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A Cultural Adaptation of Dialectical Behavior Therapy in Nepal

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Growing evidence exists on the potential for adapting evidence-based interventions for low- and-middle-income countries (LMIC). One opportunity that has received limited attention is the adaptation of psychotherapies developed in high-income countries (HIC) based on principles from LMIC cultural groups. Dialectical behavior therapy (DBT) is one such treatment with significant potential for acceptability in South Asian settings with high suicide rates. We describe a tri-phasic approach to adapt DBT in Nepal that consists of qualitative interviews with major Nepali mental health stakeholders (Study 1), an adaptation workshop with 15 Nepali counselors (Study 2), and a small-scale treatment pilot with eligible clients in one rural district (Study 3). Due to low literacy levels, distinct conceptualizations of mind and body, and program adherence barriers, numerous adaptations were required. DBT concepts attributable to Asian belief systems were least comprehensible to clients. However, the 82% program completion rate suggests utility of a structured, skills-based treatment. This adaptation process informs future research regarding the effectiveness of culturally adapted DBT in South Asia.

Suicide and suicidal behavior are serious global public health concerns (World Health Organization [WHO], 2014). Suicide is among the 10 leading causes of death in many countries, and for every incident of completed suicide, there are an estimated 20 attempts. In 2012 alone, over 800,000 people died of suicide internationally, representing a global mortality rate of 11.4 people per 100,000, or approximately one death every 40 seconds. Of these deaths, the majority occur in low- and middle-income countries (LMIC), resulting in significant economic, social, and psychological strain at individual, community, and national levels.

In Nepal, suicide accounts for 16% of all deaths among Nepali women of childbearing age, making it the number-one cause of mortality in this demographic (Suvedi et al., 2009). Despite the noted significance of this finding, it has received scant attention in the form of targeted intervention. In Nepal, suicide is primarily managed via law enforcement, whose main role is documentation, and emergency health services that address attempts such as ingesting pesticides (Hagaman, Maharjan & Kohrt, 2016). For those who receive emergency care, few are referred to psychological or psychiatric services.

Current activities to address suicide have increased since the 2015 earthquakes in Nepal, with programs including establishment of a suicide prevention hotline. Programmatic efforts by local nongovernmental organizations (NGOs) and international collaborators to integrate mental health care into primary care settings are also currently underway (Jordans, Luitel, Pokhrel, & Patel, 2016), and raising suicide awareness among health workers is often a component of these programs. However, the impacts of these efforts on suicide have not been specifically evaluated.

Although comprehensive, evidence-based interventions (EBIs) for suicide and self-harm exist, they are not frequently deployed in LMIC settings like Nepal (WHO, 2014). When implemented, they have primarily targeted reduction in diagnostic symptoms of mood disorders and posttraumatic stress, rather than self-destructive behaviors. Further, the majority of these interventions have failed to consistently account for a client's unique cultural values and norms (Bernal, Jiménez-Chafey & Domenech Rodríguez, 2009). In response to increased recognition of cultural influences within the treatment process, psychotherapy adaptations that attend closely to the role of

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culture are rapidly expanding (Castro, Barrera, & Steiker, 2010). This is particularly significant for suicide, because interventions must address a complex web of social, personal, and historical factors. At the time of study initiation, however, there were no systematic attempts at adapting EBIs for suicide in Nepal.

Historical and Emerging Guidelines for Cultural Adaptation

Processes for cultural adaptation, which vary widely with regard to the original treatments being adapted and the target populations, can be loosely categorized into three domains. The first of these approaches includes adaptations that are manifold, nonempirical in nature, and largely based on subjective clinical encounters and experiences (Hwang, 2006). Adaptations in this domain are often rooted in moral decrees, namely that unique cultural values and competencies are significant and demand respect, regardless of their context. This adaptation modality is decreasingly invoked because of concern regarding the deleterious impacts that haphazard or inappropriate adaptations can have on the fidelity and effectiveness of interventions.

Recent approaches to cultural adaptation, in contrast, are increasingly systematic, with clear, conceptual frameworks that propose content suggestions for determining when and how interventions should be modified (e.g., Hwang, 2006; Lau, 2006). A third domain—stage models— have also been proposed for cultural adaptation of interventions. A crucial aspect of these stage models is the inclusion of deliberate and specific steps to guide data collection to determine the need for cultural adaptation, intervention components that require modification, and preliminary effectiveness of modifications. Of these guidelines, a majority are iterative and process-driven, incorporating multiple manual revisions and various stages of feedback from clients and clinicians (e.g., Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008; Wingood & DiClemente, 2008). In other frameworks, top-down approaches to adaptation are complemented by community engagement and participation, resulting in a process model for adaptation that incorporates frequent user, provider, and community-level feedback (e.g., Domenech Rodriguez, & Wieling, 2004).

Form and Structure of Cultural Adaptations

The theoretical underpinnings supporting cultural adaptations of EBIs are rich and varied. One pragmatic orientation conceives of successful adaptations as existing between two oppositional extremes (Benish, Quintana, & Wampold, 2011). On one end of the spectrum lie exclusively Western models of psychotherapy, which are evidence-based, abundant, and recognized as universally pliable. The opposing end contains the grounded theory model, which roots itself in the belief that a maximally efficacious adaptation is (a) constructivist by nature; (b) designed with one specific ethnocultural population in mind; and (c) nongeneralizable outside of its specific development context. An effective adaptation may exist between these two poles. A number of studies (e.g., Hinton et al., 2005; Van Loon, van Schaik, Dekker, & Beekman, 2013) have followed this middle-ground approach, which ensures fidelity to an evidence-based therapy while still allowing for inclusion of culturally salient elements.

For cultural adaptations in LMIC international settings, efforts must also address the paucity of trained mental health professionals in these settings (Patel, 2009). A growing body of literature in global mental health advocates for the role of task-sharing, or the involvement of nonspecialists with limited-to-no prior background in mental health service delivery in care provision. Therefore, in addition to modifying treatment design and content, international adaptations have also emphasized novel training and supervision requirements to encourage delivery by nonspecialists or lay providers. In one program for perinatally depressed Pakistani mothers and their infants (Rahman et al., 2008), basic CBT principles were simplified in order to encourage skillful delivery by local female health workers. Studies utilizing task-sharing are flourishing in LMIC, with trials in Uganda (e.g., Bolton et al., 2003; Singla, Kumbakumba & Aboud, 2015) and India (e.g., Chowdhary et al., 2015; Patel et al., 2010), among many others.

Objective

In this study, we sought to culturally adapt and pilot a Dialectical behavior therapy (DBT: Linehan, 1993a) program for reducing suicidal behaviors in a rural, resource-poor Nepali setting. DBT was selected for several reasons, the first being that it is an empirically supported therapy targeting self-destructive behaviors. Given the high suicide prevalence in Nepal, DBT had the potential to fill an essential public health need. Second, DBT emphasizes a flexible, contextual, and principle-driven view of behaviors (Hayes, Villatte, Levin, & Hildebrandt, 2011). Delivery of DBT requires tailoring of techniques or strategies to the client's unique circumstances; because of this inherent flexibility, it was considered ideal for cultural modification with ethnic Nepalis. Third, DBT's emphasis on teaching practical, real-world skills via group setting allowed for development of a manualized protocol for use by lay Nepali counselors with no prior education or training in the treatment. Fourth, DBT explicitly integrates Zen Buddhist principles, mindfulness, and acceptance into treatment. Its conceptualization of clients