



“You Didn't Cause Racism, and You Have to Solve it Anyways”: Antiracist Adaptations to Dialectical Behavior Therapy for White Therapists

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There are currently no published studies that investigate or discuss the cultural responsiveness of Dialectical Behavior Therapy (DBT) to the needs of Black/African-American clients. In addition, no published scholarly works offer guidance to therapists on how to practice antiracism within the context of delivering evidence-based treatment. Methods for developing a culturally responsive antiracist treatment are discussed within a dialectical framework and from the perspective of critical race psychology. We propose that an antiracist adaptation to DBT is needed to correct for context minimization errors in the DBT model that create an invisibility of racism. Recommendations are made for an additional DBT Therapist Agreement that encourages labeling and targeting therapist treatment-interfering racist behavior. An additional Therapist Consultation Agreement is also proposed to guide therapist antiracist advocacy and functional validation for Black/African-American clients. The DBT technology is used in conjunction with other multicultural theoretical models to recommend strategies for developing White DBT therapists' antiracist competencies. Future directions for developing critical race psychological research are discussed.

ANGELA DAVIS has said that “in a racist society, it is not enough to be non-racist, we must be anti-racist.” Her statement identifies the problem as a racist society, and the need for ideological and behavioral change in response to this problem. When using problem-solving skills as they are taught in Dialectical Behavior Therapy (DBT), the first task is to accurately define the current problem situation. This task is critical to ensure that the solution generated will effectively address the true nature of the problem at hand. Examining the current problem situation that is racism is a complicated task, to be sure. We turn to the theory, principles, and tools within DBT to guide our efforts towards progressive change for greater racial equity for Black/African-American clients in therapy. We first present a dialectical framework for understanding both the current problem and proposed solutions that follow. In addition, we introduce the major tenets of a

Critical Race Psychology (CRP), developed by [Salter and Adams \(2013\)](#), as a framework for analyzing psychological theories and practices from the perspective of Critical Race Theory (CRT). Using CRP as a lens for analysis of DBT, we offer recommendations for adapting the treatment to develop antiracism in White DBT clinicians.

The term “dialectic” refers to a fundamental worldview that is used as the organizing theoretical framework for the DBT treatment model ([Linehan, 1993](#)). As Linehan described in her original text, a dialectical worldview has three primary characteristics: the principle of interrelatedness and wholeness (i.e., every system consists of parts, one of which cannot exist without the other), the principle of polarity (i.e., within every system, there is constant tension between two opposing forces, a thesis and an antithesis; e.g., good and bad, person and environment), and the principle of continuous change (i.e., opposing parts synthesize creating new wholes that are also comprised of polarized parts, which also synthesize in a constant process of ongoing change).

At the core of DBT is the dialectic of acceptance and change. For example, on the one hand, a DBT thera-

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pist communicates acceptance of a suicidal client by acknowledging how it is understandable that the client views suicide as an escape from misery, while at the same time insisting that the client must change their behavior and commit to staying alive. The DBT therapist accepts that the client is doing their absolute best at all times, and insists that change is still needed for the client to positively transform their life. Taking a dialectical stance in DBT means that multiple valid perspectives may exist simultaneously. Whenever the DBT client or therapist locks into a narrow point of view about an issue at hand, the dialectical stance reminds us to consider: what is being left out?

A Dialectical View on Fighting Racism With DBT

The authors believe that there is currently just one side of a dialectic represented by existing literature on the cultural responsiveness of DBT for racially marginalized clients, which is a focus on helping clients cope with the harmful effects of racism. There are six published peer-reviewed studies to date that investigate the efficacy of modifying or adapting DBT to improve outcomes for specific racial, ethnic, and cultural groups, including cultural adaptations of DBT for Chinese international students (Cheng & Merrick, 2017), Navajo adolescent females (Kohrt, Lincoln, & Brambila, 2017), Spanish-speaking Latine adults (Mercado & Hinojosa, 2017), Nepali women (Ramaiya et al., 2017, 2018), and Native American/Alaskan Native youth (Beckstead et al., 2015). This slim literature on the cultural responsiveness of DBT mainly consists of uncontrolled trials and case studies. A preliminary review at the time of writing indicated that there are no studies focused on treatment outcomes for Black/African-American DBT clients and no published peer-reviewed studies exploring modifications of DBT for Black/African-American clients. Enhancing the cultural responsiveness of an evidence-based treatment can also be achieved in part by investigating methods for increasing access to and engagement in DBT within Black/African-American communities; however, no such studies were identified at the time of writing. This represents a stark, problematic void in the existing literature on DBT outcomes and highlights insufficient efforts to evaluate the cultural responsiveness of DBT to the needs of Black/African-American clients.

While this paucity of research represents a significant problem for future studies to address, there is another critical area concerning the intersection of race and therapy that remains entirely unexplored in peer-reviewed published DBT research and scholarly works: the presence of racism in the practice of DBT.

In the past year, the president of the American Psychological Association (APA) recently defined racism as a pandemic (APA, 2020), and both the American Medical Association (AMA) and the Centers for Disease Control (CDC) have declared racism a serious public health threat. The AMA further acknowledged race as a social construct, rather than a biological or genetic determinant, effectively silencing the debate of racial essentialism (AMA, 2020). The recent highly publicized serial police killings of Black/African-Americans such as George Floyd and Breonna Taylor heightened public awareness that such definitions are needed to convey both the magnitude and weight of harm caused by racism, as well as the collective social responsibility for the lethal consequences of anti-Black racism in America.

The myriad of harmful effects caused by anti-Black racism cannot be overstated—it includes disparities in physical health and mortality (e.g., the death rate for Blacks/African Americans is generally higher than Whites for heart diseases, stroke, cancer, asthma, influenza, pneumonia, diabetes, HIV/AIDS, and homicide; Kochanek et al., 2020; see also: Cobbinah & Lewis, 2018; Feagin & Bennefield, 2014; Paradies et al., 2015), psychological well-being (for systematic reviews, see David et al., 2019, and Kirkinis et al., 2018), education (e.g., Carter & Welner, 2013; Ladson-Billings, 2006; Lopez, & Jean-Marie, 2021; Milner, 2012), economic opportunity (e.g., the 2019 U.S. Census Bureau reported that 21.2 percent of non-Hispanic Blacks in comparison to 9.0 percent of non-Hispanic Whites were living at the poverty level; Kochanek et al., 2020), and rights of equality, essentially disadvantaging Blacks/African-Americans across every sector of life and society (e.g. Blackmon, 2009; Brondolo et al., 2009; Ruef & Fletcher, 2003). Racism devalues, demeans, and oppresses Black Americans by treating them as lesser than White racial counterparts, often lesser than any racial counterpart, and denying equal access and opportunity for health, safety, happiness and prosperity. The history of racial oppression, exploitation, and inhumane treatment of Black individuals from African descent dates back to at least as early as the 15th century when the trans-Atlantic slave trade first established a racialized system of slavery (Elliott & Hughes, 2019). It has been well-documented by empirical literature across multiple disciplines that Black/African-American individuals have suffered long after the Emancipation Proclamation due to the combined effects of intergenerational trauma and systemic, institutionalized racism (for a primer on the history of racism in America, we recommend consulting: Alexander, 2010; Kendi, 2017; Rothstein, 2018; Tatum, 2017). Needless to say, it is

beyond the scope of this paper to detail the widely discussed, well-established empirical literature that describes the constellation of deeply harmful effects caused by anti-Black racism. Despite centuries of transcontinental Black oppression and decades of mounting scientific knowledge about the lethality of racism, this topic has scarcely been touched within the DBT academic research community.

The APA's acknowledgment that we are living in a racism pandemic begs the question of what is being done to address this within the psychological research and clinical community. It appears that antiracist efforts can be found in a slim body of literature advising clinicians and medical practitioners on how to handle racism in their patients (e.g., [Drustrup, 2020](#); [Kueakomoldej, 2018](#); [Singh et al., 2015](#); [Paul-Emile et al., 2016](#)), and in the growing literature that investigates culturally adapted cognitive behavioral therapy (CA-CBT) for specific racially marginalized groups (e.g., see [Bennett & Babbage, 2014](#), for CA-CBT with Aboriginal Australians; see [Hernandez et al., 2020](#), for systematic review of CA-CBT with Latine patients; see [Ennis et al., 2020](#), for systematic review of CA-CBT for trauma; see [Hodges & Oei, 2007](#), for CA-CBT for Chinese patients; see [Naeem et al., 2010](#) for CA-CBT with South Asian Muslim patients). However, the principles of antiracism instruct us to examine White Supremacist institutions with an inward scrutinizing gaze that locates the problem within stakeholders of power, rather than adopting a deficits-based perspective that pathologizes the needs of racially marginalized communities. This would require an examination of how clinical psychology research methodologies and therapeutic practices must change to eradicate racial inequity, and this analysis does not yet exist in the scholarly literature discussing the theory, practice, and efficacy of DBT.

Returning to the notion of dialectics, it can be said that mitigating the harmful effects of racism through psychotherapy represents an acceptance pole within a dialectic of acceptance and change. Acceptance as a DBT concept means to acknowledge reality just as it is, without judgment, approval/disapproval, and without validating what is invalid. Acceptance of racism (i.e., acknowledgment of this reality) within the DBT research community represents a necessary precursor to dismantling the systems and policies that maintain racism; a person cannot change a problem that they are not seeing clearly or refusing to accept in the first place. At the same time, helping racially marginalized clients to better cope with racism does not change the racist attitudes or behaviors that harm them, while it communicates an implied acknowledgment that racist behaviors exist "out there," beyond the walls of the ther-

apist's office. Focusing scientific investigation, academic discussion, and clinical intervention around helping clients to better cope with the harmful effects of racism, without demonstrating similar efforts to understand and change racist ideas and behaviors within our own academic, research, and clinical DBT community, silently invalidates racially marginalized therapists and clients by way of omission (see [Franklin & Franklin, 2000](#), for a discussion of the psychological invisibility of the Black/African-American experience). The question then becomes, what is being left out?

We believe that there is another change-focused side to the dialectic that has not yet been addressed by scholarly research in the DBT community: using tools from DBT to dismantle racism by changing the attitudes, beliefs, and behaviors that sustain and perpetuate racism. This is the task of creating an antiracist adaptation of the DBT model. The term antiracist refers to ideas and actions that reduce racial inequity and reflect the understanding that "racial groups are equals and none needs developing" ([Kendi, 2019, p. 24](#)). An antiracist therapy must not only seek to reduce racial inequities through improving access to treatment, community engagement, and matching therapeutic tools to the needs of the client. An antiracist therapy must also meet the needs of the client by reducing racist behavior and increasing antiracist competencies in the practice of the therapy itself.

The dialectic at hand then follows: DBT therapists must respond to the needs of racially marginalized clients who experience harmful effects from racism, and at the same time White DBT therapists must actively work towards increasing their antiracist competencies and reduce their own racist behaviors that interfere with the effective treatment of racially marginalized clients. We assert that the challenge of dismantling racism within the realm of evidence-based treatment is an undertaking most appropriately assigned to White therapists delivering EBTs. This behavioral change is primarily required by White therapists due to the overwhelming evidence that White individuals hold a disproportionate amount of power and influence in the systems and institutions that sustain racism in comparison to any other racial group. Therefore, we call on White DBT therapists to take on the onus of problem solving to find ways of implementing our proposed antiracist adaptations to the DBT model.

We synthesize the tension between thesis (accepting that racism exists) and antithesis (changing racist behaviors) by proposing modifications to DBT for treating clients who cope with the harmful effects of racism, as well as adaptations of DBT that promote antiracist therapeutic practice. The present discussion focuses mainly on antiracist adaptations to DBT for

White therapists, including new guiding principles and practices in DBT as well as DBT-informed strategies for increasing therapists' antiracist competencies. Within these recommendations, there are also modifications proposed to improve the cultural responsiveness of DBT to the treatment needs of Black and African-American clients. Future papers will elaborate on specific modifications to DBT coping skills and stylistic elements of DBT. We close with a discussion of suggested applications for the ideas presented here, including future directions in research that incorporate critical race methodologies to investigate the efficacy of DBT for Black and African-American clients and further develop modifications to the treatment that are informed by clients' narratives.

Throughout this discussion, we focus on increasing the cultural responsiveness of DBT and its clinicians to the needs of Black/African-American clients and reducing anti-Black racism in the practice of DBT. We use the term African-American to refer to individuals whose ancestral origin includes descendants brought to the United States as slaves. We use the term Black in conjunction with African-American to reflect the understanding that anti-Black racism also impacts individuals whose ancestry does not include American slavery. We offer this rationale for defining the terms of our discussion in order to clarify how the ideas presented here will fit into a broader discourse about race in the scientific study of psychological treatment (Agyemang, Bhopal, & Bruijnzeels, 2005).

We focus this paper on the development of an antiracist adaptation to DBT specifically for White therapists attempting to meet the needs of Black/African-American clients for two reasons. One being that the authors believe it is most effective to think critically about the harmful effects of racism for particular groups rather than generalizing across the experiences of all racially oppressed people. While there are commonalities to racism as it is experienced across different groups of racially marginalized people, there are specific racist ideas, beliefs, and behaviors that are most often enacted by White people against Black/African-American people, just as there are different and specific racist ideas, beliefs, and behaviors most often enacted by White individuals against other racially marginalized people. We recognize that the label "Black/African-American" is also wrought with problems from lacking descriptive specificity, as the term does not represent a monolithic group but rather a collective comprised of intersectional identities. We recommend that future papers explore further development of antiracism in DBT by providing specific discussion and recommendations germane to additional cross-racial therapist/client dyads.

A second reason for focusing on an antiracist DBT practiced by White therapists treating Black/African-American clients relates to the authors' own racial identities. The first author is a Non-Hispanic White cis-gendered American woman; the second author is a South Asian cis-gendered woman; and the third author is a Black/African-American cis-gendered woman. As a multiracial authorship team, we developed this proposal by drawing from personal experiences of recognizing racism in ourselves and directly experiencing its harmful effects through interactions with colleagues, supervisors, clients, and institutions. Throughout this discussion, we use self-involving self-disclosure about experiences of racism in order to model the suggestions put forth by this paper. Our recommendations for antiracism competency development were developed through our consultative discussion with one another over the course of training and supervision in DBT. We believed we were most capable of developing an antiracist adaptation of DBT for White therapists working with Black/African-American clients based on our own racial and cultural identities and the decision to use personal lived experiences of being subjected to racism and committing racist behaviors as a primary vehicle for this discussion. In line with our goal of modeling, we consulted and agreed with consensus that the authorship positions should reflect our shared belief that the onus must be placed most heavily on White individuals in the field of psychology to carry out antiracist work. Rather than disempowering racially oppressed people, we take this stance in effort to flip the script that has required marginalized individuals to explicitly produce work that forces others to question the stereotypes and damaging treatment by a White-dominant society.

DBT as a Critical Race Psychology

CRT provides a highly relevant lens for evaluating which specific changes are needed in the DBT model in order to adapt it for antiracism in therapeutic practice and psychological science. Broadly speaking, CRT posits that racism is real while race is not: specifically, there is no biological or scientific basis for the racial categorization of people (AMA, 2020), but rather the social construct of race exists as a highly effective, functional means by which White-dominant institutions manipulate power through the exploitation of non-White individuals (for an authoritative text on CRT, see Delgado & Stefanic, 2001). Originating from the Civil Rights and antiracist student movements of the 1960s and 1970s, CRT argues that we can harness the power of socially constructed beliefs about race in order to wield real change in how society operates and work towards a dismantling of White Supremacy

(Vox, 2020). Applications of psychological science in CRT can easily be found (e.g., many psychology sub-disciplines document phenomena such as racial discrimination and implicit bias), yet few scholars have articulated a CRT application to psychology. Salter and Adams (2013) provide the seminal work establishing a Critical Race Psychology (CRP), built upon a synergistic foundation of related studies in multicultural counseling, Black psychology, Indigenous psychologies, whiteness studies, Liberation Psychology, Cultural Psychology, and critical psychologies of racism. CRP highlights the central role of race and racism in the contemporary study and practice of human psychology (Salter & Adams, 2013, p. 784). The authors provide five basic tenets of a CRP analysis, which we adopt as a lens for the development of an antiracist adaptation of the DBT model.

The five tenets of a CRP analysis include the following: (1) *racism is systemic*, i.e., racism is common and ordinary, permeating the structure and fabric of society, rather than existing within the hearts and minds of biased individual actors; (2) *neoliberal individualism white-washes race and launders inequality*, i.e., prominent ideologies and practices in psychological science locate action and experience in isolated individuals who are abstracted from social context; such practices have the effect of minimizing issues of identity as problems of “otherness” through comparison to White standards; (3) *racial equality necessitates interest convergence*, i.e., dismantling racism requires White people to “disinvest in constructions of reality that afford them privilege” and effectively motivating such action requires aligning antiracism with personal best interest on some level; (4) *White identity is a profitable, possessive investment*, i.e., identity-defensive motivations make it difficult for White people to perceive their relatively privileged position as an illegitimate and objectionable product of ongoing racial oppression; (5) *counter-narratives are instrumental tools for a psychology of racial justice*, i.e., storytelling by racially oppressed people can effectively dismantle the “standard” constructions of reality that confer White privilege by revealing ways in which racism is infused in everyday worlds (Salter & Adams, 2013, pp. 785-789).

These five tenets of a CRP analysis provide a guiding framework for an antiracist adaptation of DBT. We recognize that the ideas set forth in these five tenets of a CRP analysis may represent radically new concepts for some that prompt judgments and defensive reactions. For those readers, we recommend turning first towards the broader literature that discusses CRT, as well as additional recommended texts to facilitate self-education about race and antiracism before proceeding with the remainder of our discussion (see

University of Denver, 2020, for one helpful multimedia library guide, including suggested reading/media organized by stages in White racial identity development).

In the sections that follow, we outline our analysis of the DBT model through the lens of racial power, beginning with a definition of antiracism, proceeded by specific recommendations for antiracist adaptations to DBT. We offer recommendations for using the tools from DBT for the goal of shaping the White-dominant institutions of psychological science and clinical practice for the ultimate task of dismantling racism.

Antiracist Adaptations to DBT

American novelist Ibram Kendi (2019) explained that the term antiracism refers to human behavior rather than people, and human behavior is either racist if it allows racial inequities to persevere (through action, passivity, avoidance), or the behavior is antiracist if it actively confronts racial inequities and changes policies to reduce and prevent continued racial inequities. Kendi emphasized that there is no middle ground between racist behavior and antiracist behavior. This dichotomy may seem a contradiction to the dialectical worldview of DBT. However, we view this distinction between racist behavior and antiracist behavior as an example of a discriminating judgment, in that the definition helps us discern what meets a threshold of oppression versus anti-oppression.

As Linehan explains in her teaching of the nonjudgmental stance, a mindfulness skill in DBT, there are times when we must make discriminating judgments about what is and what is not meeting a benchmark (e.g., fruit is bad when it is spoiled, a student passes or fails an exam). This can be distinguished from evaluative judgments about good and bad or right and wrong, which are subjective and vague in their factual meaning (e.g., the fruit is gross, he is a bad student). It is therefore imperative that we label DBT therapist behaviors as racist or antiracist to communicate clearly about the function and consequences of specific behaviors. Only then can we identify solutions for reducing therapist’s racist behavior and work to increase antiracist behavior in our clinical practice of DBT. When behaviors are not clearly described, or identified at all, it prohibits behavioral change. It is clear to many that antiracist change is needed across a multitude of systems and institutions, including therapeutic practice.

Labeling therapist behavior as racist reflects an agreement that all DBT providers commit to upholding, which is the agreement that we are all fallible by design of human nature. The Fallibility Agreement reminds us (with irreverence) that “therapists are all

jerks” and “we have all probably done whatever problematic things we are accused of” (Linehan, 1993, p. 118). DBT therapists routinely acknowledge this fallibility by identifying our own treatment-interfering behaviors in discussion with peers and clients alike. Furthermore, DBT therapists routinely engage in consultative discussion with team members to better understand and modify our treatment-interfering behaviors so that we may become more effective clinicians. A nonjudgmental stance is practiced by team members during consultative discussions about any therapist’s treatment-interfering behavior. At the same time, team members are reminded to avoid fragilizing one another through avoiding such discussions, for example, out of fear or discomfort about how the therapist will cope with receiving constructive feedback.

An antiracist adaptation of DBT must include a more explicit agreement that therapists will commit to identifying their own racist ideas, beliefs, and behaviors and seek out consultation from team members to foster growth in this competency area. The fallibility agreement easily compliments the first tenet of a CRP analysis, which requires the admittance and nondefensive acceptance that racism is ubiquitous. To this end, we propose addendums to both the “Therapist Agreements” and “Therapist Consultation Agreements” in the DBT manual (Linehan, 1993). The Therapist Agreements are a set of six commitments that therapists make and communicate to their clients, so that clients are aware of the specific expectations they can hold for their DBT therapist. We propose adding a seventh therapist agreement, the Antiracist Therapist Agreement, which consists of the following:

Therapists must assess their competencies in antiracism prior to beginning treatment with clients or as soon as possible once they enter the therapeutic relationship. This is advised for work with clients of any identity and background, and is absolutely required as preparation for working with racially marginalized clients. This agreement is incumbent on White DBT therapists without exception, and is encouraged for all DBT therapists. Therapists will share their self-evaluation of competencies in antiracism with consultation team members, in order to facilitate effective team support for therapists’ growth in this competency area. Therapists will make every reasonable effort to increase their competencies in antiracism, including but not limited to: engaging in consultative discussion, openly receiving feedback from others about racist behavior, completing self-reflective exercises about race-related values, attitudes, and beliefs, increasing race-specific knowledge through educational activities, completing homework assigned by consultation team members in

order to foster growth in specific antiracist competencies, and making repairs to team members and/or clients when therapist racist behavior is identified.

The Antiracist Therapist Agreement reflects similar aspects from four of the existing Therapist Agreements in the DBT manual, including: the Every Reasonable Effort Agreement (i.e., therapists “will make every reasonable effort to conduct therapy as competently as possible,” Linehan, 1993, p. 115); the Ethics Agreement (i.e., therapists will “obey standard ethical guidelines and professional codes,” Linehan, 1993, p. 116); the Respect-for-Patient Agreement (i.e., “the therapist must be willing to respect the integrity and rights of the patient,” Linehan, 1993, p. 116); and the Consultation Agreement (i.e., “therapists agree to obtain therapy consultation when needed,” Linehan, 1993, p. 116). The Antiracist Therapist Agreement extends beyond what is communicated by the six existing therapist agreements by explicitly setting the expectation that DBT therapists make a commitment to increasing their competencies in antiracism.

An additional Therapist Consultation Agreement is needed to facilitate antiracist therapy practice in the DBT model. The Therapist Consultation Agreements are a set of six agreements that clarify how to follow DBT guidelines within the context of supervision or case consultation meetings. These agreements also provide guidance for how to stay within a DBT frame when working with clients. One of these six agreements is the Consultation to the Patient Agreement, which states that therapists do not serve as intermediaries for clients with other professionals. Instead, therapists must consult with their clients on how to interact with other therapists, so that the focus is on helping clients increase skillful means to effectively navigate their own relationships and environment (Linehan, 1993). For example, when a client complains that her skills group leader is chronically 5 minutes late to start the group therapy session, the DBT individual therapist encourages the client to use assertiveness skills to directly approach the group leader and request that the therapist change their behavior. The DBT individual therapist would not intervene with the client’s environment by approaching the skills group leader about this request on the client’s behalf, as it might reinforce the client’s passivity and ineffective problem solving.

Linehan acknowledges that there are times when conditions mandate environmental intervention, such as when the problem is an intransigent, high-power environment (Linehan, 1993). Racism is a chronic, pervasive invalidating environment that operates by an intransigent power differential, systematically disadvantaging Black or African American clients (e.g.,

Fruzzetti et al., 2020). Racism is perpetuated by racist policies that promote the idea that Black and African-American individuals can escape racial inequities by becoming more skillful problem solvers. The systems and institutions that maintain racism and result in racial inequities are so many, so varied that it behooves us to include a therapist consultation agreement that reflects our understanding of this reality. To this end, we propose the following Antiracist Consultation to the Environment Agreement:

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

The Antiracist Consultation to the Environment Agreement reflects elements of three existing Therapist Consultation Agreements in DBT: the Dialectical Agreement (therapists agree to accept a dialectical philosophy), Consistency Agreement (therapists do not have to tailor their response to be consistent with all members of the team), and Fallibility Agreement (therapists agree ahead of time we are each fallible). This new consultation agreement extends beyond the current six Therapist Consultation Agreements by reminding DBT therapists that it is necessary to engage in antiracist advocacy through environmental intervention in order to combat racial inequities for Black and African-American clients. Furthermore, the proposed Antiracist Consultation to the Environment Agreement reflects two of the major tenets of a CRP analysis, namely that racism is systemic and that an individual's experience must always be placed within their cultural context (i.e., neoliberal individualism launders inequality).

We recommend that these two new DBT agreements are integrated within all DBT trainings, especially foundational DBT trainings, as well as printed literature and websites that provide both sets of the DBT therapist and consultation agreements, in order to facilitate antiracism through their regular use in clinical practice of DBT. We further recommend that the Antiracist Consultation to the Environment Agreement be incorporated into the weekly practice of reading aloud a consultation agreement during DBT consult team meetings. Based on personal experiences from piloting

this at our own consult team meetings, we advise DBT team leaders to require reflection by White team members in particular when this agreement is read, in order to normalize the practice of openly identifying and discussing issues of race and racism in the team setting.

By adopting these new therapist agreements, we propose that there is a greater likelihood that DBT therapists will identify and consult with one another about therapist racist behaviors and utilize tools from DBT to increase antiracist competencies. To facilitate this endeavor, we provide a list with examples of therapist treatment-interfering racist behaviors in Table 1. These examples are adopted from Harrell's (2014) discussion of indicators that suggest attention is needed to address a therapist's deficits in race-related multicultural competence. Examples of deficits are derived from the work by Williams (2020) and Sue et al. (2007), who provide guidance on targeting microaggressions in clinical practice. We also draw from personal experiences to include autobiographical examples for some of these indicators and wherever possible throughout the present discussion.

We propose that antiracist clinical practice represents a multifaceted competency domain including four areas: (1) a therapist's race-specific awareness of their values, beliefs, and attitudes; (2) knowledge; (3) skills; and (4) advocacy (AKSA; Ratts et al., 2015; Sue, Arredondo, & McDavis, 1992). The AKSA framework was developed by the Multicultural and Social Justice Counseling Competencies, which revised the Multicultural Counseling Competencies created by Sue et al. (1992).

This framework was created to guide counselors in how to implement multicultural and social justice competencies into counseling theories, practices, and research (Ratts et al., 2015). In Table 1, indicators of antiracism deficits are categorized by these four aspirational competencies.

After identifying therapist treatment-interfering racist behaviors during consultative discussion with DBT team members, therapists must take steps to change racist beliefs, ideas, and behaviors. We propose that this process will be similar to addressing any other skill deficit in DBT, such as when clients or therapists demonstrate a lack of skillful means with mindfulness, interpersonal effectiveness, emotion regulation, or distress tolerance. DBT skills and additional activities are therefore suggested as strategies for fostering growth in specific antiracist AKSA competencies, as outlined in Table 2. These recommendations were informed by research findings from four studies (Berg & Simon, 2013; Chang et al., 2021; Malott et al., 2019; Naz et al., 2019) that offer guidance for White antiracist practices in clinical psychology. In addition, two

Table 1
Therapist Treatment-Interfering Racist Behaviors

Indicator	Description	Example
Awareness Deficit		
Gaps in self-awareness	Race and privilege are not acknowledged parts of identity, experience	"I don't really think of myself in terms of race."
Invisibility of race	Absence of race as a consideration	Excluding race in clinical assessments, reports
Minimizing, devaluing	Dismisses race-related content/process as irrelevant or unimportant	Excluding influences of race and racism in case conceptualizations
Naïve, idealizing	Expressions of color-blindness; romanticizing interracial interactions	"I don't see you as a person of color. I just see you as a regular person."
Knowledge Deficit		
Lack of knowledge	Limited knowledge of history of racism	Refers to racism and White Supremacy as a problem caused by extremist hate groups
Oversimplification, superficiality	Making broad generalizations about race without critical analysis	"Black people need to calm down."
Context minimization error	Attributing race-related issues to problems or pathology of groups	Taking a "one-size-fits-all" approach to treatment, conceptualization; pathologizing differences in behavior, communication that do not reflect White assimilation
Skills Deficit		
Guilt, shame, internalized racism	Self- or group-deprecating remarks and sentiments	White person displays emotional dysregulation during discussions of race
Interpersonal skills	Anxiety, lack of empathy, distancing, aggression	Fragilizing clients; shifting focus towards White reactions to racism; introduces tangential issues of discrimination
Reactivity	Strong negative emotional reaction to racial material	"I feel like you are attacking me."
Advocacy Deficit		
Unfamiliarity, inexperience	Limited life experience with racially marginalized people	"I've never really talked to anyone who is like this person."
Avoidance	Avoiding confrontation about other's racist behavior	Does not label other's or own behavior as racist

Note. Adapted from Harrell (2014).

basic tenets of a CRP analysis are reflected in these suggested strategies: the assumption that racial equality necessitates interest convergence, and that White identity is a profitable, possessive investment. Specifically, we propose that DBT clinicians will be more motivated to engage in antiracism if it is aligned with their competency development in the four DBT modules, and if clinicians explicitly connect their personal values with actionable steps targeting racism in themselves and their institutions (i.e., interest convergence). It is reasonable for White DBT clinicians to expect identity-defensive responses in themselves and by colleagues while team members build antiracism competencies (i.e., White identity is a profitable, possessive investment); therefore, suggestions are provided to support team members in using DBT tools for coping with emotional responses to antiracism work.

When White DBT clinicians are working with Black/African-American clients, feelings of guilt, shame, and

anxiety about making mistakes can lead to avoidance behaviors such as skirting topics related to race and racism. While the function of guilt and shame are generally adaptive by motivating us to repair relationships and maintain a sense of belongingness, shame about privilege functions to perpetuate racism when it motivates avoidance behaviors in a White therapist treating a Black/African-American client. For example, the White therapist's avoidance of topics related to race and racism promotes a self-focus that interferes with communicating acceptance and validation to the Black/African-American client (Naz et al., 2019). When a White therapist experiences anxiety, guilt, or shame about racism while working with racially marginalized clients, Naz and colleagues (2019) recommend that the therapist redirects their attention towards empathy and understanding of the client's experiences. Specific coping strategies recommended by the authors include: tolerating uncertainty and vul-

Table 2
Strategies for Increasing Antiracism in DBT (Includes DBT Skills From [Linehan, 2014, 2014a](#))

Competency	Objective	Suggested DBT Skills	Examples of DBT Skill Practice	Additional Activities/Skills
Awareness	Reframe one's experiences within context of White racial identity/group membership	<ul style="list-style-type: none"> • Mindfully Observe and Describe biases, stereotypes, prejudices • Beginner's Mind • Validation about race-specific experiences for self and other 	<ul style="list-style-type: none"> • "I'm noticing assumptions that this client has the same political views as my Black friend." • "I'm noticing surprise that this client is psychologically minded." • Curious, open stance to noticing defensive reactions to topics of race/racism 	<ul style="list-style-type: none"> • White Racial Identity Self-Conceptualization
Knowledge	Define systemic racism, situate one's personal experience of White privilege	Problem Solving to increase race-specific knowledge	<ul style="list-style-type: none"> • Identify plan to fill in specific gaps in knowledge with set deadlines; communicate plan to consult team, ask for follow up 	<ul style="list-style-type: none"> • Attend multicultural competency workshops • Read/listen/watch media to fill in gaps in knowledge of racism and White Supremacy
Skills	Use tools to progress in one's White identity development	<ul style="list-style-type: none"> • Tolerating intense affect cued by topics of race/racism in therapy • Check the Facts on guilt, shame, reactivity • Opposite Action to reduce ineffective reactivity • Problem Solving, Repairs for justified guilt, shame • Radical Acceptance of past racist behavior • Non-judgmental stance 	<ul style="list-style-type: none"> • Intense shame about racist behavior fits the facts and is ineffective at times due to mismatch between action urge and goal/value of dismantling racism • Acting opposite to avoidance urge when shame fits the facts • Bringing up clients' individual and cultural identities; inquiring about clients' experiences of racism in therapy; continuing to work with racially marginalized communities despite feeling a lack of confidence • Validating hurt caused by racist behaviors • Accepting painful facts including intense guilt, shame, sadness about past racist behavior • Using non-judgmental, non-defensive stance towards self/others when identifying racist behaviors 	<ul style="list-style-type: none"> • Identify support network of diverse peers • Daily calendar tracking of invalidating behaviors • Utilizing supervision, attending workshops to develop confidence with engaging in antiracism work • Focusing on a compassionate, open stance to cultivate empathy for experiences of racism • Wise Affect (Chang et al., 2021)

Table 2 (continued)

Competency	Objective	Suggested DBT Skills	Examples of DBT Skill Practice	Additional Activities/Skills
Advocacy	Use tools to identify and interrupt racial micro-aggressions in one's daily life; actively participate in dismantling racist systems	<ul style="list-style-type: none"> • Balancing Being Mind and Doing Mind • Finding and Getting People to Like You • Problem Solving steps to increase advocacy • Dialectics, Walking the Middle Path • Accumulating Long-Term Positive Events 	<ul style="list-style-type: none"> • Balancing knowledge-based with action-based antiracist skill development; being present/accepting of current progress, balanced with building mastery into the future • Identifying specific actionable steps aligned with antiracist values 	<ul style="list-style-type: none"> • Organizing, participating in volunteer work, protests, activism • Identifying specific barriers to racial equity within one's organization/institution

nerability, bringing up clients' individual and cultural identities, inquiring about clients' experiences of racism in therapy, continuing to work with racially marginalized communities despite feeling a lack of confidence, utilizing supervision, and attending workshops to develop confidence (p. 10).

Chang et al. (2021) adopted a critical race perspective to analyze therapeutic alliance ruptures in cross-racial dyads (specifically, a White therapist treating a racially marginalized client) and recommended three essential therapist skills for repairing such ruptures: (1) critical self-awareness of how power, privilege, and identity inform the therapist's affective and behavioral responding in the moment; (2) "Wise Affect," defined as the capacity to skillfully regulate negative affect and emotional responses that lead to othering by observing these reactions as they occur, instead generating positive emotions to cultivate compassion and interconnectedness; and (3) an "anti-oppressive interpersonal engagement, (defined as) the capacity to empathize with the client's experience and sensitivity to the ways that the relationship may be shaped by dynamics of oppression" (p. 372).

The concept of Wise Affect is drawn from mindfulness and compassion practices that encourage one's capacity to observe cognitions, emotional responses, and physical sensations in the present moment with openness, curiosity, and compassion. Assuming this positive, prosocial stance during discussions of race may better facilitate White DBT therapists' engage-

ment with Black/African-American clients in a manner that is consistent with their antiracist values and intentions. Wise Affect can be likened to the Wise Mind state of being in DBT, in which therapists may notice emotional responses to race/racism, resist the ineffective urges for avoidance behaviors that are naturally produced by feelings of shame and anxiety, turn their attention towards personal values that promote care and compassion, and align their action in the moment with these personal values.

It should be noted that there are several theories already developed for working with racially marginalized clients that may also serve as useful reference points for antiracist DBT, with an important one being cultural humility (e.g., Danso, 2018; Greene-Moton and Minkler, 2020; Hook et al., 2017). Cultural humility can be defined as "a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficially and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998, p.123). When working with vulnerable populations, especially those that have experienced discrimination, a more collaborative approach that focuses on addressing their needs rather than advising them on what their needs are could be more effective, hence why this approach is used for populations with multiple different marginalized identities beyond race (Greene-Moton and Minkler, 2020). Although the details of

employing this approach clinically are beyond the scope of this paper, we would encourage clinicians to embody this approach in addition to our recommended antiracist strategies, especially when working with Black/African-American clients. Cultural humility can be used in DBT teams as a larger framework to understanding a client's experience by taking a humble and collaborative approach, ensuring more balance in the power dynamics between Black/African-American clients and White clinicians, and exploring White clinician's own racial identities.

Malott and colleagues (2019) took a phenomenological approach to analyzing the lived process of engaging in antiracism by studying a group of 10 participants who were selected for study inclusion on the basis of their regional, national, and international levels of recognition for antiracist activism. Results from the study illuminated several commonly used antiracist tactics employed by these individuals, four thematic struggles commonly encountered in the act of antiracism, as well as three thematic findings of coping strategies used to counterbalance these struggles. We draw from these findings to offer DBT-informed strategies for increasing therapist antiracist competencies within the AKSA framework. In addition, we identify objectives for antiracist competency building that are derived from a study by Berg and Simon (2013), who developed a seven-session psycho-educational antiracist group for White undergraduate students.

In the proceeding section, we discuss each of the DBT-informed strategies for targeting racist behavior and increasing antiracist competencies within the AKSA framework.

Increasing Antiracist Awareness

The main objective in fostering antiracist awareness is to increase the therapist's ability to reframe one's experiences within context of their White racial identity and group membership. Indicators demonstrating concerns about deficits in this competency area may include statements that demonstrate gaps in self-awareness, expressing an invisibility of race, minimizing and devaluing race-related content or interpersonal dynamics as irrelevant or unimportant, and a naïve or idealizing attitude about race (e.g., race-specific fetishizing, speaking in slang or using culturally appropriated language exclusively when interacting with Black/African-American clients). Awareness deficits may be suspected due to what the White therapist is leaving out of a discussion, rather than what is overtly stated (e.g., failing to assess or report race in clinical documentation, failing to include consideration of race in case conceptualization, failing to describe reactions to racial differences in interracial

therapist-client dyad). Deficits in antiracist awareness may also be suspected when White clinicians make statements reflecting "White Saviorism," or the racist assumptions that Black/African-American clients are in need of saving because they are inept at leading the transformation of their own oppressive conditions, and dependent on White external forces to improve their well-being. White saviorism may be present when antiracist advocacy appears to be motivated by a "big emotional experience that validates privilege," and is vacant of personal accountability for participation in White supremacy (Cole, 2012). We recommend adopting a nonjudgmental stance to behaviorally describe potential indicators of White saviorism rather than using this label in consultation team settings.

Strategies recommended for increasing antiracist awareness include: using the "Observe" and "Describe" mindfulness skills to increase awareness of thoughts/reactions to Black/African-American clients that reflect biases, stereotypes, prejudices, as well as to increase the ability to factually describe such reactions without minimization, justification, or other statements influenced by heightened emotional reactivity; practicing validation about race-specific experiences for oneself and for Black/African-American clients; adopting a "beginner's mind" (a Zen practice used in DBT core mindfulness strategy) to increase curiosity and reduce assumptions about a universal, shared experience that denies realities of race and racism.

To facilitate the above strategies, it is also recommended that White DBT therapists who demonstrate antiracist awareness deficits complete an exercise in writing their White racial identity self-conceptualization. This self-conceptualization should be completed within the framework of Helms' (1992, 1995) White Racial Identity Model, which proposes that a White person develops racial identity through a process of ongoing changes in attitudes, emotions, and behaviors. These developments are represented by six statuses, previously referred to as stages, which characterize the White person's patterns of responding to race in their environment. An individual can be in multiple co-occurring statuses of White racial identity, moving in between and back and forth statuses in a nonlinear process of continuous growth. In this sense, Helms' White racial identity model fits well with the dialectical worldview of DBT.

One approach for completing this self-conceptualization exercise is to ask White therapists to tape record self-interviews in which they are asked to describe their prior experience and contact with racially oppressed people, their attitudes about race and racial issues, images of racially marginalized people, and their personal identity in terms of race. Ther-

apists may then view these recordings and complete a written analysis of the responses that conceptualizes their White racial identity through Helms' model. This exercise has been completed with positive effects, as described by Lawrence and Tatum (1998), who investigated the efficacy of an antiracist educational course using a qualitative study design with a sample of White educators.

Increasing Antiracist Knowledge

The main objective to developing antiracist knowledge is to demonstrate the ability to define systemic racism and situate one's personal experience of White privilege within this broader context and in relation to others from racially marginalized groups. Indicators suggesting deficits in this area may include demonstrated lack of race/racism-specific knowledge, oversimplification about race/racism, and context minimization error. Context minimization error refers to focusing primarily on an individual's behavior and overlooking or discounting the structural factors that shape and influence the person's lived experience. This may "lead to psychological theories and research findings that are flawed or that hold true only in limited circumstances. These errors can also lead to therapy interventions or social programs that fail because they attempt to reform individuals without understanding or altering the contexts within which those individuals live" (Dalton et al., 2013, p. 10). We refer back to context minimization error in our discussion of strategies for increasing antiracist advocacy in therapeutic practice.

Strategies recommended for increasing antiracist knowledge include: utilizing support from the consultation team to engage in problem solving to identify steps for increasing race-specific knowledge, which may also serve to correct biased beliefs and naivety (Awareness deficit); attending multicultural competency workshops; participating in antiracist book clubs; and extending consultation team meetings on a routine basis to include presentation/discussion of multicultural issues.

Increasing Antiracist Skills

The main objective to developing antiracist skills is to use tools to progress in one's White racial identity development. These efforts will be greatly facilitated by first completing the previously discussed exercise in which the therapist prepares a White racial identity self-conceptualization with support and feedback from consultation team members. Indicators of deficits in this competency area may include a therapist's expression of intense guilt, shame, anxiety, lack of empathy, distancing, aggression or otherwise strong negative

emotional reactivity to topics of race and racism and during interpersonal exchanges with Black/African-American clients. This may occur in the context of discussions with White peers and/or in discussions with colleagues and clients from diverse backgrounds.

For example, a therapist becomes emotionally dysregulated while sharing intense feelings of guilt/shame in response to conversations about racism. Problematic responses by team members in this situation may include turning the discussion towards reassurance that invalidates the therapist's justified guilt or shame for past racist behaviors. More effective team responses may include supporting the therapist in using DBT coping skills to reduce ineffective reactivity to discussions of race/racism. Strategies recommended for increasing such antiracist skills include: increasing distress tolerance from justified guilt and shame, acting opposite to urges for cathartic emoting during discussions about race/racism when it presents a distraction from the group discussion due to intensity of emotional display (especially to support coping ahead for when topics of race/racism arise in therapy sessions); turning the mind away from thoughts that intensify distressing guilt and shame; practicing a nonjudgmental stance; practicing radical acceptance of past racist behavior.

The previously described example illustrates difficulties with emotion regulation that are likely to interfere with one's ability to engage in antiracist therapeutic practice. Antiracist skill deficits may also include ineffective interpersonal behaviors exhibited during discussions about race/racism. For example, during a discussion about the Black Lives Matter movement, a White therapist reminds the team that there are additional examples of discrimination that also deserve attention, such as conspiracy theories about the Holocaust being a hoax. This example highlights the cognitive distortion overgeneralization: the therapist implies that the emotional pain caused by Holocaust conspiracy theory believers is relevant to a discussion about ongoing police killings of Black/African-American individuals because both topics fall under the broad category of racial/ethnic discrimination. If this statement was made in the company of a Black/African-American colleague or client, this reaction would also represent an empathic failure due to the invalidating consequences from such an oversimplification about racism.

When White therapists rely on their Black/African-American clients for education about racism and guidance on antiracism, this too represents an example of therapist treatment-interfering racist behavior suggesting deficits in antiracist interpersonal skills. While it is skillful to adopt a curious, open-minded approach to

conversations with a Black/African-American client and avoid preconceived notions about their lived experience, therapists must balance this with sensitivity to the power differential in the therapeutic relationship. When therapists rely on Black/African-American clients to facilitate the work of building their own antiracist knowledge, it places the client in a double bind by obligating the client to care for the therapist, develop the therapist's antiracist competency, while also tolerating the therapist's ignorance, all in an effort to reduce the client's risk of being uncared for in therapy. Furthermore, the client cannot challenge the therapist's errors too strongly or with apparent (justified) anger for fear of being pathologized (Brown, 1991).

To foster growth in the three antiracist competency areas discussed thus far, we developed an additional tool that promotes a therapist's greater awareness of their own invalidating behaviors, referred to as the Levels of Invalidation. This tool is offered as part of an antiracist adaptation of DBT in hopes that it may also be used in treatment with clients who demonstrate antiracist competency deficits and engage in harmful acts of invalidation. The original concept for a DBT skill that teaches levels of invalidation came from a webinar presented by Fruzzetti and colleagues (2020), who outlined four levels of invalidation. Each of these examples of invalidation are reflected in the skill presented here, though labeled and defined differently, with three additional levels added. Table 3 provides an overview of the seven Levels of Invalidation along with examples illustrating each level. Therapists and

clients can further utilize this tool as a reference for tracking their invalidating behaviors, to foster greater antiracist awareness and interpersonal skills.

Increasing Antiracist Advocacy

The main objective to developing antiracist advocacy is to use tools to identify and interrupt racial micro-aggressions in one's daily life, and actively participate in dismantling the racist systems that the individual White therapist has most access to and influence within. One indicator that may suggest deficits in this competency area is having limited life experience with racially marginalized people; however, the inverse (i.e., having a racially diverse friend group) does not mean that the individual engages in antiracist advocacy.

Still, Malott et al. (2019) found that prominent antiracist advocates stressed the importance of maintaining lifelong relationships with racially marginalized peers as well as White antiracist allies. To most effectively foster antiracist relationship building, a White therapist will first need to prioritize growth in antiracist awareness, knowledge, emotion regulation, and interpersonal skills. Once the White therapist demonstrates a commitment towards building these competencies, they are positioned to have greatest success in forming close, sustainable relationships with Black/African-American and White antiracist peers/colleagues.

A second and more likely indicator of deficits in antiracist advocacy is seen through a number of avoidant behaviors by White therapists in response to racism, including: minimal participation in discussions

Table 3
Levels of Invalidation

Level	Label	Description	Examples
1	Empathic failure	Undesirable behavior receives attention and emotional experience is ignored; may be intended as caring	"You should have eaten something instead of studying all day!"
2	Dismissive	One person invalidates a person's specific behavior	"You're not sad, you're acting like a baby"
3	Stigmatizing	One person or small number of people invalidate a person's specific behavior(s) or experience	"He's fine, he's just an overly sensitive kid;" child is stigmatized by peers, teachers, caregivers
4	Gaslighting	Maintains that the person deserves or caused mistreatment; accuses person of misperceiving	"I didn't mean anything hurtful, you obviously misunderstood me;" "He shouldn't have been driving with a broken headlight"
5	Internalized	Beliefs, actions, behaviors collude with invalidation; e.g., internalized racism	"I was hired as the token Black person"
6	Abusive	Invalidation threatens safety, blames the victim, may include actual harm	Child abuse, intimate partner violence, sexual abuse
7	Systemic	Many people in the person's community invalidate their essential worth, value, legitimacy	"Blue Lives Matter;" policies maintain racial inequities, e.g., lack of sliding fee scale in private therapy practice

Note. Adapted from Fruzzetti et al. (2020).

about racism, failure to share observations of others' racist behavior in discussions with clients or colleagues, failure to initiate discussion of one's own racist behavior, responding defensively when others highlight the therapist's racist behavior, and failure to initiate discussions about race and racism with clients. These avoidant behaviors can be best understood through the DBT tool referred to as the "Missing Links Analysis," which identifies what interfered with the occurrence of an effective (antiracist) behavior. This exercise may be followed by a chain analysis to further understand the controlling variables for specific racist avoidant behaviors. This practice is especially recommended when therapists or team members recognize patterns of recurring racist avoidant behaviors interfering with antiracist advocacy.

To increase antiracist advocacy, a White therapist must make a critical analysis of the organizations, systems, and institutions in which they participate and identify specific policies and practices that maintain racial inequities. After racist policies and practices are identified, the White therapist must utilize the power and privilege they hold within those systems to advocate for changes that reduce continued racial inequities. This may include actions taken to correct for context minimization errors in the practice of therapy: for example, making a critical analysis of the theories, principles, and tools that guide therapeutic practice, and identifying aspects of those theories, principles, and tools that ignore/minimize (invalidate) the realities of racism by paying disproportionate attention to a person's pathology while failing to account for the influence of context (i.e., racism).

Correcting Context Minimization Errors in DBT

The current proposal for an antiracist adaptation of DBT represents one such effort to correct context minimization errors that are present in this evidence-based treatment. This includes the proposed addendums to DBT Therapist Agreements (Antiracist Therapist Agreement) and Therapist Consultation Agreements (Consultation to the Environment Agreement), as previously discussed. These new agreements correct context minimization errors in the DBT model by fostering greater antiracist awareness in treatment with Black/African-American clients, and by guiding therapists to adopt an antiracist approach to therapeutic practice by demonstrating this understanding of person-in-context. Further antiracist adaptations are needed to address the invisibility of racism throughout the DBT manual and DBT skills training materials. Several examples are proposed for reducing the likelihood of context minimization errors in DBT practice, as outlined below.

Antiracist adaptation to biosocial model. Guidance is needed on how to account for racism in a biosocial conceptualization about emotion dysregulation experienced by Black/African-American clients. This may include: identifying generational transactions of trauma as a biological vulnerability, characterizing racism as a chronically invalidating environment, accounting for the transactional relationship between racism and the Black/African-American client's efforts to adapt and cope with racist invalidation, accurately labeling justified emotional reactions to racism and effective passivity in response to powerful, racist environments, distinguishing these adaptive behaviors from skill deficits and broader patterns of emotion dysregulation, and accounting for internalized racism as a form of self-invalidation that results from the transaction between person and environment. Hagan and Donnison (1999) offer a compelling case for incorporating concepts of social power within the theory and practice of CBT. The authors make the following recommendations: reframing the difficulties of socially marginalized/oppressed clients as being in part overdetermined by their social position and serving functions of survival in an unequal social world; changing the potentially pathologizing terminology of CBT; and changing the practice of therapeutic work to include problematizing the social world. Similarly, we recommend that an antiracist adaptation of the biosocial model must include an analysis of social power when identifying characteristics of a client's invalidating environment. In addition, clinicians must be cautious of accepting historical diagnoses and past treatment history as factual evidence of bonafide mental illness (or a biological predisposition for emotion dysregulation) in Black/African-American clients, given frequent trends of pathologizing normative responses to systemic racial oppression. Clinicians are encouraged to reframe dysfunctional or ineffective patterns as "lessons learned to survive" (Hagan & Donnison, 1999, p. 132). Clinicians are also encouraged to adopt an open, curious stance towards the possibility that such patterns of cognition and behavior may still be functional in the face of adversity within the client's family and community, and collaborate with Black/African-American clients to construct treatment target hierarchies so that quality-of-life interfering behaviors are deemed such by the clients themselves.

Antiracist adaptations to DBT skills training materials. Guidance is needed on how to teach DBT coping skills in a way that more clearly communicates that therapy is not a one-size-fits-all approach. For example, no DBT skills training handouts or worksheets include explicit mention of race or racism as factors that are relevant

to skillful behavior. Materials on emotion regulation skills and interpersonal effectiveness skills do not reflect an understanding that Black/African-American clients operate within systems that sometimes apply lethal punishment for assertive behavior and pathologize displays of justified emotional reactions. For example, in teaching the emotion regulation skill “Check the Facts,” the DBT therapist supports their client in examining factual evidence that confirms or disconfirms the client’s emotional response, and helps the client entertain additional interpretations of a prompting situation. When imploring a client to scan their past and present for data that confirms it is possible to re-interpret a distressing belief, people who have suffered many forms of abuse, neglect, and oppression may find that disconfirming material is scarce. Alternatively, the therapist may find it more effective to focus explicitly on unequal power relations to assist the client in clarifying the origins of their beliefs (Hagan & Donnison, 1999).

Upon joining a DBT skills training group, clients are asked to review a list of “skills training assumptions,” or core beliefs that are considered foundational to the DBT model. One of these working assumptions in DBT is the belief that people do not create their own problems and they must solve them anyways. For example, clients did not choose or cause their invalidating environments and still they must develop effective ways to cope with resulting trauma, emotion dysregulation, and ultimately change their own destructive behaviors. We propose adopting an antiracist stance when presenting this particular skills training assumption by including the irreverent example that applies specifically to White therapists and White clients: “You didn’t cause racism, and you have to solve it anyways.” We recommend the following metaphor when presenting this skills training assumption to White DBT therapists/clients:

Imagine you have two plants potted on the same day, one placed in the sunlight, the other placed in shade. Both plants will grow, but of course the plant in the sun will grow faster and with greater ease. The plant in the shade may show its resilience by bending towards the sun, growing slowly but surely. In this sense, the shaded plant’s growth is defined in many ways by its distance from the sun. Meanwhile the sundrenched plant has never needed to bend or stretch to absorb its nutrients and flourish. Ignorance is bliss for the sundrenched plant! It is the same with power and privilege afforded by White racial membership.

Additional skills recommended for engaging in antiracist advocacy include the following DBT mindfulness skills: Balancing Doing Mind and Being Mind (e.g., “Being Mind” may include increasing cultural aware-

ness, educating oneself about racism, while “Doing Mind” may include planning and executing specific, actionable steps that aim to dismantle racism), the nonjudgmental mindfulness “how” skill (e.g., describing one’s own and others’ racist beliefs, thoughts, interpretations, behaviors nonjudgmentally), and Walking the Middle Path: Finding the Synthesis Between Opposites (e.g., identifying actions that balance the two opposing realities of current racist systems/policies and antiracist goal-setting).

Antiracist advocacy in DBT must also address barriers to treatment access and engagement for Black/African-American communities. This may include problem solving barriers in the referral and screening process for entry into DBT, such as adjusting thresholds on screening measures when indicated to improve equitable access to DBT, increasing outreach efforts following a first missed intake appointment, including self-referral routes to intake, and prioritizing referrals for Black/African-American clients.

Beck and Naz (2019) discuss recommendations for improving service access and engagement in CBT for Black and other racial minority communities. The authors suggest that researchers develop a steering committee comprised of community stakeholders who represent the breadth of voices from underrepresented groups, including a range of intersectional identities within such communities. The research team consults with the steering committee to develop research questions about service configuration and unmet clinical needs. These questions are then used in qualitative interviews with potential and actual service users, and responses are analyzed using quantitative and qualitative methods. Researchers continue to consult with the steering committee to seek guidance on the interpretation of responses and application of findings. The authors highlight several advantages seen from taking this approach in their past work within a British South Asian community, including: a shift in community perspective and improved reception towards the treatment service, improved understanding about the values and cultures of the communities served by the clinic, wide dissemination of the research by community members, better community recognition of need, increased likelihood of referral to the service, increased likelihood of engagement in the treatment service, and improved understanding of how to adapt delivery of CBT to the community members. This approach by Beck and Naz (2019) reflects a core tenet of a CRP analysis, which is using counter-narratives by racially marginalized individuals as a tool for racial justice in psychology.

Additional opportunities for antiracist advocacy exist in DBT research, by using study design and

methodology that foreground topics of race and racism. Storytelling by Black/African-American clients is a powerful tool for antiracism advocacy in psychological research, in that narratives by these individuals can be used to challenge White normative standards and highlight the ubiquitous nature of racism. More guidance is needed for developing methods in critical race psychological research, though cues can be taken from the field of education research where there has been relatively greater use of critical race methodologies. In general, it appears that the use of quantitative methods is rarely seen in studies that adopt a critical race perspective, as such methods can be viewed as antithetical to the tenets of CRT (Carbado & Roithmayr, 2014, as cited by Sablan, 2019). However, Sablan (2019) and others have proposed that quantitative methods are compatible with critical race perspectives so long as they are used to emphasize the assets (versus deficits) of racially marginalized groups and to highlight the overarching structure of racism and racial inequity in the framing, interpretation, and approach taken by the research study. For example, quantitative methods can be used in CRP research by demonstrating evidence of the CRP assumptions and documenting racial inequity through descriptive and inferential statistics that compliment qualitative counter-narratives (Sablan, 2019). A counter-narrative, or counterstorytelling, involves use of qualitative tools such as narrative analysis to showcase the lived experiences of marginalized people and challenge “master narratives” of White privilege (Solorzano & Yosso, 2002, p. 32).

Applications, Future Directions, and Limitations

Cross-cultural work has mainly taken a top-down approach by focusing on treatment adaptations or climate surveys. However, these can impede getting in-depth information on the perspectives of racism from White clinicians and racially marginalized clients. Our recommendation therefore is for future research to focus on gathering more comprehensive, detailed narratives to gain a thorough understanding of the impact of racism on Black/African-American clients, including influence on treatment and interference with treatment. We recommend the same approach be taken in future research in order to identify factors that support and hinder antiracist competency development in therapeutic practice.

Improving the cultural responsiveness of the DBT technology to the needs of Black/African-American clients will require phenomenological studies that explore the construct of suicide and emotion regulation in these cultures. This approach would improve our understanding of these complex constructs in this

population. Furthermore, a bottom-up phenomenological approach is critical in order to correct for context minimization errors that pervade psychological theory and research, due to the history of psychology and inferential statistics being grounded in eugenics and discriminatory practices against Black/African-American people (Zuberi & Bonilla-Silva, 2008). Phenomenological studies have also been recommended in working with Black/African-American populations as a qualitative methodology takes into account the perspective of those being studied, which is thought to be more appropriate for populations that have traditionally been understudied and underrepresented in the field (Helms, 1993; Wilson & Gail Washington, 2007). Conversely (or dialectically), research should also be conducted with White supervisors and clinicians with a specific focus on their experiences and self-reported barriers with engaging in antiracist behavior. One study using in-depth interviews found that implicit organizational bias for an “ideal” client (one that is verbal, accepts services, etc.) was a barrier for clients of Latine and Asian backgrounds (Desai et al., 2020). This example illustrates that phenomenological studies can facilitate a richer understanding of a person’s experiences with racism and antiracism, which can thereby influence sustainable, effective changes in the delivery and practice of evidence-based treatment.

As previously noted, more guidance is needed for developing critical race methodologies in psychological research. Sablan (2019) argues for using a full range of quantitative methods in critical race research beyond descriptive statistics, including predictive regression models, experimental/quasi-experimental and evaluative modeling; although these approaches are rarely seen to date and there is little extant discussion offering guidance in how to apply such methods within critical race research. One specific future direction in research could be the application of CRP to the area of measurement theory; for example, by incorporating counter-narratives into studies evaluating survey methodology and scale development. This represents a major area for future researchers to address, in order to develop and refine guiding frameworks for critical race psychological research.

There are several limitations to note about the present discussion. One limitation is that the ideas presented here can be formulated even further through a systematic review of a broader literature base (e.g., peer-reviewed journals in social psychology, educational psychology, social work), as well as additional major works in American literature and journalism that discuss antiracism. Another limitation is that the current discussion applies to a broadly defined population

of Black/African-American individuals who represent a diverse group with distinct backgrounds, racial identities, intersectional identities, and treatment needs that vary by additional factors beyond their broadly defined racial group membership. This limitation also highlights the need for future studies using qualitative research methodologies that will include sensitivity to individual differences when further developing DBT modifications.

Closing Remarks

To the authors' knowledge, the present discussion represents the first peer-reviewed published paper proposing an antiracist therapist adaptation of an EBT, and specifically the first proposal for an antiracist adaptation of DBT. Here, we presented the rationale for developing this application of the DBT model by taking a dialectical stance to defining the task of antiracism in the context of therapeutic practice and psychological research on cultural responsiveness of EBTs. Our dialectical synthesis proposes that DBT therapists must respond to the harmful effects from racism, and at the same time White DBT therapists must actively work towards increasing their antiracist competencies and reduce their own racist behaviors that interfere with the effective treatment of Black/African-American clients. CRP was used as a theoretical lens for our analysis of the DBT model, building upon the work by [Salter and Adams \(2013\)](#). Recommendations for an antiracist DBT adaptation so far include the following: a new Antiracist Therapist Agreement, a new Antiracist Consultation to the Environment Agreement, defining antiracism as a competency domain consisting of four areas (AKSA: awareness, knowledge, skills, advocacy), sample indicators of concerns for each antiracism competency, DBT-informed strategies for building antiracist competencies, as well as preliminary recommendations for modified skills training materials to increase cultural responsiveness to Black/African-American clients in DBT. We recommend that future research adopt a phenomenological approach for studying DBT modifications for Black/African-American clients in order to most effectively prevent continued context minimization errors in treatment development. We also recommend that future studies guide the application of critical race methodologies in psychological science research.

We hope that this paper serves as a starting point for our DBT community to look inwards at the theory and practice of DBT and examine the ways that the technology can target White therapists' racist ideas, beliefs,

and behaviors in therapeutic practice. In his writing on applications of CRT, [Gillborn \(2018\)](#) advises:

Racism cannot be understood adequately by a perspective that focuses only on the separate beliefs, actions, and fears of individual actors, but neither is racism purely a facet of a depersonalized system; racism is remarkably resilient because it is both systemic and shaped by individual agency. (p. 67)

For this reason, we recommend that the proposed antiracist adaptations of the DBT model be viewed as universally applicable and critical for all White DBT therapists to adopt, regardless of whether they are presently working with racially marginalized clients or colleagues. We assert that these changes to the practice of DBT will enhance the efficacy of the treatment by White therapists and promote antiracist competency development within the DBT community. The ideas and recommendations put forth by this paper are meant to support the evolution of DBT as a living therapeutic model that benefits from an ongoing, continuous synthesizing of dialectics. While this paper has used the term "adaptation" in discussing changes to DBT practice, we believe that the recommendations outlined here are vital for the DBT community to incorporate as regular practice going forward to effectively respond to the realities of lethal racism in present day society.

When life presents us with challenges, [Linehan \(2014a\)](#) advises us to consider four options for solving any problem we may encounter: (1) solve the problem by changing the situation; (2) feel better about the problem by changing emotional responses; (3) accept and tolerate the problem; (4) stay miserable by doing nothing or making it worse. We believe that using tools from therapy to support Black/African-American clients who cope with harmful effects from racism represents options two and three: i.e., guiding Black/African-American clients to accept the reality of racism, tolerating the pain it causes, and changing emotional responses to increase resilience amidst ongoing systemic oppression. We hope that this paper represents the beginning stages of a path that represents option one, i.e., solving the problem by changing White therapists' racist beliefs and behaviors in the theory and practice of DBT and within broader mental health institutions. In closing, we return to the wise mind of Angela Davis who once wrote, "I am no longer accepting the things I cannot change. I am changing the things I cannot accept."

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