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Julien Basque

(Student Name)

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"It's Not Always Named":

Critical Perspectives on Antiracist Dialectical Behaviour Therapy with Racialized Youth

Julien A. Basque

School of Social Work, York University

Author Note

The following work is a practice-based research paper submitted to the York University School of Social Work in partial fulfillment of the requirements for the degree of Master of Social Work. This research was supervised by faculty advisor Dr Soma Chatterjee.

Abstract

Dialectical behaviour therapy (DBT) is a respected therapeutic modality that is broadly used in youth mental health care. Yet, there is a paucity of research on its applicability to and effectiveness for racialized clients. DBT is an evidence-based practice that rests on the dominant Eurowestern knowledge base of the mental health disciplines, rendering it a potential tool of domination. Some argue that critical race theory and critical race psychology can be used to develop an antiracist DBT framework, however, this approach is yet to be studied in practice. Using the lenses of critical race theory, critical race psychology, and postcolonial psychiatry, this research explores how critical practitioners account for race in practice and imagine possibilities for an antiracist DBT framework with racialized youth clients. Through semi-structured interviews with practitioners who integrate critical perspectives into their DBT work with racialized youth, this study highlights emerging themes related to critiquing and adapting DBT foundations, the relational foundation of cultural humility, and reimagining DBT through critical justice-oriented frameworks. This research seeks to contribute to the urgent need for therapeutic approaches which attend to race for racialized youth, who face disproportionate vulnerabilities in a mental health care system with an unrepresented dialectic of a fundamentally racist society.

Keywords: Dialectical behaviour therapy (DBT), antiracism, racialized youth, critical race theory, critical race psychology, postcolonial psychiatry, cultural humility.

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Chapter 1: Introducing a Seed of Doubt

Dialectical behaviour therapy (hereafter DBT) is a respected therapeutic modality that I have frequently encountered throughout my career in the child and youth mental health care field. Broadly, DBT is a type of therapy that connects thoughts, feelings, and behaviours, and seeks to build emotional resilience through self-regulation skills. Early in my career, I recall having a discussion with my then manager about the upcoming implementation of a DBT-based program at our organization. My manager, a Black Caribbean-Canadian man, expressed reservations about the new program, saying that "DBT is not for Black kids." As an emerging White social worker, I did not fully grasp this statement at the time, but it planted a seed of suspicion about the limitations of DBT that has persisted to this day.

DBT requires participants to take significant accountability for their role in their thoughts and actions. But what about young people whose struggles are influenced by external systems of power? Does encouraging minoritized youth to self-regulate rather than addressing the source of harm recreate systems of domination? While many organizations claim policies of inclusion and cultural safety for diverse service users, evidence-based practices (hereafter EBPs) such as DBT are often used broadly among clients without regard to their unique identities and experiences. There is growing knowledge that EBPs rest upon dominant knowledge structures, rendering them potential tools of supremacy when universally applied. Many racialized young people may benefit from these treatment approaches. Yet, I have seen clients held accountable for their emotional or behavioural responses to racism and racial trauma under the use of a DBT framework. While DBT is lauded for its effectiveness, I fear its current form does not adequately account for the environmental factor of race for racialized youth, putting them at risk of harm.

Youth aged 16 to 24 have the highest rates of mental health concerns across all age groups in Canada and experience the most unmet health care needs (Kourgiantakis et al., 2023). Ontario youth face many barriers to adequate mental health care, including lack of service availability, long wait times, prohibitive costs, and fragmented services (Kourgiantakis). Racialized (particularly Black) youth are disproportionately vulnerable in mental health care, where they face inequitable access, poorer outcomes, and increased negative and invalidating experiences (Gajaria et al., 2021). Limited availability of culturally responsive services increases wait times, and experiences of racism, social and family stigma, and the Eurocentric nature of services prevent access (Kourgiantakis). While young people generally face significant barriers to mental health care access, racialized youth are disproportionately burdened, which renders this research imperative.

Behaviour therapies may pose a particular risk to young, racialized clients due to preconceived notions about the expression of emotional dysregulation versus typical behaviour. Biases and assumptions about aggression and externalization can lead to poor interpretation of behaviours and pathologization of distress in racialized children (Kamody et al., 2023). Evidence suggests that Black youth are less likely to receive mental health care, are more likely to be misdiagnosed with behavioural issues, and have poorer mental health treatment outcomes than non-Black peers (Bernard, et al., 2021). Some suggest that applying mainstream treatments to racially minoritized groups may be less effective or harmful due to the potential disregard for or pathologization of cultural values, family relations, attachments to others, or emotional expression (Cheng & Merrick, 2017). These critiques raise urgent questions about the safe and ethical application of DBT with racialized youth.

Discussions of race and power, including the use of language, are steeped in historical context and lived experience. This paper uses the term *racialized* to refer to individuals and groups who are Black, Indigenous and People of Colour (also commonly referred to as *BIPOC*). This term was chosen to identify that the category of *race* is socially constructed and political. *Racialized* encompasses perceptions and attitudes about race that have been enforced by dominant racial groups, typically Whites of European origin, through the process of *racialization* (Gajaria et al., 2021). Specific racial terms such as *Black* and *Indigenous* are capitalized to indicate reference to a racial identity as opposed to a plain description. The term *White* is also capitalized to indicate that it refers to a racial group with political and perceptual context. This choice is also meant to reject the notion that whiteness is the default raceless state from which racialized "others" deviate (Salter & Adams, 2013). While much of the literature refers to *cultural adaptations* of DBT for racialized populations, this paper will additionally use the terms *reimagination* or *reclamation* as a way of challenging the idea that EBPs must be adapted for the racialized "other." The term *adaptation* may be used when adjustments are made to an aspect of DBT without a foundational change. This language was chosen with careful consideration, and I acknowledge that my position as a White social worker may impart racial bias into my perspective, including choice of language.

This report contains a critical examination of DBT and its application to racialized youth, culminating in an emerging framework for an antiracist DBT approach supported by literature and data from critical clinicians. The first chapter contains this introduction and serves to ground this study by providing an overview of the DBT model, including its origins and evolving applications. This chapter touches on the therapy's theoretical underpinnings in behaviourism, mindfulness, and dialectics (Swales, 2018), and explores the evidence-base of DBT, highlighting

concerns about its demonstrated efficacy with racialized youth. “Chapter 2” delves into the literature to situate race within mental health disciplines, questions the use of universally applied EBPs, and explores existing adaptations to DBT and emerging antiracist approaches. This chapter examines the unrepresented dialectic of a racist society within the DBT model and exposes a focus on cultural adaptations that allows race and power to remain unexamined in the literature.

The third chapter outlines this study’s theoretical and methodological frameworks. It details the use of critical race theory (hereafter CRT) and associated critical race psychology (hereafter CRP) as primary theoretical lenses, with intersecting support from postcolonial psychiatry. This chapter introduces research design, including the use of semi-structured in-depth interviews with critical DBT practitioners, and reviews ethical considerations. “Chapter 4” presents a discussion and analysis of interview data, highlighting emerging themes regarding critiquing and adapting DBT foundations, the relational foundation of cultural humility, and reimagining DBT through critical and justice-oriented frameworks. The fifth and final chapter begins with a review of proposed elements for an antiracist DBT framework based on the data, literature, and an emerging program. The chapter concludes with a discussion of study limitations and explores directions for future research on this understudied and emerging topic.

DBT: An Overview

DBT originated in the early 1980s with psychologist Dr Marsha Linehan to treat persistent suicidal behaviour through therapeutic intervention (Haft et al., 2022). This therapy was later found to be strongly effective for individuals with a diagnosis of borderline personality disorder (hereafter BPD) who demonstrated a high level of suicidality. With this discovery, DBT was developed into a successful treatment for self-harm and suicidal behaviours. It became the

first reported effective intervention for BPD-diagnosed clients who had not had success with prior treatments (Linehan et al., 1991). DBT has since been expanded to address many other populations with complex mental health concerns including those with substance use disorders, concurrent disorders, eating disorders, post-traumatic stress disorder, attention deficit hyperactivity disorder (hereafter ADHD), and adolescents (Camp, et al., 2023; Haft et al., 2022; Lei et al., 2024; Wagner et al., 2004). The therapy focuses on the therapist-client relationship as a supportive and validating context for behavioural change.

DBT is a principle-driven treatment that combines elements of behaviourism, mindfulness, and dialectics (or the coexistence of opposite concepts; Swales, 2018). The therapy focuses on specific skills to increase self-regulation through improving tolerance, emotional control, self-awareness, and relationship management. These skills ultimately serve the long-term goal of building a "life worth living" for the client (Miga et al., 2018, p. 417). The four main skill modules are: *mindfulness*, which is understood in DBT as the ability to be present without judgement in a given moment; *distress tolerance*, or the ability to cope with and navigate intense emotions or challenges; *emotion regulation*, as in the ability to label, understand, and manage emotions; and *interpersonal effectiveness*, which is the ability to communicate assertively, set boundaries, and build and maintain healthy relationships (Haft et al., 2022). DBT is attributed as the first therapy to use mindfulness (Swales, 2018), although this practice is historically rooted in Eastern and Christian traditions (Dimidjian & Linehan, 2003).

Realizing that the standard model of once-per-week therapy would not meet the needs of the target population, Linehan designed a treatment program that included weekly skills training groups, individual behaviour therapy, after-hours phone consultation and coaching, and therapist consultation teams (Swales, 2018). This problem-solving therapy accounts for clinically complex

clients by utilizing a targeted treatment approach. First, current treatment priorities are established, and then specific behaviours are targeted to achieve priority treatment goals. Therapists engage in a stepped process of treatment in which clients work toward reducing target behaviours through behaviour and solution analyses. Once clients reach "behavioural stability" (Swales, 2018, p. 13) they may move on to stage two which involves emotionally processing past events. This comprehensive treatment plan presented challenges to therapists who aimed to provide DBT in a variety of settings with different populations. DBT has since been adapted to have greater flexibility, and specific skills are now widely used in various settings including youth mental health care (Harned et al., 2022).

Theoretical Underpinnings

DBT stems from the third wave of cognitive behavioural therapies (CTBs) and is primarily constituted by three main philosophies: behaviourism, mindfulness (or Zen), and dialectics (Swales, 2018). The therapy emphasizes behaviour rather than cognition, which is a departure from previous waves of CBT. Under the DBT framework, all individual actions including thinking, feeling, acting, and perceiving are conceptualized as behaviours through behaviour theory. This allows practitioners to target unwanted behaviours rather than particular diagnoses and understand motivation as a result of behaviours rather than a personal success or failure.

Zen, or mindfulness, is a longstanding practice that is simplified for DBT into utter acceptance and engagement with the present moment. This component of the therapy attempts to integrate aspects of Zen Buddhism and other practices with origins in Eastern meditative and Christian contemplative traditions (Dimidjian & Linehan, 2003). Dialectics is the core philosophy of DBT and provides a context to balance what some may view as opposing change-

focused behaviourism with acceptance-focused mindfulness. It is a structural approach that centres on the interactions between opposing ideas and forces, conceptualizes truth as emerging from contradiction, and views reality as dynamic and multiple (Swales, 2018). This dialectical understanding moves beyond a binary view of acceptance and change, to a third space in the relationship between the two. Dialectics allows therapists to "shift between positions of acceptance and change" (Swales, 2018, p. 6) to progress through therapy and find new solutions.

Linehan, the originator of DBT, attempted to explain the cause of BPD and associated significant emotional dysregulation through the biosocial model. This model identifies two factors that contribute to the development of chronic emotional dysregulation, which are a biological predisposition to emotional vulnerability and an emotionally invalidating environment. Potential biological factors are identified as limbic dysfunction, neurotransmitter dysfunction, and genetic predisposition to traits such as impulsivity (Crowell et al., 2009). An invalidating environment is described as a context that is intolerant to the expression of emotions during development, such as a caregiver who suppresses their child's emotional reactions or a home with unmanaged mental illness (Oshin & Rizvi, 2024). Together these factors promote an emotional system that cycles between inhibition and extreme emotional expressions (Crowell).

A small subset of the literature situates DBT in relation to feminist theory and feminist therapy (Oshin & Rizvi, 2024; Staples, 2023). While feminism is not named in Linehan's original articulations of the therapeutic approach, the concepts of interrelatedness, validation, and empowerment align with the principles of feminist therapy. Both DBT and feminist therapy encourage a genuine therapeutic relationship between client and therapist using the tools of self-disclosure, transparency, and collaboration (Staples). In this way, feminist theory may be implicit in DBT principles and practice aspects. However, critics point out that standard articulations of

DBT do not address environmental factors (such as gender, race, class, etc.) and make no reference to structures of power or oppression (Pierson et al., 2022; Sloan et al., 2023).

Evidence Base

The general evidence base for DBT is considered to be robust and growing (Beckstead et al, 2015; Camp et al., 2023; Chang et al., 2023; Haft et al, 2022; Kohrt et al, 2017; Mercado & Hinojosa, 2017; Oshin & Rizvi, 2024). This therapy is highly researched and evaluated for the effective treatment of BPD in a variety of applications, as well as other complex mental health and behavioural concerns previously listed. According to a critical review of DBT clinical efficacy, hundreds of publications have analyzed the theory and effectiveness of this therapy, including 31 randomized control trials as of 2018 (Miga et al., 2018). However, this chapter notes that DBT trials have faced criticism for a lack of methodological rigour compared to CBT trials published during the same period. Additionally, the authors state that the plethora of research with varying designs, formats, and foci obscures what is truly known about DBT's efficacy.

Despite the broad evidence base, critical literature points out that evidence is lacking in regard to the applicability and efficacy of DBT with minoritized groups. Some argue that there is insufficient evidence for the generalization of empirically supported treatments to racialized clients (Bernal & Scharrón-del-Río, 2001; Castro et al., 2010; Chang et al., 2023; Harned et al., 2022). The original studies of DBT did not include many racial and ethnic groups, which brings their applicability into question (Haft et al., 2022). A systematic review of the inclusion of ethnoracial and other minoritized groups in 18 randomized control trials found that racialized groups were well represented but noted that none of the reviewed studies examined if treatment outcomes differed for minoritized groups (Harned et al., 2022). Black clients and communities

are particularly understudied, with no published peer-reviewed studies regarding the use of DBT with Black populations (Pierson et al, 2022).

Alongside this gap in evidence, there is little guidance on how to attend to the unique environmental factors of clients using DBT, including race, ethnicity, and culture (Staples, 2023; Pierson et al., 2022). Others note that the effectiveness of "culturally informed" adaptations of DBT is poorly understood and state that there have been no published studies examining the effectiveness of culturally adapted versus standard DBT with racialized clients (Sloan et al., 2023). However, the validity of cultural adaptations to other therapies is empirically supported (Haft et al, 2022). While the evidence base for DBT as an intervention for BPD is strong, there is a paucity of research on the specific effectiveness and limitations of this therapy's application to racialized youth.

Chapter 2: An Unrepresented Dialectic in the Literature

Situating Race in Mental Health Disciplines

The sparse literature on the application of DBT to racialized clients suggests that dominant Eurowestern perspectives in mental health disciplines have handed down a knowledge base that may not include or be relevant to racialized clients (Bernal & Scharrón-del-Río, 2001; Pierson et al., 2022). Historically, research and education have rarely addressed environmental factors and systemic racism in relation to the mental health of racialized young people (Gajaria et al., 2021). However, racial trauma is increasingly understood to be a social determinant of health (Kamody et al., 2023; Gajaria et al., 2021). Arguments have been made for the inclusion of anti-Black racism as one of the Adverse Childhood Experiences (ACEs) that correlate to increased physical and mental health risks (Ayodeji et al., 2021; Bernard et al., 2021).

This lack of focus on the care of racialized people is inherited from the historical and ongoing Eurowestern knowledge base of the psych disciplines. There is growing recognition that behavioural science treatments are constructed for and measured against subjects who are Western, educated, industrialized, rich, and democratic (WEIRD) and often White (Henrich et al., 2010). Explicitly or implicitly, researchers conceptualize who is a "standard subject" through the inclusion or exclusion of subjects in studies, and the generalization of findings across lines of difference. In this way, the White (Eurowestern, male, heterosexual, etc.) body is constituted as the standard body, and "there is no more powerful position than being seen as 'just human'" (Dyer, 1997, as cited in Badwall, 2015). Whiteness becomes the standard by which "racial/ethnic minorities are evaluated, judged, and often found to be lacking, inferior, deviant or abnormal" (Sue, 2006, p. 15, as cited in Pon, 2009, p. 59) Through omitting discussions of race in the

mental health space, the Eurowestern White subject becomes the default subject and therefore racially neutral and capable of speaking for all others (Frankenberg, 1993).

Psychiatrist, political philosopher, and activist Franz Fanon challenged the assumption of a universal "human" which is frequently seen in Eurowestern thought. Fanon argued that this concept typically reflects a Eurocentric standard that excludes the particular experiences of the colonized and racialized (Jean-Marie, 2017). Fanon posited that racism and colonialism are the sources of "psychopathologies" experiences by Black people and other marginalized communities in the context of domination. External systems of domination can be internalized resulting in Black experiences of inferiority and alienation while normalizing the desire for and subjugation to Eurowestern White people and culture (Fanon, 1986). It's reported that Fanon grappled with his social duty as a medical doctor and his social responsibility as an intellectual and activist. He understood a key problem in politically charged psychiatry with Black or colonized patients, which is that "in a society where there is no freedom, to cure is not to free, but to restore the patient to the discipline, to comply with oppression" (Menozzi, 2014, p. 370). Racism and colonialism have become embedded in psych discipline frameworks and practices, both pathologizing Blackness and exerting control over racialized (particularly Black) subjects.

Early psychiatry and related mental health disciplines held explicitly racist theoretical frameworks and clinical practices. During the early to mid-20th century, psychiatry in the transcultural context focused on perceived cultural and biological differences between the superior Eurowestern mind and the "primitive" minds of colonized peoples (Antic, 2024). This type of thinking is part a legacy of dehumanizing colonized people, which has justified violations of Indigenous land sovereignty and the transatlantic slave trade. While many mental health professionals have and continue to grapple with this legacy, psychiatric inequity remains a

pressing concern. Anti-Black Sanism is the intersecting oppression of anti-Black racism and sanism visited upon Black/African people in the global North (Meerai et al., 2016). This pervasive form of violence allows psychiatric diagnoses and interventions to limit dignity and freedom through pathologization, overdiagnosis, and incarceration. Scholars have argued that racism is a cause of mental illness and called mental health care "a deeply perilous place" for those in Black bodies (Meerai et al., 2016, p. 26).

The accounting of race in the psych disciplines brings to light the limitations of Eurowestern perspectives in the treatment of racialized (particularly Black) populations, which have dangerous consequences. There is evidence that Black youth are more likely to be misdiagnosed with behavioural issues, less likely to receive mental health care, and have poorer treatment outcomes than non-Black peers (Bernard, et al., 2021). This legacy is part of the genealogy of modern EBPs including DBT, and as such, this therapy is at risk of reinscribing harm to racialized and colonized peoples. As mental health care has been commodified within capitalist societies, recipients of mental health services become inextricably linked to for-profit models of care. While outside the scope of this study, Eurowestern models of care are tied to a legacy of profitable exploitation of racialized and colonized people, which would be well-situated in a racial capitalism framework.

DBT for Racialized Youth Populations

Troubling DBT for Racialized Youth

The lack of data about DBT's application to racialized clients raises concerns that the therapy "may not be responsive to or culturally consistent with all cross-cultural or racial and ethnic groups." (Haft et al., 2022, p. 788). Some argue that applying mainstream treatments to racially minoritized groups may be less effective or harmful due to potential disregard for or

pathologization of cultural values, family relations, attachments to others, or emotional expression (Cheng & Merrick, 2017). It must be noted that changes to the evidence base of DBT may not reflect the whole picture of its efficacy or risk, as traditional research focuses on quantifiable data rather than embodied and subjective experience.

A systematic review of DBT identified themes of common challenges to accessing DBT for racialized populations such as therapy and mental health stigma from community and family (Ramaiya et al., 2018), barriers to access including lack of transportation (Kohrt et al., 2017; Mercado & Hinojosa, 2017) client feelings that physical concerns were not adequately addressed (Ramaiya et al., 2018), and difficulty comprehending therapy homework materials and numeric scales (Haft et al.). Others noted language barriers during English-language skills groups (Cheng & Merrick), lack of therapist knowledge of cultural practices (Kohrt et, al.), and incongruence with client cultural context (particularly interpersonal effectiveness skills with individualist objectives; Cheng & Merrick, Ramaiya et al., 2018). This diverse list demonstrates that barriers are highly dependent on distinct racial, cultural, and language backgrounds, and cannot be generalized to "racialized populations" as a universal group.

On the topic of addressing oppression in DBT, some identified barriers included a lack of understanding about how to address client-therapist identity differences (Cheng & Merrick, 2017), therapist beliefs that the impacts of oppression fall outside of DBT scope, and therapist lack of training or discomfort in discussing the impacts of oppressive systems (Oshin & Rizvi, 2024). The experiences of systemic racism can be difficult to define in the therapy context, and racial microaggressions may also be a barrier to engagement with the therapy. In a study exploring youths' experiences talking about race in DBT, participants reported that issues regarding race and culture were often overlooked, which perpetuated the neglected impact of

racialization on their mental health. The study identified the necessity of discussions about race yet noted participants' desire not to become a “spokesperson” for racialized issues to therapists with identity mismatch (Lei, et al., 2024). Standard articulations of DBT do not address structural power related to race or other environmental factors, leaving therapists and clients without guidance to navigate race in the therapy room.

DBT is particularly poorly studied in relation to Black youth (Pierson et al, 2022). Some argue that racial stereotyping makes this population highly vulnerable to harm from behaviour therapies. Preconceived notions about what constitutes emotional dysregulation versus typical behaviour amplify bias, and assumptions about externalization and aggression can lead to poor interpretation of behaviours (Kamody et al., 2023). There is evidence that Black youth are more likely to be misdiagnosed with behavioural issues, less likely to receive mental health care, and have poorer treatment outcomes than non-Black peers (Bernard, et al., 2021). In Canada, Black youth typically wait twice as long as non-Black youth for mental health services, are more likely to access care through hospitalization or youth justice, and are more likely to have negative and invalidating experiences in mental health care (Gajaria et al., 2021).

“Culture” in Adaptations

Culture is a highly complex, dynamic, and difficult-to-define construct. Generally speaking, culture is made up of “the world-views and lifeways of a group of people” (Castro et al, 2010, p. 3), and includes a shared system of beliefs, values, norms, and traditions or customs. Culture can be shared among different types of groups including ethnic, racial, or social/subcultural groups. There is significant heterogeneity in racial and ethnic groups, which makes the consideration of subcultural groups, population segmentation, and individual variation key to preventing essentialization or “cultural gloss” (Castro et al.). The majority of reviewed

literature regarding adaptations to DBT for racialized populations discusses culture tied to racial or ethnic background. Adaptations for other minoritized social groups, such as the LGBTQ2S+ community, are generally outside of the scope of this research.

Literature on DBT for racialized youth primarily consists of case studies and uncontrolled trials. All reviewed literature containing studies of direct implementation of DBT with racially or ethnically minoritized populations referred to culture in some way. Approximately half of the articles referred to "cultural adaptations" (McKimmy et al., 2023; Mercado & Hinojosa, 2017), "cultural modifications" (Staples, 2023), or both terms (Cheng & Merrick, 2017; Kohrt et al., 2017; Ramaiya et al., 2018). Many discussed "cultural sensitivity" (Berk et al., 2020; Mazzeo, et al., 2016; Mercado & Hinojosa; Wagner et al., 2004), and "cultural responsiveness" (Cheng & Merrick; McKimmy et al.; Mercado & Hinojosa). Terms that occurred less commonly were "cultural relevance" (Kohrt et al.; McKimmy et al.), "cultural fit" and "cultural specificity" (McKimmy et al), and cultural "context" (Ramaiya et al.; Staples).

The concept of "cultural competence" was referred to directly in one article regarding the application of DBT to racialized populations (Wagner et al., 2004), and an author of another article stated their background in "multicultural competency" (Cheng & Merrick, 2017). Some literature regarding the application of culturally adapted EBPs including DBT adopted a cultural competence framework (Castro et al., 2010; Haft et al., 2022). The underlying assumptions of culture present in cultural competence have been called into question in recent years. Cultural competence is broadly understood to be a collection of behaviours, attitudes, and policies that are in line with a particular cultural context to facilitate effective cross-cultural work (Pon, 2009). This approach attempts to define and account for culture without consideration of power, such as how power operates in the creation of culture discourse, who is considered to have culture, and

how concepts of culture are implicated in the "othering" of racialized groups. Cultural competence essentializes and universalizes assumptions about racial groups and has been equated to new racism that conceals racial othering through culturization (Pon). This calls into question the power that underlies concepts of culture in DBT adaptations for racialized populations.

Existing DBT Adaptations for Racialized Youth

The structure and approach of DBT make it well-suited for adjustment. The therapy's flexible and modular nature allows reworking for application to a variety of clinical populations (Swales, 2018), which may be extended to racialized clients. The emphasis on the role of invalidating environments in emotional and behavioural health may be transferable to invalidating and oppressive experiences related to racism or racial trauma or "cultural and environmental stressors" (Chang et al., 2023; Yeo et al., 2020). DBT's structure and pre-treatment phase may be used to assess values and beliefs of racialized youth clients, and the principle-based treatment approach can be flexibly adapted while maintaining core principles. Additionally, the concept of mindfulness is tied to Eastern philosophy, which has the potential to link to components of Zen Buddhism, meditative, or Christian traditions (Haft et al., 2022).

A systematic review of cultural adaptations to DBT identified eight types of adaptations found among 18 articles. Cultural adaptations were made to the dimensions of language, persons, metaphors, content, concepts, goals, method, and context (Haft et al., 2022). Changes to the language dimension refer to adaptations including translating DBT materials and conducting group and individual therapy in various languages (Ramaiya et al., 2018; Mercado & Hinojosa, 2017), using a mix of languages in therapy (Cheng & Merrick, 2017), and/or using non-stigmatizing word choice for therapy group titles. The persons dimension includes adaptations to

therapist training, the inclusion of racialized therapists or therapists from local Indigenous nations (Beckstead et al., 2015), client-therapist language matching (Mercado & Hinojosa), and self-disclosure of therapist cultural background (Cheng & Merrick).

Within the dimension of metaphors, cultural mythology and proverbs were used to illustrate therapy concepts (Ramaiya et al., 2018), familiar sayings, stories, and images were used for rapport-building (Mercado & Hinojosa, 2017; Kamody et al., 2020), and metaphors rooted in the natural world were used with Indigenous clients (Kohrt et al., 2017). Content adaptations included adjustments based on cultural knowledge, consultation with cultural leaders including the use of ceremony and incorporation of spirituality (Beckstead et al., 2015), the addition of new skills, and the use of a cultural lens in the interpersonal effectiveness model (Cheng & Merrick, 2017). The concepts dimension was adapted through tailoring biosocial theory to include CRT (Kinsey, 2014, as cited in Haft et al., 2022), incorporating cultural understandings of reciprocal family relations (Mercado & Hinojosa), the use of Navajo concepts of defeating a monster to overcome illness (among other concepts; Kohrt et al.), and the use of cultural philosophical concepts (Cheng & Merrick).

The goals of all reviewed articles were generally aligned with the overarching goal of DBT, which is to build a life worth living, and this domain was less commonly adjusted (Haft et al., 2022). Goals were adapted to be client-derived by increasing social harmony instead of focusing on the client's personal skills (Cheng & Merrick, 2017), and, in another case, by increasing client's ability to cope with mental health and therapy stigma in the cultural context (Ramaiya, et al., 2018). The methods domain was adapted through efforts to destigmatize treatment by running skills groups without accompanying individual therapy (Kamody et al., 2020), including the sharing of meals (Mercado & Hinojosa, 2017), making changes to written

materials based on literacy levels (Ramaiya), including Indigenous healing practices (Beckstead et al., 2015; Kohrt et al., 2017), and making changes to eligibility criteria to make formal diagnoses unnecessary for access, among others. The final dimension, context, was adapted by acknowledging intergenerational trauma including through the use of a genogram to highlight the collective and historical roots of distress (Kohrt et al., 2017). Another study acknowledged the unique challenges of being an immigrant (Cheng & Merrick) and the unique stress of being a racialized person (Kamody et al.), while others described access barriers such as transportation, literacy, education, and community and cultural stigma surrounding mental health care (Haft et al., 2022).

While data on the subject is sparse, the literature suggests that attending to race and culture in DBT is achievable and may improve outcomes for racially minoritized populations (Haft et al, 2022). Evidence suggests that culturally adapted DBT may help enhance emotional regulation and other indicators of client success (Berk et al., 2020; Ramaiya et al., 2018; Yeo et al., 2020). There is evidence that adapting other evidence-based therapies to be more accessible and aligned with client cultural backgrounds increases their efficacy for racially minoritized clients (Haft et al.). More research is needed about these types of adaptations to DBT and their impact on treatment responsivity.

Antiracist Reclamation of DBT

Reviewed cultural adaptations generally aim to make DBT more “congruent” with clients' ethnic, racial, or cultural backgrounds to increase applicability and effectiveness. However, adapting therapy to clients’ cultural context does not necessarily unsettle the operation of power and whiteness found within DBT. While several studies and articles attempted to account for individual variation in experiences of culture, and others discussed invalidating

experiences related to minoritization, few directly addressed structural power or the impacts of racism. In contrast to the cultural adaptations found in the majority of the literature, one article explores antiracist adaptations to DBT for White therapists (Pierson et al., 2022). This article includes theoretical and practical changes to DBT without a case study or application of these adaptations. The authors note that at the time of publication, there were no scholarly published writings that guided therapists in the use of antiracism during evidence-based therapies, which presents a particular risk to Black clients, as previously discussed.

The authors situate a racist society as the overlooked problem in DBT (Pierson et al., 2022). They introduce the principles of CRP as an analytical framework to assess psych discipline theories, including DBT, through the lens of CRT (Salter & Adams, 2013). Using the dialectic framework found in DBT, the article identifies "that there is currently just one side of a dialectic represented by existing literature on the cultural responsiveness of DBT" (Pierson et al., 2022, p. 797), which is a focus on supporting clients to cope with the effects of racism. However, helping clients manage racial trauma does nothing to address the attitudes or behaviours that harm them, which "silently invalidates" racialized clients and therapists (Pierson et al., 2022, p. 798). The authors propose that the problem of a racist society, including the mental health systems and its practitioners, is the unrepresented dialectic. This problem can be targeted through antiracist adaptations to DBT that focus on dismantling beliefs and behaviours that perpetuate racism within the therapy and the therapist. The authors direct these adaptations to White DBT therapists as White clinicians hold a disproportionate amount of power within mental health disciplines and social work systems and, therefore, must undertake the work of unsettling systemic racism.

Antiracism rests on the idea that all human behaviour is either racist by allowing racial inequity to endure (whether actively or passively), or antiracist by actively confronting racial inequities (on a variety of levels; Pierson et al., 2022). The article offers a framework for antiracist DBT by seeking to correct therapist treatment-interfering racist behaviours and build antiracist therapist competencies. Treatment-interfering behaviours include deficits in racial self-awareness, knowledge, or skills, minimizing and invisibilizing race, and oversimplification or conflict minimization error, among others. Antiracist competencies include areas of racial awareness, knowledge, skills, and advocacy. The authors offer additions to standard DBT including an Antiracist Therapist Agreement that holds therapists accountable to their antiracist competencies goals, and Antiracist Consultation to the Environment Agreement to encourage clinical consultation regarding effective antiracist practice. While the authors briefly reference the value of cultural responsiveness, they reject cultural competence narratives by problematizing racism instead of cultural incongruence within DBT.

While not represented in academic literature, another example of an antiracist approach to DBT can be found in a Toronto organization's therapeutic group for racialized young adults. Stella's Place is a registered charity located in Toronto, Canada, that provides free mental health services to local young adults aged 16 to 29, with a focus on inclusivity, equity, accessibility, and creativity (Stella's Place, n.d.-b). This organization offers a 12-week DBT program tailored to the needs and experiences of racialized young people. With recognition to the barriers that racialized youth may encounter in mental health care, such as stigma, service availability, long wait times, and lack of culturally relevant support. Stella's Place co-designed this program with a group of 13 racialized young adults (Stella's Place n.d.-a). According to the organization's

website, this group has shown higher rates of retention when compared to general DBT groups and has expanded to include a BIPOC Drop-In Support Group.

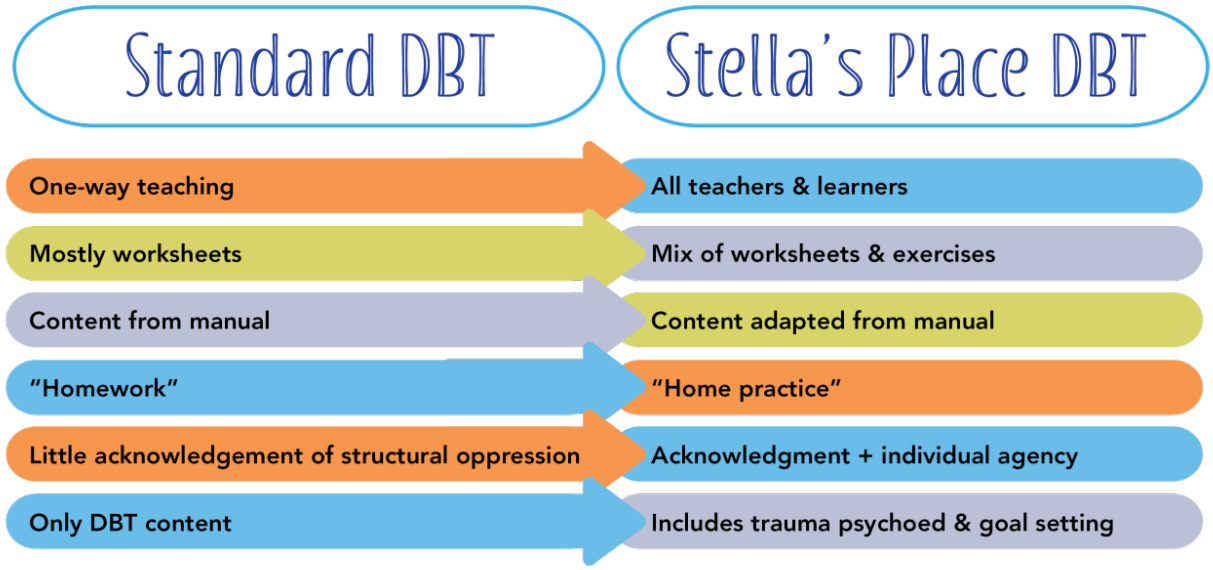
Although the program aims to be culturally responsive, it moves beyond "cultural adaptation" into antiracist reclamation through its attention to race and power. According to a clinician quoted on their website:

> 'Yes we offer DBT and the skills, but we're also trauma-informed and we incorporate anti-oppressive practices as well as anti-racist practices. Because it's a bit more flexible, we can really talk about how folks are in this group, how their identity or their social location has really impacted their mental health and the intersection of these things,' explains Vanessa. (Stella's Place, n.d-a, para. 14)

As shown in Figure 1, Stella's Place co-designed this program with several key adjustments. Highlights include reframing power in the therapy room from therapist to client to a more collaborative teaching and learning approach; acknowledging structural oppression and promoting agency; and including trauma-informed approaches that attend to racial trauma (Figure 1). These critical changes align with antiracism practice as they aim to confront racial inequity in therapy access and outcomes through addressing barriers specific to racialized young people.

Figure 1

Depiction of Comparison Between DBT Model and Stella's Place BIPOC DBT Group Model



Note. This image was sourced from the Stella's Place Blog to show the changes made from a standard DBT model to the Stella's Place co-designed BIPOC DBT model. From "A new program for racialized young adults" by Stella's Place (n.d.-a). Copyright 2021 by Stella's Place.

Unexamined Power and Invisible Race

Literature on the consideration of race in DBT and potential cultural adaptations stresses the paucity of research on its applicability to and effectiveness for racialized clients (Bernal & Scharrón-del-Río, 2001; Castro et al., 2010; Chang et al., 2023; Harned et al., 2022). There are limited case studies and pilot applications that explore the use of DBT with racialized populations, and even fewer randomized control trials. Black populations were particularly poorly represented (Mazzeo, et al., 2016; Wagner et al., 2004; Yeo et al., 2020), were not primarily targeted by any identified studies, and no published peer-reviewed studies about DBT with Black clients have been identified (Pierson et al, 2022). Young people were also underrepresented to a lesser degree, with slightly below half of reviewed studies targeting youth

or adolescents (Beckstead et al, 2015; Berk et al., 2020; Kohrt et al., 2017; Mazzeo, et al., 2016; Yeo et al.). Further research is needed to explore DBT's effectiveness and applicability to racialized youth clients.

The voices of racialized youth are glaringly missing from the current knowledge base of DBT's application to racialized populations. Only one identified study about cultural adaptation used interview data that directly included the client's voice; however, this study was conducted with women in rural Nepal and may or may not apply to the Canadian context (Ramaiya et al., 2018). One study examined the experiences of racialized youth talking about race during DBT, however, this article discussed standard DBT without attention to cultural or antiracist approaches (Lei et al., 2024). A critical ethnography of Black women's experiences in the psychiatric hospital setting included interviews with Black women engaged in DBT (Creswell, 2014). The women in this study identified that DBT was beneficial, yet they felt a lack of trust in the system, however, the article did not primarily focus on DBT. The direct voice of the therapist, clinician, or social worker was not present in any reviewed literature.

Despite a purported focus on race, ethnicity, and/or culture, race and power remained concealed in much of the literature. The primary focus of adaptations appeared to be increasing access to DBT through changes to language, content, and goals without a thorough examination of racism and whiteness within the fabric of the therapy. Several studies addressed concepts of racial or cultural stressors (Yeo et al.), invalidation, or included a brief exploration of racism (Kamody et al., 2017; McKimmy et al., 2023; Mercado & Hinojosa, 2017; Wagner et al., 2004; Staples, 2023). Yet an interrogation of power, references to CRT, or the use of an antiracist framework were only present in one article (which was not a study; Pierson et al., 2022) and one active program (Stella's Place, n.d.-a). Taking a purely cultural adaptation approach that aims to

minimize cultural incongruence allows race to remain invisible within DBT, even in its application to racialized clients.

The mental health disciplines are founded on a historically established Eurowestern knowledge base that constitutes the White subject as the "standard" subject; when standard DBT is applied to the "standard" White subject, and culturally adapted DBT is applied to the "other" racialized and culturized client, the operation of whiteness within the therapy remains unexamined. There is extremely limited exploration of how racism can be embedded in the framework of DBT and its practitioners, or opportunities for a critical antiracist reclamation of DBT. The nature of the literature and its gaps inform the guiding question of this research: How do critical DBT practitioners attend to race in practice and imagine possibilities for an antiracist DBT framework with racialized youth clients?

Chapter 3: Theoretical & Methodological Frameworks

Theoretical Frameworks

This research primarily uses a CRT and CRP framework with intersecting support from postcolonial psychiatry. The topic of study necessitates the use of CRT due to the historical and ongoing embedment of race and racism in society, and the socially constructed nature of race. CRT posits that "racism is real while race is not" (Pierson et al., 2022, p. 780), as racial categorization is socially constructed and not based in biology, yet the construction of race is used to promote White dominance in very real ways. Antiracism, which is intrinsically tied to CRT and CRP, holds the foundational idea that all human behaviour is either racist and allows racial inequity to endure (whether actively or passively) or antiracist by confronting various racial inequities (Pierson et al.). Some tension exists between the poststructural leaning, fluid understanding of truth in CRT, and the binary categorization of racism versus antiracism in antiracist thought. However, they can be used in combination to navigate nuances of race in mental health care while taking a racial-justice-oriented stance of action.

CRP is founded on CRT and emerged from a collection of activists and scholars who study the relationship between race, racism, and power, and question "the very foundations of the liberal order" (Delgado & Stefancic. 2021, p. 3, as sited in Salter & Adams, 2023, p. 782). There are five tenets of CRP, which are as follows: (1) racism is systemic and exists not only in individuals but in the fabric of society; (2) race is White-washed and inequality is laundered by neoliberalism and individualism, in that dominant psych discipline ideologies individualize experience while minimizing identity and otherness; (3) dismantling racism requires interest convergence, especially White people's divestment of privileging systems; (4) Whiteness is a profitable investment, which makes it difficult for White people to perceive privilege as a

resulting from racial oppression; (5) counter-narratives are essential tools in creating racially just psychology as stories can unsettle default constructions of the world (Salter & Adams, 2013; p. 785-798).

A key figure in postcolonial psychiatry, Frantz Fanon (1925-1961) was a Martinique-born psychiatrist whose experiences working in colonial Algeria deeply shaped his views on the relationship between mental health and colonial oppression (Menozzi, 2014). After witnessing the dehumanization of racialized and colonized peoples, Fanon became a strong critic of colonial psychiatry, which reinforced the concept that colonized people were psychologically inferior. His practice and writings explored the impacts of colonial alienation and the internalization of inferiority by Black people, particularly in his prominent book *Black Skin, White Masks* (Fanon, 1986). As Fanon understood, in a society without freedom, the "cure" is not to free a patient, but to bring them into compliance with their oppression (Menozzi, 2014, p. 370). The understanding of psychiatry, or broader mental health treatment, as a potential tool of colonial control is fundamental to this research.

Postcolonial psychiatry provides a lens for understanding that mental health disciplines are not culturally or racially neutral but deeply rooted in dominating colonial origins and continuities. This raises questions about the impact of colonialism on Eurowestern approaches to mental health care, and how theories, approaches, and practitioners can function as agents of oppression. This research seeks to explore how the use of DBT and behaviour therapies may be implicated in an agenda of racial and colonial control. Attention to historical context and the operation of racial and colonial power is essential to unpacking the use of an evidence-based therapeutic modality with racialized youth in a colonized nation.

Research Design

Sampling, Recruitment & Participants

This study collected primary data from mental health care practitioners who use DBT and who serve a population that includes racialized youth. Practitioners of the therapy were targeted due to the lack of clinician voices present in the literature, alongside ethical considerations that are expanded upon in the final section of this chapter. Sampling was purposive as potential participants were selected based on specific criteria, with an element of convenience sampling of participants who were accessible or previously known to the researcher. There was unintentional snowball sampling as prospective participants recommended other clinicians for this study, however, this was outside of the researcher's purview (Kirby et al, 2017). Each participant was compensated with a 15-dollar coffee chain gift card for their time and contributions.

Potential participants who were known to the researcher or recommended by word of mouth were recruited exclusively through email. Potential participants were also recruited through public domain online therapist directory tools that included local Toronto directories, such as healingincolour.com and psychologytoday.com. Refer to Appendix A for a recruitment email template. Inclusion and exclusion criteria were as follows: participants must have been practising DBT (in whole or in part) in some professional capacity and practising with a population that includes racialized youth between the ages of 11 and 24 during the timeframe of the interview. Practitioners who did not use DBT, or who exclusively practiced with White or non-youth populations, were excluded. This research intended to target practitioners with critical perspectives on race in the mental health space, but the criterion was not formally included due to the subjective nature of a “critical” lens.

The target sample size was six to eight participants, while the final sample size was five participants. Eleven potential participants who were known to the researcher through professional or educational connections or snowball reccomendations were contacted by email, while five potential participants were contacted via public domain therapist directories. Of the clinicians that responded, seven met the inclusion criteria. Two participants withdrew before the interview stage due to unrelated life circumstances. Minimal demographic information was collected for ethical and confidentiality purposes, but the sample was made up of a diverse group of five clinicians. The sample included three registered social workers and two registered psychotherapists with professional experience varying from several years to over a decade. The group included two participants who identified as South Asian, one who identified as Black, one who identified as White, and one who identified as biracial (White and East Asian). Two participants identified as men, and three identified as women. The small size of this sample must be considered in regard to generalizability of the data, which is further discussed in Chapter 5.

Data Collection and Analysis

The framework for data collection was descriptive in nature, as the research aimed to explore how critical practitioners attend to race in practice and imagine possibilities for an antiracist DBT framework with racialized youth clients. The study sought to highlight the voices of practitioners, which are largely absent from the literature. Data was collected through semi-structured in-depth interviews conducted by the researcher with each participant individually. Interview questions were designed to elicit the perspectives and experiences of practitioners who utilize DBT with racialized youth, gather detailed qualitative data to explore nuanced practices and ideas, and contribute to a description of how practitioners attend to race and envision an antiracist DBT framework. The completed interview guide may be referred to in Appendix C.

Interviews were securely recorded and transcribed for analysis. Each interview lasted between 35 and 70 minutes, culminating in 268 minutes of recorded data. Initial transcription was completed using Microsoft Word's dictation function, and further cleaning was completed manually by the researcher through two rounds of concurrent listening to interview recordings while editing transcripts to ensure accuracy. To protect participants' confidentiality, all persons' names, institution names, and references to specific neighbourhoods were removed and replaced with a placeholder to maintain accuracy (such as "I used to work at [agency name] in [Toronto neighbourhood]"). Each participant was assigned a pseudonym to anonymize transcript data and ensure confidentiality while humanizing the practitioner.

Data was interpreted using critical thematic analysis, which included an iterative process of reading and coding transcripts, organizing codes into themes, and re-reading transcripts with cross-reference to codes and themes to promote credible analysis (Kirby et al, 2017). Coding was completed manually using Microsoft Word by using colour-organized highlighting and comments to separate data into codes. Codes were organized into themes based on thematic similarities, which evolved flexibly over multiple rounds of reading, coding, and reorganizing. Further discussion of codes and themes that emerged from the analysis can be found in "Chapter 4: Enhanced Understandings."

Ethical Considerations

This research involved human participants and is considered to have minimal risk. As such, it falls under the ethical guidelines outlined in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. I, the researcher, have maintained fidelity to the principles outlined in this document in the following ways: I have committed to demonstrating respect for persons by obtaining freely given, informed, and ongoing consent. I closely reviewed

the informed consent form (which can be found in Appendix B) with each participant prior to and at the beginning of each interview. I explicitly outlined voluntary participation, including participants' right to withdraw at any time prior to the completion of data analysis without reprisal. I selected participants that I have not had a supervisory or power-imbalanced relationship with, and excluded participants with whom I had worked closely to avoid undue influence. I took care to explain that participation or refusal to participate in this research would not influence any preexisting professional or academic relationship with the researcher.

I demonstrated concern for welfare by maintaining confidentiality and attempting to prevent emotional harm or embarrassment. I have made every effort to ensure confidentiality, including secure storage of data and clear communication about limits of confidentiality. I engaged with the principle of justice by targeting adult practitioners rather than youth with multiple vulnerabilities and by using methodologies that expose racial and colonial power. These participants were selected due to the lack of practitioner voices in the literature, but also due to the additional emotional and ethical risks of interviewing participants who are multiply marginalized as young and racialized people in the mental health care system. I come to this research as a racial outsider, and as such, I have chosen critical racial-justice-oriented approaches with the hope of bringing value to the community targeted by this research, reducing potential harms, and preventing white-saviourism. This research was reviewed and approved by the York University Research Ethics Board, and a certificate of completion of ethical training may be referred to in Appendix D.

Chapter 4: Enhanced Understandings from Critical Practitioners

This research seeks to explore the nuances of utilizing DBT with racialized youth, with attention to the historical context of mental health disciplines and an antiracist reimagining of the therapy. Interview data reveals participants' impressions that while DBT may offer valuable tangible skills, its structured and manualized approach can be restrictive and is often flexibly adapted to suit the diverse needs of racialized youth. Participants raise concerns about the potential mismatch between the Eurowestern-rooted principles of DBT and the lived experiences of racialized youth. The data emphasizes the critical importance of humility regarding culture and race and the need for individualized approaches that are responsive to clients' unique identities and experiences. Three key themes emerge from analysis of the data, which are outlined below.

Theme 1: Critiquing and Adapting DBT Foundations

The first theme captures participants' critiques of DBT in its standard form, and their corresponding adaptations. Participants raise concerns about the Eurowestern-origin model of standard DBT, the need for a flexible "DBT-informed" approach, concerns about accessibility and engagement, and attention to environmental factors related to the therapy.

Challenging the Standardized DBT Model

All participants share some level of critique for the standard DBT model, including concerns about the therapy's origins in Eurowestern mental health care traditions. Participants question the applicability of certain skill areas to racialized youth, particularly mindfulness and interpersonal effectiveness. One participant notes:

> I would say, I personally as a practitioner, I struggle with the very structured and manualized kind of approach… Maybe such a like structured and manualized approach

> with groups who have been historically kind of like controlled and managed and oppressed isn't necessarily a great thing in my opinion. (Robin)

Her comment raises the question of how a structured therapeutic approach, such as DBT, may be connected to oppressive and colonial control over racialized people in the therapy context. Alongside these critiques, each participant notes some value in DBT, with Jackson and Addae noting that DBT skills are "tangible" and "valuable", while Simone mentions that distress tolerance skills are helpful in crisis situations. The interviews reveal tension between criticism of the origins, structure, and applicability of DBT, and beliefs that the therapy may offer benefits to racialized youth. Several participants identify dialectics as a feature of DBT that supports an additive "yes, and" approach, which attends to nuance and rejects binary thinking.

Flexibility and Individualization

All five participants offered critiques of standard DBT's structured and manualized approach, noting that it was not necessarily conducive to meeting the social realities of racialized youth with diverse life circumstances. Participant Addae notes that "flexibility and agility is extremely important" and shared the need to "bob and weave", using DBT as one of many therapeutic tools. Participants Jackson and Robin both stressed the importance of getting to know the unique circumstances of each client to provide individualized support. Jothika and Simone spoke about using relevant DBT skills on an "as needed" basis, noting that traditional DBT takes a high level of resources from both the therapist and the client. Prioritizing flexibility and individualization involves taking a "DBT-informed" approach that moves beyond rigid adherence to the manual to tailoring the therapy to individual needs.

Accessibility and Engagement

Participants noted the importance of offering DBT to racialized youth in a way that is accessible and engaging. Several noted difficulties engaging youth with written materials and "homework" as part of DBT and shared a need to make concepts more accessible and appealing. Robin reports taking a responsive approach to see what clients gravitate toward and build on that engagement, "trying to package concepts in a way that people would be more engaged to it." On accessibility, Simone reports the need to take a creative approach for racialized youth who may face social or family mental health stigma. She reported a need to meet youth "where they are at" to increase accessibility and engagement based on each youth's needs and circumstances. Rather than taking a prescriptive approach, participants describe a collaborative stance that centres youth needs and interests.

Systemic Factors & Power

All participants gestured to a lack of consideration of environmental factors in DBT, including race and other determinants of social power. As one participant shared regarding EBPs such as DBT:

> There's often like this- I don't know, narrative that this is all within your control. And if you could just see how this is in your control, and you put these good adaptations in, life would be so much better, you know and, yeah. That's definitely not the case with really big issues or social determinants of health or racism and things like that. (Jothika)

The participant goes on to question what is being said or ignored about race and social power in written materials and worksheets. Jothika makes the key distinction that environmental factors, such as race and racism, are outside of clients' individual control. She encourages normalizing the harmful impacts of systemic oppression rather than jumping to address personal responses to racism, which directly highlights the missing half of the unrepresented dialectic in DBT with

racialized youth (Pierson et al., 2022). The participants highlight the behavioural focus on the individual in DBT, and the importance of considering broader systems of power that impact individual experiences.

Adapting Specific DBT Skills

Participants note the need to attend to race and culture particularly in regard to the skill areas of emotion regulation, interpersonal effectiveness, and mindfulness. Robin speaks about the importance of seeking to understand the social and cultural context of emotional expression for racialized youth, saying, "if you're looking at it through a lens of race… by regulating somebody's emotions, are we regulating, like, their cultural expression?" She points out the importance of allowing the client to express what their emotional "norms" are to avoid imposing a Eurowestern lens. Participants speak about the need to contextualize emotional regulation, as emotional expression and perceptions are highly impacted by social, racial, cultural, and family factors.

Interpersonal effectiveness skills are particularly critiqued for imposing Eurowestern relational norms. While Robin notes that this skill area is rooted in "certain expectations" that cannot be universally applied, she also shared that skills for communication and assertiveness could be a tool to "empower how they might speak up for themselves in a situation" and promote self-advocacy. Some participants criticize the DEAR MAN[1] skill, which is a tool for assertive communication, as potentially too direct for communication between child and parent in some cultural contexts, despite the fact that is it widely recommended for communicating with parents.

[1]DEAR MAN is a DBT skill acronym that is intended to promote effective communication and advocate for one's needs. It stands for the following: describe the situation; express feelings and opinions; assert what one wants or needs; reinforce the positive impact of getting what you need; mindfully keep focus on the present goal; appear confident; and negotiate with the other party (Lei et al., 2024).

Simone notes that she uses interpersonal effectiveness skills infrequently, initially stating that she was unsure why, but later reflecting on a sense of mismatch with racialized youth clients' relational experiences and norms. Participants share the importance of using this skill area carefully with attention to clients' social and cultural realities.

The skill area of mindfulness receives both significant critique and praise from participants. Jothika notes the origins of mindfulness in Zen Buddism, and raises the concern that it may not resonate with individuals from different cultural or religious backgrounds. She shares a story about how certain mindfulness modalities can trigger a trauma response in people who have faced persecution by particular religious or ethnic groups, possibly indirectly referring to the Rohingya people. Simone stresses the importance of identifying mindful activities in each client's spiritual, social, or recreational practices, noting "a really powerful piece around like, this is something that they're already doing." Addae shares the need for trauma-informed mindfulness that takes client readiness into account. He suggests the use of narration or narrative therapy, starting with the client's story "and then being able to build in mindfulness." Participants generally discuss taking a measured, individualized, and trauma-responsive approach to mindfulness.

Theme 2: The Relational Foundation of Cultural Humility

The second theme highlights the need for cultural humility in DBT work with racialized youth, and how it is built upon human connection. Participants discuss the essential nature of a trusting client-therapist relationship, the value of a curious non-assumptive approach, the need for validation, and attention to cultural context in therapy relations.

The Therapeutic Relationship

Each participant referred to the essential nature of a trusting relationship in meaningful therapeutic work. As said by Addae, “you have to be human, have to be connected. You have to be able to connect, have to be able to listen.” Simone notes, "...it's the relationships that we form and develop in our therapeutic processes that ultimately underlies everything that we do.” Addae uses the metaphor of music to describe the therapeutic process, saying a practitioner must “be able to listen and hear the song that's being sung. Yeah, and be able to hear where there's notes missing… and then be able to be thankful that you heard.” Some participants label relationship-building as a strength of DBT, while others question whether the structured approach leaves room for rapport-building. The participants stress that rapport, genuine connection, and caring empathy are the building blocks of a meaningful therapeutic relationship with racialized youth clients.

Validation

Participants note the importance of validation in the therapeutic relationship, identifying it as a tool for connection and also a way to mitigate power dynamics. One participant states:

> And also validation would be a big part of DBT that I think is a great skill, but it's also just kind of something that we use as a therapist. But it’s a DBT thing, and that can be, you know, helpful as well to sort of show empathy and understanding and validate this other person's experience that, like, maybe we don't look alike. Maybe we haven't had all the same experiences. We’re different people, but I can still sit with you in space and understand and validate your experience of something or your emotions in a situation, right? So that you can feel more seen and heard. And I think that validation can help to kind of break down some of that power dynamic a little bit. (Robin)

She links validation with the ability to share connection with clients across lines of racial and power difference. Other participants refer to validating their racialized clients' emotions while also critically witnessing experiences related to race and racial trauma. As Addae shares, “In my

experience, it's ‘less could be more,’ especially with racialized youth. And I think my experience has taught me to listen, validate, and not intervene”, referring to his tendency to offer clients the agency to address their own concerns. Jothika discusses how chronic invalidation can lead to dysregulation, referring to Linehan’s biosocial model (Crowell et al., 2009). Participants frame validation as a crucial step to building rapport and understanding, particularly regarding experiences of marginalization.

Curiosity and Openness

Four participants explicitly discuss the power of taking a curious and open approach, while the fifth described learning from racialized youth clients in a way that aligns with curiosity. Participants caution against making assumptions about clients’ experiences and identities, and reject generalization among racial groups. Jackson notes maintaining an open stance of discovery when working with youth who share his “racial context,” emphasizing that a shared racial identity does not equate to a shared experience. One participant says of his approach:

> You go in with such a place of honoring that person, and it exudes because you're coming in from a place of wanting to learn, wanting to share, wanting to receive. And that alone shifts the dynamics ever so slightly, and being curious ever so slightly, rather than coming in like, OK, this is what you need, this is what I said. (Addae)

Participants identify curiosity and openness as tools to minimize assumptions and biases against racialized youth, which can be used to promote cultural humility and shared power. Participants report using a curious stance to assess client strengths and needs and responding flexibly with the relevant components of DBT to suit their individual context, rather than broadly prescribing the therapy.

Cultural Context and Humility

Practitioners demonstrate attention to the ways in which cultural norms, values, and expectations can influence young, racialized clients' engagement with DBT. Clinicians particularly label interpersonal effectiveness, emotion regulation, and mindfulness as skill areas that are impacted by cultural context. Participants identify using a reflexive stance that attends to one's own cultural background alongside the client's, without judgment or assumptions. This position aligns with growing critiques of the cultural competence model, as it rejects the notion that culture is an unchanging and knowable dividing force (Pon, 2009). Rather than making universalizing cultural adaptations to DBT, practitioners describe grappling with power in race and culture discourses and in the therapeutic relationship. However, cultural humility does not remove the risk of culturization as a form of new racism, without a deep understanding of the political and economic understanding of culture in Canada's multi-cultural society (Pon). While the term "cultural humility" was not used by any participants, each interview featured themes of cultural humility, including openness and curiosity, respect, recognizing personal limitations and bias, taking an individualized approach, and valuing client skills and culturally relevant practices (Pierson et al., 2022).

Theme 3: Reimagining DBT Through Critical and Justice-Oriented Frameworks

The third theme encompasses participants' contributions to reclaiming DBT with racialized youth as a critical and liberatory practice. Participants discuss historical context, antiracist therapy work, and approaches that are critically trauma-informed, which centre clients' strengths and abilities.

Attention to History

The historical context of mental health disciplines is discussed in some form by all participants. Several refer to the Eurowestern roots of EBPs and question dominant sources of knowledge regarding mental health and therapeutic care. Some refer to legacies of historical racial trauma, which is discussed further in the section *Critical Trauma-Informed Approach.* Participants refer to themselves in the context of a problematic mental health care system with a history of harm. One participant discusses concerns about the history of mental health care, noting a level of responsibility while voicing hope for a path forward. He says:

> I think if I've learned anything in school, it's not to, like, throw everything out. It's to kind of understand, you know, the good, the bad, the ugly, and to grow from that. And I think we have a long way to go, but. I mean, you're doing this research, and we're having this conversation. I think things are happening. (Jackson)

This reflection promotes the need to take action in service of a future that both acknowledges and diverges from the past. Participants responses indicate a dialectical approach to hold accountability for historical harms and a drive to work toward a more just future.

Antiracism

The participants demonstrate an awareness of antiracism and identify ways that they infuse antiracist principals into their work. While some had not previously identified their approaches with the term “antiracist”, all practitioners engage in some form of practice that rejects racial bias and supports racial equity. Several identify the racist and colonial origins of mental health disciplines, question the operation of whiteness in EBPs, attend to power dynamics, and refer to a reflective process regarding their own biases. Simone identifies bringing antiracism into work with White clients who witness or participate in incidents of racism. She spoke about using therapy to work through “guilt” or a “culture of avoiding things” in order to

support White clients in using their privilege to challenge racism within themselves and their social environment. Each of these approaches aligns with antiracism work as they seek to understand and confront racial inequities on a variety of levels (Pierson et al., 2022).

Critical Trauma-Informed Approach

The need for a critical trauma-informed approach that includes racial and colonial trauma is discussed by four of the five participants. Participants identify traumas linked to race that are associated with migration, family dynamics, value mismatch, and societal stigma. Simone refers to the importance of a racial trauma-informed approach to exploring emotions, noting that "if you're in a Black body and you express anger, you get into trouble, like, it's not safe or not understood", and how societal perceptions may create or exacerbate trauma. Participants note that experiences of racism and colonialism may constitute traumas in and of themselves, or compound into trauma over time.

Addae discusses the role of generational trauma in mental health, saying that fear is passed through "epigenetics" from "generation to generation", noting, "if all those fears of water, fears of going into the forest, or, what you may call as walking through the trails… is passed down through the genes and through the womb and, and it's now become that I'm now petrified." He stresses the need for therapists to be attentive to generational trauma in the way that a doctor would attend to a family history of physical illness. Addae also discusses racial trauma in the context of mindfulness, saying that mindfulness can pose a risk to racialized youth who are not ready to stop and reflect. As he says:

> One of the things that I think is endemic in racialized communities is the ability to get to the next thing, kind of push down the emotion, the feelings part and move on and keep it moving because you can't stop you. You feel it when you stop. And it's hard for them to feel it, and so they keep moving. So, working with that to keep it moving, where are the points that we can stop and feel? (Addae)

Strength-Based and Agency-Building Approaches

Participants universally refer to identifying clients' inherent strengths and skills, and using them to promote control and empowerment. Participants discuss how skills that racialized clients may develop in response to adversity can be reframed as adaptive strengths, rather than pathologized. Addae reports that framing is essential to understanding client strengths and resources and notes that "using [client] strengths and their resilience factors to adjoin with some of the pieces of the DBT" enhances the therapy's value to clients. Jothika and Simone both discuss the need to identify client competencies and use DBT skills that build on existing strengths. These approaches promote an antiracist framework which refuses to pathologize the adaptive skills of racialized youth developed in response to a racist world.

Chapter 5: "It's Not Always Named," But Always Present

Towards an Antiracist DBT Framework

Enhanced understandings brought forward by research participants and existing literature culminate in an emerging framework for a critical antiracist approach to DBT with racialized youth. The data reveals three pivotal themes: the pressing need to critically examine and adapt the standard principles of DBT and their Eurowestern origins to maximize accessibility and applicability, while minimizing colonial and racist generalizations and harms; the foundational significance of a relational therapeutic context which emphasizes curiosity, validation, and cultural humility; and the necessity of reimagining DBT through critical and justice-oriented lenses, incorporating historical consciousness, antiracist principals, and approaches which are critically trauma informed and centred on client strengths.

These themes find alignment with the approach described in Stella's Place BIPOC DBT program, which transcends essentializing cultural adaptation and strives toward an antiracist reclamation of DBT. This program actively seeks to restructure power within the therapeutic space, both as a function of race and as a function of the client-therapist relationship (Stella's Place, n.d.-a). This collaborative model of teaching and learning, with responsive materials and service delivery, promotes client agency, and works to address the impacts of racial trauma on racialize youth and young adults. Additionally, the co-design process rejects universalizing the experiences of racialized youth, instead approaching with curiosity and openness to the self-determined needs of the population. Reported rates of higher retention within the BIPOC DBT group at Stella's Place may offer preliminary evidence of the efficacy of this approach for racialized youth, although further research is needed (Stella's Place).

Critical insights from the literature intersect with the enhanced understandings of this research to advance a framework for antiracist DBT. Knowledge from CRT and CRP underscore the inherent limitations of therapeutic interventions that focus on cultural adaptation. CRT understands racism as not merely an individual prejudice but a deeply embedded feature of society, which pushes for a move away from simple adaptations to fit cultural norms and toward actively dismantling ways in which racism may be embedded in the therapy and its delivery. CRP offers specific psychological principals that inform an antiracists DBT framework, highlighting the systemic nature of racism and the need for counter-narratives as tools for creating a racially just psychology (Salter & Adams, 2013).

The CRP concept that whiteness is profitable, making it difficult for White people to acknowledge and divest from privilege, underscores the importance of an antiracist approach that recruits White therapists. Pierson et al., (2022) posit that an antiracist approach to DBT must confront the unrepresented dialectic of a fundamentally racist society and mental health care system. While the study presented in this paper does not directly target a particular racial demographic of practitioners, Pierson et al.'s proposed framework for White DBT therapists argues that an antiracist approach necessitates active confrontation of racial inequities and power beyond surface level adaptations. This understanding aligns with the theme of reclaiming DBT through critical and justice-oriented lenses, rather than adapting the therapy through a superficial or essentializing cultural lens.

Postcolonial psychiatry offers a critical historical lens that seeks to reveal the dominating origins and continuities of Eurowestern mental health disciplines. This framework allows for an interrogation of the impact of colonialism on therapeutic approaches and ways in which mental health interventions can function as agents of oppression. As Fanon said, the "cure" for the

oppressed patient is not to be freed, but to be brought into compliance with subjugation (Menozzi, 2014). Therefore, a justice-oriented DBT framework must prioritize client agency and liberation. This necessitates a shift from understanding distress as a wholly individual experience to seeing distress as a response to structural determinants of mental health inequities, which stem from colonial and racial systems of power. Attention to history and power is reflected in the enhanced understandings brought forth by critical service providers in this research.

An antiracist approach to DBT for racialized youth requires more than simple adaptation; it demands a foundational shift informed by critical theories and stakeholder voices. CRT and CRP provide an underlying understanding of racism and the social construction of race, which rejects the idea of a racially neutral therapy. Postcolonial psychiatry highlights the role of mental health disciplines in controlling colonized and racialized peoples, emphasizing the need for liberatory approaches. These theoretical frameworks necessitate a critical examination of the Eurowestern origins of DBT and a shift to acknowledging the impact of systemic power and racial trauma. Existing programs, such as Stella's Place BIPOC DBT Program, demonstrate a move toward an antiracist reclamation of the therapy through seeking to address racial trauma and restructure power. An antiracist framework for DBT must explicitly engage with race, power, and oppression to move toward a transformative and justice-oriented approach for racialized youth.

Limitations & Future Directions

While this research has gleaned insights from critical DBT practitioners and existing literature, it is not without limitations. The constraints of time and resources available for a practice-based research paper completed at this educational level necessarily limits the scope and depth of this study. Ideally, a significantly larger sample size would have been recruited to

increase the depth of data and support generalizable results. Additionally, while the voices of a small sample of clinicians were captured in this study, the unrepresented voices of racialized youth were not included. This was due to ethical considerations of the risk of harm to racialized youth who are multiply marginalized, and concerns that the results of a study at this level would not yield benefits that justified potential risks to racialized youth participants. Future research must prioritize capturing the lived experiences and perspectives of racialized young people to ensure a truly responsive and relevant therapeutic approach.

Another essential limitation of this study is the categorization of the target population under the broad term "racialized youth." While this term identifies a shared experience of systemic power related to race and age, it risks overlooking the significant variation between and within these communities and the unique intersectional experiences of individuals. This term is therefore at risk of ethnic or cultural glossing that blends and universalizes experiences within groups, such as "racialized youth." While this study remained broad and exploratory due to the scarcity of existing literature, future research may benefit from increased specificity about the target population.

A critical consideration persists beyond this research about the fundamental compatibility of DBT with the goals of antiracist practice, despite the application of CRT, CRP, and postcolonial psychiatry. It must be noted that the inherent focus on individual self-regulation within DBT may fall short of addressing systemic and structural power, despite this study's efforts to reimagine the practice. Additionally, while the relational foundation of cultural humility emerged as a key theme, the potential limitations of this lens cannot be overlooked. Cultural humility has been proposed as a critical alternative to the problematized model of cultural competency, yet it is not without risk of reinscribing culturization and essentialism (Pon,

2009). Without a deep engagement with the political and economic role of culture within Canadian multi-cultural society, cultural humility can also reinforce "otherness", serve to freeze communities in time, and obscure the impact of systemic power. In line with this critique of cultural humility, future research could be greatly enriched by a racial capitalism lens as racial dominance is a means to the dominance of capital.

This research centred on antiracist DBT with racialized youth, yet a theme emerged from the literature and collected data about recruiting White practitioners and clients into antiracist practice. Future opportunities include building on the work of Pierson et al. (2021), who propose antiracist adaptations to DBT specifically for White therapists. Studies could explore the practical application and effectiveness of these proposed changes and further investigate how White therapists can develop racial self-awareness, knowledge, and skills to dismantle beliefs and behaviours that perpetuate racism. As suggested by a participant in this study, antiracist DBT is not solely for racialized clients. Future research could examine an antiracist approach with White clients that seeks to address their role in perpetuating or dismantling systemic racism, which may promote interest convergence and an understanding of White privilege. Exploration into how to bring antiracism principles into work with White clients who witness or participate in racism may also be an avenue for critical research toward a comprehensive integration of antiracism with DBT.

While this study offers valuable insights into the perspectives of critical practitioners building on existing literature, its limitations including time and resource constraints, small sample size, lack of youth voices, and broad categorization, necessitate further investigation. The fundamental questions of DBT's commensurability with antiracist and liberatory goals, alongside limitations of a cultural humility lens, remain critical considerations. Future research

would benefit from larger and more diverse samples, actively centering the experiences of racialized youth, and exploring new avenues for liberatory and justice-oriented mental health care. This research has sought to bring into focus that which is "not always named," but is always present; the unrepresented dialectic of a fundamentally racist society and its impact on racialized youth navigating DBT, a reality that demands continued critical engagement and action in the mental health disciplines.

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Appendix A

Recruitment Email Template

Study Name: "It's Not Always Named": Critical Perspectives on Antiracist Dialectical Behaviour Therapy with Racialized Youth

Researcher:

Julien Basque
Master of Social Work Student
York University
jbasque@yorku.ca

Hello,

I am writing because I understand that you are a mental health care practitioner who uses Dialectical Behaviour Therapy (DBT) in your practice. I am conducting research as part of my MSW degree through York University. This research will explore how critical practitioners attend to race in practice and imagine possibilities for an antiracist DBT framework with young, racialized clients. Interviews will be conducted with DBT practitioners to explore DBT practices, how practitioners integrate race into DBT, and thoughts on potential antiracist DBT framework

To be eligible for this study, you must be currently practising DBT (in whole or in part) in some professional capacity AND practising with a population that includes racialized youth between the ages of 11 to 24. Interviews will be scheduled during the months of January and February 2025, and may take place virtually or in-person. Interviews will take approximately 30 to 60 minutes, and participants will receive a 15-dollar gift card for their contribution.

Should you choose to participate, your identity, and any names of workplaces or educational institutions will be kept confidential. No identifying information will be included in research findings, and all efforts will be made to protect your privacy and confidentiality

If you are interested in sharing your experience and insights, and meet the criteria above, please email me at jbasque@yorku.ca. You will have the opportunity to ask any questions you have about the research and review an informed consent form that contains further details.

Please share this email with anyone you feel may be interested in participating. Thank you for your time and consideration,

Julien Basque (she/her)
jbasque@yorku.ca
Master of Social Work Student
School of Social Work, Faculty of Graduate Studies
York University

This study is being conducted under the supervision of Dr. Soma Chatterjee and has received ethics clearance through York University’s Research Ethics Board.

Appendix B

Informed Consent Form

Date: December 4, 2024

Study Name: "It's Not Always Named": Critical Perspectives on Antiracist Dialectical Behaviour Therapy with Racialized Youth

Researcher:

Julien Basque (she/her)
jbasque@yorku.ca
Master of Social Work Student
School of Social Work, Faculty of Graduate Studies
York University Supervised by Dr. Soma Chatterjee

Purpose of the Research:

This research will explore how critical practitioners attend to race in practice and imagine possibilities for an antiracist DBT framework with young, racialized clients. The primary goal of this study is to identify how DBT can be reimagined to better serve racialized youth by addressing race and power within the therapy. The objectives include exploring DBT practices among critical practitioners, understanding the ways practitioners integrate race into DBT, and developing recommendations for a potential antiracist DBT framework in conversation with existing literature.

What You Will Be Asked to Do in the Research:

You will be asked to partake in semi-structured in-depth interviews administered by the principal investigator. Audio recorded interviews will take place virtually (via Zoom) or in-person at your preference during the months of January and February 2025. Interviews will be a one-time commitment and will take approximately 30 to 60 minutes depending on your availability. During the interview, personal information collected from you will include racial, cultural, or ethnic self-identity, and general professional, academic, and educational background (without specific institution names). Interview questions will explore DBT practices among critical practitioners, how you may integrate race into DBT, and your thoughts on potential antiracist DBT framework. Immediately following the interview, you will receive an incentive in the form of a gift card with a value of $15. You can anticipate a time commitment of 45 to 75 minutes throughout the entire process.

Risks and Discomforts:

This research is identified as minimal risk and therefore may carry some risk of harm to you. Interview questions include critical discussions of race and racialization and reflection on your professional practice, which may prompt complex emotions. To minimize psychological or emotional risks, the researcher will provide complete information about the research process as well as potential risks and benefits. The researcher will strive to create a nonjudgemental and open interview environment and provide you with additional supports as needed

Teleconferencing/videoconferencing technology has some privacy and security risks. It is possible that information could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can't be completely eliminated. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps in person or via telephone. Please contact Julien Basque at jbasque@yorku.ca for further information.

Benefits of the Research and Benefits to You:

Potential benefits to you include contribution to the critical mental health and DBT knowledge body by sharing your practice experience, insights, and hopes. The interview process may present an opportunity for reflection and critical thinking about your practice. You may benefit from engaging with the findings of the study if you hope to imagine possibilities for an antiracist DBT framework. Additionally, this work may promote further study about the DBT's applicability and effectiveness for racialized clients.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the any relationship you may have with the researcher or the nature of your relationship with York University either now, or in the future. If you stop participating, you will still be eligible to receive the $15 gift card for agreeing to be in the project, even if you withdraw prior to completion of the research. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete.

Confidentiality:

Unless you choose otherwise all information you supply during the research will be held in confidence, and your name will not appear in any report or publication of the research. The researcher will keep a link that identifies you to your coded information, but this link will be kept secure and available only to the principal investigator the research supervisor. Any information that can identify you will remain confidential.

Your Interview will be audio recorded for the purpose of transcribing the data for analysis. Audio recordings and transcriptions will be securely stored and encrypted in password-protected folders on a laptop computer only accessible to the researcher. Any hard copy data will be safely stored in a locked filing cabinet placed in a locked room, and only researcher and research supervisor will have access to this information. All data will be destroyed on or before December 31, 2025. Hard copy data will be destroyed by shredding in a cross-cut shredder and shredded materials will be disposed of. All electronic data will be destroyed by permanent deletion. Confidentiality will be provided to the fullest extent possible by law.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

***Limits of Confidentiality**:* Participants and researcher are engaged in mental health practice with youth who may be minors. As a result, confidentiality will not override duty to report if you disclose that a minor youth is in need of protection or at risk of harm. This limitation could include statements that a minor is being abused or neglected and that you have not reported to relevant

authorities. In this case, the researcher would report their findings (on this particular matter only) to the Children's Aid Society of Toronto per duty to report.

Additional consent

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

2. **Consent to use of quotes**

☐ I consent to the use of anonymized quotations in any final reports/publications of the research

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact researcher Julien Basque by email at jbasque@yorku.ca or research supervisor Dr. Soma Chatterjee either by telephone at (416) 736-2100, extension 33385 or by e-mail (schat@yorku.ca).

This research has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Manager, Research Ethics in the Office of Research Ethics, York University (e-mail ore@yorku.ca). This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

Legal Rights and Signatures:

I_____consent to participate in Beyond Self-Regulation: Imagining a Critical Antiracist Approach to Dialectical Behaviour Therapy conducted by Julien Basque. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Principal Investigator

Appendix C

Interview Guide

Study Name: "It's Not Always Named": Critical Perspectives on Antiracist Dialectical Behaviour Therapy with Racialized Youth

Researcher:

Julien Basque
Master of Social Work Student
York University
jbasque@yorku.ca

1. Introduction and Consent

a. Thank you for your participation in this study. Before we begin, I would like to remind you that your participation is voluntary, and you are welcome to decline questions or choose to end the interview at any time. This choice will not impact our working relationship (if one exists) in any way, and you will still receive your gift card incentive. This interview will be recorded for future transcription and analysis. Do you have any questions about the consent form before we begin?

b. Do you have any questions you would like to ask about the research or interview process?

2. Background Information

a. Can you briefly describe your professional and educational background? (You may exclude institution names to preserve your privacy and/or institution names will be removed during transcription.)
b. Can you describe your experience with Dialectical Behaviour Therapy (DBT)?
c. Can you tell me a bit about the clients that you might use DBT with?
    - Prompt for race and ethnicity and demographic info; presenting concerns also interesting
d. Can you tell me about your racial, ethnic, and/or cultural background? (Demographic information may be generalized to protect your privacy)

3. DBT Practice, Race, and Power

a. How do you use DBT in your practice with racialized youth?

b. When you're using DBT, what are your main goals for clients? (social change, self-regulation, normativity, goal mismatch) What are your hopes for them when using this modality?

i. Have you encountered situations where the principles of DBT conflict with the cultural or social realities of your racialized clients? I.e. the internal focus missing the scope of external/environmental/social issues.

ii. Have you observed differences in how it is received by clients with different racial or cultural backgrounds?

iii. Have you made any changes to the way you use DBT based on racial identity? If so, what prompted them, and were they impactful?

iv. Are there aspects of DBT that you think work really well for certain populations or maybe not so well for others?

c. (OPTIONAL) The mental health disciplines have a long history fraught with racism and colonialism, and there's always a risk of inheriting these traits from previous practices. We all have our reflective process for dealing with this. Is this legacy something that you factor into your work, particularly with racialized youth?

i. If so, how?

ii. Prompt for reflections on DBT, EBP's, etc.

3. Conclusion

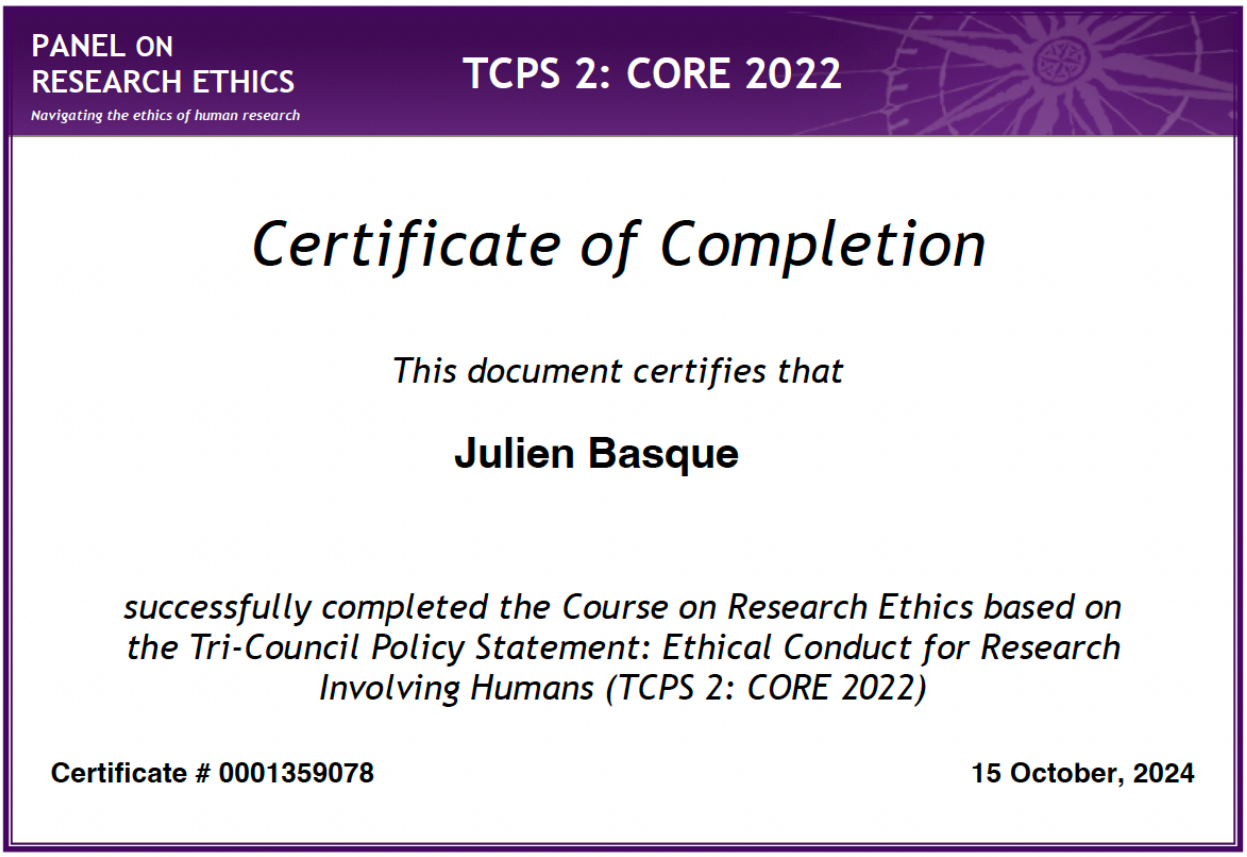
a. Is there anything else you would like to share that we have not discussed in this interview?

b. Do you have any final questions for me about this research?

Thank you for your time and invaluable contribution to this research.

Appendix D

Research Ethics Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

Julien Basque

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0001359078 **15 October, 2024**