SERVICE MODELS, FORMS OF DELIVERY AND CULTURAL ADAPTATIONS OF CBT

Exploring adolescents' experiences of talking about race, ethnicity and culture during dialectical behaviour therapy (DBT): a qualitative study using thematic analysis

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Abstract

Although anti-racist adaptations to dialectical behaviour therapy (DBT) are emerging, little qualitative research exists exploring adolescents' perspectives on therapists' approach, cultural competency and humility regarding ethnicity, race and culture (ERC) within DBT. This study explored diverse adolescents' experiences of talking about ERC during all aspects of DBT treatment. Ten adolescents from diverse ERC backgrounds who attended DBT at a National and Specialist Child and Adolescent Mental Health Service (UK) completed semi-structured individual interviews that were transcribed verbatim and analysed using reflexive thematic analysis, adopting a critical realist approach. Five over-arching themes were developed from the data. Theme 1 captures the power for explicit ERC-related conversations to facilitate change, as they are frequently overlooked in therapy. Theme 2 discusses factors that facilitate or inhibit ERC-related discussions. Theme 3 captures the difficult 'double bind' that adolescents find themselves in: not wanting to be a spokesperson for ERC issues whilst hoping for their therapist to facilitate/model ERC-related discussions. Theme 4 explores how adolescents navigated their identity in relation to ERC, their wider systemic context, and experiences of ERC-related trauma. Theme 5 explored therapeutic alliance, and how therapists might encourage DBT skills use with greater ERC sensitivity, emphasising validation. Using a bottom-up approach, we show a clear mandate from diverse adolescents for (White) clinicians to proactively create the space and safety required for ERC-related discussions. We emphasise the importance of anti-racist praxis including cultural humility, multi-cultural competencies, and validation of ERC-related difficult experiences within a wider systemic context.

Key learning aims

(1) A recent publication by Pierson *et al.* (2022) has raised the importance for White DBT therapists to adopt an anti-racist position and actively reflect on how a lack of anti-racist stance can form therapist treatment-interfering behaviours.
(2) The current study explores the views of adolescents from diverse ethnic, racial and cultural (ERC) backgrounds on how ERC issues are being brought into DBT.
(3) Adopting a bottom-up approach, we identify key themes from adolescents' perspectives on the barriers and facilitators to talking about ERC in the therapy room, why such discussions are important in supporting adolescents to navigate their own identity in therapy, and recommendations for clinicians to consider on ways of increasing and enhancing such conversations in the clinical setting.

Keywords: Anti-racism; Cultural humility; DBT; Multi-cultural competencies

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Introduction

In recent years, a number of reviews and meta-analyses have brought attention to the significant negative impact racism has on the mental health of children and adolescents (Pachter and Coll, 2009; Paradies *et al.*, 2015; Priest *et al.*, 2013; Trent *et al.*, 2019). Systemic issues exist within child and adolescent mental health research, stemming from inconsistent recording of ethnic, racial and cultural (ERC) diversity information amongst participants (Kollins, 2021), begging the question of how generalisable is the evidence and 'evidence-based practice' to individuals who come from racialised backgrounds? In the UK, clear disparities in access to mental health services exist when comparing adolescents from diverse ERC backgrounds with their White British peers (Edbrooke-Childs *et al.*, 2016; Kapadia *et al.*, 2022). Adolescents from diverse ERC backgrounds are more likely to grow up with repeated encounters of racial discrimination and environmental invalidation, which negatively impact self-esteem and identity development (Akhtar, 1995; Durham, 2018; Jones *et al.*, 2020), and increase their vulnerability to emotion dysregulation and mental health difficulties (Ayodeji *et al.*, 2021; Gajaria et al., 2021; Pachter and Coll, 2009; Priest *et al.*, 2013). Despite a number of studies evidencing these relationships, none explored how racial discrimination influenced adolescents' perception of and satisfaction with the quality of care they received (for a review, see Pachter and Coll, 2009). Adopting a systemic lens to understand adolescents' identity in the context of their ERC background can help clinicians better interpret and formulate adolescent's mental health difficulties (Gurpinar-Morgan *et al.*, 2014).

Recently, members of the dialectical behaviour therapy (DBT) community called for anti-racism adaptations and active efforts to increase diversity and inclusion (Pierson *et al.*, 2022). DBT is an evidence-based treatment specifically targeting life-threatening and quality-of-life-interfering behaviours amongst individuals with self-harm and suicidal behaviours (Linehan, 2018), with demonstrated efficacy in adolescent populations (for reviews, see Johnstone *et al.*, 2021; Kothgassner *et al.*, 2021). DBT adopts a biosocial model and views emotion dysregulation as a result of the transactions between an individual's biological/temperamental vulnerability to emotion sensitivity (Fruzzetti *et al.*, 2005), and invalidation of the individual's emotional experience from social interactions (Linehan, 2018). Within this framework, racial discrimination can be conceptualised as prolonged traumatic invalidation from the environment where adolescents from ERC backgrounds may be made to experience guilt, shame and stigma associated with their identity. Levels of invalidating behaviours include empathic failure, dismissal, stigmatisation, gaslighting, internalised racism, abusive and systemic racism (Pierson *et al.*, 2022). Although individuals from diverse ERC backgrounds may be at increased risk for socio-political invalidation, evidence on how to adapt DBT or the therapeutic benefits of non-adapted DBT for this client group is sparse. One systematic review identified that 16 out of 18 randomised controlled trials (*n* = 1018 participants) of DBT included clients from racialised backgrounds (Harned *et al.*, 2022). Therefore, the scarce information on the acceptability and effectiveness of DBT for individuals from diverse ERC backgrounds means it is unclear whether DBT needs to be adapted for this group.

In a call for White DBT therapists to adopt an anti-racism approach in their clinical practice, Pierson and colleagues (2022) highlighted the importance for White-majority clinicians to increase their awareness and knowledge of their White privileges, to use skills to self-regulate emotions such as guilt and shame when supporting clients who disclose encounters of racism during therapy, and to draw on their position of power to advocate for anti-racism practice (Pierson *et al.*, 2022). The article highlighted the importance for clinicians to be self-critical and reflective, and to embody cultural humility by maintaining an open and curious position when discussing lived experience of diverse clients (Pierson *et al.*, 2022). At the same time, the same study highlighted the dialectical position of relying on clients to educate professionals about their context in relation to ERC, and how potential power imbalances in the therapeutic relationship

between clinician and client may have an impact on clients' readiness for ERC-related disclosure in treatment (Pierson *et al.*, 2022). Given that adolescence marks a developmental stage that is particularly sensitive to peer acceptance and rejection (Blakemore and Robbins, 2012; Foulkes and Blakemore, 2018), initiating conversations in therapy regarding ERC may be particularly anxiety-provoking due to fear of negative evaluation and judgement from others.

No known studies to date have adopted qualitative methodology to explore adolescents' perspectives on how therapists approach issues around ERC within DBT, and how adolescents perceive clinician's competence and humility when bringing such topics. This qualitative study aims to (1) explore the experiences of adolescents from diverse ERC backgrounds regarding talking about ERC-related issues whilst completing a national Child and Adolescent Mental Health Service (CAMHS) DBT programme (UK), and (2) improve anti-racist practice in DBT by disseminating the current experience of adolescents from diverse ERC backgrounds.

Method

Service context

The National and Specialist CAMHS DBT service at the South London and Maudsley NHS Trust delivers evidence-based dialectical behaviour therapy to young people aged 13–18 years with severe and pervasive emotion dysregulation, self-harm, suicidal behaviours, and associated mental health difficulties. Referrals are accepted from Tier 3 Community CAMHS and Tier 4 Adolescent Inpatient Units/Specialist services at both local and national level. During this study, the DBT programme included up to 12 months of weekly individual sessions for young people, 21 weekly sessions of skills groups for both young people and parents/carers (for the first 6 months of treatment), telephone coaching for adolescents and parents/carers (to promote generalisation of skills use into daily life), and a weekly team consultation meeting for therapists (to build therapists' motivation, capability and adherence to the treatment manual). DBT family sessions were provided as needed, and parents/carers were also allocated a team therapist with whom they could meet to promote their own skills practice and their support of their child.

Participant recruitment

Recruitment took place within an out-patient CAMHS DBT service working with adolescents with severe emotion dysregulation and associated difficulties. We used purposive sampling and invited adolescents within the service who self-identified as coming from a racialised ERC group to participate after completing DBT skills groups (i.e. the first 6 months of treatment), to ensure they had attended a significant portion of their DBT treatment to provide reflections across all modes of DBT. Participants were approached by email or during clinical contact and sent information to read about this study. All 10 of the invited adolescents took part in the study (see Table 1 for demographic and symptom information as noted on clinical records), and all completed the interviews with no drop-outs.

Materials

Interview topic guide

The first and second authors developed the interview topic guide (see Appendix 2 in the Supplementary material) to gain insight into adolescents' experiences of talking about ERC in DBT. Adopting a critical realist approach, we were interested in how adolescents would describe navigating their own identity in the context of ERC. Adolescents were asked to reflect on all aspects of DBT treatment including assessment, individual therapy, and skills group, as well as parent involvement in therapy, and to explore their experiences regarding ERC discussion during

Table 1. Adolescent demographic information at baseline ($n = 10$)

	Mean (SD)	Range
Age (years)	17.80 (0.90)	15.89, 18.61
Symptom severity		
SCID-II (borderline personality symptoms)	7.90 (1.45)	5, 9
SCARED Total (anxiety symptoms)	54.90 (10.94)	39, 72
MFQ-C Total (depression symptoms)	48.60 (5.17)	40, 56
Sex assigned at birth	***n***	**Percentage**
Male	1	10
Female	9	90
Gender identity	***n***	**Percentage**
Male	1	10
Female	7	70
Non-binary	2	20
Other/unknown	0	0
Sexuality		
Bisexual	3	30
Gay	1	10
Heterosexual	3	30
Prefer not to say	3	30
Ethnicity		
Black British – Caribbean	2	20
British Asian	2	20
Mixed: other	1	10
Mixed: White and Asian	2	20
Mixed: White and Black Caribbean	1	10
Other: Asian – Arab	1	10
Other: Asian – Filipino	1	10
Looked after children	2	20
Number of adolescents with a childhood autism diagnosis	5	50

Childhood autism diagnoses were derived from the International Statistical Classification of Diseases and Related Health Problems 10th Revision. MFQ-C, Mood and Feelings Questionnaire-Child [scores >29 indicate likely major depression, and scores >20 indicate likely any other mood disorder (not major depression, e.g. dysthymia)]; SCARED, Screen for Child Anxiety Related Disorders (scores >25 may indicate the presence of an anxiety disorder, and scores >30 are more specific); SCID-II, Structured Clinical Interview for DSM-V Axis II Personality Disorders (using the SCID-II, scores >5 meet the diagnostic criteria for borderline personality disorder or emotionally unstable personality disorder). All adolescents exceeded clinical cut-off score on all three measures of symptom severity.

DBT. The first semi-structured interview schedule (see Appendix 2a in the Supplementary material) had more open questions that asked adolescents to reflect on their experiences in DBT more broadly, with ERC-specific topics as follow-up questions. The first authors reflected on how some adolescents did not naturally approach the topic of ERC issues when asked open questions about their general experience in treatment. In consultation with supervisors, the first authors re-worded the questions to focus on ERC conversations during each stage of DBT. The second interview schedule (see Appendix 2b in the Supplementary material) elicited richer accounts from adolescents and allowed them to jump into ERC issues more quickly and directly.

Measures

For participation symptom characterisation (see Table 1), we used the the Structured Clinical Interview for DSM-V Axis II Personality Disorders to assess traits related to borderline personality disorder, the Screen for Child Anxiety Related Disorders to assess anxiety symptoms, and Mood and Feelings Questionnaire-Child version to assess depression symptoms (see Appendix 1 in the Supplementary material for details on each measure).

Procedure

All adolescents received an information sheet and provided consent to take part at the start of the interview. Only the young person and interviewer were present during the interview. Interviews took place between September 2021 and May 2023 via Microsoft Teams video call; field notes were taken by the interviewer during the interview to facilitate use of prompts during questioning, and video recordings were transcribed. Interviews lasted 30–45 minutes, and adolescents received a £15 Amazon gift voucher upon completing. Seven adolescents completed the first version of the interview schedule (Appendix 2a in the Supplementary material) with interviewer 1, and three adolescents completed the second version (see Appendix 2b in the Supplementary material) with interviewer 2. Both interviewers were female psychology trainee clinicians at the doctorate level in the team with extensive experience of conducting qualitative research at the doctorate level. Both self-identified to come from diverse ERC backgrounds and were members of the service evaluation project group, with an interest in improving the experience of accessing DBT for young people from diverse ERC backgrounds. To ensure the young people were familiar with the interviewers but did not have potential conflict of interest that may inhibit their ability to share their opinions, we ensured that interviewers may know young people from DBT skills group as one of two to three group facilitators and were not the young person's personal individual DBT therapist. Interviewer 2 also took the lead in data analysis (first author). No repeat interviews took place, and all transcripts were checked by two interviewers/coders to ensure accuracy. We reflected on power dynamics that may have been present during interviews (i.e. as an adolescent service user and DBT team member) and during feedback (i.e. more junior team members identifying as from racialised backgrounds, presenting to a predominantly White specialist team). We considered how to ensure accurate representation of adolescents' views during feedback and decided to code primarily the explicit surface meanings (i.e. semantic features) of the interview data to avoid misunderstanding or misinterpreting the underlying assumptions or meanings (i.e. latent features) of the data. We acknowledged the potential for strong emotions to arise amongst clinicians.

Analysis

We (joint first authors) followed the Braun and Clark (2006, 2013) method to complete thematic analysis. Drawing on Critical Race Theory, we adopted a critical realist approach and primarily coded the semantic features (by interpreting the explicit surface meanings) of the interview data. After familiarising with the data through transcribing, reading and re-reading the transcripts, we (joint first authors) critically evaluated whether observations made in the 'experiential' and 'actual' spheres (young people's perceptions of when and how ERC conversations took place during DBT, and relating conversations to their own identity) may be related to the 'real' sphere as outlined by Critical Race Theory (i.e. that racism is a part of society and individuals from minoritised backgrounds are chronically exposed to diverse forms of everyday racism).

After uploading transcripts to NVivo version 14, the first authors each independently reviewed and developed initial codes for each of the transcripts and then met together to evaluate each other's interpretations of the transcripts. When assessing inter-rater reliability and examining similarities and differences in initial codes, we reflected on our own position and interpretation of the transcripts in relation to our own personal background. J.L. is a doctoral level clinical psychology student who identifies as Chinese in race and ethnicity and emigrated to the UK during childhood. B.W.-M. is an assistant psychologist who identifies as being of mixed heritage (British and Congolese descent) and has experienced racism both as a child and adult living in the UK. During discussion of codes, we reflected on how our personal heritage and ERC background may have influenced our interpretations of the semantic content of young people's transcripts upon initial reading, actively acknowledging when we noticed strong emotions when reading descriptions of race-related trauma. We reached agreement on the final set of themes and

subthemes after iterative rounds of reviewing each transcript together. It should be highlighted that we did not use data saturation as an indicator for when to stop data analysis, and this is supported by Braun and Clarke (2021). Instead, we adopted a reflexive approach in our thematic analysis, where codes were not fixed at the start but rather allowed to evolve and develop over time through discussions between the two coders, in line with reflexive thematic analysis approach as described by Braun and Clarke (2021).

Preliminary interpretation of the data and themes derived from the qualitative interviews by both coders was fed back to the wider clinical service during a team training session with DBT clinicians from a range of professional disciplines (including nursing, clinical and counselling psychology, psychiatry) and ERC backgrounds (including White British clinicians). The purpose was to gauge clinicians' understanding, interpretation and feedback of young people's interviews, and discuss clinical implications aimed to improve service development and clinician practice from young people's perspectives. Wider team discussion helped to inform both coders on finalising themes and ensuring the content from interviews can directly inform clinical practice based on the team's feedback, hence further strengthening the clinical implications derived from the results. A full guide to reporting of the qualitative procedures according to COREQ Checklist (Tong *et al.*, 2007) is reported in Appendix 3 of the Supplementary material.

Results

Adolescents' demographic information is provided in Table 1. Table 2 provides a guide for the overall thematic structure: five themes were identified, and a narrative synthesis is outlined below, with relevant quotes summarised in Table 2.

Theme 1: The importance of talking about ERC

Three subthemes were identified from adolescents' accounts when thinking about why talking about ERC is important in the context of therapy.

Connection beyond differences

Adolescents spoke about how understanding the individual in the context of their ERC is crucial for interpreting behavioural function during treatment, especially when behaviours may be driven by differences in personal values because of ERC differences. Adolescents emphasised clinicians showing cultural humility and curiosity in wanting to explore their ERC background with an open mind allows the adolescent to see that someone is keen to explore their point of view. Participation in DBT skills group allowed adolescents to build connections with others in relation to shared mental health difficulties, beyond individual differences in ERC. Finding shared experiences helped adolescents from racialised backgrounds feel included in conversations about mental health, recognising they are not singled out to receive a '*different treatment because I'm a different skin colour or had a different family background*' (F6) but rather everyone is here for their shared mental health difficulties.

Dangers of overlooking ERC issues

Adolescents reported that issues related to ERC are often overlooked by professionals in therapies they received prior to DBT. This perpetuated ambiguity around the appropriateness of raising ERC issues in therapy, and unhelpfully modelled neglecting the impact of ERC on their mental health difficulties.

Table 2. Summary of themes and subthemes including quotes from adolescents

Theme	Subtheme	Quote
Theme 1: The importance of talking about ERC	Connection beyond differences	We all have our individual morals of what we think is right or wrong … growing up in a background where for years and years in a cultural background it was this was how it is … it might be a bit of a shock or something different for someone who hadn't experienced that and I feel like there's a barrier there and there's a blurred line with me being able to have a conversation with my therapist (F6)
		I think having a kind of understanding, you don't have to have the perspective of it, but just understanding someone else's cultural background … a kind of ground point where you can understand, it would be better to understand the young person's point of view (F6)
		I do have like common experiences and stuff and it's nice and quite validating to know that I'm not the only one that experiences certain things due to culture (J10)
		I think we are here for our mental health … so picking out a difference between a young person as opposed to all the other young people – so me as a black person in a group of white people and giving me different treatment or wanting to talk about different treatment because I'm a different skin colour or had a different family background makes me feel weird (F6)
	Dangers of overlooking ERC issues	I think the main reason that a lot of these things happened or overlooked is just because we don't talk about it (A1)
		I think it was just sort of treating it like a normal topic and not something that you need to be touchy about because it shouldn't be a touchy subject at all (C3)
	Active conversations about ERC facilitates change in attitudes	I think there are some experiences that I sort of face growing up … I think it's quite universal for anyone else who falls … for people of colour. I think allowing the space in therapy to talk about those really bad experiences revolving racism could be helpful (I9)
		It shouldn't be something talked about in between people I feel like, meaning group, you know between us, I guess people that look and sound like me, I don't think it should be just between us. I think it should be a very open conversation (D4)
		I think it would have been useful for a lot of people there of any race because I think like if you are looking at people of colour it would have been useful for them to understand maybe their similar issues shouldn't be ignored … for those who weren't of colour for them to just notice or be more aware of slight little jokes or little things that they could then again take to their school lives or things like that and maybe just adjust (A1)
Theme 2: Factors influencing ERC discussions taking place	Facilitating factors	Me personally with the good rapport I built up with my individual therapist I was able to speak with my therapist about certain things (F6)
		I feel like it would take a little time … I wouldn't jump right in, I'd feel like I'd have to do it bit by bit (I9)
		To make it more likely for someone to open up about those … let them know that they can say what they want to say, and that they have the right to talk about, just make them feel sort of protected in a way? And that you are sort of willing to support them … I think just letting them know that it is a safe space to talk about like … whatever struggles you have, whether it's racial, or just that they have a voice (I9)
		As a family, we are generally comfortable talking about stuff like that and we do have a lot of conversations about our upbringing and stuff … (D4)

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
	Inhibiting factors	I think I've noticed that recently that masking problems are not actually fully identifying what things are, does come out to be worse than kind of saying that … like beating around the bush in a way (H8)
		That pissed me off because it was like, why am I getting dismissed … and the way of how I was getting dismissed it wasn't like that type of dismissal, it was just kind of like a skim like 'anyways' … (B2)
		I always feel weird talking to someone who isn't an ethnic minority about race problems cause … there's been a few situations where like something's happened and I've been talking to someone about it … it hasn't been the best talking to someone who isn't an ethnic minority just because you do get it but like you don't get it … (B2)
		It is kind of like a bit harder especially if you have a white therapist or like you know … therapists who aren't from minorities or whatever so I think it would be a bit harder to bring it up, there's that and especially if you are in a group and there's lots of people who aren't from minorities and you are (C3)
		Oh this is just the normal like every … every hour there's some argument going on, this is just normal (H8)
	Invalidating and downplaying the need for ERC discussions	I actually think I would appreciate it, because these kinds of things they get quite downplayed and people push it under the rug (I9)
		I think like a lot of people of colour are asked to push it down and they are very much used to that … There's a lot of things that they would think to bring up or think to say 'oh yea this had made me feel different growing up' or this has made me feel like lesser than other people purely because they don't want to appear too sensitive, and they've been told they would be so (A1)
		It could be like because obviously if I hadn't had an issue with it, I wouldn't want a space dedicated to it if I had never had that and I have only had a few (A1)
		I just didn't because it wasn't that big of a deal, like it wasn't one of those things where it was like I have to go out of my way to properly like say this thing (B2)
Theme 3: Where to bring ERC discussions and who is responsible?	Is DBT the right space for ERC discussions?	I didn't feel like I wasn't able to do that if I had wanted to … but at the same time it was never brought up anyway (G7)
		When you are around people who aren't of colour you feel as though you bringing it up is sort of you being too sensitive … (A1)
		There was only me that I could see of colour … I kind of see it as being the elephant in the room and everyone discussing the obvious elephant in the room without discussing the elephant in the room with all the cameras on (F6)
		It can cause conflict or bring up certain emotions around other people because it's kind of putting people to the side … like there becomes a separation, I feel like it would also affect the dynamic of the group (D4)

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
	Should I (adolescent) be the spokesperson for ERC?	I remember feeling really embarrassed because I felt like 'Oh I shouldn't have said that' or 'Oh why did I say that' and like because of how the group reacted to it, it just made me feel embarrassed and a bit ashamed in a way, which I shouldn't have felt ashamed … but I did feel ashamed (B2)
		I think I wouldn't want to make people feel uncomfortable I suppose … the people who were White might not be able to like relate or I wouldn't want to … I don't know I guess like give them second hand guilt (A1)
		When I first joined group … I was aware that I was the only ethnic person of colour there. The young people and all the psychotherapists or what have you, they were all you know white or Caucasian background and I kind of felt in my head I didn't really say it but I kind of felt like I'm a bit different here (F6)
		I've been in class before and like, oh let's talk about the key moment in history about black people … everyone turns to me and everyone expects me to know everything about it, like top to bottom, everything. Whereas like I don't actually know everything, I just kind of exist … I do my part but like I don't know everything and all of you people are looking at me thinking I'm going to get up and teach you about all of these things (B2)
		I don't know one person's more … One person's race is more victimised than the other, so they might feel like the problems that they may experience are not as bad as the others (H8)
	Professionals to initiate beyond facilitate	If another person brought it up, then I would happily engage in that conversation … because it's probably something that I find a bit difficult to talk about and I find it easier when someone else talks about it (J10)
		I think if it was brought up so they could know that they could bring it to the table and it would be treated as just as important as any other piece of information and would be addressed in a very serious way I think would've been really useful (A1)
		Maybe just sort of asked if I had ever felt like different due to my race, if I had ever felt singled out or anything like that, and even if in that moment I hadn't brought it up just being able to question whether I had and being able to look back and think … (A1)
		Everyone should educate themselves about … each young person that they work with and educate themselves on their ethnicity and culture. To have a general understanding of when something comes up, so it's not so surprising (J10)
Theme 4: Understanding myself through ERC discussions	Finding my identity in the context of my ERC	There was a time where I literally hated going outside … I'm worried about what people will think of me, so I changed my outfit so many times … my dress sense changed and I started wearing turtlenecks and like smart clothing. Because of like the area I live in, because I wanted to fit in and not be like labelled … (H8)
		I think it would have helped to talk about it at the start but … because I hadn't really thought too much and then … cause I might feel a bit uncomfortable but I think I had overlooked it myself just purely because it had been overlooked a lot in therapy (A1)

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
	ERC in the wider systemic context	They should also try to have an understanding that being Asian has an impact but also if you are like a female from ethnic minority background in DBT, like female, people do need to realise like a female from ethnic background has all these difficulties … my family would be like oh you can't have an opinion because you are a girl (E5)
		I personally believe that the reason there isn't a lot of people of colour of different backgrounds or ethnicities in these kinds of groups is because it's kind of social stigma … (F6)
		It's kind of made me hone in on my values and my beliefs about myself that it's like I guess my opinion matters more than what other people think I guess. It's like I'd rather be depressed or something and be myself, rather than being depressed and trying to change who I am because some person thinks I'm … it's like a comforting feeling that even if things aren't going the way I would like it to be, I am myself (H8)
		The Asian part of my family isn't really in my life … I would have loved to have been more involved in that side of my family but I didn't really get the chance to … it was definitely good to talk about it (A1)
		They [parents] didn't understand, because it's not something that is talked about in their culture, it's kind of ignored, or make it seem like it was something else. But I understand I guess because that's how they were raised, and I was raised different, I was raised in the UK, so it's more open here (D4)
		The way I think DBT fits with my parents' cultural values is … like they just sort of want in the end the best for their children. Even if that means like parenting in a different way than they are used to. Where my family is from, the punishment and pushing your child to succeed in such extremes is seen as a way of love to them I think? But now they hear, they are learning more in DBT, they sort of realised that's not right, so they've changed that behaviour to the opposite way, but still out of love … back then all I knew was what they were born and raised with … so I think being here [in DBT] has really opened their eyes a little bit, like they are more educated, they have more knowledge on what's going on, I think that's very key (I9)
		I guess the problem is that I think in culture, in like the black community, I feel like that is the culture, the father being the overruler, the king and whatnot, everyone's kind of beneath and not equal. I think that dynamic's common … (H8)
	Trauma associated with ERC	I think having my own person to talk to [individual therapist] is amazing and I do love that, but then having someone relay it back to them [parents] all the time or give them skills even though I personally don't think they are benefiting from it, it doesn't help at all. It just gives them a kind of power advantage against the weaker or the mental one, and they are the more authoritative and powerful one in the relationship … that's personally how I felt with my mum being involved (F6)
		It feels like I'm targeted … I know it sounds really bad talking about it now … it was because of me (H8)
		My colour had affected the way people had behaved, the way people had acted towards me (A1)
		As a black human being … I kind of get dismissed … You know and then people just kind of write me off as just not talkative … and I think a part of that writing me off and a part of that whole stigma around … what do you call it me as a black human being and having mental illness is actively … I want to say happening? (B2)

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
		As I go out, it lowers my mood, the more I go out because I see people. It's like I could see someone like nowhere near me, but they crossed the road, or like someone else on the other side of the road, and they put their phone away or things like that … before when I went home it used to hit me hard … I think there was a time where it was like probably the biggest problem … in the hierarchy sense it would have been a very high problem or a major problem because it has stopped me from going out and doing things I like by myself (H8)
		I didn't really change, just like I had to cope … I was like now I feel like now I'm not really focused on that because every time I would think that I'll tell myself, well I'm not going to do any of what they probably think I'll do … guess it's helped with my identity in a way … because I feel like I can also be black while being the way I am you know, dressing punky and what not. Before it was like I didn't really feel black, because most people said I don't dress like I'm black (H8)
Theme 5: Therapy effectiveness in relation to ERC sensitivity	Teach DBT skills with ERC sensitivity	I was on the phone with someone from DBT [about progressive muscle relaxation] … the therapist told me to scrunch my fists until they go white, now my fists don't actually go white they go yellowish whenever I do it like really hard … when I said like 'oh I'm actually black so that doesn't really happen', the therapist was like 'oh!', and the reaction made me think so you did assume that I wasn't black (B2)
		One skill I can think of is DEAR MAN. So it's putting your needs forward, communicating how you feel in an effective way is how I would describe it. The reason I think why that would clash with elder, or speaking to people who are older than you, is because like as they are older than you, you shouldn't be telling them what to do or advising them what to do … we were talking about DEAR MAN and one of the group facilitators they talked about culture and how it can sometimes impact on us using skills. I found it good that they were acknowledging that there are other people in the group, although it might not be everyone, it's like they are not excluding other people which I think is great (I9)
		I'd like use more discrete skills and it's quite helpful … I find paced breathing quite helpful. I wouldn't feel comfortable to do ice diving. They [family members] might question why I need to do something like that … (J10)
	Validation of ERC experiences is crucial	Something had happened with me and my dad … and I was talking to my therapist about it and after I'd finished my therapist told me to check the facts and actually see if like this thing is … but it was like no I know it's this thing because I've experienced this before and I felt invalidated because my therapist was kind of like making it out to be in my head … the situation had happened to me from these people … that's how I knew it was because of my race, I felt like this kind of got invalidated by the whole check the facts thing … (B2)
		I think if a patient comes to someone like, about that I think it should number one first of all be validated like 'I'm sorry that happened to you that must have not been very nice' and then maybe like if, cause obviously check the facts is a DBT skill … so maybe explain that 'I understand this is about race but within the DBT service it is check the facts we have to do … and it's not invalidating the situation but this is the skill for a situation' (B2)

(*Continued*)

Table 2. (*Continued*)

Theme	Subtheme	Quote
	Alliance, ruptures and repairs	I think we both felt quite validated by talking about it because there's never been like a real place where we could talk about it before or at least there has been but it hasn't been a place where you would actually get validated, it was sort of just 'oh sorry that must have been hard' kind of thing (C3) I think it might be helpful because it helps others feel seen, and not invisible. Like the struggle that they face is actually real, and should be paid attention to because it's not so easy (I9) Obviously my therapist is white, I don't expect her to have much knowledge around my culture and my beliefs and all of that … but my therapist is quite understanding in that sense … like things that are specifically due to culture and that kind of thing (J10) [my therapist] wasn't telling me about my about my um culture or anything. They were more so asking and quite understanding … without me having to over-explain (J10) We have touched upon culture and if there are any differences I have that … may clash with the therapy. Because in the culture that I come from, elders are to be seen and treated with respect. Although yes therapy is important, the culture is just as important as well… (I9) I've only obviously had my therapist but I know that when I bought it up they were incredibly respectful and they-they reacted in basically the perfect way that I wanted to, and it really did reassure me (A1) I remember once one particular thing happened … and I went to go talk to my old DBT therapist about it and like their reaction to it kind of threw me off talking about those problems … I felt like I didn't really have a space to be able to talk about it … in the end we ended up clearing it all up and I remember I did say to them that … after that situation I didn't feel like I properly had a space to talk about things around being black and … it was difficult, and even after like we had cleared it all up, I was still very much still talking about it but I didn't feel like I could talk about talk about it … after I'd explained it and like he had spoken to me about it and like we'd actually like spoken about the situation like I felt as if um … I felt as if I could, and I think since then it was like better talking about it if that makes sense (B2)

Active conversations about ERC facilitates change

In contrast, adolescents felt validated, heard and seen when clinicians named racism as the elephant in the room, normalising conversations about ERC regardless of individuals' ERC background models that such conversations are acceptable in a therapy context. Open conversations held amongst everyone in a non-judgmental way allows everyone to re-examine their behaviours more mindfully, to '*be more aware of slight jokes or little things that they could then again* [take] *to their school lives or things like that and maybe just adjust* [their behaviours]' (A1), to be more inclusive of adolescents from racialised backgrounds both in DBT and in their everyday life.

Theme 2: Factors influencing ERC discussion

Three subthemes were identified that examined what facilitated or inhibited ERC discussions from taking place during therapy.

Facilitating factors

Having good therapeutic alliance with their individual therapist can make disclosures around ERC feel easier. Although given the sensitivity of the topic, clinicians should approach the topic at the adolescent's pace. Clinicians who explicitly offer to talk about ERC topics, who emphasise the value of such conversations in therapy, and who are patient and able to reframe and revisit this topic with adolescents over time can increase the chance of ERC conversations taking place. Finally, families who model discussions of ERC issues at home can be encouraging for adolescents to feel more comfortable sharing with individual therapists or other adolescents in treatment.

Inhibiting factors

Adolescents discussed how '*masking problems . . . not actually fully identifying what things are . . . beating around the bush in a way*' (H8) when it comes to ERC issues can create more ambiguity and confusion. Adolescents spoke about how being one of a few (if not the only) person from racialised background in a White-majority group setting, or in individual therapy with a White therapist can make it feel more difficult to bring up ERC issues. This is partly stemming from believing other people from non-racialised background can only relate to this at a surface level '*just because you do get it but like you don't get it . . .*' (B2). In addition, some adolescents discussed when sharing personal accounts of ERC-related stories, responses from others in the room can feel dismissive or simply not giving the experience the time and attention it deserves for the group to process the account together, '*the way I was getting dismissed it wasn't like that type of dismissal, it was just kind of like a skim like "anyways" . . .*' (B2).

Invalidating and downplaying the need for ERC discussions

Adolescents held pre-conceived notions as to whether it would be acceptable to discuss ERC publicly with others, as they have learnt from others that ERC issues should be '*downplayed and people push it under the rug*' (I9) so they do not come across as being too sensitive when they experience racism in their daily lives. The idea that ERC should be kept behind closed doors translated to adolescents internally calibrating what may be worthwhile to bring to discussion and invalidating their own experiences by thinking '*it wasn't that big of a deal*' (B2) and does not deserve to be mentioned in therapy.

Theme 3: Where to bring ERC discussions and who is responsible?

Three subthemes were identified that outlined environmental considerations in therapy that would influence the likelihood of ERC conversations taking place. Considerations for adolescents' perceived responsibility in discussing ERC in relation to professionals' roles are discussed.

Is DBT the right space for ERC discussions?

Adolescents reported sometimes feeling unsure if therapy would be the right context to bring up ERC conversations, especially when thinking about participating in DBT skills groups and being one of a few (if not the only) racialised individuals in the session. Adolescents discussed how ERC discussions may bring up strong emotions, potentially segregating the group based on ERC issues, and this would rupture groups dynamics.

Should I (the adolescent) be the spokesperson for ERC?

Adolescents noted that by recognising they were one of a few (if not the only) individuals from a racialised background that stuck out in group, they often felt both personally responsible for bringing up ERC and to manage the group's emotions to not upset others. Adolescents felt conflicted about this perceived position to be the spokesperson for ERC issues in therapy, especially when they felt like all they could do is '*do my part but like I don't know everything and all of you people are looking at me thinking I'm going to get up and teach you about all of these things*' (B2). Adolescents were mindful to not make people feel othered in group, as ERC is a personal topic and not a competition, '*I don't know one person's race is more victimised than the other, so they might feel like the problems that they may experience are not as bad as the others*' (H8).

Professionals to initiate beyond facilitate

Adolescents commented that ERC is often overlooked by professionals, and professionals can actively model how to bring up ERC conversations first. Adolescents voiced that they would feel more comfortable participating rather than initiating conversations about ERC. Adolescents emphasised professionals have a responsibility to understand each adolescent's ERC so they can respond in a culturally sensitive way to their stories and behaviours. Adolescents discussed professionals need to be patient and show some persistence when supporting adolescents to talk about ERC that may be difficult at first, because '*even if in that moment I* [adolescent] *hadn't brought it up just being able to question whether I had* [felt singled out or anything like that] *and being able to look back and think ...*' (A1) would be helpful in the long run for therapy.

Theme 4: Understanding myself through ERC discussions

Three subthemes were identified as adolescents spoke about finding their own identity in the context of ERC including trauma associated with ERC, and how ERC sits within the wider systemic context.

Finding my identity in the context of my ERC

Adolescents spoke about experiences of changing their personal identity to fit in with societal expectations and recognising sometimes their own identity clashes with and is rejected by their own cultural background. Adolescents reflected on the impact discussions about ERC in therapy have on their personal journey of navigating their own identity – such as re-examining their experiences and questioning the extent to which judgements from others influence their own judgements about themselves, arriving at a place that is more accepting of their own identity. Adolescents spoke about intersectionality and that their identity is multi-faceted and exists

beyond ERC issues, '*people do need to realise like a female from ethnic background has all these difficulties . . . my family would be like oh you can't have an opinion because you are a girl*' (E5).

ERC in the wider systemic context

For adolescents from mixed heritage, one's closeness to different ERC identity depends on complex family dynamics. Adolescents spoke about power imbalances in the family home in the context of their ERC, for parents to be in a position of authority, '*I guess the problem is that I think in like the black community, I feel like that is the culture, the father being the over-ruler, the king*' (H8). Adolescents recognised that although parents often are doing the best they can, they can still do better, with DBT providing an environment for parents from ERC backgrounds to learn from other people from diverse backgrounds and practise different ways of parenting the adolescent.

Trauma associated with my ERC

Adolescents talked about being targeted in their daily lives because of their race and skin colour, '*my colour had affected the way people had behaved/acted towards me*' (A1) and fighting other's perception of the self to not let their opinions take over the adolescent's life.

Theme 5: Therapy effectiveness in relation to ERC sensitivity

Three subthemes were identified as adolescents spoke more directly about how DBT as a therapeutic model can benefit from greater ERC sensitivity, the necessity for validation to come before teaching DBT skills, and the importance of repairing therapeutic ruptures when there is misunderstanding around ERC.

Teach DBT skills with ERC sensitivity

Adolescents discussed how DBT skills, when taught without explicitly bringing in cultural adaptations, can embody colour-blind racial attitudes. Including cultural perspectives, especially in interpersonal effectiveness skills, can be helpful for adolescents to consider how to safely practise the skills such as asserting one's needs when talking to older people without potentially making themselves vulnerable to criticism from others. In addition, practising a variety of skills including those which are more discreet can be helpful, as the adolescent will not need to explicitly explain the skill to others who may not understand what it is for.

Validation of ERC experiences is crucial

Adolescents spoke about when DBT skills are taught as part of solution analysis without first validating the adolescent's disclosure around ERC can feel very invalidating, '*I felt invalidated because my therapist was kind of like making it out to be in my head . . . I felt like this kind of got invalidated by the whole check the facts thing*'[1] (B2), especially when the therapist does not share the adolescent's racialised status and is insensitive. Adolescents emphasised the need for validation in sessions to feel seen and heard by others. They stated validation is not a skill that requires therapists to share the adolescent's racialised status to convey understanding, '*obviously my therapist is white, I don't expect her to have much knowledge around my culture and my beliefs and all that . . . but my therapist is quite understanding in that sense . . .*' (J10).

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[1]'Check the facts' is a DBT emotion regulation skill and encourages the young person to check their interpretation of the events against the factual information about the situation.

Alliance, rupture and repairs

Adolescents shared culturally affirming practices whereby their therapist explicitly offered a space to explore '*experiences that I've had due to culture* … [which] *wasn't done in a patronising way*' (J10). Particularly for cross-cultural therapist–client dyads, adolescents emphasised the importance of their therapeutic relationship to create the safety needed to discuss ERC; '*with the good rapport I built up with my um individual therapist I was able to speak with* [them] *about certain things*' (F6). Adolescents valued '*the way they* [their therapist] *were quite curious, quite validating*' (C3), and the protected time and space to explicitly acknowledge the impact of racism '[they were] *really respectful and definitely did dedicate the necessary time for it and like talked about the effect it would have on me*' (A1). Therapeutic ruptures around ERC-related discussions occurred in cross-cultural therapist–client dyads; ruptures within the therapeutic relationship had the potential to leave adolescents feeling '*weird talking to someone who isn't an ethnic minority about race problems*' (B2). Repairing ruptures required therapists and clients to revisit ruptures to understand where the therapist failed to empathetically connect with the impact of racism and/or microaggressions on the adolescent; '*after I'd explained it and like they had spoken to me about it and like we'd actually like spoken about the situation* … *it was like better talking about it*' (B2).

Discussion

This study highlighted the perspectives of adolescents from diverse ERC backgrounds accessing a national and specialist CAMHS DBT service on their experience of talking about ERC in DBT, and their reflections on how standard DBT fits with their cultural context. Adolescents reflected on many facilitators and barriers to holding ERC discussions in DBT, acknowledging the importance of such discussions to provide context for treatment delivery and promote self-discovery. This finding is consistent with one previous qualitative study with adolescents aged 16–18 years from racialised ethnic groups who accessed CAMHS in the UK on their perspectives of talking about ethnicity in therapy (Gurpinar-Morgan *et al.*, 2014), where adolescents spoke about the dialectic between staying faithful to family origins and conforming to mainstream British culture. Adolescents noted that conversations about ERC can feel threatening at the start of therapy, and negatively impact therapeutic alliance if the clinician does not clearly explain how ERC discussions can help with formulating difficulties and treatment planning (Gurpinar-Morgan *et al.*, 2014).

  Participants' reflections echo many of the therapist treatment-interfering racist behaviours outlined by Pierson *et al.* (2022). Adolescents identified that race is often overlooked in the context of accessing mental health treatment, and clinicians may express colour-blind racial attitudes (Okah *et al.*, 2022), and lack awareness of how race, privilege and power may have a direct influence on experience and identity development. Conversations about ERC may elicit guilt, shame and internalised racism in White clinicians or peers that reduces the likelihood of such conversations taking place in therapy (Pierson *et al.*, 2022). At the same time, adolescents spoke about how clinicians hold responsibility for educating themselves about each adolescent's ERC background to help contextualise their behaviour within their context, and the need to maintain cultural humility when clinician's experience and interpretation of events may differ from that of the client's, especially when using skills such as 'check the facts' and 'DEAR MAN'[2] in the context of DBT. Adolescents emphasised the dialectical position they held in both recognising the responsibility they felt for talking about ERC when they may be one of a few, if not the only, racialised person in a predominantly White mental health setting, *and* at the same time not wanting to emphasise their 'differences' and upset the White majority through vulnerable self-disclosures. Adolescents' dilemmas reflect the double bind that Pierson *et al.* (2022) highlighted,

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[2]DEAR MAN is a DBT interpersonal effectiveness skill, and stands for Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate. It encourages the young person to assert their view whilst holding the perspective of the conversation in mind and be willing to negotiate on outcome.

where clients from diverse ERC backgrounds may be positioned in the balancing act of educating their therapist and improving their anti-racist stance, *and* tolerating the therapist's lack of self-awareness, all to seek improved care. Previous studies have found that it is the process of the therapist demonstrating willingness and understanding of the adolescent and their cultural background that facilitated engagement in therapy (Pope-Davis *et al.*, 2002), regardless of therapist's ethnicity (Gurpinar-Morgan *et al.*, 2014). There is growing literature evaluating the multi-cultural competencies that therapists can develop to improve the experiences of racialised individuals in therapy; for example, in a recent meta-analysis, Yi and colleagues (2023) highlighted the importance of therapists taking up anti-racist praxis in therapy through diversity openness, racial/ethnocultural empathy, and adopting a social justice orientation.

Similarly, adolescents in the current study identified validation as a key ingredient for therapists to actively acknowledge systemic racism where adolescents have been invalidated, and increase their validating responses (Pierson *et al.*, 2022). Therapists need to self-reflect and approach topics of empathic failure and invalidation re-enacted in the therapy room to repair the therapeutic relationship with the adolescent. Adolescents discussed the importance of White clinicians embodying cultural humility and approaching topics of ERC throughout therapy to support linking these aspects of identity to their experience. Linking identity to experience allowed adolescents to adopt a more self-reflective lens, moving away from operating from internalised oppression and instead adopting a more self-affirming and self-embracing perspective (Edmond, 2023). This may be particularly pertinent given the pervasive invalidating racist environments that young people from diverse ERC backgrounds are likely to experience, and the importance of these transactions in the development of psychological distress (Grove and Crowell, 2019; Linehan, 2018). Therapists will therefore likely need to emphasise validation strategies in their practice, and use the fallibility agreement to hold a non-defensive stance (Linehan, 2018), similar to recommendations for applying DBT to other marginalised and racialised groups (Camp *et al.*, 2023).

The journey of navigating self-identity in the context of ERC mirrors what Pierson *et al.* (2022) proposed: that clinicians can support clients from diverse ERC backgrounds to acknowledge and understand the lack of safety, pain and distress that racism brings. Supporting adolescents from racialised backgrounds to foster ethnic-racial identity (connecting with one's racial group) may also be an entry point to developing critical consciousness (to challenge social inequities) (Mathews *et al.*, 2020). The latter is linked to clinicians' role in supporting adolescents to safely and effectively manage their distress associated with racism by sensitively discerning the instances when changing one's emotional response to instances of racism is appropriate versus the times where resistance and advocacy (adopting a social justice orientation) are more effective for the adolescent's identity and wellbeing. For White clinicians to become an ally in anti-racist efforts to support their clients, adolescents' voices in the current study echo 'skills competency' outlined by Pierson *et al.* (2022), which highlights White clinicians' responsibility to tolerate their own intense emotions when faced with topics on race or difference. Therapists can check the facts on guilt, shame and reactivity, and use opposite action, problem solving, radical acceptance and non-judgemental mindfulness skills to self-regulate in the therapy room, *and* actively introduce and invite clients to openly discuss their ERC and related experiences (Pierson *et al.*, 2022).

Strengths and limitations

This study emphasises the importance of actively reflecting on clinical teams' skills competence in eliciting, initiating, and effectively using ERC conversations to promote clients' self-discovery and reduce psychological distress through a DBT framework when working with a diverse group of adolescents. A key strength to this study is the conscious effort that authors held to minimise input from White clinicians during the qualitative research process, with the intention to reduce potential 'double bind' that adolescents may feel when discussing ERC topics in an interview facilitated by White clinicians, and to actively acknowledge power differential in the interview. At

the same time, the first authors experienced the double bind described by adolescents; as junior team members and people of colour, the first authors reflected deeply on the themes emerging from the data before feeding back results to predominantly White senior clinicians. Whilst the first authors' unique contributions as people of colour were highly valued in propelling the project forward, it perhaps highlights the missed opportunity for White clinicians to reflect upon and evaluate their cultural competencies through grappling with uncomfortable accounts from diverse adolescents via the research process during data analysis and synthesis. In line with Pierson *et al.* (2022), we advocate for future studies relating to ERC and anti-racism issues in clinical settings to search for the synthesis through balancing the needs, experiences and expertise of adolescents as well as different members of the clinical team during every stage of the research process, to emphasise learning through self- and team-reflection. Whilst acknowledging the conceptualisation of this project stemmed from adolescent feedback in routine service evaluation, adolescents were not involved in the interview schedule development. Adopting a participatory framework by including service users throughout may further address any power imbalance (Beck and Naz, 2019; Jennings *et al.*, 2018).

Clinical implications and future directions

Having listened to adolescents' perspectives on the ways in which DBT clinicians can promote more skilful and sensitive ERC-related discussion in therapy, we invite clinical teams to reflect more broadly on ways of promoting equality, diversity and inclusion in the social change ecosystem (Iyer, 2020; Roe, 2020). As a clinical team, we have actively reflected on the anti-racism stance in DBT as proposed by Pierson *et al.* (2022). The team has noted our responsibility as healthcare professionals to be *frontline responders* (i.e. to address community crises by marshalling and organising resources, networks and messages) to current issues around diversity, inclusion, and institutional racism. To that end, this study worked to support adolescents from diverse ERC backgrounds to serve as both *guides* (i.e. to teach, counsel, and advise, using gifts of well-earned discernment and wisdom) and *storytellers* (i.e. to craft and share their community stories, cultures, experiences, histories, and possibilities through their narratives). Not only has this facilitated our understanding of how conversations pertaining to ERC are approached in our national and specialist CAMHS service; it has enabled some consideration of these issues in the broader context of DBT. The first two authors reflexively used their personal experiences to adopt the role of both *weavers* (i.e. to see the through-lines of connectivity between people, places, organisations, ideas and movements) and *builders* (i.e. to develop, organise and implement ideas, practices, people and resource in service of a collective vision) to help bridge the narratives of adolescents with the clinical team's position on their commitment to anti-racism. We hope to encourage team consultation and reflection underpinned by the voices of adolescents from racialised backgrounds. Through this, our hope is that clinicians, and White clinicians in particular, can become both *disruptors* (i.e. to take uncomfortable and risk actions to shake up the status quo, to raise awareness, and to build power) and *healers* (i.e. to recognise and tend to the generational and current traumas caused by oppressive systems, institutions, policies and practices). These roles are integral in challenging and dismantling the structural and institutional racism that interferes with the provision of care mental health settings.

Key practice points

(1) We highlight adolescents' voices on the importance for clinicians, especially those who identify as coming from a White majority background, to build awareness of their knowledge gap in ERC issues.

(2) We emphasise the need for clinicians to use validation, embody cultural humility, and develop skills competence to model initiating ERC discussions in the therapy room when delivering DBT.

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