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Chapter 2

Biosocial Theory and Cultural Assessment

In clinical practice, the lived realities of marginalized and oppressed individuals, such as BIPOC clients, can easily be overlooked. But we know those lived experiences are just as important as genetics in determining a client's mental health. Understanding this connection—between environment and biology—and conducting a thorough cultural assessment for harmful experiences related to sociocultural diversity can help the DBT clinician provide more robust treatment for diverse clients. Further, exploring the historical experiences of diverse clients, including details such as the dynamics of their family relationships and their family history, may help uncover key information such as patterns of intergenerational trauma. And while assessing the aforementioned, the culturally proficient and humble DBT clinician must also look within and interrogate their own cultural identity and learn to self-assess for bias if they are to keep treatment from becoming an invalidating environment.

This chapter begins with a consideration of the biosocial theory, which posits a transactional relationship between biological factors (such as genetics) and environmental factors (such as upbringing, childhood trauma, or adversity) in determining mental health. Specifically, we consider how the biosocial theory relates to BIPOC clients through a consideration of historical factors and adverse experiences that may have impacted individuals, and the role that diversity awareness plays in

diagnosis and DBT treatment. The case of Lola is used as an example of the use of a cultural genogram in DBT pretreatment.

In the 1990s, Marsha Linehan introduced the biosocial theory as a way to understand the development of borderline personality disorder (BPD), arguing that the disorder is based on the interplay between biological and social factors (1993a) and how these factors, together with emotional vulnerability, or persons with "thinner skin," lead to BPD. That is, per Linehan, some persons are biologically more sensitive and have more intense emotions that are longer lasting which add to challenges of regulating emotion and are associated with an increased risk of more impulsive behavior. In terms of biological factors, the theory posits a genetic basis for emotion regulation; this theory is supported by literature that notes that a higher rate of certain mental disorders, such as BPD, can be found in immediate family members, known as first-degree relatives, who share half of the client's genes (Freeman, 2024; Sun et al., 2023). Interacting with these biological factors are social (environmental) factors, which consist of the transactions between the individual and their environment, particularly if that environment is invalidating. Linehan posits that an individual's negative experiences within their immediate family and also within the broader context can create experiences of invalidation. In support of this, researchers have noted that early childhood adversity within the primary family unit, as well as more external environmental factors, such as violence, poverty, and deprivation, can have negative effects on neural development and the stress-responsive systems (McLaughlin et al., 2014; Huether, 1998; Smith et al., 2020).

This chapter begins with an exploration of some of these environmental factors in more detail, including family history, cultural issues, and events. Although our focus here is on the above factors that are of particular relevance to the DBT clinician, it is also important to recognize the role of epigenetics in mental health. Epigenetics is the study of how the events that happen to us (e.g., traumatic events) as well as our own behaviors (e.g., trauma responses, diet and exercise) can change the way our genes work. In other words, genes don't just impact who we are by themselves; depending on what happens to us and what we do in our lives, our genes will express themselves differently, thus changing how we turn out. While epigenetics plays a role in the development of BPD (Juraś-Darowny et al., 2023), a full discussion is beyond the scope of this book. For further information, we recommend reviewing the literature on epigenetics and the biosocial model of borderline personality disorder,

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such as the work of Salavati and Selby (2025), Jokinen (2024), Ansari et al. (2023), and Mielke et al. (2023).

Because these environmental factors play such an important role in determining mental health, it is important to focus on diversity when conducting a diagnosis and assessment in DBT. While a disorder like BPD, for example, is prevalent in multiple cultures and countries and has been noted in emerging research as a general psychological syndrome (Brüne, 2016), it may manifest differently in each culture. Cultural factors are important not only in the diagnosis of BPD (DSM-5-TR; American Psychiatric Association, 2022) but in treatment considerations as well (Hwang et al., 2008). As DBT clinicians consult on cases, they may be challenged to explore diversity aspects intertwined with clinical issues. Clients' contextual and historical factors are important for the clinician to explore during pretreatment assessment to identify possible effects on a client's treatment and to identify potential blind spots that may inform treatment strategies.

INVALIDATION AND THE ISMS

In accordance with the biosocial model of BPD, ongoing invalidating experiences and environments are a key feature of emotion dysregulation. It is important to recognize that persons may experience invalidation via an ism, or through a number of socioculturally related factors that are oftentimes under-addressed in the DBT treatment setting. We've provided some examples of isms which may be associated with invalidation in Table 1.1. The next section focuses on the ism associated with race, and specifically how it impacts some BIPOC clients, although we underscore that experiencing an ism due to being a BIPOC is not a rule of thumb nor a fact for all individuals. The isms are unique to each individual. In this chapter we could have chosen to use the examples of the isms of ageism or sexism, and we chose racism. We encourage you to pull the concepts that you deem most helpful from this chapter and apply them when working with clients who endorse their own lived experiences with applicable isms.

Throughout the DBT assessment, pretreatment, and treatment phases, clinicians must ensure they are addressing key cultural factors, and that they do not avoid or under-address the impact of the isms. Moreover, DBT clinicians are encouraged to engage in additional

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assessments, such as exploring potentially invalidating and/or discriminatory experiences due to the isms and environments which may have occurred throughout the client's life course. Using a broad application of the biosocial theory, beyond just the client's family system, should help prevent this by facilitating an intentional exploration of potential sociocultural and contextual factors, such as oppression and race-based stress, that may contribute to the client's emotional dysregulation. Please refer to Tables 1.2 and 1.3 for examples of invalidating environments beyond the family unit.

CULTURAL ASSESSMENT: CONSIDERING HISTORICAL FACTORS AND ADVERSE EXPERIENCES

In conceptualizing the diagnosis of BPD and exploring a culturally proficient and humble DBT approach—again, using the example for BIPOC individuals—clinicians should consider not just the biosocial theory but also historical factors that undergird a client's racially and culturally invalidating environment. Some of these historical factors are known as adverse experiences. They include the negative effects of oppression and abuse of power by one group over another, such as slavery, colonization, segregation, and racial violence. In addition, on a macro-systemic level, BIPOC clients have endured a historical background of inequity in employment, education, and healthcare. Access to educational and employment opportunities has always been a challenge for BIPOC individuals in the United States and abroad (Dohrmann et al., 2022; Darity, 2003). For many African Americans and other BIPOC clients in the United States, racism has also been associated with poor physical and mental health outcomes (Dopelt, 2025; Williams & Mohammed, 2013; Darity, 2003; Sue et al., 2007). All of these factors result in intergenerational trauma, which is trauma passed down from generation to generation. Of note, it is important to consider the application of not just one diversity variable as a person's sole identity, but the intersectionality of these variables. For example, the experience of an African American who is also a female may be very different than that of an African American who is a male.

Further, because many of these adverse historical experiences were enacted by European, White-dominant groups (Fields, 1990; Eltis, 1993), they have been described as being predicated on White supremacy and privilege (Gordon-Reed, 2018). However, as discussed

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in Chapter 1, White fragility often leads this history to be overlooked, skirted around, or overtly denied by dominant groups (DiAngelo, 2022; Gibbons, 2018).

Racial violence is not a new story in American history books (Jackson, 2022). Moreover, there has been resurgence of racial violence in recent history, such as the 2020 murder of George Floyd by police brutality; an event which was broadcast widely on media outlets (Elias et al., 2021; Lund, 2020; Tao & Fisher, 2022). One study of BIPOC youth reported that racial violence and its continued viewing on social media may engender racial trauma (Tao & Fisher, 2022). In clinical practice, some psychotherapists felt confused about how to respond to the events of racial violence during the pandemic, and about how their clients responded to them in psychotherapy (Lipscomb & Ashley, 2020; Morris & Rawlings, 2023; White, 2022). The 2025 U.S. administration's dismantling of diversity initiatives, research, and programs, along with the murder of George Floyd, reminds us that we are not in a post-racial society, as we may have believed. Although these topics may be difficult to grapple with, we cannot deny their existence. Similarly, we recommend that in practice, DBT clinicians be willing and open to have candid discussions with their clients in assessing their experiences regarding past and present experiences of the isms (Table 1.1).

We suggest that clinicians adopt a beginner's mind with gentle curiosity and a culturally humble posture when they approach assessment of a DBT client's (or consult team member's) perceived adverse events, both present and historical. This is relevant to treatment as the experience of stigmatized racial and ethnic identities is a widespread reality for many BIPOC clients (Williams, 2020) and can be a controlling variable for their emotion dysregulation, suicidal ideation, self-harm behaviors, substance abuse, and other problem behaviors (Keum, 2023; Rudes & Fantuzzi, 2022; Coimbra et al., 2022).

CULTURALLY PROFICIENT DBT CLINICIAN PRO TIP

What: It is important to understand historical factors and present-day adverse experiences that affect a client's presentation, as this information may help inform conceptualization and treatment planning.

How: Ask your client to educate you about potential historical harms that they may have experienced. Create an adverse experiences timeline, in which experiences are chronologically depicted including present day experiences.

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DBT PRETREATMENT: BUILDING PHENOMENOLOGICAL EMPATHY THROUGH THE BIOSOCIAL THEORY

DBT has a pretreatment period that allows for engagement with and assessment of the client, offering an opportune time to gather important contributors from the client's culture at the onset of the treatment (Linehan, 1993a). In addition to assessing the client's internal emotional vulnerability, the clinician should explore the family and social environment and interpersonal networks that contribute to the individual's behavioral, cognitive, and emotional response and functioning. In particular, DBT is looking for the invalidating environment where normal responses are invalidated or where invalid responses are normalized.

Individuals with BPD often grow up or are in current social contexts where their emotional experiences are ignored (Linehan, 1993a). This continuous dismissal of their private experiences can lead the individual to question their own cognitive and emotional perceptions of external events. This can happen in the family of origin, school, friendship groups, and professional and educational settings. Similarly, microaggressions can also occur in the client's closest network, including their familial and intimate relationships. In addition, racial and cultural experiences can compound an already invalidating environment. The biosocial theory of BPD and the cultural assessment can help the DBT practitioner determine how to intentionally explore discriminatory racial events and race-based stress contributing to a client's emotion dysregulation. Beginning in pretreatment, the clinician should consider the BIPOC client's sociocultural experiences of invalidation in relation to each of the three core aspects of the invalidating environment: (1) the pervasive invalidation experienced, (2) the disregard of low-level expressions of distress and the intermittent reinforcement of escalation, and (3) oversimplification (see Chapter 6 for more on validation and invalidation).

CULTURALLY PROFICIENT DBT CLINICIAN PRO TIP

What: Use pretreatment in DBT as a critical time to assess a client's experiences of the isms (Table 1.1).

How: In a phenomenologically empathetic stance, ask the client to educate you and share if they have experienced any of the isms. Adopt a beginner's mind stance of fallibility and humility as you work with your client.

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PREVENTING TREATMENT FROM BECOMING AN INVALIDATING ENVIRONMENT

To be culturally proficient, the DBT clinician should be mindful of the transactional nature of their own relationship with the client, as laid out in the biosocial theory. It is not just an interaction—the behavior of the environment and the client transact over time to result in the current environment, including the treatment environment. What the clinician does or does not say or do will influence what the client does or does not say or do. Moreover, the clinician and client must work reciprocally toward a common goal, in companionship or in partnership—which is one of the core concepts of anti-oppressive practice. Clinicians should be mindful of their own behaviors, attitudes, and perceptions in response to a client's sociocultural factors, such as assumptions they may have based on the client's cultural appearance or diverse presentation. Further, because therapy involves an ongoing series of exchanges, clinicians should be mindful of how these exchanges influence their choice of interventions and responses in treatment (McKenzie, 2011).

Clinicians should take time to reflect after sessions and consider any potential implicit biases they may have had and their potential impact on treatment. It is important to highlight personal bias when attempting to deliver culturally sensitive mental health care (Sue et al., 2022). A culturally humble clinician is aware of the impact of implicit social cognition about cultural characteristics of their clients including race, gender, and ethnicity (Petersen, 1986). The clinician's awareness of the bi-directional nature of the therapeutic relationship—meaning that it is transactional in nature—is critical in multicultural therapy and therapy with diverse populations.

To try to prevent invalidating the BIPOC client, the clinician should avoid adopting a detached clinical posture. In harmony with DBT practice, they should use radical genuineness and search for the "kernel of truth" in a client's narrative. A DBT clinician, skills group leader, or consult team's lack of culturally humble and proficient practice may mean they are unprepared to treat cultural minorities and marginalized populations. In fact, the pull from the dominant culture may encourage them to do the opposite and operate on the side of the dialectic that overlooks cultural and racial differences in individuals. An example of this might be the assumption that evidence-based mental health treatments will

have the same outcomes on clients, regardless of ethnicity, race, or cultural factors (Huey et al., 2014).

When responding to a BIPOC client's description of their invalidating environment in the past or present, it is important for the DBT clinician to keep in mind the concept of healthy cultural paranoia, as described in Chapter 1. It can be all too easy for clinicians from a dominant community to question the validity of a client's perceptions of discrimination or invalidation in their environment without meaning to be invalidating. This is a time for phenomenological empathy and looking for the non-pejorative interpretation of the client's experience.

To prevent treatment from becoming an invalidating environment, the clinician should use reciprocal communication strategies and remind the client that they are in a relationship between equals. We provide more on these recommendations in chapters 3 and 7. Further, we encourage the DBT clinician to welcome the client's feedback regarding what may be working or going well in treatment and what may not be working or may need to be improved. DBT clinicians can also ask clients directly if anything in treatment has felt invalidating, and encourage clients to openly and candidly share their feedback.

USEFUL STRATEGIES FOR CREATING A VALIDATING ENVIRONMENT IN DBT

Acknowledgment of Sociocultural Diversity

To create a validating environment, it is key that a culturally proficient and humble DBT clinician acknowledge their client's sociocultural diversity variables (see Chapter 1, ADDRESSING framework or RESPECTFUL model). When a clinician fails to recognize and acknowledge an individual's identities, it can be harmful to the therapeutic process. For example, if a clinician adopts a color-blind stance, it may pose a hazard in counseling by ignoring racial or ethnic factors that a client may identify as part of their core identity and which influence many aspects of their life. Instead, the clinician should humbly assess factors such as the client's socioculturally diverse background, including historical or background information that the client may deem pertinent.

The professional ethics codes on multicultural competence and ethics in mental health professions highlight the importance of addressing multicultural factors in treatment. For instance, the APA Ethics Code

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Principle E—Respect for People's Rights and Dignity—states the following:

> Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (cited in Fisher & Vacanti-Shova, 2012)

Not only are clinicians ethically called to address multicultural factors, but in an effort toward culturally proficient care, they must acknowledge the harmful effects of racial silence and color blindness, which can obscure important dialectics. Hwang et al. (2008) highlight the importance of the relationship between culture and its impact on mental health. Further, it is important to also consider the assessment and acknowledgment of concepts such as acculturation (Berry & Annis, 1974). Acculturation is the process of integrating into a dominant culture. Individuals may find this process psychologically challenging and associated with acculturative stress (Berry & Annis, 1974). In experiencing acculturative stress, a person has a greater chance of experiencing psychological harms such as anxiety disorders, major depression, eating disorders, substance misuse, and overall poorer psychological well-being (Lerias et al., 2025).

Lastly, the DBT clinician should be mindful of sociopolitical events and policies that might negatively impact their clients. Culturally proficient and humble DBT practice calls clinicians to inquire and assess the potential ramifications of such events on their client's psychological well-being. For example, with the push to remove the teaching of critical race theory in academic institutions (Crenshaw et al., 1995; Del Toro et al., 2025; Serrurier, 2024), BIPOC clients are likely to experience systemic cultural invalidation and distress. Another example of political policies that could invalidate and negatively affect diverse clients is the 2025 defunding of diversity initiatives, such as those that support

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LGBTQIA+ and DEI programs, grants, and diversity training, including federal contracts and employment. Lastly, immigration policies targeting immigrants such as Latina/o/e/x have been found to be associated with an increase in depression, distress, financial strain, and insomnia (Olguin-Aguirre et al., 2024).

Clinician Self-Assessment

As with any psychotherapy, it is essential that we acknowledge our own basic tendencies and understand how they will impact the client and the psychotherapeutic process, such as the way we comprehend other cultures and the limits our culture places on our comprehension of clients and their biosocial history. To this end, cultural proficiency and humility in DBT practice involves the clinician engaging in self-assessment on concepts of cultural identity, including issues of privilege, and inquiring into how these shape their work with diverse populations. We recommend clinicians use Table 1.1 as a guide to asses for potential identities of privilege and/or oppression. They may also use the ADDRESSING framework or RESPECTFUL model to engage in a self-assessment.

Engaging in a self-assessment should apply to all DBT clinicians. Further, we suggest that the White identity development model and the concept of White fragility, discussed in Chapter 1, may potentially also be applied to other dominant identities or power groups as outlined in Table 1.1 (e.g., being able-bodied, heterosexual, a cisgender male, or a speaker of the dominant language). Clinicians are encouraged to explore how those identities developed and where they might lead to fragile responses.

Another approach that might be helpful here is Jereb's tripartite model for cultural assessment (1982), in which DBT clinicians may ask themeselves the following questions during their self-assessment:

1. Within what framework or context can I understand this client (assessment)?
2. Within what context do you determine what change in functioning is desirable (goal)?
3. What culturally responsive techniques may be used to effect the desired change (intervention)?

The clinician can use these questions during any phase of DBT treatment,

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in preparation for individual sessions, or as part of their work with the DBT consultation team. By using Jereb's tripartite model for cultural assessment the clinician may gain a better understanding of their sense of self in relation to the client. For example, if the clinician understands the client from a place of privilege (in terms of seeing themselves as having a higher socioeconomic income), asking the question, "Within what framework or context can I understand this client?" may enable them to consider potential barriers or limitations that the client faces which they themselves do not. They may recognize that the client does not have the financial resources to download and use a DBT Diary Card phone application, and thus be more understanding and accepting of a hard copy, paper-pencil Diary Card. The hope is that the tripartite questions may aid the clinician and client in considering DBT interventions that are better suited to address the needs or capabilities of diverse clients in therapy.

Furthermore, to conduct a sociocultural self-assessment in DBT, we also offer the DBT Clinician Cultural Self-Assessment shown in Figure 2.1, a model inspired from the seminal work of Pamela Hays (2022) on

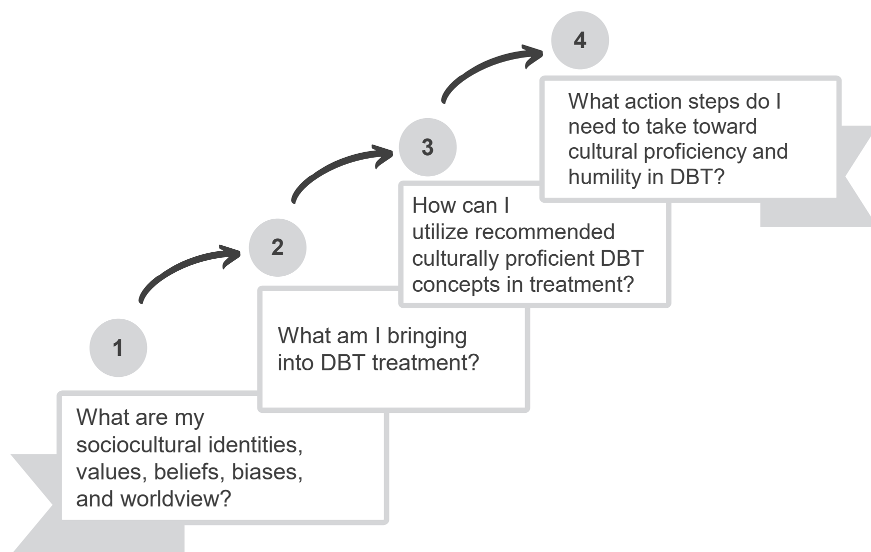

FIGURE 2.1. DBT clinician cultural self-assessment.

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cultural self-assessments. Step 4 of the model assumes that the clinician acknowledges areas of growth and considers the question, "What action steps do I need to take toward cultural proficiency and humility in DBT?"

Client Cultural Assessment

In addition to the clinical interview, a cultural assessment of the client should be conducted and should involve self-report measures and an assessment of past and present adverse experiences. For example, the Adverse Childhood Experiences questionnaire is a widely used, validated instrument that can assess early childhood experiences (Felitti et al., 1998). To assess current racial experiences, the clinician may consider using the Racial Micro-Aggressions Scale (RMAS; Mekawi & Todd, 2018) or the Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011). While the scope of this chapter does not allow for a complete listing of the numerous assessment tools that may be used in conducting a cultural assessment, it is imperative that the clinician consider the use of some form of cultural assessment in working with diverse populations. For example, some concepts that are recommended for assessment are (1) race-based traumatic or discriminatory experiences; (2) acculturation levels; (3) multigenerational experiences related to diversity variables such as slavery and/or migration; (4) diversity-related present experiences of marginalization or oppression due to the isms; and (5) historical experiences, depicted by a timeline which illustrates experiences of discrimination, exclusion, losses related to specific diversity variables of the client (e.g., experiences of marginalization due to race or ethnicity, such as redlining).

Assessing for Sociocultural Trauma

Assessing for sociocultural trauma in DBT requires clinicians to be explicit in the search for potential traumas associated with client's sociocultural factors and history. This may be difficult at times as a clinician may struggle with their own unconscious biases (unbeknown to them) which in turn may influence their thoughts, emotions, or behaviors. For example, a clinician treating an older-adult, European American female client of high socioeconomic status who holds a doctoral degree,

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may assume that the client has somehow had a "good life" since the client appears to be high-achieving. However, upon a cultural assessment, the clinician may learn that the client identifies as being Jewish and as being raised by a single mother whose ancestors survived the Holocaust. Further, the client may also reveal numerous experiences of anti-Semitism and covert discrimination because of her culture. This said, the DBT clinician should actively work on reflecting on their own thoughts, assumptions, and emotions during treatment—and explore if they are potentially unhelpful and/or biased. As such, assessment of sociocultural trauma—explicitly looking for what might be left out—helps clinicians to challenge their own implicit bias and adopt a culturally sensitive stance.

Cultural Genogram

A genogram is a visual or graphic representation of a family tree, which can provide a wealth of information for clinicians in treatment. Genograms that are focused on gathering cultural information are useful assessment tools that a clinician can use with a DBT client in pretreatment or early in treatment (Hardy & Laszloffy, 1995; Shellenberger et al., 2007). The cultural genogram may aid rapport building between the clinician and client, and challenge culturally based stereotypes by gathering descriptive information on the client's biosocial model. It may also help the clinician identify culturally based emotional triggers or family-of-origin areas where the client becomes emotionally dysregulated (Hardy & Laszloffy, 1995). It is best to go back three generations for the cultural genogram, noting anyone who was a caregiver and including extended family networks, also known as fictive kinship in some BIPOC communities (including "aunties" and "uncles"; McCullough-Chavis, 2004). Genograms may help the client and clinician with identity building and coming to a synthesis between various identities, including personal and family beliefs. Furthermore, the clinician may identify areas in the client's biosocial history that are culturally linked and might affect DBT treatment.

One of the key factors of completing a cultural genogram as part of the cultural assessment is to identify symbols that represent each person's diversity variables, such as (and not limited to) social identities, including birth order, gender identity, sexual orientation, age, ethnic and

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racial identity, and relationship to significant others. Symbols for relationship status, religious practices and beliefs, deaths, and incarceration are noted, as well as those for factors like substance addiction, excessive spending, or gambling. We recommend the book *Genograms: Assessment and Treatment* by McGoldrick et al. (2020) as a resource for learning how to create genograms and how they may inform treatment. Another recommended resource is the work of McCullough-Chavis (2004) which provides examples of using genograms with diverse populations such as African American families.

We encourage clinicians to conduct a cultural genogram to assess historical, cultural, familial, and contextual factors that may influence the client's presentation and treatment plan. Completing a cultural genogram may help the clinician get a bird's-eye view of factors that they may not have considered relevant in treatment. It may also be eye-opening to the client and serve as an educational piece in terms of behavioral patterns, maladaptive relationships, contextual harms, and intergenerational trauma. It is recommended that the genogram be completed during the pretreatment phase. When the clinician is gathering information from the client to develop the biosocial model of treatment, the genogram may help the clinician understand more of the client's familial, relational, and social influences and their possible contributions to the client's presentation.

The genogram may also provide helpful information regarding the quality of relationships between the client and relatives, such as if the relationship is supportive or estranged. This may shed light on potentially invalidating relationships or relationships that reinforce target behaviors. The genogram may also help engender a shared understanding of cultural issues in the client's background. This is helpful for DBT treatment planning and to highlight potential cultural dialectics that the therapeutic dyad will encounter as they work on the client's presenting problem.

Once the genogram is completed, the clinician and client may then have a helpful graphic representation of the current family relationship. Consider the family constellation, including who is part of the nuclear family and the extended family network (McCullough-Chavis, 2004; Bell, 2009). Any number of potential questions may be appropriate and should be used to gather a deeper understanding of the relationships between the individuals in the genogram. Below are just a few examples:

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- What beliefs, cultural traditions, and religious beliefs are practiced by the client's family? How are these beliefs and traditions transmitted to the next generation?
- How does each family member communicate with the others?
- What is the nature of intergenerational relationships in the family?
- What are the family's perspectives on work, education, and achievement?
- What are the key messages about race and religion that the client has received from their family?
- What aspects about the client's family make them feel ashamed?
- What roles do extended family and community play in the client's life?
- What family messages or beliefs influenced the client's intersecting identities? What aspects of their culture are the most difficult for the client to embrace? What are the easiest for the client to reject?
- What are some of the family's resources and strengths?
- What makes the client feel proud about their family?

In order to secure a broader understanding of behavior and potential invalidating environments, explore the family network for unhelping patterns such as maladaptive communication patterns or experiences such as abuse. Note patterns of addiction and biological transmission of mental or medical illness as well as strengths within the family network. Use the cultural genogram as a working tool throughout treatment and with the DBT consultation team.

CULTURALLY PROFICIENT DBT CLINICIAN PRO TIP

What: Completing a cultural genogram may supplement the standard assessment by providing a greater, more comprehensive look at factors—such as historical events or family maladaptive behavioral patterns—which in turn may inform treatment.

How: The cultural genogram may take a few sessions to complete, and it is recommended to do so during the 4-week pretreatment–early treatment phase in DBT.

Information gathered by the genogram may not just inform the clinician's work in pretreatment and early phases of DBT treatment but throughout the course of treatment. For example, during Stage 2 of DBT,

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where the focus is on the treatment of trauma, the genogram may shed light on traumas that the client may have experienced. These traumas may have easily gone undetected if not for the use of the genogram as a cultural-assessment tool.

Form 2.1 at the end of this chapter provides a list of example questions clinicians may use in preparing a cultural genogram with their client as well as in exploring pertinent information on the diagram that may inform treatment. For example, asking the client if they notice any patterns of substance abuse or trauma among family members may shed light on whether they have experienced any harms as a result of the aforementioned.

In the following section we share the case of Lola and provide examples of the cultural assessment and genogram used in her treatment. We also weave Lola's case into future chapters to illustrate the application of recommended strategies.

The Case of Lola

Lola, who is a fictional character, is a 23-year-old, bicultural African American-Latina/o/e/x client who is bilingual (English and Spanish) but grew up in a household where one parent spoke primarily in Spanish. Lola's pronouns are "she," "her," and "ella" ("her" in Spanish). When asked about her sexual orientation, she shared she is queer with a gender identity of non-binary.

Growing up, Lola was given the pet name of "La Negra" (the Black one) by her immediate family because of her darker skin tone, which she got from her father. Lola's mother treated Lola with rejection and invalidation, as if Lola was a burden to her. Her mother, who was a bus driver, primarily raised Lola, and Lola would sit in the bus with her for hours when childcare was not available. Because Lola's father had children from another woman, whom he had subsequently gone to live with, Lola felt rejected, with the thought "My dad only loves my siblings and does not love me."

When Lola was referred to DBT by her psychiatrist, she had made a first suicide attempt by asphyxiation when she used a belt to hang herself from the ceiling fan in her bedroom, resulting in an overnight hospitalization during the COVID-19 pandemic. In the 6 months prior to DBT, Lola was hospitalized for 14 days. She had no prior history of mental health treatment and was currently engaging in self-harm and cutting on her thighs (not detectable by her mother).

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Below is additional identifying information regarding Lola:

Psychological

- Diagnosis of borderline personality disorder and major depressive disorder.

Social

- In a relationship with someone she met on social media; has been dating them for one year, has never met them in person, and has sent them money.
- Closest "friend" is a cousin.

Academic

- Graduated high school with a low grade point average.
- Started attending community college; struggling academically; does not have a working laptop, so uses the library computer or a borrowed laptop from her cousin.
- Provisional diagnosis: learning disability, dyslexia.

Employment

- First employment was school-based work study.
- Cafeteria, food services.

TABLE 2.1. Cultural Assessment Tools Used with Lola

Tools focused on the assessment of the past	Tools focused on the assessment of the present or past
Adverse Childhood Experiences Self-Report Measure (Felitti et al., 1998)	Racial Micro-Aggressions Scale (RMAS; Mekawi & Todd, 2018)
Cultural genogram (example illustrated in the next section)	Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011)
Diversity-related historical experiences timeline	Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000)
	Brief Acculturation Scale for Hispanics (Mills et al., 2014)

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In her cultural assessment of Lola, the clinician gathered the aforementioned identifying information using the ADDRESSING framework (Table 1.4). Table 2.1 also lists the cultural-assessment tools Lola's clinician used during pretreatment.

LOLA'S CULTURAL GENOGRAM

Faith was one of the organizing principles for Lola's family on both her paternal and maternal sides, which were different cultures: African American and Latinx. For the most recent generation of Lola's family, religion and participation in a faith community was a value that was transmitted from the previous generation, who were avid churchgoers who engaged in religious practices and holidays and leaned on their belief in a higher power during difficult times. Lola's cultural genogram includes symbols such as relationship status (strong or distant), incarceration, mental health illness (anxiety, depression), and addiction. The intercultural marriage between her mother and father is noted because there was a blending of two distinct cultures, worldviews, and belief systems around family systems, communication, child-rearing, and faith.

A critical incident from Lola's maternal grandparents' generation was their immigration from a small, rural pueblo (town) in Mexico to Los Angeles, California. Lola's grandparents left the town after farm work dried up. Her grandfather moved to Los Angeles ahead of his wife and children and was employed as a migrant worker in neighboring Riverside County. After a year and a half, he sent for his wife and three children. Lola's uncle died in Mexico before he could move with the family due to lack of access to health care. The move to Los Angeles was difficult, as no one knew the language outside of Lola's grandfather, who had learned enough English to get by. Lola's grandmother was heartbroken because she left her beloved pueblo, cousins, friends, and parish. She was used to rural living and had to adjust to urban living without a car.

Lola's paternal grandparents were coping with segregation and racism in the South and moved to California for a better life. Her grandmother was a domestic worker and did not attend school after the fifth grade. Because of discrimination and racism during those times, her father never realized his dream of becoming an accountant, engaging in blue-collar work as a mechanic instead to support his family. A maternal cousin molested Lola when she was 5 years old, and another maternal cousin died by suicide after struggling with substance use and mental

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illness. Lola's brother is incarcerated. Racism was a common thread for each side of Lola's family, as they struggled with acculturative stress on her mother's side, segregation on her father's side, and systemic racism on both sides. In conducting a cultural genogram, we recommend that descriptive words that illustrate culturally relevant experiences or cultural concepts such as "segregation" or "acculturative stress" be included. As you can see in the legend and the genogram in Figure 2.2, there are multigenerational experiences that showcase Lola's cultural variables.

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LOLA'S EXPERIENCES OF CULTURAL TRAUMA

The tools discussed so far may be used to assess for trauma and intergenerational trauma. In the case of Lola, the genogram depicts that her grandparents had experiences of racism. In this example, the clinician may ask, how does race-based stress and Lola's own discriminatory experiences contribute to her presentation? It is the hope that with this information, the culturally proficient DBT clinician will approach the client with humility, curiosity, and with radical validation in conjunction with exploring the client's thoughts regarding the use of DBT skills toward healing.

In the interaction shown below, Lola was provided a copy of her working genogram, and it was discussed in session. Although the genogram was not yet completed, the clinician wanted to obtain Lola's feedback thus far and collaborate with her on continuing to complete it.

CLINICIAN: Hi, Lola, here is your genogram so far. I wanted to get your thoughts on it and also continue to work on it together. That sound OK?

LOLA: Sounds good.

CLINICIAN: Does anything stand out to you?

LOLA: Yeah, I see that my family has struggled with a lot of hardships dating back to my grandparents on both sides of my family.

CLINICIAN: Yes, I see that. What, if anything, may that tell you about them?

LOLA: It tells me that they must have had to endure a lot of pain and also that they are very strong role models for me.

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FIGURE 2.2. Cultural genogram analysis for Lola.

CLINICIAN: That is true Lola. I can definitely see how resilient you are, and I am sure you get some of that from them. Is there anything else that stands out?

LOLA: I also see that my racism was experienced by my grandparents. I know also my mom and dad experienced it, so we should add that. I also have, and it has always been a huge trigger for me. It pisses me off and makes me feel helpless.

CLINICIAN: I'm sorry Lola. I can't imagine the feeling. You are justified to feel that way for sure. Remember I shared about the biosocial theory of emotion dysregulation and invalidation with you? Well, similarly, one's experience with racism is socially invalidating and can definitely lead to emotion dysregulation.

LOLA: That makes sense.

CLINICIAN: A primary goal of DBT is to help with understanding and communicating emotions, including learning how to regulate emotions to engage in problem solving, with the goal of making your life worth living.

LOLA: I have never thought about using any skills to help me deal with strong emotions and hurtful experiences, but I am willing to try it.

CLINICIAN: Great, thank you Lola. Is there anything else that stands out on the genogram that you want to talk about right now? If not, how about we continue to work on it?

LOLA: Nothing else stands out at the moment. Yes, let's continue to work on it.

Lola and her clinician eventually completed the genogram and additional information that was gathered was the importance of Lola recognizing that many of her family members had chronic health conditions. For example, diabetes and heart disease was a health condition that was identified by several family members. This led to a discussion on the relationship between health outcomes and racism (Dopelt, 2025; Williams & Mohammed, 2013; Darity, 2003; Sue et al., 2007), which offered Lola a sense of both awareness and validation in her understanding how much impact one's environment may have on them.

Additionally, her maternal grandparents struggled with acculturative stress; they experienced emotional and psychological stress after

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migrating from Mexico. They felt marginalized from the dominant culture due to language barriers and racism. As noted in the genogram, Lola's clinician included the words "acculturative stress" to describe her maternal grandparents' experience. Similarly, they wrote the words "racism and segregation" to describe her paternal grandparents' experience. Although it is recommended that symbols are used instead of words, these are included as an example, that all data is "good" data, and it is acceptable to include text in order to ensure the data is captured.

As illustrated, the genogram was a helpful tool in understanding Lola's life story and history. We posit that all data gathered from our clients is good data that may potentially be useful in allowing clinicians to offer more comprehensive and culturally proficient care. In terms of the cultural genogram, we stress that there are no rigid rules on how to conduct a "perfect" genogram, and clinicians should avoid getting stuck on what must or should be on the genogram. Rather, creating the genogram should be a collaborative client–clinician experience and in the end be a helpful assessment tool. The process of creating a genogram should be one in which the clinician adopts a humble, nonjudgmental stance, with the overarching aim of gathering important data to better serve the client.

CONCLUSION

As illustrated in this chapter, it is important to not only assess the client's environments, to assess if they are invalidating, but also assess the client's current and past lived experiences in an effort to capture present and historical harmful experiences or patterns that may increase the risk of harms. That said, conducting a cultural assessment is an important first step.

On the path toward culturally proficient and culturally humble DBT practice, this chapter also highlighted the importance of the clinician engaging in a cultural self-assessment as (Figure 2.1). It is recommended that the DBT therapist also adopt measures that assess for concepts related to sociocultural diversity, such as acculturation or experiences of racial microaggressions. The genogram may further inform Linehan's model and provide a greater picture of potential stressors such as historical trauma that may influence the client's presentation—beyond the standard assessment. We recommend the genogram as a cultural-assessment

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tool, which may help the DBT clinician conceptualize the client within a greater context including a more robust cultural framework, given that the insight it provides on cultural history may not be otherwise obtained.

Although recommended in pretreatment, the DBT clinician aiming to be culturally informed should consider adopting the aforementioned suggestions at any stage in treatment. The inclusion of these strategies may aid the culturally proficient and humble DBT clinician toward the aim of providing more robust and just treatment for socioculturally diverse clients. On this path, another core component of such treatment is striving toward maintaining a relationship between equals in treatment. The next chapter applies an anti-oppressive lens to the DBT assumptions.

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