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A Framework for Culturally Humble Therapeutic Responses Using the Deliberate Practice Multicultural Orientation Video Prompts

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There is limited practical and behavioral guidance for cultural humility in response to racially charged patient material in clinical practice. Although general principles exist, these are often vague and fail to provide the nuanced, objective understanding required for clinical responses that address both diversity and therapeutic needs. The goal of this article is to contribute toward what we perceive as a clinical and supervision training gap in cultural humility. We present a framework for understanding and delivering culturally humble and therapeutically effective responses. Using the deliberate practice multicultural orientation framework video prompts, we provide clinical responses to standardized behavioral patient vignettes to illustrate a framework that is both culturally humble and therapeutically meaningful. Using videos of patients from diverse backgrounds and varying experiences of discrimination, through four graded clinical responses, we illustrate a framework that combines cultural humility and therapeutic effectiveness. We comment on a variety of responses that characterize such principles in practice. This work fills an important gap in the clinical practice and training of cultural humility, especially in recent times of racial unrest.

Clinical Impact Statement
This article provides practical guidance for responding to patient disclosure of discriminatory experiences using video vignette prompts. This work fills an important gap in the clinical practice and training of cultural humility and diversity for clinicians and supervisors.

Keywords: cultural humility, diversity, clinical training, supervision

Although cultural humility is highlighted as a priority in clinical practice (American Psychological Association, 2017), competency in this area remains elusive and behavioral exemplars unclear. While much guidance has been promoted, it is often vague (e.g., having an other-oriented stance or curiosity) or overly specific. Lack of operationalization and specific behavioral examples for cultural humility may lead to the misconception that cultural humility is subjective and in the eye of the beholder. On the other hand, overly prescriptive approaches may be hindered by their narrowness. One example is the Cultural Formulation Interview from the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (*DSM–5*; American Psychiatric Association, 2013) that is useful for building

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Nancy H. Liu envisioned the article, which emerged from a training in the deliberate practice training by Tony Rousmaniere and Jesse Owen that both Jason L. Herndon and Nancy H. Liu attended. Both Jason L. Herndon and Nancy H. Liu envisioned the article structure and wrote the article. Nancy H. Liu edited the final version and coordinated editorial communications. Both authors contributed to reviewing and revising all drafts of this article.

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cultural sensitivity but limits its focus to diagnostic considerations. Thus, there is a dearth of guidance for the subsequent interactions that comprise the mainstay of standard psychotherapy treatment.

This gap is especially alarming given the context of increased racial unrest in the nation—such as the Black Lives Matter and Stop Asian Hate movements—efforts that burgeoned following the 2020 murder of George Floyd in Minneapolis and the 2021 shootings in Atlanta. Limited practical guidance in clinical settings may lead to harm to patients, especially when they share about experiences of discrimination, which has increased among Black and Asian Americans amid the coronavirus disease 2019 (COVID-19) pandemic (Pew Research Center, 2020). Without objective guidance during treatment sessions, well-intentioned clinicians may unintentionally cause harm with poorly implemented attempts at cultural humility in response to a patient's disclosure of discriminatory experiences. Such harm can range from mild discomfort or awkwardness to exacerbating clinical symptoms and complete treatment dropout. The latter is particular concerning, given these groups already face significant and well-documented barriers to mental health treatment (Green et al., 2020).

Therefore, those seeking clinical proficiency in these areas are left without benchmarks about *what to do*. This may be further deepened in supervision, where supervisors themselves may not have been adequately trained in how to respond to a patient's experience of discrimination or are learning to consider diversity issues more seriously for the first time (Callahan & Watkins, 2018b; Galán et al., 2021). Indeed, many have recently called into question existing clinical training, especially standard training in cultural competence (Callahan & Watkins, 2018b, 2018c). As trainees may be learning to work with diverse patients for the first time, vague guidelines or bad habits may be perpetuated without correction. This could also lead to frustration and burnout among trainees who come from diverse backgrounds with supervision and training, as trainees from underrepresented groups report that faculty cultural competency is in need of considerable improvement (Callahan & Watkins, 2018a).

Nevertheless, there is a rich literature that can inform practical examples and behavioral benchmarks, including *what not to do*. Drinane and colleagues (Drinane et al., 2017) have shown that despite best intentions, differences in worldviews between therapists and their patients can make cultural humility challenging and a lack of cultural humility can increase the likelihood of perceived microaggressions in the therapeutic context. Indeed, Sue and colleagues (Sue et al., 2007) name three forms of racial microaggressions that they argue can occur clinical practice: microassault, microinsult, and microinvalidation. Microassaults are explicit racial derogations (e.g., "Oriental"), microinsults are more subtle snubs that convey rudeness or insensitivity (e.g., avoiding eye contact, implying inferiority), and microinvalidations exclude, negate, or nullify experiential realities (e.g., "I do not see color"; Sue et al., 2007). Hardy (2016) highlights how the consideration of contextual variables such as race, gender, and sexual orientation, among others, are essential within the process of supervision and training and this literature contains principles of better practices for supervision and training in cultural humility.

Cultural Humility

While a review of this literature is beyond the scope of this article, we provide a brief overview. Cultural humility includes an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and curiosity, and with a lack of superiority toward an individual's cultural background and experience (Hook et al., 2013, 2017). Cultural humility requires attunement toward cultural beliefs and values. As part of a larger multicultural orientation framework proposed by Hook and colleagues (Hook et al., 2017), cultural humility functions as a foundation that drives two other pillars of this framework: cultural opportunities and cultural comfort (Hook et al., 2017). Cultural opportunities are moments within a session when aspects of a patient's cultural identity might be explored and these opportunities are presented multiple times during the typical treatment session (Hook et al., 2017). Cultural comfort refers to a clinician's ability to effectively regulate themselves against the emotional challenge of a cultural opportunity, foster collaboration between the patient and the clinician, create an environment for emotional safety, which will increase the likelihood that patients will broach cultural topics with their clinicians (Owen et al., 2017). Cultural humility drives both cultural opportunities and cultural comfort and has been associated with improved patient outcomes (e.g., Owen et al., 2014). This building

up of cultural opportunities and cultural comfort through cultural humility likely facilitate patient disclosure of discrimination and foster opportunities for broaching in session (Day-Vines et al., 2007). And while even the most skilled therapist will not respond perfectly to patients all the time, it is recognized that cultural humility can serve as a reservoir of trust and also acts as a buffer against missed cultural opportunities. Indeed, when patients perceive their therapist as having higher levels of cultural humility, the impact of that same therapist's missed cultural opportunities diminishes the impact on subsequent patient-reported outcomes (Owen et al., 2016). That is, there is greater room and space for disclosure and exploration when cultural humility exists as a foundation.

Therapeutically Meaningful

Cultural humility alone though, is not enough. In fact, in our clinical experiences, clinicians may sometimes overcorrect or overemphasize cultural humility with patients from diverse backgrounds and fail to provide therapeutically meaningful treatment. As all patients seeking individual psychotherapy have presenting problems understood through a case formulation (Eels, 2010), it is imperative that responses are rooted in an idiographic understanding of that patient given their unique intersecting identities, history, contexts, and life experiences that together guide a comprehensive case formulation. Our assumption is that a patient's experience of racial discrimination will impact the patient in a deep way similar to any personally salient stressor and will likely have relevance for the case formulation and inform an effective treatment plan. The definition of therapeutic meaningfulness can change based on case conceptualization, phase of treatment, and treatment modality. For example, Persons (2008) identifies four stages of treatment within a cognitive behavioral therapy (CBT) conceptualization—pretreatment, early treatment, middle treatment, and termination—each with its own set of goals. Miller and Rollnick (2012) conceptualize motivational interviewing as including overlapping processes, which they call engaging, focusing, evoking, and planning, each presenting unique tasks to be accomplished. Interpersonal psychotherapy, which is derived from psychodynamic theory, focuses on major interpersonal areas as the causes of mental health symptoms (e.g., grief, role dispute, and role transition; Markowitz & Weissman, 2004). Ultimately, therapeutically meaningful comments are those that promote, target, and facilitate change within patients based on an understanding of universal psychological processes. A review of this work is beyond the scope of our article, but several authors have explored and articulated common mechanisms of treatment (e.g., Gibbons et al., 2009; Magill et al., 2015; Singla et al., 2017) and integrative theories (e.g., Katerud & Kongerslev, 2021).

Both Culturally Humble and Therapeutically Meaningful

In this article, we extend the work of training in cultural humility by offering examples that practically illustrate the combined principles of cultural humility and therapeutically meaningful, in the context of a therapist responding to a patient disclosure of discriminatory experiences—experiences that have become more salient in recent times. We propose that in response to these experiences, clinician responses should strive to be both culturally humble and therapeutically meaningful. At its heart, this "formula" recognizes the different levels of human functioning and distress: universal, group, and individual (Muñoz & Mendelson, 2005). The therapeutically meaningful captures those universal characteristics, for example, consistent presentations of mental distress (e.g., panic attacks, major depressive episode) and common elements of effective treatments, also known as active ingredients. The culturally humble recognizes group-based differences (e.g., police violence against Blacks, model minority stereotypes among Asian Americans, and homogeneous origins of Latin Americans) but also the individual variance and intersecting identities within these groups. This latter concept is known as intersectionality (Crenshaw, 1991) where individual experiences remain nuanced by different identities and contexts. Clinical responses to disclosures of patient experiences of discrimination that contain only one element may be invalidating (i.e., only therapeutically meaningful) or overfocus on diversity at the expense of treatment progress (i.e., only culturally humble).

To illustrate practical examples, we use standardized video clinical vignettes. With permission from the authors, we use training videos that are freely available to the public (https://sentio.org/mcovideos) and developed for deliberate practice for improving multicultural outcomes (Rousmaniere et al., 2017). While we remain agnostic about

deliberate practice as an approach to improving clinical skills, we use these videos for their value in anchoring skills in standardized videos. This can facilitate the effective illustration of practical guidelines for clinicians, trainees, and supervisors. Continued practice with and discussion around these prompts and potential responses is also likely to facilitate a deeper reflection and we encourage their use.

Below, we provide possible responses with commentary on what makes these responses more or less effective. Our responses below assume basic clinical skills and facilitative conditions, such as attunement, empathy, and active listening. These response are also meant to describe well-intentioned responses that may differ in their quality and effectiveness based on the degree to which they uphold both elements, with the assumption that the best clinical responses are both culturally humble and therapeutically meaningful. While we artificially attempt to include both elements in a single response, we recognize that in practice therapeutic conversations exhibit a natural back-and-forth. Actual conversations may include many brief responses that in aggregate communicate both elements. In general, we recommend that clinical conversations prioritize these two areas over the course of a session rather than a single response. Clinical timing, while difficult to operationalize, will also be key to effective responses. Our assumption is that, as with any other patient experience, these expressions of diversity are an opportunity to further lean into understanding the patient and link this to the larger clinical formulation so as to enrichen the therapeutic effectiveness, alliance, and personal relevance of applied interventions.

Clinical Vignettes and Responses

Using these video prompts, we describe various types of clinical responses labeled as four graded responses: ugly, bad, good, and better. We provide additional commentary describing the elements or principles that led to their being categorized in this way. Below, we provide a brief description of each case as presented on the above-mentioned website. We encourage individuals to first review each video vignette, consider a response they might give, highlighting the two "ingredients" (e.g., culturally humble and therapeutically meaningful) and then review our sample responses and commentary below for further reflection on effective responses.

Case 1: Patient 1, Clip 4

https://www.youtube.com/watch?v=SRscT8meGxQ&feature=emb_logo.

Patient is a cis, straight, Black/Ethiopian American man who came to therapy for help with anxiety symptoms. This is your third session of therapy. In response to the patient in the vignette, the clinician provides the following response:

- **UGLY:** *I don't think those are questions we can really answer . . . but I know it is causing you a lot of distress. You mentioned that your chest was tightening up and you felt really scared. That sounds a lot like what we would consider a panic attack. What was happening before this panic attack happened? It can be helpful to understand the triggers leading up to this panic attack.*

UGLY Commentary: This response, while accurately addressing a major clinical concern and following an appropriate clinical formulation, overlooks the experience of discrimination. Although the clinician seeks to understand triggers for the panic attack, by ignoring the experience of discrimination, the implicit message is that race does not matter or is not worth exploring and considering. While it does address an important clinical component, it dismisses this experience, specifically the context in which the panic attack is occurring. It contains only half of an appropriate response (i.e., therapeutically meaningful) but is missing the element that validates, explores, and addresses diversity and culture, the culturally humble component.

- **BAD:** *As a non-Black person, I can't begin to imagine what that must have been like for you . . . that sounds really upsetting, so much that it triggered another panic attack.*

BAD Commentary: While this response acknowledges the discrimination, the attempts to validate the distressing experience (e.g., "I cannot imagine . . .") may have the counterproductive effect of distancing the patient and their experience, leaving them feeling alone and more isolated in this experience, reducing the sense of cultural comfort. Choice of words when reflecting emotions may need to be considered carefully, as "upsetting" might suggest mild discomfort or a mild annoyance, which may be further received as invalidating. Jumping ahead to something therapeutic (e.g., fear, panic attack) again dismisses the experience

and may result in the patient feeling more isolated in his experience.

- **GOOD:** *It sounds like you felt a lot of fear not being able to protect your son, and that's important to you. You didn't mention this, but I wonder if this is tied to larger events about being a Black man in our society . . .*

GOOD Commentary: This response validates the specific experience of racial discrimination and gently hypothesizes that it might be due to the patient's specific identity and opens up the door to further exploration; however, this response also misses the therapeutically meaningful. Such a response may lead to a rich discussion about discrimination without addressing its connection to the patient's significant clinical considerations, that is, panic attacks. Ultimately a clinician heading down this path will want to tie these experiences back to the panic attacks, as illustrated below.

- **BETTER:** *There is real difficulty in managing worry in the face of very real threats to your well-being based on how you look. At the same time, you're beginning to question how you teach your son how to move through the world in a way that is safe and free from fear. It sounds like the intense anxiety you were feeling and your desire to avoid instilling that same worry in your son contributed to what sounds like a very real and frightening panic attack.*

BETTER Commentary: This response adequately validates the racial discrimination and communicates to the patient that his concerns and experience are real, distressing, and worthy of attention and further exploration. At the same time, the clinician remains focused on the clinical considerations at hand (e.g., fear, panic, and worry) and this response can easily lead to discussing treatment that addresses these concerns in a way that is individualized and tailored to this patient's unique presenting concerns as well as his reality in society.

Case 2: Patient 2, Clip 6

https://www.youtube.com/watch?time_continue=1&v=2iRts0oLxVM&feature=emb_logo.

Patient is a heterosexual Latinx/Greek woman who came to therapy for help with anxiety symptoms. This is your third session of therapy. In response to the patient in the vignette, the clinician provides the following response:

- **UGLY:** *Oh, I know exactly what you mean. Unfortunately, there aren't many therapists of color in our field, but I have taken it upon myself to study and do the work. I have read a lot of books, engaged in a lot of self-reflection and trainings and marched in the BLM protests. I do believe that I have the expertise to help you.*

UGLY Commentary: This response lacks both cultural humility and the therapeutically meaningful. In addition, this response fails to provide the validation and reassurance the patient is seeking. It also demonstrates the lack of cultural attunement to the patient's fears through an overemphasis or overconfidence in the therapist's ability to understand. It may be characterized as what some have termed "virtue signaling." This response risks trivializing or invalidating the patient's concerns and shifts the focus on the therapist's abilities rather than the concerns of the patient. It could be received as dismissive, avoidant, and lacking cultural comfort, as it centers the therapist's experience over that of the patient.

- **BAD:** *Yes, absolutely, I completely understand. I'm open to your bringing up whatever you want.*

BAD Commentary: This illustrates a missed cultural opportunity and while it may seem to offer comfort, it might paradoxically, in its openness, create a barrier. The clinician has created an environment where it is the patient's responsibility to bring up these issues instead of a collaborative, shared process between patient and therapist. While it may appear to emphasize cultural humility, it also misses the therapeutically meaningful and leaves therapy open-ended and without guidance while burdening the patient.

- **GOOD:** *You're right and I think that's very important for a therapist. I also recognize I can't be aware of all of my biases. I wonder if you would feel comfortable pointing out to me if I make a mis-step or say something offensive?*

GOOD Commentary: This response demonstrates an openness and an other-orientation. The clinician accepts the patient's concerns without judgment and offers to collaborate with the patient while admitting fallibility and imperfection. This

response reaches a level of attunement that is therapeutically meaningful in its focus on strengthening the alliance and creating an opportunity for a corrective emotional experience. However, it may still reduce cultural comfort in its keeping the onus on the patient to bring up her concerns.

- **BETTER:** *It makes sense that you're concerned that some therapists may not understand how much injustice is in the world when that's such a part of your experience. I'll attempt to be more intentional with my language moving forward and I'd appreciate if you pointed out any time that I miss the mark. If you're willing, I'd like to discuss whether there have been any moments when I or others have diminished your experiences. When you're ready, I'd like to better understand those moments in your life when you were treated unjustly or witnessed injustice done to others and how that has affected you.*

BETTER Commentary: This response deepens the openness in the clinician's culturally humble stance. It assumes the possibility of past and future missteps and works to identify and resolve them, and potentially contributes toward exploring recurrent relational experiences and patterns in the therapeutic context. This response also ties this content to the patient's past, recognizing the value expressed in the patient's initial statements and exploring whether the violation of those values contributes to their presenting clinical concerns.

Case 3: Patient 3, Clip 1

https://www.youtube.com/watch?v=WgLoM57gaB0&feature=emb_logo.

Patient is a queer, Black/African American woman who came to therapy for help with anxiety symptoms. This is your third session of therapy. In response to the patient in the vignette, the clinician provides the following response:

- **UGLY:** *It made you angry that your manager made these unprofessional comments. It also sounds like some of this occurred outside of work hours or were his attempts to be funny. I wonder if there might be some other ways to understand or interpret his behavior. . .?*

UGLY Commentary: This response lacks cultural humility as it fails to acknowledge the patient's concerns about racism in their workplace. In this clinician's attempt to move toward therapeutic effectiveness, they miss the cultural opportunity presented by the patient and even more concerning, suggest that the problem lies in the patient's perception rather than validating the discriminatory experiences.

- **BAD:** *Your job—and especially this manager—is a significant source of stress to you, given his behavior, and it's worsening your anxiety. It also sounds like this is a job you can't afford to lose right now. Many people struggle with the conflicts, difficult personalities, and demands of their job.*

BAD Commentary: Similar to the response above, this response overemphasizes therapeutic effectiveness, taking a common humanity approach which implies acceptance. The clinician may have leaned toward acceptance, given the patient's additional concerns about financial security. This response does not validate the experience of discrimination with openness and a genuine desire to understand more deeply and instead side-steps this by generalizing the manager's "behavior." While this may well be a useful strategy for some patients who are not disclosing an experience of racial discrimination, here it minimizes the patient's concerns in the moment and may invalidate the patient through the lack of explicit acknowledgment of the role racism is playing at work. The clinician may feel uncomfortable "opening the box" of discrimination and may unintentionally send the message that overt expressions of racism are part of an imperfect work environment and should be tolerated.

- **GOOD:** *Wow, that is completely inappropriate. You're working with someone who is overtly racist and these comments are really hurting you. I can also hear in your voice a lot of frustration and worry, because you can't afford to lose this job right now. On top of that, it sounds like reporting this may make things worse. So, you are feeling really stuck . . .*

GOOD Commentary: This reflection of the patient's situation validates the role of discrimination and its very real impact on the patient. It also accurately summarizes the dilemma the patient is facing at the moment. Adding a therapeutically meaningful component would be the next step.

- **BETTER:** *Wow, that is completely inappropriate . . . and it makes sense you're feeling*

panicked right now. You're in this decision about whether or not to confront your employer about this harmful racist behavior or stay silent and continue to deal with it. I know you also really need this job right now. You're in a difficult situation and all of this is making your symptoms worse. You mentioned your uncertainty about whether to report this to HR. I wonder whether we can explore this more and see if there might be a way we're not thinking of yet to do this in a way that feels safe for you . . .?

BETTER Commentary: This response includes the cultural humility of the previous response (i.e., explicitly naming the racism, validation) and moves the discussion forward in a therapeutic direction. It also accomplishes this in a collaborative manner. By asking whether this patient would be comfortable addressing this with their employer, the clinician opens the door to a more layered conversation about the patient's dilemma—uncertainty over whether the employer will understand and recognize this as discrimination and offer support over the higher-powered manager and the risks to their job stability if the patient is vocal about the manager's racist conduct. It does not assume that assertiveness is the best answer and validates the patient's dilemma. The clinician accepts the patient's concerns with openness and gently suggests problem-solving.

Case 4: Patient 4, Clip 2

https://www.youtube.com/watch?v=U0SPzu9qQFo&feature=emb_logo.

Patient is a gay, Asian American cis-man who came to therapy for help with anxiety symptoms. This is your 3rd session of therapy. In response to the patient in the vignette, the clinician provides the following response:

- **UGLY:** *This comment by your friend while he was drunk really affected you. Given what you've shared about your background and multiple identities, being gay and Asian-American, I'm wondering which one you find more offensive . . .?*

UGLY Commentary: While this response attempts to be curious, it instead shifts the narrative away from what the patient has presented and may be viewed as dismissive of the discriminatory experience. While the question toward the end may appear as curiosity, it could be received as voyeurism, lacking a deeper understanding about these identities and the patient's pain. The closed-ended nature of the question may give a sense of interrogation rather than exploration. The response also ignores the larger social context that is of relevance to the patient's presenting concern. Furthermore, the attempt at empathy through a simple reflection may subtly reinforce the patient's tendency toward self-invalidation by unintentionally suggesting that the friend's behavior should not be taken as seriously because he was intoxicated.

- **BAD:** *It sounds like you didn't speak up in the moment and now worry about its larger impact. This seems to be causing a lot of shame for you. I'm wondering if you've had problems in the past with assertiveness?*

BAD Commentary: While this response attempts to validate the emotional impact of what the patient has described, it may assume more than what is presented. It falls short of leaning into the discussion of discrimination, prematurely naming shame as the dominant emotion in the patient's experience instead of engaging in the cultural opportunity to understand more about the meaning of this experience. There is a similar premature assumption and therapeutic focus on a lack of assertiveness that may reduce cultural comfort and lead to the patient feeling misunderstood, mischaracterized, or worse, stereotyped.

- **GOOD:** *You were on the receiving end of a comment that was both racist and homophobic, and all coming from a friend . . . but I'm also hearing you explain it away or minimize it. What do you make of that?*

GOOD Commentary: This response displays the openness and curiosity of cultural humility while also naming and validating the patient's experience explicitly (discrimination). It also begins to link this toward the therapeutically meaningful; however, it may neglect an important aspect of his concern—the social context and his larger interpersonal patterns. In jumping ahead to something within the patient alone, it may unintentionally oversimplify the implied solution and clinical formulation. We would recommend responding to the full complexity of the patient's presenting concerns to provide a more effective therapeutic response.

- **BETTER:** *Wow, that is offensive—and all the more so because it came from a friend. It sounds like it really hurt you and has*

> *ruptured a sense of trust and security with him. It also sounds like it's having a larger ripple effect on your wider friend group. I could imagine you feeling quite isolated, which maybe you've felt before as someone who is both gay and Asian-American, never really fitting in perfectly . . .? It sounds like you didn't speak up in the moment and . . . but I also hear you almost dismissing it, by saying he was just drunk or worrying your friends won't take it seriously, they may call you "too sensitive." I'm wondering if there's more here, maybe other times when you've felt isolated from others or that others have let you down? Or . . . maybe you've had to, in the past, silence or downplay your own feelings, out of concern for what others will think?*

BETTER Commentary: This response labels the discriminatory experience and its harmful impact, while also noting potential patterns of self-invalidation and interpersonal functioning, linking this experience to the patient's larger case formulation. It gives the clinician an opportunity to understand more about the patient's previous experiences and better understand the impact and meaning of this statement, particularly as someone with intersecting identities. This exploration will be useful toward fostering greater openness and trust in the therapeutic alliance, potentially creating a corrective emotional experience, while also helping the patient learn to self-validate and navigate vulnerability and trust in relationships.

Discussion

In this article, we use standardized video vignettes to illustrate elements of cultural humble therapeutic responses in response to patient reports of discrimination. Our overarching thesis is that both cultural humility and therapeutic meaning are necessary for ongoing effective treatment with diverse populations. We strive to provide nuance within each of these elements and some general principles emerge. First, within cultural humility, there is a "sweet spot" of explicitly naming and validating experiences of discrimination while not presuming to understand more than what the patient has expressed or being so open-ended so as to place an additional burden on the patient—both of which can result in patients feeling more alienated in their experience. Second, within the therapeutically meaningful, an experience of discrimination should not be isolated from the larger clinical case formulation. As any emotionally significant experience also occurs within the context of a unique patient's prior experiences and predispositions, linking it back to therapeutic goals remains imperative for effective therapy.

Indeed, one of our main goals of this article is to caution against overfocusing on cultural humility at the expense of patient treatment. By providing actual responses and additional commentary, we hope that this work provides a framework for clinicians seeking to improve their skills in cultural humility and ultimately, therapeutic effectiveness with diverse patient populations. We recommend reviewing videos and discussing vignettes and potential responses as ongoing scaffolding to continue to improve the way we train culturally competent and humble clinicians and supervisors. However, we recognize there are many limitations to this work. As these responses are born out of the authors' specific therapeutic stances, they will not fit into every therapeutic approach, particularly those that deemphasize direct, interpretive statements. We encourage clinicians to apply this culturally humble therapeutic framework in a manner that is consistent with their therapeutic approach. Additionally, we do not pretend that our responses are the definitive way to respond to patient disclosure of racial discrimination, nor is there always one "right" way to respond. We share these sample responses and commentary as if we were colleagues consulting on diversity issues, knowing that each clinician will know best which elements are useful take-aways relevant for their own patients. Finally, while we are unable to provide empirical data on the effectiveness of this approach, we hope that this and similar work will spur more objective and empirical approaches that examine methods to enhance the clinical effectiveness and training in working with diverse populations of novice clinicians and supervisors.

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