differences in interpersonal relationships between American and Chinese cultures (Cheng & Merrick, 2017). One study added a module on nonacceptance, self-blame and criticism, and stigma encountered by clients with suicidality from family members, peers, and local communities (Ramaiya et al., 2018). In addition, this study also increased emphasis on somatic concerns (e.g., abdominal discomfort, facial redness, and other common distress-related somatic complaints) into weekly chain analyses. Finally, one study replaced the "mindfulness of current emotions" skill (which involves observing, describing, and experiencing emotions without judging them) with an interpersonal effectiveness review, given concerns that this skill may be too complex to deliver in a one-time group setting due to language and educational barriers (Arunagiri, 2021).

Concepts

Eight (53%) studies implemented cultural adaptations that involved *concepts.* Two studies described tailoring ideas presented in biosocial theory (Cancian et al., 2019; Kinsey, 2014), such as the incorporation of tenets from Critical Race Theory (Kinsey, 2014), the concept that racism is embedded within societal structures and policies. Two studies with Spanish-speaking clients incorporated concepts of *personalismo, familismo* (reciprocal connectedness and support among family members), *respeto* (deference to others), and *fatalismo* into the therapeutic relationship and methods (McFarr et al., 2014; Mercado & Hinojosa, 2017). One of these studies conceptualized client symptoms as *nervios* ("nerves"), a more culturally acceptable idiom used to express distress (Mercado & Hinojosa, 2017). The Navajo concept of slaying a monster to defeat illness *(nayee)* as well as concepts of *lifeworld, lived body,* and *understanding* were used to frame DBT skills in one study (Kohrt et al., 2017). In adapting DBT to Nepal, the DBT concept of "Wise Mind" was described as a synthesis of heart–mind (*man*) and brain–mind (*dimaag*), and therapists de-emphasized culturally unfamiliar concepts such as the interpersonal goal of self-respect (Ramaiya et al., 2018). In a study in China, the DBT principle of dialectics was framed using the culturally familiar concept of golden mean (*zhongyong)* thinking, which is a philosophy derived from Confucianism that emphasizes pursuit of a middle ground (Yang et al., 2020). In implementing DBT with a Chinese international student, the therapist described emphasizing Chinese concepts of maintaining social harmony and respecting elders in the interpersonal effectiveness module (Cheng & Merrick, 2017).

Goals

In general, all studies aligned with the DBT goal to build a life worth living. *Goals* were the least common domain adapted by studies in this review with only two studies (13%) describing efforts to obtain client-derived intervention goals based on the client's cultural values. One study described an explicit treatment goal of increasing social harmony versus a traditional DBT goal of increasing the client's own personal assertiveness skills (Cheng & Merrick, 2017). Another study described a client-derived treatment goal of increasing effective coping with cultural and community stigma

surrounding suicidal ideation and receiving therapy (Ramaiya et al., 2018).

Method

The *methods* used to achieve treatment were adapted to be more culturally relevant in nine (60%) of the included studies. Several methods focused on destigmatizing mental health treatment—for example, one study of Black adolescents involved DBT skills group only and not individual treatment, given that a group format was perceived by study authors as less stigmatizing compared to seeking individual care (Kamody et al., 2020). However, another study in Pakistan used the opposite method—individual therapy was conducted with incorporation of DBT skills, but skills groups were not due to community stigma (Butt et al., 2020).

Three studies reported using shared meals and potlucks in skills groups as a way to build community and honor shared cultural backgrounds pertaining to food (Arunagiri, 2021; Kinsey, 2014; Mercado & Hinojosa, 2017). Two studies altered diary cards, such as by simplifying and shifting to nonnumeric ratings in a context of low literacy (Ramaiya et al., 2018). Another used Mexican Bingo Rewards Card *(La Lotería Mexicana Tarjeta de Recompensa)* to reinforce diary card completion (McFarr et al., 2014). Two studies focused on Native Americans incorporated healing circles and sweat lodge ceremonies into the treatment plan (Beckstead et al., 2015; Kohrt et al., 2017). One of these studies also used a genogram to "show respect for collectivist cultures and systemic problems, rather than pathologizing the individual" (Kohrt et al., 2017, p. 90). This genogram helped to highlight an intergenerational pattern of psychological distress resulting from the United State government's historical subjugation, internment, and forced assimilation of the Navajo Tribe. Another study of Native American (Suquamish) clients adapted eligibility criteria for DBT to not require mental health diagnoses to participate, given these were incongruent with conceptualizations of mental illness within their tribal community (Kinsey, 2014). Instead, clients were identified by tribal stakeholders as "individuals who want more from life" and were invited to participate.

Two studies cited cultural values as fueling a heavy emphasis on family involvement in treatment, often with adults (Kamody et al., 2020; McFarr et al., 2014). One study in Nepal included male in-law family members as a method of implementing assertiveness skills—for example, a female client asking a father-in-law to help convey a request to her husband (Ramaiya et al., 2018). Finally, one mentioned generally using methods that drew from both Chinese and American cultures for an acculturating international student (e.g., delivering DBT in two languages, framing interpersonal effectiveness skills in both individualist and collectivist cultural values) (Cheng & Merrick, 2017).

Context

Ten studies (55.6%) described adaptations to consider clients' broader cultural context. Three studies acknowledged the role of intergenerational or historical trauma (Kinsey, 2014; Kohrt et al., 2017; Mercado & Hinojosa, 2017). For example, one study used a genogram to illustrate the intergenerational nature of trauma, and to highlight the importance of the client's connection to the tribe (Kohrt et al., 2017). One study acknowledged acculturative stressors and challenges unique to being an immigrant (Cheng & Merrick, 2017). One study argued that stress and experiences unique to people of color (e.g., trauma, racism) may be a more culturally appropriate conceptualization of the maintaining mechanisms of binge-eating behaviors in diverse populations compared to existing theories (Kamody et al., 2020). Access barriers were described by several studies, including transportation (Kinsey, 2014) and low literacy and educational backgrounds (Arunagiri, 2021; McFarr et al., 2014). Transportation barriers were addressed in one study by delivering treatment in a nonstandard setting (offices and buildings throughout the tribal land; Kinsey, 2014). One study substituted pictures for words on the diary card to address low literacy (McFarr et al., 2014). Finally, another highlighted challenges associated with engaging female clients in treatment in a patriarchal society (Ramaiya et al., 2018), and three studies acknowledged the unique challenges of community and cultural stigma surrounding mental health and treatment (Butt et al., 2020; Fan & Leung, 2015; Ramaiya et al., 2018).

Outcomes and Effect Sizes

Of the included studies, 16 (89%) included at least one quantitative measure as an outcome, and nine of the studies included enough quantitative information to calculate effect sizes. The most common outcome measures used were depressive symptoms ($k = 5$) and suicidality ($k = 5$). See Table 1 for a full list. For studies with calculated effect sizes with between-group designs ($k = 4$), a total of 19 effect sizes (d_s) ranged from −0.56 to 1.82. For studies with calculated effect sizes and within-group designs ($k = 5$), a total of 19 effect sizes (d_{av}) ranged from −0.55 to 4.49. A total of two studies reported effect sizes that indicated that clients deteriorated in measured outcomes over the course of treatment (Arunagiri, 2021; Cancian et al., 2019). Due to the variability in outcome measures and study designs, it was not possible to quantitatively pool effect sizes across studies.

Critical Appraisal

Table 3 depicts quality assessments of included studies using the QuADS Tool. The highest scores occurred in the domains of statement of research aims, appropriate study design, theoretical underpinning to the research, and critical discussion of strengths and limitations. The lowest scores occurred in justification of analytic method selected, description of data collection procedure, and evidence that stakeholders had been considered in the research design or conduct.

Common Challenges

Several common challenges were reported across studies in implementing DBT with people of color and people from non-Western countries: fear of stigma from community and family members (Butt et al., 2020; Kamody et al., 2020; Ramaiya et al., 2018), trouble with comprehension of written homework materials and numeric scales (Arunagiri, 2021; Butt et al., 2020), transportation and access barriers (Arunagiri, 2021; Cancian et al., 2019; Kinsey, 2014; Kohrt et al., 2017; Mercado & Hinojosa, 2017), and clients' beliefs that somatic concerns were not sufficiently addressed (Ramaiya et al., 2018). Therapist–client identity differences were

Table 3

Quality Assessment of the Included Studies Using the Quality Assessment With Diverse Studies (QuADS) Tool

	Author																	
Criteria	Arunagiri, 2021	Beckstead et al. (2015)	Butt et al. (2020)	Cancian et al. (2019)	Chang et al. (2022)	Cheng and Merrick (2017)	Fan and Leung (2015)	Gomez et al. (2017)	Kamody et al. (2020)	Kinsey, 2014	Kohrt et al. (2017)	McFarr et al. (2014)	Mercado and Hinojosa (2017)	Montero Fernández et al. (2013)	Moritz et al. (2021)	Padilla Torres et al. (2017)	Ramaiya et al. (2018)	Yang et al. (2020)
1	2	2	1	2	2	3	2	2	3	3	2	2	3	2	1	2	2	3
2	3	3	2	3	3	2	3	3	3	3	2	2	2	2	3	2	3	3
3	2	2	1	3	2	2	3	1	3	3	2	0	3	2	3	2	2	2
4	3	2	2	2	2	3	2	3	3	2	2	2	2	2	2	3	3	3
5	2	2	1	2	2	2	2	1	2	1	2	0	2	0	3	2	2	2
6	3	3	1	1	3	2	3	2	2	3	3	1	0	0	1	1	2	3
7	2	2	1	2	2	2	2	3	2	2	3	1	2	1	1	2	3	3
8	2	1	0	1	1	1	2	1	1	3	2	1	1	0	1	1	2	2
9	2	1	2	3	1	1	1	1	1	1	1	1	1	1	3	0	1	3
10	0	3	0	1	1	0	1	0	3	3	0	0	0	0	1	0	3	2
11	2	3	2	2	3	1	1	1	3	2	1	0	1	2	3	2	3	3
12	1	3	1	3	1	0	2	0	2	2	2	1	1	0	0	0	3	1
13	3	2	2	3	3	2	2	2	3	2	2	0	1	2	2	1	3	3

Note. 1. Theoretical or conceptual underpinning to the research. 2. Statement of research aim(s). 3. Clear description of research setting and target population. 4. The study design is appropriate to address the stated research aim(s). 5. Appropriate sampling to address the research aim(s). 6. Rationale for choice of data collection tool(s). 7. The format and content of data collection tool are appropriate to address the stated research aim(s). 8. Description of data collection procedure. 9. Recruitment data provided. 10. Justification of analytic method selected. 11. The method of analysis was appropriate to answer the research aim(s). 12. Evidence that the research stakeholders have been considered in research design or conduct. 13. Strengths and limitations critically discussed.

also mentioned as a challenge, specifically lack of clarity on whether and how to address these differences (Cheng & Merrick, 2017), and barriers in therapist understanding of certain client cultural practices (Kohrt et al., 2017). Two studies mentioned challenges when skills groups were conducted in English when this was not the clients' native language (Arunagiri, 2021; Cheng & Merrick, 2017)—for example, a client expressed frustration with not understanding nuances in terminology used to refer to certain emotions (Cheng & Merrick, 2017). Several studies mentioned that the interpersonal effectiveness module was especially difficult and at times incongruent with clients' cultural contexts (Arunagiri, 2021; Cheng & Merrick, 2017; Ramaiya et al., 2018; Yang et al., 2020). Across studies, clients perceived that this module prioritized attainment of individual objectives over those of the group, whereas their cultural beliefs emphasized social cohesion and social goals. At times this was even viewed as dangerous: in Nepal, assertiveness skills were a violation of female cultural norms—these skills were not incorporated into sessions as they had the potential to create physical and emotional harm to clients within this patriarchal context (Ramaiya et al., 2018).

Discussion

In our review, 18 studies met inclusion criteria and varied widely in terms of sample demographics, study design, and adapted aspects of DBT. We identified key themes in extant DBT cultural adaptations, reviewed preliminary data on outcomes and efficacy, and summarized common challenges to these adaptations.

Studies adapted the *language* domain by either translating written materials, delivering DBT in a non-English language, or including specific terms in the clients' native language when delivering DBT in English. In the *persons* domain, studies acknowledged therapist–client ethnic and linguistic matching, and described efforts to find individuals from clients' communities to deliver DBT. Studies adapting the *metaphors* domain incorporated imagery from the natural world in cultures that prioritize connections with the environment, culturally familiar stories, and culturally familiar images and descriptions. The *content* adaptations at times added new material (e.g., discussion of cross-cultural differences, acknowledgment of community stigma) while others completely removed material (e.g., self-respect and assertiveness modules). Overall, studies adapting the *content* domain drew parallels between core DBT concepts and skills and concepts and values in heritage cultures (e.g., dialectics as akin to *zhong-yong* thinking)—in some cases, concepts were de-emphasized or fully removed. Those adapting DBT *goals* focused on client-derived treatment targets based on culture, such as interpersonal effectiveness skills to foster social harmony or learning skills to combat community stigma. In the *methods* domain, studies made homework and diary cards more culturally congruent, emphasized the incorporation of family members and shared meals to foster community. For *context*, studies explicitly addressed intergenerational or historical trauma, transportation barriers, low educational or literacy levels, community stigma, and treatment delivery settings.

Preliminary outcomes and effect sizes for culturally adapted DBT are difficult to interpret given wide heterogeneity in study design and no comparison to standard, unadapted DBT. Of the 42 total effect sizes reported, the majority showed improvement while four indicated a deterioration in client symptoms. Common challenges included those that were systemic (transportation barriers, community stigma) as well as culturally specific and not directly addressed by DBT (e.g., somatic concerns, emphasis on the group over the individual, lack of adequate translation). Overall, this review suggests that culturally adapting DBT is feasible and can improve symptoms; however, more work is needed to improve its acceptability, accessibility, and effectiveness.

Implications for Best Practices

Broader Psychotherapy Recommendations

Our findings suggest several recommendations relevant for psychotherapy regardless of treatment modality. First, translation of materials and delivery in clients' native language is critical and word-for-word translation may be insufficient. Best practices for translation include concurrence by multiple experts and back-translation by those familiar with the target culture (Dubose et al., 2019). Second, in addition to training culturally competent clinicians, programs should consider outreach for training mental health professionals *already* integrated into racial, ethnic, or cultural communities, as was done in several of the reviewed studies (Beckstead et al., 2015; Kinsey, 2014; Ramaiya et al., 2018). Including cultural experts (i.e., "stakeholders") in the design, implementation, and dissemination of culturally adapted interventions have the potential to increase their effectiveness and acceptability. Third, therapist self-disclosure was common (Arunagiri, 2021; Cheng & Merrick, 2017; McFarr et al., 2014; Mercado & Hinojosa, 2017; Ramaiya et al., 2018) and can enhance therapeutic rapport while rendering material more understandable given shared cultural backgrounds. This may be particularly helpful among racial and ethnic communities who mistrust medical authorities, while aligning with certain cultural concepts such as *personalismo* in Latino communities (McFarr et al., 2014). Finally, clinicians can also address access barriers (e.g., transportation), which contributed to attrition in several studies (Arunagiri, 2021; Cancian et al., 2019; Kinsey, 2014; Kohrt et al., 2017). Flexible meeting times can help families from low socioeconomic backgrounds with demanding work schedules (Kamody et al., 2020). Telehealth could increase access but may also could pose other challenges, such as lack of stable internet or privacy (Hyland et al., 2021; O'Hayer, 2021; Zalewski et al., 2021).

DBT-Specific Recommendations

There are several unique aspects of DBT that may benefit from adaptation based on the reviewed studies. First, when possible, language consistency should be maintained throughout all DBT treatment components including consultation team, which allows for the accurate communication of emotional subtleties that might be lost in translation when seeking support and consultation (McFarr et al., 2014). Second, clinicians from underserved communities or lower middle income countries may face many barriers to accessing DBT training, which requires extensive and expensive training, a certification process, and ongoing resources, including a consultation team. This may be unrealistic in communities with few mental health professionals. Virtual training and consultation teams and scholarships may address these barriers for diverse communities. Third, diary cards are meant to be idiographic, which can be tailored

to fit individual and cultural needs, as described above (Arunagiri, 2021; McFarr et al., 2014; Ramaiya et al., 2018). Sensitive assessment when using diary cards should account for needs like low literacy (e.g., using pictorial representations like filling up a water glass to reflect amounts). Although the standard DBT diary card tracks emotion words and urges, clinicians might add in physical sensations for those who express symptoms somatically (Arunagiri, 2021; Mercado & Hinojosa, 2017). Furthermore, culturally relevant contingencies can be used to reinforce homework completion (McFarr et al., 2014).

Fourth, somatic symptoms may be a more culturally acceptable way of expressing emotions, such as *nervios* (nerves) in Latino communities (Arunagiri, 2021; Mercado & Hinojosa, 2017). These can be easily incorporated into chain analysis and may include de-emphasizing standard emotion labels, while also increasing interoceptive awareness of these symptoms and providing psychoeducation about the model of emotions. Fifth, the pretreatment phase can prepare clients for how to address community stigma (Butt et al., 2020; Kamody et al., 2020; Ramaiya et al., 2018) or be added as a separate module, as done by Ramaiya et al. (2018). These conversations can inform treatment setting or delivery modifications. As cultural groups may differ in what aspect of DBT is most stigmatizing (e.g., Kamody et al., 2020 vs. Butt et al., 2020), setting aside time and space to discuss this can likely improve overall treatment acceptability and feasibility.

Sixth, discussion of historical and intergenerational trauma, acculturative stress, cultural differences, and discrimination and racism should be explicitly integrated into the biosocial theory in the pretreatment phase. A recent article highlighted that "no DBT skills training handouts or worksheets include explicit mention of racism as a factor that interferes with skillful behavior" (Pierson et al., 2021). Adding the intergenerational impact of historical trauma into DBT was relevant for Native Americans (Kinsey, 2014). This might also be integrated into the conceptualization of maladaptive behaviors, such as disordered eating as a reaction to racial stressors among Black adolescents rather than assumed to be a cosmetic desire to be thin as noted in their White counterparts (Kamody et al., 2020). Further, discussing and validating acculturative stress as a salient environmental stressor is relevant for the growing population of immigrant communities (Cheng & Merrick, 2017). DBT teams can adopt the Antiracist Consultation to the Environment Agreement into supervision and consultation as described by Pierson et al. (2021):

> At times when the problem is an intransigent, high-power environment, as is always the case when the problem is racism, we agree to actively seek out ways to support the client through antiracist advocacy. We agree to take a dialectical stance by ensuring that consultation to the environment is done in tandem with consultation to the client, so that environmental intervention does not fragilize or disempower the client. We agree to provide functional validation (i.e., responding with action) to racially marginalized clients by using our own resources of privilege and power to change racial inequities (p. 18).

Finally, interpersonal contexts and interdependent relationships may need to be emphasized for clients from certain cultures when teaching the Interpersonal Effectiveness skills module. Standard DBT emphasizes that interpersonal effectiveness skills such as DEARMAN (an acronym indicating steps to achieve objectives through Describing, Expressing, Asserting, Reinforcing, Mindfulness, Appearing confident, and Negotiating) and FAST (an acronym signifying steps to maintain self-respect by being Fair, not Apologizing, Sticking to values, and being Truthful) are context specific (Linehan, 2014). Clinicians can specifically discuss with clients the appropriateness of these skills based on their cultural situation (e.g., geographic location, cultural background, important individuals in their life, etc.), using the Interpersonal Effectiveness Worksheet 1 ("Pros and Cons of Using Interpersonal Effectiveness Skills") from the DBT skills manual to help guide the conversation (Linehan, 2014, p. 167). Hierarchical relationships should be acknowledged and validated as existing within all contexts, and may be emphasized in certain contexts over others, whether it be between a teacher and student, a supervisor and an employee, an elder and a younger person or between genders in patriarchal contexts. Interpersonal effectiveness skills must be adaptable to power differentials in order to be effective and at times, nonassertive approaches may be the most effective approach. Clinicians can review the section "Is the environment more powerful than my skills?" on Interpersonal Effectiveness Worksheet 7 to engage in this conversation with the client (Linehan, 2014, p. 179). Overall, clinicians should be sensitive to these needs, aware of their own cultural assumptions, and aware of the consequences within the client's context. Our review suggests that the interpersonal effectiveness module may require additional tailoring to people of color and cross-cultural clients, over and above the tailoring needed for other DBT skills concepts.

Limitations

This systematic review has several limitations. We were not able to meta-analytically pool study outcomes due to availability of needed data. We could not assess the efficacy of culturally adapted DBT as no study compared adapted to nonadapted DBT, a critical area in need of future research (Hall et al., 2016). We only included cultural adaptations that have been reported in research articles and acknowledge that in practice, many clinicians may already be culturally adapting DBT. Finally, some studies reported culturally adapting DBT, but did not fully detail the process of the adaptation, which is needed to reliably replicate findings and inform standard practices of culturally adapted DBT.

Perhaps owing to the lack of clarity on the concept of *cultural adaptation*, we found that several studies considered "cultural adaptations" of DBT components that are already standard aspects of DBT (simply applied to specific cultural groups). Understanding what constitutes a cultural adaptation is particularly challenging within DBT, as DBT is inherently idiographically sensitive to clients. For example, therapist self-disclosure does not necessarily represent a cultural adaptation of DBT, as disclosure of therapist personal information and personal interactions to the client's behavior are already used as standard therapeutic tools within DBT (Köhler et al., 2017). The general concept of relating content to the client's experience—as was done with the use of *dichos* and *cuentos* (stories and sayings) with Latino clients, the use of metaphor, and adapting the diary card to the needs of a specific client—is also woven into the fabric of DBT (McFarr et al., 2014; Mercado & Hinojosa, 2017). The added skill of "meaning making" in one study mirrors the "Meaning" component of the DBT IMPROVE the moment skill (Kinsey, 2014), which is an acronym that helps clients tolerate distress with imagery, meaning, prayer, relaxing actions, one thing in the moment, a brief vacation, and with self-encouragement and rethinking the situation. The added element of spirituality and emphasis on God ("it's in God's hands") in one study exemplifies the "Prayer" component of the

IMPROVE skill, as well as the DBT concept of radical acceptance, which focuses on fully accepting when situations are out of one's control (Mercado & Hinojosa, 2017). The concept if *zhong-yong* thinking that was central in culturally adapting DBT in China aligns with the basis of standard DBT in Eastern philosophy (Yang et al., 2020). Yet, even though many elements highlighted throughout this article are part of standard DBT, these elements may not be routinely or effectively implemented in practice with people of color and cross-cultural clients. To render DBT more culturally sensitive, clinicians and researchers must maintain the dialectic of both training culturally responsive DBT clinicians while also acknowledging that DBT itself reflects a biased context and adapt it accordingly."

Future Research Directions

A key first step for DBT treatment research priorities pertaining to cultural adaptations is to ensure inclusion of racially and ethnically diverse participants in future studies examining DBT. Specifically, within-group study designs of various racial, ethnic, and cultural groups are increasingly necessary to move research beyond the view of culture as a static individual trait. Within the United States, immigration is projected to account for 95% of the population increase by 2060 (Camarota & Zeigler, 2019), and this growing population of acculturating individuals will endorse values from *both* their host and heritage cultures. Research examining the dynamic, continuous relations between clients' bilinear host and heritage cultural orientations and key treatment factors (i.e., goals for treatment, language preference, social norms) will be particularly informative in serving clients from immigrant backgrounds.

Second, research clarifying whether the mechanisms of change in DBT differ by client racial, ethnic, or cultural identities is needed. Current evidence suggests that DBT skills practice is a key mechanism of change (Chapman & Owens, 2020), but studies are needed to determine whether some DBT skills are more helpful than others for clients in certain cultural contexts. For example, one of the reviewed studies indicated that the skill of radical acceptance was endorsed by Black clients as the most useful and most accepted skill for regulating emotions pertaining to race-related stressors (Kamody et al., 2020). Third, while a large literature highlights the importance of the therapeutic alliance in DBT and other therapies, few have examined potentially relevant therapeutic processes within the DBT skills group. One recent study found that the strength of relationships among members with each other and with group leaders in DBT skills training was associated with individual treatment outcomes (Cavicchioli et al., 2020). Understanding the role of group processes in client treatment is particularly relevant for racially, ethnically, and culturally diverse clients, as group harmony and interdependent functioning was a key cultural value and priority for several participants in the reviewed studies (e.g., Cheng & Merrick, 2017; Yang et al., 2020). Fourth, research testing the cultural acceptability and efficacy of skills from the DBT Emotion Regulation module is needed. Skills such as opposite action (acting opposite of action urges) prescribe a typical action urges to each emotion in the DBT skills manual, which may not apply to all clients given cultural variance in emotional expression. Some clients who may have less familiarity with experiencing emotions verbally may also benefit from an increased emphasis on the physical expressions of emotions and may benefit from increased interoceptive awareness. Finally, few studies in the present review included rigorous measures of client acceptability of treatment, which is needed for culturally adapted DBT. Future research on this topic should include outcome measures beyond symptomatology, as symptom reduction may not be a culturally congruent goal or concept, especially those from native American backgrounds (Kinsey, 2014; Kohrt et al., 2017).

This review is the first to systematically examine cultural adaptations of DBT in people of color within Western countries and cross-cultural groups. These results can guide future research on how to adapt DBT to diverse populations, and we provide practical suggestions for delivering culturally adapted DBT. We recommend future research focuses on expanding the diversity of study samples, comparing culturally adapted DBT to nonadapted DBT, and that studies include both qualitative and quantitative measures from both clients and clinicians to assess efficacy, acceptability, and feasibility of culturally adapted DBT.

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