Lessons from the Field

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Adapting Dialectical Behavior Therapy for Transition-Age Youth and Young Adults in Foster Care

In September 2013, the Children's Bureau (CB), in the Administration for Children and Families (U. S. Department of Health and Human Services), funded 18 grantees for two years. Each grantee developed a plan to reduce homelessness in three specific populations of older youth that had been involved with the child welfare system. Over those two years, these projects conducted a detailed data analysis to determine which of these youth were at the greatest risk of homelessness. Based on the risk and protective factors of the populations, the grantees also reviewed the service array to identify gaps in services and supports and structured an approach to best meet the needs of each population. Grantees identified or developed comprehensive service models to address the gaps in services and supports. This work, known as Youth At-Risk of Homelessness Phase I (YARH-1), was the foundation for the next four years of effort on the project.

In September 2015, CB invited the 18 YARH-1 grantees to compete for a second phase of funding to refine and implement the models they had developed during the planning process. CB awarded funds to six grantees for the second phase of YARH (YARH-2). YARH-2 grantees refined their comprehensive service models and conducted usability tests and a formative evaluation to determine whether they could implement their model as intended and whether they had achieved progress toward desired outcomes. YARH-2 grantees also developed intervention manuals to support the continued implementation and possible replication or expansion of their service models.

For more information on YARH, please see https://www.acf.hhs.gov/opre/project/building-capacity-evaluate-interventions-youth/young-adults-child-welfare-involvement.

The Youth Transitions Partnership (YTP) in Alameda County, California, blends service coordination, intensive case management, and dialectical behavior therapy (DBT) to help transition-age youth in foster care engage with available support systems and improve their outcomes. Throughout the program, practitioners and evaluators have worked to increase enrollment and promote engagement among YTP participants. With these goals in mind, the YTP evaluation team at Chapin Hall and the Alameda County Social Services Agency explored ways to make DBT more relevant to YTP's diverse youth population. This brief details what they found from a review of DBT and adapting evidence-based interventions literature, interviews with DBT subject matter experts, and a focus group with young adults who had been in foster care in Alameda County. This brief includes implications for adapting DBT materials and coaching in YTP to be more racially and culturally relevant.

Dialectical behavior therapy (DBT) is an evidence-based cognitive behavioral psychotherapy that teaches people how to live in the moment, develop healthy ways to cope with stress, regulate their emotions, and improve their relationships with others. It was originally developed in the 1980s to treat adults but has since been adapted for use with adolescents. [1,2]

DBT is a key component of Youth Transitions Partnership (YTP), an innovative model of service coordination, intensive case management, and individualized supports for transition-age youth in foster care who have multiple risk factors for experiencing homelessness. YTP aims to increase young people's ability to engage with available support systems and thereby improve their outcomes. It was developed and implemented by the Alameda County Social Services Agency (SSA) through the Children's Bureau's Youth At-Risk of Homelessness grant program.

Although YTP participants are expected to attend weekly DBT group sessions, attendance varies widely, and about 40 percent of youth do not attend any DBT sessions while they are in the program. Furthermore, 50 percent of Black YTP participants do not attend any DBT sessions, compared with 32 percent of their non-Black peers. This difference is important because 40 percent of YTP participants are Black. Interview data collected from YTP coaches by the YTP evaluation team at Chapin Hall

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in 2020 suggested that one potential barrier to increasing attendance might be that DBT language does not resonate with the racially and ethnically diverse population of youth in foster care that YTP serves. Specifically, coaches noted that youth of color have commented on the disconnect between DBT language and the language they use (for example, "This is some White people stuff" or "I would never say this").

Because YTP's continuous quality improvement (CQI) process aims to investigate what drives DBT attendance, Chapin Hall and Alameda County SSA explored whether increasing DBT's relevance to YTP's youth population could increase attendance rates. As a first step, Chapin Hall conducted a review of the relevant literature on the use of DBT with transition-age youth; best practices for adapting evidence-based interventions; and adaptations of DBT for use with transition-age youth, Black youth, or youth with histories of foster care. Then, Chapin Hall interviewed subject matter experts, including clinicians who use DBT, about cultural inclusivity and youth engagement in DBT. Chapin Hall also conducted a focus group with fellows from the WestCoast Children's Clinic Youth Advocate Program (YAP), a youth advisory group, to elicit feedback on the DBT materials YTP is currently using.[a]

This brief begins with an introduction to DBT and an overview of the YTP model. This is followed by a review of the literature on best practices for adapting evidence-based interventions such as DBT and literature on existing DBT adaptations specifically for transition-age youth, Black youth, and youth in foster care. Next, the brief summarizes what was learned from the DBT professionals and the YAP fellows. It concludes with a discussion of the implications of the reviewed literature and the information gathered from the interviews and focus group, as well as recommendations for further exploration or expansion of this work.

What is DBT?

DBT is an evidence-based cognitive-behavioral psychotherapy that has been shown to reduce suicidal behavior, nonsuicidal self-injury, psychiatric hospitalization, treatment dropout, substance use, anger, and depression, and to improve social and global functioning.[3] DBT was originally developed in the 1980s to treat adults with borderline personality disorder and emotion dysregulation who were considering suicide.

A growing body of research supports the use of DBT with young people. Positive effects have been observed in small nonrandomized trials with adolescents across a variety of settings (for example, residential, outpatient, and day program) and among youth with particular behaviors (for example, nonsuicidal self-injury and suicidal ideation) and youth with psychiatric disorders (for example, mood disorders, substance use disorders, eating disorders, and posttraumatic stress disorders).[4,5,6,7,8,9,10] DBT has also been rated as a program with "promising research evidence" by the California Evidence-Based Clearinghouse for Child Welfare.[11]

Full implementation of DBT consists of four components: (1) individual therapy, (2) skills training groups, (3) telephone coaching, and (4) a therapist consultation team.

YTP's program model

SSA partners with First Place for Youth, an Alameda County-based foster care service provider that trains and supervises the YTP coaches, and Chapin Hall, which conducted a comprehensive formative evaluation of YTP and continues to manage a robust CQI process. An independent DBT consultant provides guidance and support to YTP staff.

SSA coordinates the initiative by managing program enrollment and acting as a liaison with Alameda County child welfare staff. Each month, SSA evaluation staff complete a risk assessment using administrative data to identify potentially eligible youth currently in foster care. This risk assessment considers six risk factors and one protective factor.[b] Youth must have a risk score of at least +2 to be eligible for the program.

What makes YTP unique is the pairing of support from coaches, who provide intensive case management, with group-based DBT skill development. Each youth who enrolls in YTP is assigned a YTP coach, and each YTP coach has a maximum caseload of 10 to 13 youth. Coaches meet regularly with youth (weekly during the initial engagement period and at least biweekly thereafter) in their homes, in the community, or (since 2020) virtually to provide case management services,

[a] YAP fellows are young adults, ages 18 to 24, who had been in foster care in Alameda County. Fellows engage in advocacy work and inform child welfare policy and practice decisions. More information about the program is available at https://www.westcoastcc.org/what-we-do/training-education/youth-advocate-program/.

[b] The six risk factors, each given a score of +1 if present, include the following: age of entry, time in care, placement instability, mental health, congregate care placement, and parenting. The one protective factor, given a score of -1 if present, is Transitional Housing Placement-Plus-Foster Care placement.

assess their strengths and areas of need, and offer practical and emotional support. They also work with youth to develop goals in the areas of housing, education, employment, social/emotional well-being, financial management, personal relationships, and (when applicable) parenting skills. Coaches then collaborate with youth to formulate an action plan to achieve those goals. A clinical supervisor provides guidance on how coaches can help participants who have experienced trauma regulate emotions, manage anger, and develop independent living skills.

DBT teaches skills that participants practice in a weekly group setting, and these skills intend to address emotion dysregulation, psychological inflexibility, and interpersonal conflict. These symptoms, which can result from trauma, can impede young people's ability to engage in services or develop lasting connections with supportive adults. Youth leverage the strong relationships they develop with their coaches and the skills they gain through DBT to access services and achieve their goals even after their YTP participation ends.

Additional YTP information

For an overview of YTP, see Alameda County's Youth Transitions Partnership Program – A Promising Model for Supporting Transition-Age Youth in Foster Care.

For more information about the YTP CQI process, see Alameda County's Youth Transitions Partnership Program – A Practical Example of Using CQI to Support Successful Program Implementation.

DBT at YTP

DBT was included in the YTP model to address emotion dysregulation, isolation, self-harming behaviors, and lack of persistence and future orientation among older youth in foster care. SSA, with the support of the YTP planning team and feedback from youth and young adults, added three of the four DBT components to its coaching and service coordination model: DBT skills training groups, a DBT therapist consultation team, and phone coaching. The model does not include individual therapy because youth reported that they already receive individual therapy within the standard service array and wanted something different. Individual therapy is also the most expensive of the DBT components, and coaches would require a higher level of training than what they need to conduct the DBT skills groups. This decision was supported by the results of a recent randomized controlled trial of DBT that demonstrated the effectiveness of providing coaching and skills groups but not individual therapy.[12]

YTP coaches deliver DBT to youth in the program. They lead DBT skills groups and provide phone coaching, in addition to working with youth consistently to apply and practice DBT skills outside of the structured skill-building and during on-the-spot application moments. Coaches use a combination of the DBT curriculum for adults and one designed specifically for use with "adolescents who struggle to control their emotions and behaviors."[13]

DBT skills groups

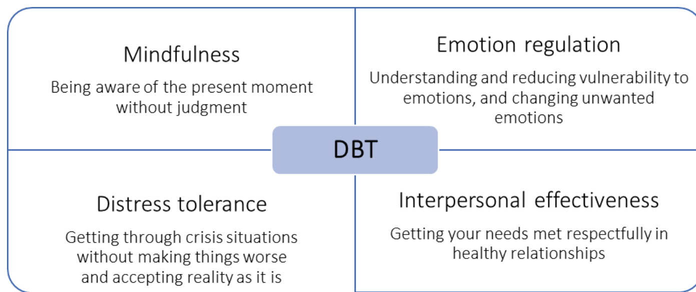
Cohort-based, weekly skills groups focus on teaching youth skills that many youth in foster care struggle to develop because of their history of trauma: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Figure 1). Skills groups prepare youth to engage in therapeutic services that address grief, trauma, and system involvement. The skills groups also support youth involvement in services to improve outcomes in four key domains: social-emotional well-being, housing and placement stability, connecting to adults and community, and education and employment services.

Two coaches conduct each group—one to lead and one to co-facilitate. Groups are run like a class, with YTP coaches teaching skills and assigning homework to help youth practice using the skills they learn in their everyday lives. Groups are for youth younger than 18 or for youth ages 18 and older. As much as possible, groups are scheduled so as not to clash with school or work schedules. Skills groups are typically held at First Place for Youth but have also been held at other locations that are more accessible for some participants.

The skills training is composed of three eight-week modules: (1) distress tolerance, which focuses on how to accept and tolerate distress in difficult situations; (2) interpersonal effectiveness, which focuses on how to ask for what you want and say no while maintaining self-respect and relationships with others; and (3) emotion regulation, which focuses on how to change emotions that you want to change. A mindfulness component—focused on being aware of the present moment without judgment—is incorporated into each of the modules.

Youth are expected to cycle through the three modules twice during their time in the YTP program, in keeping with standards established by DBT's developer, Marsha Linehan. Youth who completed two DBT cycles during the formative evaluation did so, on average, in 14 months.

Figure 1. DBT framework



Telephone coaching

DBT uses telephone coaching to provide youth with in-the-moment support to cope with difficult situations in their everyday lives. Between DBT skills groups, youth can call their YTP coach 24/7 when a situation arises for which they might need help implementing the skills they have learned in the DBT group.

DBT consultation

DBT consultation aims to support the coaches who lead the DBT skills groups. The DBT consultant is an expert DBT clinician and attends group supervision biweekly to provide technical guidance on effective use of and fidelity to the DBT intervention.

Literature review: Adapting evidence-based interventions

Chapin Hall reviewed literature on the use of DBT with transition-age youth, best practices for adapting evidence-based interventions, and adaptations of DBT for transition-age youth, Black youth, or youth with histories of foster care. A search of academic databases using keywords and a snowball method helped to identify other relevant sources.

The literature on the use of DBT with Black youth, other youth of color, or youth who have experienced foster care is very limited. This might reflect the fact that DBT is most commonly used with clients who have private health insurance or the financial means to pay out of pocket. Anecdotally, this form of therapy is often used by doctorate-level clinicians who work in a private practice setting and charge $150 to $300 per weekly session.[14,15] DBT can cost considerably more depending on specialization, clinician credentials, array of activities (that is, individual therapy, skills groups, or phone coaching), and setting (for example, residential or private practice).

Interventions that have been shown to improve outcomes for particular populations might be adapted for implementation with a different population, in a different context, or under different circumstances. According to implementation science, adaptations to evidence-based interventions might be made through addition, deletion, expansion, reduction, or substitution of components.[16] These can include mode of delivery, primary audience, service setting, and cultural or core components adaptations.[17] Some changes can be made with minimal risk to model fidelity, whereas others could compromise the integrity of the model.

Although DBT has been adapted, it has rarely been adapted for youth of color or youth with histories of foster care,[c] and adaptations of DBT for those populations have not been studied. There is, however, literature on making service or intervention adaptations to meet the cultural needs of clients while maintaining model fidelity. Hwang developed both the Psychotherapy Adaptation and Modification Framework, a top-down or theoretically driven approach, and the Formative Method for Adapting Psychotherapy, a bottom-up or community-driven approach to adaptation. These approaches are intended to be used in concert.[18,19]

An article by Barrera et al. proposes a five-stage approach to adaptation that includes information gathering, preliminary design, preliminary testing, refinement, and a final trial.[20] These are closely aligned with the five phases of the Formative Method for Adapting Psychotherapy: (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention.[18]

Barrera et al. also describe a scheme for structuring adaptations developed by Kreuter et al. that includes strategies for: (1) modifying the observable aspects of intervention materials; (2) changing the language of intervention materials; (3) using the cultural knowledge and experience of members of the subcultural group; (4) recognizing and building on the subcultural group's values, beliefs, and behaviors; and

[c] One example is the Young Adult Program for transition-age youth in foster care run by Thresholds, a Chicago-based organization that serves youth and adults with mental health and substance use disorders. More information about the Thresholds Young Adult Program is available here: https://www.thresholds.org/programs-services/youth-young-adult-services/residential-and-transitional-living-young-adult-program.

(5) relying on evidence to support the perception of information relevance.[21]

Effective cultural adaptation requires flexibility in applying the adapted intervention, and therapists delivering the adapted intervention must be aware of their own biases and stereotypes they might apply to clients from minority populations.[22] Of particular relevance is a recent paper by Pierson et al. that focuses on the development of an antiracist DBT adaptation for White therapists who want to meet the needs of their Black/African American clients.[23] This paper offers several recommendations for developing antiracist competencies and for making antiracist adaptations to DBT skills training materials.

A study by Lau suggests adapting evidence-based therapies by selectively identifying who would most benefit from the adapted intervention and then directing the design of the adaptation, using evidence to support modifications.[24] Failure to adapt evidence-based therapies that were developed based on work with mainstream samples can result in disengagement and reduced efficacy for specific cultural groups.[23,24,25,26,27] Because no DBT adaptations have been formally made for YTP's population(s) of young people, and because engagement and disengagement continue to be programmatic concerns, this is particularly relevant for DBT with youth in YTP.

Expert perspectives on using DBT with YTP's population

Following the literature review, Chapin Hall interviewed six subject matter experts from Chicago and the San Francisco Bay Area, some of whom were also practicing DBT clinicians. These subject matter experts confirmed that, in their experience, DBT is predominantly used in private practice settings, often by clinicians with a Ph.D. who do not accept insurance. This phenomenon is not unique to DBT. Other therapeutic modalities are also used primarily by private pay clinicians. However, it means that DBT is generally not an option for those, like youth in foster care, with public health insurance.[d] The Medi-Cal ACCESS hotline, which provides information about behavioral health services to Medi-Cal beneficiaries, does not list any DBT practitioners in Alameda County who accept Medi-Cal.[e]

Other barriers to accessing DBT faced by YTP's population include the physical location where services are offered (ex: transportation challenges or proximity) and clinicians' preference when working with young people to have parent or guardian participation and/or support.[f]

Even if YTP's population can access DBT, it may not be a good fit due to their race or ethnicity, culture, language, economic status, history of trauma, or age. The subject matter experts interviewed by Chapin Hall noted that DBT was developed by a White, middle-aged woman and is generally considered a "White person therapy" or a therapy "for rich White people." One professional stated, "Most practitioners are in private practice, and they're not working with youth of color. That's just the reality." According to these subject matter experts, the new adult DBT manual tries to address this perception, and some DBT training programs are trying to hire more trainers of color.

The clinicians discussed their experiences in the field, including their use of DBT with adolescents or young adults. Some expressed their interest in antiracist, culturally competent, and culturally informed practice, and described informal settings (that is, email lists or conversations with colleagues) where collaboration around these interests occurs. However, they noted that formal trainings or discussions of antiracist, culturally competent, and culturally informed DBT practice are limited or nonexistent. Consequently, practitioners often take it upon themselves to adapt DBT. One clinician described gradually reinventing the binder of materials used in the DBT groups they run. Another described designing their own activities for youth to practice DBT skills.

According to these clinicians, adults tend to be much more engaged in the therapeutic process, if for no other reason than they are choosing to be in and paying for therapy; young people are more likely to be told that they must participate. Consequently, engaging adolescents and young adults in DBT can be a challenge—something that YTP has grappled with since the program's inception. Clinicians recommended working with youth to identify how they want their lives to be

[d] Alameda County once offered DBT to individuals with public health insurance, but the program was too costly to sustain.

[e] Medi-Cal, California's Medicaid program, is managed by the California Department of Health Care Services. More information about Medi-Cal can be found at: https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx.

[f] Most DBT programs for young people include family or caregiver participation. For some young people, caregiver engagement may be difficult due to factors like the caregiver's availability or schedule, their transportation access, or complicated relationships between young people and their caregivers.

different, and then discussing how DBT can help them make the changes they need to make. They also recommended providing incentives.

> "Sometimes that hurdle [youth engagement] can be met best with tangible resources—something that they actually really need—to kind of show that you have some skin in the game, that you're in it. It's not just words, which is what they're used to—a lot of words."

Another way for clinicians to build relationships with YTP youth and increase youth engagement is to openly admit when they are wrong.

> "There have been times when I've worked with teens and I'm the first person who has ever said that I messed up, I'm wrong, or I made a mistake. That can be life-changing for kids to have a person in power own their own mistakes instead of saying, 'You're the problem. You need to change.'"

The subject matter experts recommended other ways to increase DBT's relevance to the YTP population. One clinician suggested using personal examples involving the facilitator or a group member. Personal examples allow more flexibility with language and are consistent with the idea of "teaching to the group," while using the DBT handouts as a framework from which to build. Another suggested weaving skill-building videos featuring people of color into DBT group sessions as a way for White facilitators to bring diverse voices and experiences into the room.

Some of the subject matter experts discussed the potential consequences of using DBT materials that do not resonate with youth.

> "Even thinking about the pictures on the handouts … changing those so it feels like, 'It's actually me on this handout versus some random person that I don't know. I don't know who this person is. This is not my life.'"

These subject matter experts also suggested that YTP work with young people individually or in a group to revise DBT language that does not resonate with them. Specifically, they recommended asking the young person/people, "If you would not say it this way, how would you say it?" or "What would feel more like 'you'?"

Recommendations for engaging youth in DBT

- Brainstorm funny and fun ways to introduce skills
- Allow for flexibility in how to teach skills (for example, make activities competitive)
- Reference popular culture and use it for discussion and skill-building examples
- Give real, personal examples so that young people can learn by example and examine how a facilitator models DBT skills and strategies in response to their own emotions

YAP fellows focus group

To better understand how youth perceive the DBT materials used by YTP, Chapin Hall conducted a focus group with the WestCoast Children's Clinic YAP fellows. After listening to a description of DBT, YAP fellows were asked for their impressions about this type of therapy. Some of their comments suggest that DBT might not be a good fit for some youth.

> "I'm just not really sure about the group therapy [DBT skills group], because I know for some people, they might not be willing to open up and they kind of want to keep to themselves."
>
> "… Everybody has, like, different needs and support, and I think it's really good to have, like, a versatility and variety of therapy, because you know, what works for one person might not work for another."

Another YAP fellow shared their thoughts as to why some young people might struggle with DBT.

> "DBT isn't like talk therapy at all. Your coach lets you know if you're doing something that's, like, hurtful to you, and isn't helpful and will keep you on the right track. Sometimes it'll make you see the bad things in yourself and, the bad things you're doing, and a lot of people don't want to acknowledge those parts of themselves. But it is an opportunity to work on them. But it's people not wanting to see themselves as bad even though, like, sometimes good people have bad parts of themselves, and it's just an opportunity to work on them."

However, two YAP fellows who had experienced DBT noted that they have used some of the skills they learned without realizing it:

> "It gets ingrained through practice and becomes subconscious."

“There have been actually a good amount of times, where I’ve just subconsciously, like, used the skills and been like, ‘Oh, yo, that’s what that is.’ Like, even if I don't remember the name of it, I’m, like, ‘I know that’s a DBT skill.’”

DBT materials

YAP fellows viewed examples of materials from the skills manual for each of the three DBT modules (distress tolerance, emotion regulation, and interpersonal effectiveness) and provided feedback.

Distress tolerance materials

Page one of the distress tolerance materials that were shared with the YAP fellows explains what each letter of the IMPROVE acronym stands for and includes a picture of a baseball player. Page two lists examples of activities youth can engage in, corresponding to each word.

Fellows discussed the importance of making sure that the Prayer section is inclusive of all beliefs.

“Because not every youth believes in God; it could be, like, a higher being and I think even wise mind was included, and that's a really big part of DBT, so reinforcing those kind of skills is really important.”

“The prayer section … I like that it says, ‘Supreme Being, God, or your own wise mind.’ I think it’s really important to be inclusive of that. I feel like there's opportunity to change some of the wording because I feel like some of it could hit wrong.”

“I think, for the prayer one, I think it’s important to add something about, like, ‘spirituality’ because I feel like the word ‘prayer’ is associated a lot with, like, religion.… Maybe adding something around spirituality.… Maybe adding ‘prayer/spirituality’ or something like that to lessen the confusion.”

Despite agreement among the participants that the IMPROVE skill would be helpful to them or their peers now, or could have been helpful to their younger selves, they suggested making sure the language does not imply that hard times are just to be endured. One YAP fellow also suggested providing more opportunities for youth to come up with their own mantras.

“I like the cheerlead yourself; that one I really enjoy a lot. It won't last forever. I will be okay … I feel like maybe that's a section that it’s really important to have fill-ins so that youth can have their own mantras.”

Emotion regulation materials

Page one of the emotional regulation materials that were shared with the YAP fellows describes the Accumulating Positive Experiences skill. Pages two and three list pleasant activities in which youth can engage.

While the group was discussing these materials, one YAP fellow commented on the importance of making sure none of the language can be construed as “inflammatory.” Other YAP fellows responded with their thoughts about what youth might interpret as inflammatory:

“Any statement based around destroying, breaking, or ruining anything should be removed.”

“When they’re reading and then they see the word ‘destroy,’ it kind of creates, like, a negative connotation without them realizing it, because their mind will just go towards the word destroy and start thinking negatively like, ‘I destroy everything.’”

Overall, impressions of these materials were positive.

“I think giving examples is really, really important, especially it being things that youth may not think of as self-care or, like, as a positive experience.”

Interpersonal effectiveness materials

The interpersonal effectiveness materials consisted of a single page that explains what each letter of the FAST acronym stands for and includes an image of a woman.

Two YAP fellows suggested making the language more positive.

“So, instead of ‘don't lie,’ you could put ‘tell the truth.’ Just because, like, ‘don't lie,’ ‘don't act like,’ ‘don't do that’ is very accusatory, especially, like, to foster and probationary youth cuz, like, that’s all we hear a lot.”

“It’s definitely really important to be mindful of how things are stated and making sure that, like, it stays in a positive note, rather than a negative note. It’s, like, that’s what youth are really accustomed to is, like, being told something’s wrong with them, they’re doing something bad, they're not doing the right thing. So just reinforcing the fact that they are doing the right thing by being in DBT and trying to get help and trying to get better … that’s what’s most important is, like, keeping that positive light on it.”

A third YAP fellow thought that suggestion should apply to all the materials in the DBT skills manual:

> "Just overall making sure, like all across the board, all the materials have positive language, like, no inflammatory statements. Just making sure, like, all across the board they're held to the same standard as the ones that we just reviewed together."

Implications

The activities described in this brief were exploratory. They were intended to lay a foundation for developing future work within YTP. The findings also have implications for adapting DBT materials and for coaching youth in general.

Adapting DBT materials

YTP coaches use a combination of the DBT curriculum for adults and one adapted for adolescents, and youth do not receive individual therapy—one of the four standard DBT components. For YTP, making certain changes to DBT materials and delivery could provide an opportunity to test meaningful adaptations while maintaining fidelity to the DBT model. These changes could include revising handouts or other materials, introducing supplemental activities or media such as games or video clips, or modifying the language used to describe DBT skills and concepts.

Some of the handouts that YTP uses, which come from the original DBT manual or the adapted *DBT Skills Manual for Adolescents,* include language about families. In particular, the Walking the Middle Path skills focus on skills for youth *and* their families.[28] For youth in foster care, the notion of family might be (and likely is) very different from the traditional nuclear, two-parent, heteronormative, biological family. Young people might be living with foster parents, with relative caregivers, with peers in a congregate care setting, or in their own apartment. The DBT materials YTP uses should be modified to ensure that language referring to "family" is inclusive.

Other handouts include language referring to physical spaces such as "your room." This language might be appropriate for suburban, White, middle-class clients in stable living situations with access to—and control over—individual, physical spaces. However, it is problematic for young people in foster care who might not have a physical space they can call their own. This language can signal that their experiences are nonnormative and/or that DBT was not designed for them, which might lead to disengagement.

Among the factors considered in existing adaptations of DBT materials for adolescents were "cognitive processing and capability differences" between adolescents and adults.[29] This led Rathus and Miller, authors of the *DBT Skills Manual for Adolescents,* to make changes to the DBT handouts, including limiting the amount of information presented, simplifying the language, adding pictures and graphics, and modifying examples to be developmentally appropriate. These types of changes are similar to the ones the DBT experts who were interviewed for YTP consider when they are trying to increase adolescent engagement.

- How can the examples used to demonstrate or discuss a skill be made more relevant to youth?
- What modifications can be made to the materials to better meet youth where they are?
- How can the content be modified to hold the attention of youth or make it more digestible?

Although the YAP fellows did not voice concerns about the graphics, which depict White-presenting characters, including images of youth of color is important because lack of representation might be off-putting to youth, particularly during the early stages of engagement.[30] Education literature about culturally responsive and culturally sustaining teaching stresses the value of being mindful of culture(s) and intentional about presentation practices while working with youth.[31,32]

"Culture" is defined by the Cambridge Dictionary as "the way of life, especially the general customs and beliefs, of a particular group of people at a particular time."[33] Considering that an ongoing program challenge is how to foster and sustain program engagement among young people in the YTP program, it might also be worth considering the importance of youth culture as a dimension on which these customs or beliefs are shared by young people in YTP.[34]

Studies of the effects of culturally responsive/sustaining teaching on youth demonstrate positive correlations with motivation, interest in content, ability to engage in discussion about content, and perceptions of themselves [as students].[35,36] According to Zaretta Hammond, author of *Culturally Responsive Teaching and the Brain*, there are six core culturally responsive "brain rules" for how the brain works, particularly in connection to one's culture:

1. “The brain seeks to minimize social threats and maximize opportunities to connect with others in community.”
2. “Positive relationships keep our safety-threat detection system in check.”
3. “Culture guides how we process information.”
4. “Attention drives learning.”
5. “All new information must be coupled with existing funds of knowledge in order to be learned.”
6. “The brain physically grows through challenge and stretch, expanding its ability to do more complex thinking and learning.”[37]

As a group-based model, DBT offers YTP participants a social network and the space to connect with other young people in a community. Because of DBT’s focus on emotion regulation, coping with stress, mindfulness, and improving interpersonal relationships, it can also help participants work toward feeling safe and secure in the company of their DBT-group peers. In service of promoting skill development, it is important for coaches and program staff to consider what might capture a young person’s attention and how to draw on their existing knowledge—cultural and otherwise—to foster engagement. Doing so requires an understanding of, and curiosity about, the cultural identity(ies) of program participants.

Coaching implications

The implications for coaching include:

- Intentionally integrating antiracist practices and skills into all coaching interactions and DBT skills groups
- Partnering with youth to develop DBT language that works for them but that does not compromise fidelity to the model (and checking with the DBT consultant when in doubt)
- Choosing relevant popular culture materials (for example, videos, games/activities, and memes) to supplement skills lessons, stimulate interest, and increase engagement
- Building rapport outside DBT skills groups and formal coaching sessions (for example, texting memes or videos)
- Using real-life and applicable examples to demonstrate skills, enhance relatability and credibility, and provide opportunities for youth to observe DBT skills in action

Finally, research suggests that there might be some benefit to matching coaches with young people based on race/ethnicity, gender identity, sexual orientation, or other relevant characteristics. However, it can be difficult to determine whether any effects are a result of matching on a particular characteristic or are attributable to connections based on other similarities or shared experiences.[38]

Conclusion

The literature to support specific adaptations of DBT for use with Black youth, other youth of color, or youth with foster care histories is limited, but what does exist provides guidance about the types of adaptations that programs could make while maintaining fidelity to the model. These adaptations could include the redesign of DBT materials. Any redesign should be collaborative, with input from youth, coaches, experts on race and culture, and DBT clinicians or consultants. It should also be done within a CQI framework that supports incremental changes, observation of the effects of those changes, and a clear road map for how the changes should be modified or the process repeated with a new focus, if that is what the results indicate. Equally important is the need for adaptations and studies of DBT specifically for Black youth, youth of color, and youth with foster care histories.

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