



CULTURAL HUMILITY AND BIAS IN CLINICAL ASSESSMENT: A SOCIAL WORK GUIDE TO REDUCING DIAGNOSTIC DISPARITY

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About the Author

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Abstract

Clinicians make cultural judgments in every assessment, whether or not they notice them. They decide which symptoms matter, which explanations sound credible, and which behaviors look like pathology. When those judgments rest on unexamined assumptions, the result can be a measurable pattern of diagnostic error that falls unevenly across racial, ethnic, and cultural groups. This intermediate course treats that pattern as a patient safety problem with practical remedies. It organizes the cultural competency content that licensing boards expect (self-awareness, knowledge, and skills) around the field's shift from cultural competence to cultural humility. Learners examine how implicit bias, stereotyping, anchoring, and colorblindness enter clinical judgment; review documented disparities in the diagnosis of psychotic, mood, attention, and developmental disorders; practice using the DSM-5-TR Cultural Formulation Interview and related tools; build skills for broaching race and culture, repairing cultural ruptures, and responding to microaggressions, including those the clinician commits; and integrate culturally responsive practice into documentation, treatment planning, referral, and professional ethics. Composite cases drawn from varied practice settings illustrate the reasoning throughout.

Learning Objectives

After completing this course, the participant will be able to:

1. Distinguish cultural competence from cultural humility and explain why a humility framework better supports ethical, effective practice.
2. Identify how clinician bias and cultural assumptions enter clinical judgment, including implicit bias, stereotyping, anchoring, and colorblindness.
3. Describe documented patterns of diagnostic disparity and distinguish differences in diagnosis rates from evidence of diagnostic error or inequity.
4. Apply the DSM-5-TR Cultural Formulation Interview and related tools to gather culturally relevant information and reduce the risk of misdiagnosis.
5. Select culturally responsive strategies for discussing culture, race, and difference, repairing cultural ruptures, and responding to microaggressions.
6. Integrate culturally responsive practices into assessment, documentation, treatment planning, and referral in a way that is consistent with professional ethics codes, practice standards, and applicable licensing requirements.

Using This Course

The course works best read in order, since each section builds on the one before it. Every section has a practice exercise. Write your answer down before you read the reasoning guide, then pick one thing to try in your own setting. The reflection questions work on your own or in supervision. The posttest assesses knowledge and clinical judgment; evaluating practice also requires observation, supervision, or review of clinical work.

Introduction

The referral note is three lines long. "31 y/o Black male, seen in ED after episode of chest pain and shortness of breath at work, cardiac workup negative. Guarded, paranoid, poor historian. Please evaluate for psychotic disorder versus anxiety."

The social worker who picks up the referral at a community mental health clinic has forty-five minutes for the intake and three more intakes after it, so about three hours of back-to-back listening. The client, Andre, arrives on time in a work uniform. He answers questions briefly. He wants to know who will see the notes and whether anything he says will go to his employer. When asked about the episode at work, he says it started after a store security guard followed him through two aisles on his lunch break, and that this has happened "more than a few times" at that store. He would rather not give the name of the store. He mentions that he doesn't sleep well and has felt "on edge for months."

The social worker has two ways to read the same facts. In one, a man with no psychiatric history describes a plausible stressor, a set of anxiety symptoms, and reasonable caution about confidentiality with a stranger who works for an institution. In the other, the chart already says "guarded" and "paranoid," and his reluctance to share details reads as confirmation. Neither panic disorder nor a psychotic disorder can be established from the referral alone. What the social worker does in the next forty-five minutes will decide which story the record tells.

This course is written mainly for licensed social workers who assess clients in community clinics, hospitals, schools, child welfare agencies, and private practice. Counselors, marriage and family therapists, and psychologists will find that the same reasoning applies to their work. The course builds on familiarity with diagnostic interviewing and cultural competence, focusing on decisions made during assessment, documentation, and treatment planning.

Two ideas run through the course. The first is cultural humility: ongoing self-examination, attention to power, and partnership with the client. It works alongside cultural knowledge and keeps that knowledge open to correction. The second is that diagnostic disparity is a patient safety problem. A wrong or late diagnosis can mean the wrong treatment, missed care, and a label that follows a person into every later appointment. Most of what follows is practical and centered on what one clinician can do in one assessment, while staying honest about the structural conditions that no single clinician can fix.

The six sections move from cultural humility and clinician self-awareness to bias in clinical judgment, diagnostic disparities, assessment tools, conversations about difference, and integration into care. Each section includes a composite case, a guided practice exercise, reflection questions, and clinical takeaways. The conclusion returns to Andre's intake.

Culture includes race, ethnicity, language, nationality, migration history, religion and spirituality, age, social class, disability, sexual orientation, gender identity, region, and their intersections. Section 3 emphasizes race and ethnicity because much of the diagnosis research uses those categories; the skills apply across identities and within groups. Labels follow the cited studies. DSM-5-TR uses terms such as "racialized" and "ethnoracial" to emphasize that race is socially constructed (American Psychiatric Association [APA], 2022).

Evidence varies in strength, and the course says which is which. Some diagnostic patterns have been observed repeatedly across decades and settings. Research on microaggressions, bias training, and cultural humility is newer and has real methodological limits. Where a recommendation comes from clinical reasoning or professional guidance rather than research, it is labeled that way.

Cases are fictional composites; any resemblance to real individuals is coincidental. They vary in setting, age, race, ethnicity, religion, and immigration history, and several show clinicians making mistakes and recovering from them, because that is where much of the learning happens in practice.

Section 1: From Cultural Competence to Cultural Humility

Cultural humility is a stance toward clients: lifelong self-examination, attention to the power a clinician holds, and partnership with the client as the authority on their own culture and life. This section covers how the field got to that idea, what the older competence model got right and where it fell short, what the research does and doesn't show about humility, and how a clinician can start with their own cultural position. It ends with a hospice case in which a clinician's confident knowledge of a client's culture caused the very harm it was supposed to prevent.

Why the Competence Model Emerged

Cultural competence entered the helping professions in the 1980s and 1990s as a response to a real problem. Services designed around the norms of White, middle-class, English-speaking clients were failing many people who did not fit that template. Clients dropped out early, were misunderstood, and were sometimes harmed by interventions that ignored their values, family structures, and experiences of discrimination. The competence model proposed a remedy that made intuitive sense: clinicians should acquire the awareness, knowledge, and skills needed to work effectively across cultural difference.

That three-part structure remains the backbone of most professional standards. The National Association of Social Workers (NASW) organizes its standards for cultural competence around ethics and values, self-awareness, cross-cultural knowledge, cross-cultural skills, and seven further standards that extend the work into service delivery, advocacy, workforce, education, language access, and leadership (NASW, 2015). Counseling's Multicultural and Social Justice Counseling Competencies use a similar structure of attitudes and beliefs, knowledge, skills, and action (Ratts et al., 2016). The competence model gave the field a vocabulary, a training agenda, and a standard that boards could require. Much of what it asks of clinicians still holds.

Where the Competence Model Falls Short

Cultural competence is sometimes taught as a catalog of group characteristics: family obligations, ways of expressing distress, or attitudes toward institutions. Population knowledge may suggest useful questions, but it cannot establish what is true of an individual client. Problems arise when familiarity with a group becomes confidence about a person whose own account has not been explored.

Critics in social work have described several related weaknesses. Competence implies an endpoint, a level of mastery that can be reached and certified, when culture is dynamic and every client brings a different combination of identities (Fisher-Borne et al., 2015). It tends to treat culture as something that belongs to the client, usually a client from a marginalized group, while the clinician's own culture remains invisible and normative. And it locates the problem in the individual practitioner's knowledge, with little attention to the institutions, policies, and power differences that shape every clinical encounter (Danso, 2018; Fisher-Borne et al., 2015).

A meta-analysis of 15 studies found an association between clients' ratings of therapist multicultural competence and treatment outcomes ($r = .38$), while therapists' self-ratings had little association with outcomes ($r = .06$; Soto et al., 2018). The data are correlational, but the gap is hard to ignore: clients' ratings tracked outcomes and therapists' confidence did not. Research also suggests that therapists differ in their effectiveness with racial and ethnic minority clients compared with White clients (Hayes et al., 2015). Client feedback and outcome review can reveal gaps that self-assessment misses.

Cultural Humility Defined

The term "cultural humility" comes from medical education. Tervalon and Murray-García (1998) proposed it as a better training outcome than competence for physicians working in multicultural settings. They described three commitments: lifelong self-evaluation and self-critique, attention to and redress of the power imbalances built into the clinician-patient relationship, and the development of mutually beneficial, nonpaternalistic partnerships with communities, which later writers have extended into institutional accountability. Their point was that no one ever finishes learning about culture. What a clinician can do is commit to a way of practicing that keeps learning, notices power, and does not presume to know a person before meeting them.

In psychotherapy research, Hook et al. (2013) defined cultural humility as having two parts. The intrapersonal part is an accurate view of oneself, including one's limitations and cultural biases. The interpersonal part is a stance oriented toward the other person, marked by respect, openness, and an absence of superiority toward the client's cultural background and experience. This definition is useful because it describes something a client can perceive. Clients cannot see what a clinician knows. They can see whether the clinician is curious, whether the clinician assumes, and whether the clinician treats the client's account of their own experience as credible.

The 2021 revision of the NASW *Code of Ethics* states that social workers "should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own culture, committing to life-long learning, and holding institutions accountable for advancing cultural humility" (NASW, 2021, Standard 1.05[c]). The same standard asks social workers to acknowledge personal privilege and to take action against oppression, racism, discrimination, and inequities (NASW, 2021, Standard 1.05[b]). The 2015 practice standards had already described cultural humility as a guiding stance toward cultural difference (NASW, 2015). For social workers, then, humility is part of the profession's written ethical standard.

What the Evidence Shows

Research on cultural humility in therapy is young, mostly correlational, and based largely on client reports, but its findings are consistent. In the original validation studies, clients who perceived their therapists as more culturally humble reported stronger working alliances and greater improvement in therapy (Hook et al., 2013). Later studies within the multicultural orientation framework, which treats cultural humility, cultural opportunities, and cultural comfort as related therapist processes, have found that how therapists handle culturally relevant moments in session is associated with client outcomes (Davis et al., 2018). Clients who perceived more missed cultural opportunities, moments when culture was relevant and the therapist did not engage it, tended to report poorer outcomes, and that association appeared weaker when clients saw their therapists as culturally humble (Owen et al., 2016). A research review identified 21 studies of cultural humility in psychotherapy and 7 in clinical supervision and concluded that the construct appears durable and practically useful, while noting that the research so far is limited in time span and geographic scope (Zhang et al., 2022).

The strongest conclusion is an association: clients who experience a therapist as open and respectful tend to do better. No single behavior has been isolated as the cause, so the practical step is to check the client's experience directly.

Limits and Misreadings of Humility

Cultural humility can be misunderstood in ways that cause their own problems, and it is worth naming them before going further.

The first misreading treats humility as a substitute for knowledge. A clinician who knows nothing about the history of forced sterilization, immigration enforcement, or religious persecution that shapes a client's

community, and who relies on the client to explain all of it, is placing a burden on the client that the clinician should carry. Humility asks the clinician to hold knowledge provisionally, as a set of questions to explore with this person, not to give up learning. Knowledge about patterns is what allows a clinician to ask good questions; humility is what keeps the answers from being assumed.

The second misreading treats humility as a posture of deference that avoids clinical judgment. A clinician can respect a client's explanation of their distress and still recognize that the client is depressed, that a child is unsafe, or that a symptom needs medical evaluation. Humility shapes how the clinician holds and communicates that judgment, with openness to being wrong and awareness of the power involved in making it. It does not remove the responsibility to make it.

Humility can also become a slogan unless it changes practice. Danso (2018) questions its conceptual vagueness and the tendency to place responsibility only on individual practitioners. Lekas et al. (2020) emphasize provider-patient power differences. The practical response includes observable behaviors, clear documentation, and organizational support for culturally responsive assessment.

Table 1 summarizes how the two frameworks differ in emphasis. The contrast is drawn sharply for teaching purposes; in practice, the strongest clinicians draw on both.

Table 1. Cultural Competence and Cultural Humility Compared

Dimension	Cultural competence (as commonly taught)	Cultural humility
Goal	Mastery of knowledge and skills for working with particular groups	Ongoing self-reflection and learning with each client
Endpoint	Implies a level that can be achieved and certified	No endpoint; a lifelong commitment
Focus	The client's culture	The client's culture, the clinician's culture, and the relationship between them
Who is the expert	The trained clinician	The client, on their own culture and experience
Power	Rarely addressed directly	Named and attended to in the relationship and in institutions
Use of group knowledge	Applied to the client	Held as a source of questions, checked against the client's account
Typical error	Stereotyping from generalizations	Deferring so far that the clinician stops learning or judging

Locating the Self of the Social Worker

Every version of cultural humility begins with the clinician. Before a clinician can notice how culture shapes a client's presentation, the clinician has to notice how culture shapes their own perception. This is harder than it sounds. The most influential parts of a person's culture usually feel like common sense. A clinician raised in a family that valued direct emotional expression may hear a client's restraint as avoidance. A clinician who has always experienced police as helpful may hear a client's fear of police as exaggerated. Neither clinician is wrong to have a culture. Each is at risk of mistaking their culture for the standard against which the client is measured.

Hays (2022) offers a practical tool for this work, the ADDRESSING framework. Its letters stand for age and generational influences, developmental disabilities, disabilities acquired later in life, religion and spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, Indigenous heritage, national origin, and gender. Hays recommends that clinicians use the framework first on themselves, noting for each dimension where they hold a dominant or privileged position and where they hold a nondominant one. Most clinicians discover that they occupy a mix: privileged in some dimensions, marginalized in others. The exercise is useful because it makes visible the places where a clinician's experience is likely to differ from a client's, and where the clinician's assumptions are least likely to have been challenged.

Positionality is the term for where a person stands within these social structures and how that position shapes what they see and what they are able to see. A clinician's positionality includes their identities and also the professional role itself, which carries power: the power to diagnose, to document, to recommend hospitalization, to report to child protective services, and to decide what goes in a record that others will read. Clients often perceive this power more clearly than clinicians do. A client who has had a family member removed by child welfare, or who has been held involuntarily, enters an assessment knowing exactly what a clinician's words can do.

A brief self-inventory can make this concrete. Clinicians can ask themselves:

- Which of my identities do I rarely think about? Those are often the ones where I hold privilege.
- What did my family teach me about emotional expression, illness, help-seeking, authority, and family obligation?
- Which client presentations make me most uncomfortable, and what does the discomfort tell me about my own expectations?
- Which groups did I have little personal contact with before entering the profession?
- When was the last time a client corrected my understanding of their culture, and how did I respond?

Revisit this self-inventory when a clinical interaction evokes unusual certainty, discomfort, or defensiveness. Use supervision to examine patterns across encounters. One reflection exercise is not evidence of competence.

The inventory rarely tells a clinician what a client needs. It shows where the clinician's own sense of "normal" has been least tested. Consider a social worker who grew up in a close-knit Catholic family in a small Midwestern town and is starting a job at a clinic that serves many refugee families. Working through the ADDRESSING dimensions, she notices that she holds a dominant position on nearly every one except gender, and that she has rarely been asked to explain her religion, her accent, or her family's way of doing things. Over the next few months, her strongest reactions in session arrive in exactly the places the inventory predicted: family obligations that override individual choice, distrust of government offices, and religious explanations of illness. She brings those reactions to supervision instead of acting on them in the room.

Intersectionality and the Limits of Single Categories

Clients do not experience their identities one at a time. A Black lesbian woman who grew up in a devout Baptist family in rural Georgia is not adequately described by any one of those words, and the parts of her identity that matter most in therapy may be the places where they meet: how her church community responded when she came out, or how her experiences of racism differ from those of her straight brothers. The American Psychological Association's multicultural guidelines describe identity as shaped by multiple, intersecting social contexts and encourage clinicians to attend to how these intersections affect clients' experiences of privilege and oppression (American Psychological Association, 2017b). NASW's revised standards likewise incorporated intersectionality and broadened the definition of culture beyond race and ethnicity (NASW, 2015).

Intersectionality has a direct implication for assessment. Knowledge organized by single categories, such as what is known about "Latino clients" or "older adults," becomes less reliable as more categories apply to the same person. A 70-year-old Dominican man who immigrated as a teenager, is bilingual, and worked for forty years as a union electrician in New York shares something with other Latino clients and something with other older adults, but his particular combination of experiences is his own. Group knowledge can suggest questions. Only the client can say which parts of it apply.

The same is true of the clinician. A clinician who is a woman of color may have deep personal experience of racism and still hold class privilege relative to a client living in poverty, or may be a member of the client's ethnic group and still differ from the client in religion, immigration history, or sexual orientation. Shared identity can ease some conversations. It can also lead a clinician to assume an understanding that has not been earned. Cultural humility applies within groups as much as across them.

Humility as What the Client Experiences as Respect

Clients rarely judge a clinician by how much the clinician knows about their culture. They notice whether the clinician seems curious or certain, whether the clinician's questions leave room for the client's own account, and whether the clinician can tolerate being corrected. Humility usually comes down to a few plain moves:

- Asking rather than assuming: "What does family mean for you in this situation?" instead of "I know family is very important in your culture."
- Treating the client's explanation of their difficulty as information, even when it differs from the clinician's formulation.
- Saying when the clinician does not know something and asking whether the client is willing to explain, while recognizing that the client is not obligated to teach.
- Checking interpretations out loud: "I may be getting this wrong, so tell me if I am."
- Responding to correction with interest, even when it stings.

Time pressure can make these practices harder to sustain. The next section examines the reasoning shortcuts through which assumptions enter an assessment.

Case 1: The Family Meeting

Rosa Delgado, 68, was admitted to a hospice program with metastatic pancreatic cancer. She had immigrated from Mexico in her twenties and lived with her eldest daughter's family. The hospice social worker, an experienced clinician who had completed several cultural competency trainings, had learned that many Latino families prefer to protect older relatives from bad news and to make medical decisions collectively. When the daughter asked that her mother not be told how little time remained, the social worker agreed that this was culturally appropriate. She arranged a family meeting with the physician, the daughter, and two sons, and she did not include Mrs. Delgado. She documented the plan as "culturally sensitive disclosure per family preference."

Three days later, a hospice aide who spoke Spanish reported that Mrs. Delgado had asked her directly, and more than once, whether she was dying. Mrs. Delgado said she had questions about her grandson's baptism, about money she had promised to send her sister in Guadalajara, and about whether she could receive the anointing of the sick. She said that her family was treating her "like a child" and that no one would answer her. She was frightened, and she was also angry.

The problem was not the possibility of family-centered decision making. It was substituting the daughter's preference for Mrs. Delgado's without asking her. A culturally responsive approach would explore the patient's own wishes privately, in her preferred language, before planning disclosure. For example: "Some people want

to hear everything about their illness, and some prefer that their family handle the details. How would you like it to be for you?" Her response may support individual, shared, or delegated decision making; it cannot be inferred from ethnicity.

The repair is still possible, though the lost days are not. The social worker might meet with Mrs. Delgado, acknowledge that she should have asked her directly, and offer her the conversation she wants, with a qualified interpreter if she prefers Spanish for medical matters. She might meet separately with the daughter to explore her fears and to explain why her mother's wishes need to guide what happens next. She might help arrange a visit from the parish priest. She would also need to revise the documentation, because "culturally sensitive disclosure per family preference" now records an assumption as if it were the patient's choice.

Clinical Practice Exercise

Using Mrs. Delgado's case, write one question that would establish her information-sharing preferences without assuming individual or family-centered decision making. Then draft a two-sentence correction to the original chart entry.

Reasoning guide: Ask the patient privately, using qualified language support as needed, how she wants information shared and who she wants involved. A revised entry should distinguish the daughter's request from the patient's wishes. If the patient's preference has not yet been obtained, document that limit and the plan to obtain it. Do not fill in an answer on her behalf.

Reflection Questions

1. Think of a cultural generalization you learned in training that you still find yourself using. When did it last help you understand a client, and when might it have led you to assume?
2. Using the ADDRESSING framework, where do you hold the most privilege, and how might that shape what you notice or overlook in assessments?
3. How do you usually respond when a client corrects your understanding of their culture or experience?

Key Clinical Takeaways

- Cultural competence gave the field a necessary vocabulary and set of standards, but as commonly taught it can turn culture into a catalog of group traits and imply an endpoint that no one reaches.
- Clinicians' self-rated multicultural competence is nearly unrelated to client outcomes, while clients' ratings of it are meaningfully related.
- Cultural humility combines an accurate view of oneself with an other-oriented stance of respect and openness, and it explicitly attends to power.
- The NASW *Code of Ethics* now names cultural humility, critical self-reflection, and acknowledgment of privilege as ethical obligations.
- Humility does not replace knowledge or clinical judgment, and it starts with the clinician examining their own cultural position, including the power of the professional role.

Section 2: How Bias Enters Clinical Judgment

Bias can affect assessments even when clinicians intend to be fair. Time pressure, incomplete information, and mental shortcuts can influence how clinicians gather and interpret information. This section examines implicit bias and the limits of bias training research, the cognitive shortcuts that carry assumptions into a formulation, the paired errors of colorblindness and cultural overattribution, and microaggressions. The aim is recognition: a clinician who can name the mechanism in the moment has a chance to interrupt it.

Implicit Bias in Brief

Implicit bias refers to attitudes and associations that operate outside conscious awareness and can influence perception and behavior even in people who sincerely reject prejudice. It is usually measured with reaction-time tasks, most often the Implicit Association Test, which detects how quickly a person pairs social groups with positive or negative concepts.

A systematic review of implicit bias among health care professionals found that physicians and nurses show implicit biases to about the same degree as the general population (FitzGerald & Hurst, 2017). Most studies in the review examined race, but others examined gender, age, weight, socioeconomic status, and substance use. Of 25 studies that examined assumptions clinicians made about patients, 20 found some bias in diagnosis, treatment recommendations, the questions clinicians asked, or the tests they ordered. A smaller group of studies linked higher implicit bias to patient interactions that Black patients rated more negatively. The authors also noted the limits of this research: methods varied widely, most studies took place in laboratory or vignette conditions, and few measured actual patient outcomes (FitzGerald & Hurst, 2017).

Two further findings shape how clinicians should think about implicit bias. First, changing scores on implicit measures does not reliably change behavior. A large meta-analysis found that experimental procedures could shift implicit measures, usually over short intervals, without corresponding changes in explicit attitudes or behavior (Forscher et al., 2019). Second, a review of interventions in health care found that they can raise providers' awareness of bias but had not produced sustained reductions in it (Vela et al., 2022). That is the evidence so far, not a verdict that training can never help.

A one-time workshop, then, is not evidence that bias has been dealt with. The more realistic target is the conditions under which judgments are made: slowing down at specific decision points, asking structured questions, seeking disconfirming information, and checking reasoning with colleagues. These safeguards come from clinical reasoning, not a tested package, and organizations should judge them by what happens to care, not by attendance or awareness scores.

When Bias Does Its Work

Implicit associations have the most influence when a clinician must decide quickly, with ambiguous information, while attending to many other demands. Burgess (2010) argued that common features of clinical settings, including time pressure, fatigue, high cognitive load, crowded schedules, and ambiguous presentations, make clinicians more likely to rely on stereotypes and less able to monitor their own reasoning. The argument fits a broader body of research on dual-process thinking, in which fast, intuitive judgments dominate when slower, deliberate reasoning is crowded out.

Social workers will recognize the settings this describes. An emergency department evaluation at 2 a.m. A child welfare assessment conducted in a home where the worker has forty minutes and a stack of other cases. A community clinic intake where the referral arrives with a diagnosis already attached. A school meeting where a teacher's account of a student's behavior has already been accepted by everyone else in the room.

None of these settings causes bias. Each makes it more likely that whatever associations a clinician carries will shape the outcome without being examined.

Cognitive Shortcuts That Carry Bias Into Assessment

Diagnostic reasoning relies on shortcuts, called heuristics, that usually serve clinicians well. The research on diagnostic error in medicine has shown that the same heuristics produce predictable mistakes, and that many diagnostic errors involve flaws in clinical reasoning rather than gaps in knowledge (National Academies of Sciences, Engineering, and Medicine [NASEM], 2015). Several heuristics are especially relevant to cultural bias.

Stereotyping is the application of a belief about a group to an individual. In assessment, it can lead a clinician to expect certain problems from certain clients: substance use in one group, somatic complaints in another, family conflict in a third. The expectation shapes which questions get asked and how answers are heard.

Anchoring is the tendency to rely too heavily on the first piece of information encountered. In mental health settings, the anchor is often a referral diagnosis, a prior chart entry, or a striking detail from the first minutes of an interview. Once a clinician is anchored, later information tends to be interpreted in light of the anchor. A related pattern, sometimes called *diagnostic momentum*, occurs when a label is carried forward from one clinician to the next, gaining authority with each repetition even though no one has reexamined it.

Confirmation bias is the tendency to seek and favor information that supports an existing hypothesis. In a study of psychiatrists and medical students given a case with a misleading preliminary diagnosis, participants who searched preferentially for information confirming that preliminary diagnosis were more likely to reach a wrong final diagnosis (Mendel et al., 2011). The study did not examine race or culture, but its mechanism applies directly: once a culturally shaped first impression forms, the search for information can quietly organize itself around proving it.

Availability is the tendency to judge likelihood by how easily examples come to mind. A clinician who has recently treated several clients from a particular community with a particular problem may overestimate how likely the next client from that community is to have it.

Credibility judgments deserve their own mention, because they are rarely named in discussions of heuristics. Clinicians constantly decide how much to believe what clients tell them, and those decisions are vulnerable to bias. In a study of 752 psychiatric inpatients, 45% of African American patients received a research diagnosis of schizophrenia or schizoaffective disorder, compared with 19% of White patients. Interviewers rated African American patients as less honest, and adjusting for those honesty ratings markedly reduced the racial difference (Eack et al., 2012). A client who seems "guarded" or "evasive" may be withholding for reasons that have nothing to do with pathology, including reasonable caution about what an institution will do with what they say.

Table 2 summarizes these shortcuts with a question a clinician can ask to interrupt each one. The questions are the course's recommendations, drawn from the diagnostic error literature and clinical reasoning; they have not been tested as a set.

Table 2. Cognitive Shortcuts and Questions That Interrupt Them

Shortcut	How it can appear in assessment	A question to ask yourself
Stereotyping	Expecting a problem because of the client's group	What would I be asking if this client belonged to a different group?

Shortcut	How it can appear in assessment	A question to ask yourself
Anchoring	Building the formulation around the referral label or first impression	What would I conclude if I had seen this client without the referral note?
Diagnostic momentum	Repeating a prior diagnosis without reexamining it	Who made this diagnosis, on what evidence, and has anyone checked it since?
Confirmation bias	Asking mainly questions that support the working hypothesis	What finding would make me change my mind, and have I looked for it?
Availability	Overweighting recent or memorable cases	Is this client actually like the cases I am remembering?
Credibility judgment	Discounting the client's account as guarded or unreliable	What reasons might this client have for caution with me, here, today?
Premature closure	Stopping the search once a plausible diagnosis appears	What else could explain this presentation, including cultural and situational explanations?

Bias Beyond Race

Most of the research on bias in clinical judgment concerns race and ethnicity, but the same mechanisms operate along other dimensions, and the review by FitzGerald and Hurst (2017) found evidence of implicit bias related to gender, age, weight, socioeconomic status, and substance use as well. A few patterns are common enough in behavioral health practice to name.

Age. A clinician may attribute depression, withdrawal, or memory complaints in an older adult to "normal aging" and stop the assessment there, or may fail to ask an older client about alcohol use, sexuality, or suicidal thinking because the questions feel out of place. The reverse error occurs with young clients, whose distress may be dismissed as a phase.

Social class and poverty. In child welfare and family assessment, the conditions of poverty, such as a crowded apartment, an empty refrigerator at the end of the month, or a child left with a neighbor during a work shift, can be read as neglect when they are constraints. A clinician who has never lived with those constraints may not see the difference.

Religion. Devout belief may be read as rigidity or as a sign of thought disorder, especially when the clinician is secular or belongs to a different tradition. A client who describes prayer, divine guidance, or spiritual struggle is describing something that matters to them, and the clinical question is how it functions in their life, not whether the clinician shares it.

Disability. Clinicians may attribute a client's mood, isolation, or frustration to the disability itself and miss depression, or may underestimate the client's capacity to make decisions about their own care.

Sexual orientation and gender identity. Two opposite errors appear here as well. One attributes every difficulty to the client's identity, so that a transgender client's panic disorder is treated as a gender issue. The other ignores identity entirely and misses the effects of family rejection, harassment, or minority stress on the presenting problem.

Across these examples, the safeguard is to make the assumption explicit, ask what information supports it, and obtain the client's account before using it in a formulation.

A Structured Pause at High-Stakes Decision Points

Because bias does most of its work under time pressure, one of the most practical safeguards is a brief, deliberate pause at the moments when a judgment carries the highest stakes (recommended practice). Those moments include assigning a first diagnosis of a serious mental illness, recommending involuntary hospitalization, making a report to child protective services, deciding that a client is not credible, and finalizing a risk assessment.

The pause can be brief: What is the strongest alternative explanation? What finding would change my mind, and have I sought it? Would I interpret the same presentation differently if the client's background differed? The last question is a self-check, not a reliable test of whether bias is present. If uncertainty affects a high-stakes decision, gather further information, consult, and document the provisional reasoning. A cultural interview must not delay urgent safety assessment or necessary medical care.

An example shows how the pause works under real conditions. An emergency department social worker is finishing an evaluation of a 19-year-old man brought in by police after a loud argument with neighbors. The officer's note says "agitated and threatening." The young man is calm now, says the neighbors called him a slur, and asks to go home. The social worker is about to recommend an involuntary hold, mostly on the strength of the officer's note.

She stops for the three questions. The strongest alternative is an angry, frightened young man after a racially charged confrontation, with no evidence yet of a mental disorder or ongoing danger. What would change her mind is a history of violence, threats he still endorses, intoxication, or psychotic symptoms, and she has not yet asked about most of these. The third question has no certain answer, but asking it shows her that the police note is carrying most of the weight in her reasoning. She completes the risk assessment, calls his mother with his permission, and documents what she found. The outcome could still be a hold. The difference is that the decision now rests on what she assessed, not on the first description she read.

Two Mirror-Image Errors: Colorblindness and Over-Accommodation

Two errors that look like opposites share a common root. Both replace the actual person with an idea about culture.

Colorblindness is the belief that the respectful or fair response to race and culture is not to notice them. Many clinicians were taught some version of this stance, and it often comes from good intentions: a wish to treat everyone the same. Neville et al. (2013) describe color-blind racial ideology as having two forms, a denial that one sees race and, more consequentially for clinicians, a denial or minimization of racism and its effects. Colorblindness can lead a clinician to treat a client's experience of discrimination as a misperception, to miss the clinical relevance of a client's racial identity, or to formulate a client's distress entirely in individual terms when it is partly a response to the client's social environment. An older analogue study found that therapists who scored higher on color-blind racial attitudes showed less empathy toward a client and were more likely to hold the client responsible for their problems (Burkard & Knox, 2004).

Over-accommodation, sometimes called cultural overattribution, is the opposite move. The clinician sees culture everywhere and attributes the client's behavior to it without checking. A clinician may fail to screen for intimate partner violence because "decisions are made by the husband in that culture," may dismiss a true hallucination as a culturally normative spiritual experience without asking how the client's own community views it, or may accept a family's account of a teenager's restrictive eating as a dietary practice. Over-accommodation can feel like respect. It can also leave real risk unassessed, and it can tell the client that the clinician sees a category, not a person. The critiques of competence-based training described in Section 1

apply here: when culture is taught as a set of group traits, the traits can stand in for an assessment (Fisher-Borne et al., 2015).

Both errors are reduced by asking how this client and their community understand the experience, then integrating that account with symptom history, function, risk, and other evidence. The client's explanation is essential information. It does not, by itself, establish or exclude a mental disorder.

Microaggressions and Their Clinical Impact

Sue et al. (2007) defined racial microaggressions as brief, everyday verbal, behavioral, or environmental slights, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to people of color. They proposed three forms: microassaults, which are explicit and usually deliberate; microinsults, which convey rudeness or insensitivity toward a person's identity; and microinvalidations, which exclude or dismiss a person's experience. In clinical work, the most common forms tend to be the subtle ones. A clinician compliments an American-born client's English, assumes a Black client grew up in poverty, says "I don't see you as Black," or changes the subject when a client raises racism.

Research on microaggressions in therapy suggests they are common and that they matter for the relationship. In a study of 120 racial and ethnic minority clients at a university counseling center, about 53% reported experiencing a microaggression from their therapist, and about 76% of those clients said it was never discussed (Owen et al., 2014). Microaggressions were associated with weaker working alliances. Clients who experienced a microaggression that was then discussed reported alliances similar to clients who experienced none, while clients whose microaggression went undiscussed reported lower alliances (Owen et al., 2014). In a larger survey of racial and ethnic minority clients, most participants (81%) reported at least one racial microaggression in counseling; the most common involved the therapist avoiding or minimizing cultural issues, and clients who perceived their counselors as more culturally humble reported fewer microaggressions (Hook et al., 2016).

The microaggression construct has also drawn serious criticism. Lilienfeld (2017) questioned its definition, its reliance on self-report and cross-sectional research, and causal claims about harm to mental health. Those limits matter when interpreting prevalence figures and outcomes. They leave the clinically relevant finding from the therapy studies in place: when a client perceives a slight from the therapist and it is never addressed, the alliance tends to be weaker.

Case 2: The Referral That Arrived With a Diagnosis

Malik, 9, was referred to the school social worker in October of his fourth-grade year. The referral form, completed by his teacher, described "defiance, refusal to follow directions, outbursts, and aggression toward peers." It noted that Malik's older brother had been "a behavior problem" at the same school and asked for an evaluation "for ODD or conduct issues." The social worker, who had a caseload of more than 200 students across two schools, observed Malik in class for twenty minutes, met with him briefly, and spoke with his teacher, who said Malik was "always looking for a fight." The observation confirmed the referral: Malik left his seat several times, ignored two directions, and argued with a classmate. The social worker drafted a summary recommending a behavior intervention plan and an outside evaluation for oppositional defiant disorder.

Before sending the summary, she reread her notes and noticed what was missing. She had not asked Malik's caregiver anything. She had not reviewed his records from previous years. She had observed one class period, chosen by the teacher. The word "ODD" had come from the referral form, and her observation had been organized, without her quite deciding it, around confirming it. She also noticed that she had read the line about Malik's older brother and had not questioned why it was there.

She called Malik's grandmother, who was his guardian. The grandmother described a boy who was loving at home but "can't sit still for anything," lost his belongings constantly, and had been "dreamy" since kindergarten. She mentioned, almost in passing, that the family had been evicted over the summer and had moved twice since, and that Malik had been sleeping on a couch at an aunt's apartment. His third-grade teacher, contacted by email, wrote that Malik had struggled with focus and organization but had not been aggressive; she had suggested an attention evaluation the previous spring, and the family had been on a waiting list when they moved.

The social worker revised her formulation. The presentation now included possible inattention dating to early childhood, recent housing instability and loss, sleep disruption, and a classroom relationship that had become adversarial early in the year. Oppositional behavior was still part of the picture, but it was no longer the whole picture, and it might be partly a response to the others. Her revised recommendation included an evaluation for ADHD, a referral to the district's homeless education liaison under the McKinney-Vento Act, a conversation with the teacher about the classroom dynamic, and supports that did not depend on a behavioral label.

Several shortcuts operated in the first draft: anchoring on the referral label, confirmation bias in the observation, availability through the comment about the brother, and a credibility judgment that accepted the teacher's account without seeking the family's. Section 3 shows that the pattern is not unique to this school. A review by Fadus et al. (2020) concluded that Black and Hispanic youth are more likely than White youth to be diagnosed with disruptive behavior disorders and less likely to be diagnosed with ADHD. The social worker in this case did not need to know that research to correct her draft. She needed to notice that her first conclusion had arrived before her assessment did.

Clinical Practice Exercise

Using Malik's case, list at least three explanations that require assessment before a disruptive-behavior diagnosis is adopted. Identify information that would support or weaken each explanation. Write a provisional recommendation that includes school supports without requiring a final diagnosis.

Reasoning guide: Consider longstanding attention difficulties, sleep disruption and housing instability, classroom interactions, and possible co-occurring conditions. Compare reports across settings and developmental history. Distinguish a referral for ADHD evaluation from an established ADHD diagnosis, and document any immediate safety needs separately.

Reflection Questions

1. Which of the shortcuts in Table 2 do you think most often shapes your own assessments, and in what settings or at what times of day?
2. When a referral arrives with a diagnosis already attached, what do you usually do with it? What would change if you read it last instead of first?
3. Think of a time a client described an experience of discrimination. How did you respond, and how did your response shape the formulation?

Key Clinical Takeaways

- Clinicians show implicit biases at rates similar to the general population, and these biases appear in vignette studies of diagnosis and treatment.
- Changing implicit associations through training has not been shown to produce lasting changes in behavior; changing the conditions and structure of decisions is a more realistic target.
- Time pressure, fatigue, ambiguity, and high caseloads are thought to increase reliance on stereotypes.

- Anchoring, diagnostic momentum, confirmation bias, availability, and credibility judgments are the main routes by which cultural assumptions enter a formulation.
- Colorblindness and over-accommodation are mirror-image errors; both substitute an idea about culture for an assessment of the person.
- Clients frequently perceive microaggressions from therapists, and an unaddressed microaggression is associated with a weaker alliance, even though the broader microaggression research has methodological limits.

Section 3: Diagnostic and Assessment Disparities Across Groups

For decades, studies in the United States have found that Black Americans are diagnosed with schizophrenia at substantially higher rates than White Americans. The finding has held across inpatient and outpatient settings and across many samples, and its causes are still debated. This section goes through that pattern and several others, looks at what the research says about where they come from, and makes the case that diagnostic disparity belongs next to medication errors and missed suicide risk as a patient safety issue.

A difference in diagnosis rates between groups is a statistical observation. A diagnostic disparity, as used here, reflects error or inequity, not simply a true difference in illness frequency. These explanations can coexist: unequal exposure to trauma or discrimination, different pathways to care, and differences in clinical interpretation. The studies below vary in their ability to separate these influences. A higher diagnosis rate is a reason to examine the assessment process; it is not, by itself, proof of misdiagnosis.

Psychotic Disorders

A review of the empirical literature found that, across studies of clinical samples, African Americans were diagnosed with psychotic disorders at rates on average three to four times higher than Euro-Americans, and that Latino Americans were diagnosed at about three times the rate in several studies (Schwartz & Blankenship, 2014). The review's authors emphasized that these diagnostic differences do not show that any group actually has more severe symptoms or a higher prevalence of psychosis, and that the causes remain uncertain.

A meta-analysis of U.S. studies found that Black individuals had about 2.4 times the odds of a schizophrenia diagnosis compared with White individuals (odds ratio [OR] = 2.42, 95% confidence interval [CI] [1.59, 3.66]; Olbert et al., 2018). The authors then split the studies by method. Studies that relied on unstructured clinical assessment produced an OR of 2.43 (95% CI [1.59, 3.72]). Studies that used structured diagnostic instruments produced an OR of 1.77 (95% CI [1.31, 2.38]). The structured estimate is lower, but the difference between the two was not statistically significant, and the disparity was present with either method. The authors noted that structured assessment may still have a small effect that the available studies could not detect. A common assumption is that structured interviews protect against bias by standardizing what clinicians ask. One possible explanation for persistent disparity is that bias can affect how answers are elicited and interpreted, even when questions are standardized. This meta-analysis did not establish that mechanism or a reduction in disparity attributable to structured assessment. Structure is still worth using; it does not replace attention to how information is elicited and interpreted.

A note on odds ratios. Several studies in this section report odds ratios. An odds ratio of 2.4 means that the odds of a diagnosis in one group were about 2.4 times the odds in another. Odds and probabilities are close when an outcome is rare and drift apart when it is common, so an odds ratio should not be read as "2.4 times as many people." For clinical practice, the direction and persistence of a disparity matter more than the exact multiplier.

More recent data from a large integrated health system point in the same direction. In a review of medical records for almost 6 million patients in Northern California between 2009 and 2019, Black patients had the highest rates of both nonaffective and affective psychotic disorder diagnoses, American Indian and Alaska Native patients also had elevated rates, and Asian patients had the lowest (Chung et al., 2023). Studies of this kind cannot by themselves distinguish true incidence from diagnostic practice. They do show that the pattern persists in a contemporary health system in which every patient studied was an insured member.

History helps explain why clinicians should treat this pattern with particular care. Faber et al. (2023) trace the association between race and schizophrenia in U.S. psychiatry to the 1960s, when some clinicians described Black civil rights activism in psychiatric terms, and earlier to a long record of pathologizing Black resistance and distress. That history does not prove that any present-day diagnosis is biased. It does mean that the link between Blackness and psychosis entered clinical thinking partly through social and political forces, which is a reason to examine it closely.

Mood Disorders Underweighted

The flip side of psychosis overdiagnosis is the underrecognition of mood disorders, particularly in Black patients. Studies by Gara and colleagues, reviewed below, suggest that when Black and White patients present with similar combinations of mood and psychotic symptoms, clinicians give more weight to the psychotic symptoms in Black patients.

Gara et al. (2012) compared race-blinded expert assessments with clinical diagnoses in 610 psychiatric inpatients and outpatients. Black participants had higher odds of a clinical schizophrenia diagnosis even after adjustment for serious affective disorder and other covariates. Overall manic and depressive severity did not differ significantly between Black and White participants, while assessed psychosis was more severe among Black participants. This was not a sample restricted to people with confirmed bipolar disorder. In a later clinic study, Black patients carrying a schizophrenia diagnosis were more likely than non-Latino White patients to screen positive for major depression on the PHQ-9 (Gara et al., 2019). A positive depression screen calls for clinical evaluation; it does not retrospectively establish that a schizophrenia diagnosis was wrong.

The clinical stakes are concrete. Bipolar disorder with psychotic features and schizophrenia call for different treatments, carry different prognoses, and lead to different conversations with the client and family. A client whose mood disorder is misread as a primary psychotic disorder may be treated with antipsychotics alone, may miss mood-stabilizing treatment, and may carry a diagnosis that shapes how every later clinician sees them (Akinhanmi et al., 2018).

Culturally Normative Experience Read as Pathology

A third pattern involves experiences that are normal or expected within a client's cultural or social context but resemble symptoms on a checklist. DSM-5-TR itself cautions that ideas that appear delusional in one cultural context may be commonly held in another, and that hearing the voice of God or of a deceased relative can be part of ordinary religious or bereavement experience in some cultures (APA, 2022).

Suspicion is a common example. People who have experienced discrimination, surveillance, or mistreatment by institutions may reasonably approach a clinician, a hospital, or the police with caution. Faber et al. (2023) describe this as healthy suspicion or cultural mistrust and note research in which perceived racism predicted both cultural mistrust and nonclinical paranoia in Black participants. A clinician who does not ask about the client's experiences may read justified caution as a paranoid symptom, which is exactly the risk in Andre's referral from the introduction.

Spiritual and religious experience is another. Faber et al. (2023) cite research suggesting that when unusual experiences were understood in spiritual or paranormal terms, the likelihood of a schizophrenia-spectrum diagnosis among African Americans was lower. Much depends on whether the clinician asks how the client and their community understand the experience. Immigrants and refugees present a related challenge. In a Canadian study described in the Schwartz and Blankenship (2014) review, 49% of patients referred to a cultural consultation service with a psychotic disorder diagnosis had that diagnosis changed to a nonpsychotic diagnosis after cultural consultation (Adeponle et al., as cited in Schwartz & Blankenship, 2014). The figure

comes from a specialized referral sample and cannot be generalized to all immigrants, but it shows how much a culturally informed second look can change.

Section 4 considers cultural concepts of distress and how to explore their meaning during a full diagnostic assessment.

Attention and Behavior Disorders in Children

Disparities in childhood diagnosis do not run in a single direction. A review of research on African American and Hispanic youth concluded that they are more likely than White youth to be diagnosed with disruptive behavior disorders, such as oppositional defiant disorder and conduct disorder, and less likely to be diagnosed with ADHD, and the authors argued that unconscious bias in how children's behavior is interpreted contributes to this pattern (Fadus et al., 2020). The distinction matters because the labels can lead to different paths. An ADHD diagnosis points toward treatment and school accommodations, while a conduct-related label is more likely to frame a child's behavior as a disciplinary matter.

At the same time, a meta-analysis of 21 U.S. studies found a pooled ADHD prevalence of about 14.5% among Black individuals, most of them children and adolescents, which is higher than common estimates for the general U.S. population (Cénat et al., 2021). The authors suggested that higher exposure to risk factors, including discrimination, may contribute, and that current diagnostic tools may not be culturally appropriate. Many of the included samples came from disadvantaged communities, which limits generalization. Read together, the review and the meta-analysis suggest that Black children may experience both higher symptom burden and lower rates of accurate ADHD identification, with some behavior that reflects attention problems being read as defiance. Case 2 in Section 2 showed how that can happen in a single school.

Autism Identification

Autism shows how disparities can change over time and still leave important gaps. Earlier national surveillance found autism identified less often among Black and Hispanic children than among White children, and that pattern has since reversed. In the 2022 surveillance year of the Autism and Developmental Disabilities Monitoring Network, overall prevalence among 8-year-olds was about 1 in 31, and prevalence was higher among Asian or Pacific Islander, American Indian or Alaska Native, Black, Hispanic, and multiracial children than among White children (Shaw et al., 2025).

Prevalence is not the only measure that matters, however. In a study of 584 African American children evaluated at four autism centers, the average child was nearly 5½ years old at diagnosis, even though parents had first raised developmental concerns more than three years earlier, and nearly half of parents reported seeing multiple specialists before receiving the diagnosis (Constantino et al., 2020). Lack of health insurance did not explain the delay. A delay of that length can mean the loss of years of early intervention, which is one of the clearest examples in this section of disparity measured in time.

Where Disparity Comes From

The research points to three broad sources, which usually operate together.

Clinician interpretation. The findings on interviewer-perceived honesty (Eack et al., 2012), on the weighting of psychotic versus mood symptoms (Gara et al., 2012, 2019), and on the persistence of disparities in structured assessments (Olbert et al., 2018) all suggest that part of the disparity arises in how clinicians hear and rate what clients say. This is the source most directly addressed by the skills in this course.

Instruments and norms. Standardized measures were often developed and normed with samples that underrepresented some groups. Items may function differently across languages and cultures, and cutoffs

established in one population may not hold in another. The *Standards for Educational and Psychological Testing* treat fairness as a foundational concern and call for evidence that a test's scores mean the same thing across the groups with whom it is used (American Educational Research Association [AERA] et al., 2014). Section 4 addresses how clinicians can use standardized measures with appropriate caution.

Structural factors. Clients reach mental health care through different pathways. Some arrive through primary care or self-referral early in an illness. Others arrive through emergency departments, police contact, or the courts, often later and in crisis, when presentations are more severe and assessment conditions are worse. Access to culturally and linguistically matched providers is uneven. Exposure to poverty, trauma, unsafe housing, and discrimination, which are themselves risk factors for mental illness, is unequally distributed (Williams et al., 2019). Shim (2021) argues that these patterns reflect structural racism within psychiatry and the systems around it, and that addressing them requires changes in institutions as well as in individual practice. A national consensus report reached a similar conclusion for health care broadly, finding that racial and ethnic inequities in care persist two decades after earlier efforts to address them (NASEM, 2024).

These sources can interact. A referral label, limited time, language barriers, and a crisis setting can constrain both the information available and how it is interpreted.

What Population Data Can and Cannot Tell You About One Client

Disparity research describes patterns across thousands of clients. It cannot tell a clinician what is true of the person in front of them, and it can be misused in two directions.

The first misuse is to treat a group's elevated diagnosis rate as a reason to expect the diagnosis. A clinician who knows that Black patients are diagnosed with schizophrenia more often, and who unconsciously treats that as a base rate, may become more ready to see psychosis in a Black client. That is the very error the research describes. Because the elevated rates appear to reflect diagnostic practice at least in part, they are not a reliable guide to the true probability of illness in any individual.

The second misuse is overcorrection. A clinician who has learned that psychosis is overdiagnosed in Black clients may hesitate to recognize it when it is present. That carries its own harm. Delayed recognition of a first episode of psychosis can mean a longer period without treatment, more disruption to work, school, and relationships, and a greater chance that the illness first comes to attention through a crisis, a police encounter, or an involuntary hospitalization, pathways that, as described above, are already more common for some groups. The goal is accuracy, not a lower or higher rate of any diagnosis.

Research also leaves important gaps. The lower psychotic-disorder diagnosis rates among Asian patients in Chung et al. (2023) could reflect incidence, access, help seeking, recognition, or several influences together. Broad categories can conceal substantial differences among communities. Sparse evidence about a particular population increases the importance of individual assessment; it does not justify filling the gap with a cultural assumption.

Use population findings to identify decisions that warrant closer review, then base the formulation on the individual's presentation, context, course, and safety needs. Document what is established, what remains uncertain, and what information will be obtained next.

Disparity as a Patient Safety Issue

The National Academies defined diagnostic error as the failure to establish an accurate and timely explanation of a patient's health problem or to communicate that explanation to the patient (NASEM, 2015). By that definition, much of what this section has described is diagnostic error: an inaccurate diagnosis of

schizophrenia in a person with bipolar disorder, an untimely autism diagnosis, a disruptive behavior label in a child with untreated ADHD.

Framing disparity as a safety issue directs attention to decisions and outcomes that can be reviewed. Organizations can examine the accuracy, timeliness, and consequences of diagnoses across groups, alongside access and case-mix differences. For clinicians, a high-stakes decision warrants explicit consideration of alternatives, appropriate consultation, and documentation of uncertainty (recommended practice).

The harms of these errors are not abstract. A misdiagnosed psychotic disorder can lead to years of antipsychotic medication with metabolic and neurological side effects, missed treatment for the actual condition, stigma within the family and community, and a record that influences every later encounter. Faber et al. (2023) also describe a greater reliance on coercive and police-involved responses to Black people in psychiatric crisis, which adds the risks of involuntary treatment and injury. A misdiagnosed or delayed developmental diagnosis can cost a child years of intervention. Unequal diagnostic accuracy is, in the plainest terms, unequal exposure to harm.

Case 3: One Presentation, Two Formulations

Terrence Hall, 27, was brought to a crisis stabilization unit by his older brother after a week in which he had barely slept, talked rapidly and continuously, spent most of his savings on recording equipment, and told family members that he had been "chosen" to deliver a message through his music. He was irritable and, when the brother tried to take his car keys, accused him of "working with the people watching me." He had no psychiatric history. He mentioned that police had stopped him twice in the past month in his own neighborhood.

The admitting clinician, working a night shift with two other admissions pending, documented "grandiose and paranoid delusions, pressured speech, agitation, poor insight" and wrote "r/o schizophrenia, paranoid features." The note recorded the police stops under "paranoid ideation." The brother, who was asked mainly about safety and medication history, was not asked about the past two weeks in detail.

A second clinician reviewed the case the next morning. Decreased need for sleep, pressured speech, spending, grandiosity, and irritability over about a week suggested a manic syndrome requiring prompt psychiatric evaluation. She asked the brother about the recent course and family history and learned that an aunt had reportedly improved with lithium. That history supported further inquiry but did not establish a diagnosis. Terrence described the police stops with dates, and his brother corroborated one. Some concern about surveillance had a factual basis, while other beliefs still needed examination. The working differential included a first manic episode with psychotic features, a primary psychotic disorder, substance-related causes, and medical causes. With Terrence's consent where required, the clinician sought collateral information and coordinated with the psychiatrist and medical team for substance-use assessment, physical evaluation, and treatment decisions. She documented the relationship of psychotic symptoms to mood symptoms as an unresolved question and did not assume mood congruence.

Almost everything in the second note had been available to the first clinician. What changed was the weight given to mood symptoms, the decision to ask whether the police stops had actually happened, and the time to build a timeline. The first note followed the pattern Gara et al. (2012) described, with psychotic symptoms emphasized and mood symptoms underweighted. The second kept psychosis on the list without letting it crowd out everything else, and acute safety assessment continued while the team gathered the rest.

Clinical Practice Exercise

Draft a brief differential for Terrence that includes mood-related, primary psychotic, substance-related, and medical explanations. Specify which facts support concern for mania, which remain uncertain, and what should happen next. Do not infer that every surveillance concern is either factual or delusional.

Reasoning guide: The week of reduced sleep, spending, pressured speech, and grandiosity warrants urgent assessment. Obtain a timeline, collateral history, substance and medication history, and appropriate medical evaluation while maintaining safety. Distinguish a provisional formulation from a confirmed diagnosis and identify who is responsible for each consultation and follow-up.

Reflection Questions

1. In your practice setting, which diagnoses carry the highest stakes for clients from groups known to be at risk of misdiagnosis? What checks, if any, currently apply to them?
2. When a client describes being watched, followed, or mistreated, how do you decide whether the account reflects real events, a symptom, or both?
3. Does your agency track diagnoses by client race, ethnicity, or language? If it did, what do you think it would find?

Key Clinical Takeaways

- Black individuals had about 2.4 times the odds of a schizophrenia diagnosis in a U.S. meta-analysis. The odds ratio was 1.77 in studies using structured instruments and 2.43 with unstructured assessment, a difference that was not statistically significant.
- Mood symptoms require careful assessment when psychotic symptoms are present. Diagnostic differences and positive screening results warrant evaluation; they do not independently prove misdiagnosis in a particular client.
- Cultural mistrust, spiritual experience, and bereavement experiences can resemble symptoms; asking how the client and their community understand an experience is part of the assessment.
- In children, disparities run in more than one direction: Black and Hispanic youth appear more likely to receive disruptive behavior diagnoses and less likely to receive ADHD diagnoses, and Black children with autism may wait years from first concern to diagnosis.
- Disparity arises from clinician interpretation, instrument and norming limitations, and structural factors that shape how and when clients reach care.
- A high-stakes diagnosis warrants explicit alternatives, appropriate consultation, and follow-up. Review group differences as possible safety signals while examining access, illness burden, and assessment conditions.

Section 4: Culturally Responsive Assessment Tools

Graciela, 58, was referred to a community behavioral health clinic by her primary care practice. The referral read: "Possible psychotic depression. Pt reports seeing and hearing deceased son. 12 lb weight loss in 3 months, poor sleep, not leaving home. States her 'spirit left her' after a robbery. Spanish speaking." The clinic assigned a bilingual social worker, who conducted the intake in Spanish. Graciela answered politely and briefly. She confirmed that she saw her son at night and heard him call her name. She said she was afraid all the time. When asked about the robbery, she said only that two men had taken her purse at the bus stop and that "since then I am not right." The social worker noted flat affect, psychomotor slowing, and perceptual disturbances, and wrote "MDD, severe, with psychotic features vs. PTSD; consider psychiatric evaluation for antipsychotic." She also noted that Graciela's Spanish was "limited" and that her daughter-in-law had done some of the talking at the primary care visit.

The case returns at the end of this section. Before it does, this section introduces the tools that changed the social worker's understanding of it: the DSM-5-TR cultural formulation and its interview, the concept of cultural concepts of distress, the practice of working with interpreters, and a set of cautions for using standardized measures with clients whose backgrounds differ from the samples those measures were built on.

The Cultural Formulation in DSM-5-TR

DSM-5-TR includes an outline for cultural formulation that asks clinicians to consider five areas in every assessment (APA, 2022):

- **The cultural identity of the individual**, including racial, ethnic, and other cultural reference groups, language, religion, migration history, and other aspects of identity that matter to the person.
- **Cultural conceptualizations of distress**, meaning how the person and those around them understand, express, and explain the problem.
- **Psychosocial stressors and cultural features of vulnerability and resilience**, including social supports, discrimination, and the role of religion, family, and community.
- **Cultural features of the relationship between the individual and the clinician**, including differences in culture, language, and social status that may affect communication, trust, and diagnosis.
- **An overall cultural assessment** that integrates the above into implications for diagnosis and care.

The outline is a framework for thinking. The Cultural Formulation Interview is the tool that puts it into practice.

The Cultural Formulation Interview

The Cultural Formulation Interview (CFI) is a semistructured interview introduced in DSM-5 and retained in DSM-5-TR. Its core version consists of 16 questions that clinicians can use during any mental health assessment to learn how culture shapes the client's presentation and care (APA, 2022). The questions are written in plain, person-centered language and avoid technical terms. They ask the client to describe the problem in their own words and to say how they, their family, and their community understand it. The core CFI is organized in four domains, summarized in Table 3.

Table 3. Domains of the Core Cultural Formulation Interview

Domain	What the questions explore	Why it matters for diagnosis
Cultural definition of the problem	How the client describes the problem in their own words, how others in their life describe it, and what troubles them most	Establishes the client's terms and priorities before clinical categories are applied
Cultural perceptions of cause, context, and support	What the client and others believe caused the problem; stressors and supports in family, community, and social environment; the role of cultural identity, including discrimination	Distinguishes culturally expected responses from pathology; surfaces stressors such as discrimination that may otherwise be missed
Cultural factors affecting self-coping and past help seeking	What the client has done to cope; what help they have sought, including from family, religious, and traditional sources; barriers to past care	Identifies resources and prior experiences of care, including harm or mistrust that shape the current encounter
Cultural factors affecting current help seeking	What kind of help the client wants now; what others suggest; concerns about the clinician-client relationship, including differences in background	Aligns the plan with the client's goals; invites the client to name concerns about working with this clinician

Note. Descriptions are paraphrased summaries of the domains. The interview itself, an informant version, and supplementary modules are available from the American Psychiatric Association.

Two features of the CFI deserve emphasis. First, it begins with the client's definition of the problem. The clinician's formulation comes later and is built on the client's account. Second, its final questions ask about the relationship with the clinician, including whether differences in background might make it harder for the client to be understood. In a single question, the CFI invites the kind of conversation about difference that Section 5 calls broaching.

The CFI has companion tools. An **informant version** gathers the same information from a family member or caregiver, which is useful when the client cannot participate fully or when collateral perspectives matter.

Supplementary modules extend the interview: eight explore the core domains in more depth (explanatory model, level of functioning, social network, psychosocial stressors, spirituality and religion, cultural identity, coping and help seeking, and the patient-clinician relationship); three address particular populations (school-age children and adolescents, older adults, and immigrants and refugees); and one addresses caregivers (APA, 2022).

DSM-5-TR describes several situations in which the CFI may be especially helpful (APA, 2022): when cultural, religious, or socioeconomic differences between clinician and client make diagnostic assessment difficult; when it is unclear whether culturally distinctive symptoms fit diagnostic criteria; when severity or impairment is hard to judge; when client and clinician disagree about the course of care; and when engagement in treatment is limited. Several of these conditions described Graciela's intake.

What the Evidence Shows About the CFI

An international field trial included 318 patients and 75 clinicians in six countries. Participants rated the CFI as feasible, acceptable, and clinically useful; clinician feasibility ratings improved with experience (Lewis-Fernández et al., 2017). These findings address usability, not proof of fewer diagnostic errors. Subsequent research includes a Swedish randomized trial of 256 outpatients: depression was diagnosed more often in the CFI group, but the overall prevalence-ratio confidence interval included no difference ($PR = 1.21$, 95% CI

[0.83, 1.75]). The trial did not reduce non-definite diagnoses (Wallin et al., 2022). A 2024 review found that 10 of 12 included studies described the CFI as helpful for diagnostic or treatment-planning tasks, while identifying gaps in how its information changes case formulation (Aggarwal, 2024). So far, the CFI has better evidence for improving the conversation than for improving the diagnosis.

A *DSM-5 Handbook on the Cultural Formulation Interview* offers detailed guidance on administration, adaptation for different settings, and training (Lewis-Fernández et al., 2016).

Using the CFI in Real Settings

Clinicians often worry that a 16-question interview will not fit a crowded intake. It does not have to be used all at once (recommended practice):

- **As a full interview** at the start of an assessment, particularly when the situations listed above apply.
- **In pieces**, by weaving selected questions into an existing intake. The questions about the client's own definition of the problem, what they believe caused it, and what help they want are often the highest-yield, and they take only a few minutes.
- **As a second look**, when an initial formulation is not holding together or when a high-stakes diagnosis is being considered for a client from a group at known risk of misdiagnosis, such as a first psychotic disorder diagnosis in a Black client.
- **With collateral informants**, using the informant version when family members are central to the client's life or decision making.

Adapt the interview to the task without presenting a shortened selection as a fully administered CFI. A child welfare worker may explore the family's understanding of agency concerns; a school social worker may examine the student's and caregiver's perspectives; a hospital social worker may focus on supports and help seeking. Document which questions or modules were used and any limits in participation or communication.

A Compressed CFI Sequence

The following example shows how a clinician might weave CFI-informed questions into ten minutes of a standard intake. The questions are paraphrased from the four core domains, not quoted from the interview, and they would not count as a full administration.

Defining the problem. "Before I ask my usual questions, I'd like to hear it in your words. What brings you in, and what would you call it?" A client might say *nervios*, burnout, a spiritual attack, or simply "I can't stop worrying." Whatever the word, the clinician uses it back.

Cause and context. "What do you think is causing this? What do the people close to you say is going on?" Then: "Is there anything about your background, like your culture, faith, or where you come from, that affects how you're dealing with it, for better or worse?" Discrimination, family obligations, and immigration stress often surface here for the first time.

Coping and past help. "What have you already tried? Has anyone else helped, such as family, a religious leader, or a healer? Have you been to a clinic before, and how did that go?" A client who answers the last question with "they didn't listen" has told the clinician something important about the present encounter.

Current help and the relationship. "What kind of help would be most useful now? Is there anything about me or this clinic that might make it harder to talk, or to be understood?" The last question can feel awkward the first few times it is asked. Most answers are brief, and some change the course of the work.

The clinician then returns to the standard intake, now holding the client's own terms, explanations, and priorities. A short line in the note records which questions were asked, so that later readers know the cultural information came from a partial interview, not the full CFI.

Cultural Concepts of Distress

DSM-5-TR uses the term *cultural concepts of distress* for the ways cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions (APA, 2022). It describes three related forms:

- **Cultural syndromes** are clusters of symptoms and attributions that tend to occur together among people in specific cultural groups and are recognized locally as coherent patterns of experience.
- **Cultural idioms of distress** are ways of expressing distress that may not involve specific symptoms or syndromes but provide collective, shared ways of talking about personal or social concerns.
- **Cultural explanations or perceived causes** are labels, attributions, or explanatory models that indicate a culturally recognized meaning or cause for symptoms, illness, or distress.

DSM-5-TR offers several examples. *Ataque de nervios*, described among people of Latin American and Caribbean heritage, involves intense emotional upset, often with shouting, crying, trembling, and a sense of losing control, frequently following a family stressor. *Susto* is an explanation, common in parts of Latin America and among Latin American communities in the United States, in which a frightening event is believed to cause the soul to leave the body, leading to unhappiness, illness, and difficulty functioning. *Khyâl cap*, or "wind attacks," described among Cambodians, involves panic-like symptoms attributed to a rising of wind-like substance in the body. *Kufungisisa*, "thinking too much" in Shona, is an idiom of distress and explanation associated with anxiety, depression, and somatic complaints. *Taijin kyofusho*, described in Japan, involves fear of offending or making others uncomfortable through one's appearance, gaze, or body odor (APA, 2022).

Cultural concepts of distress can clarify the meaning of symptoms, identify explanations that might otherwise be mistaken for psychosis, and reveal sources of help the client values. For example, a person describing *susto* may also consult a traditional healer. With permission and within professional boundaries, the clinician can explore that care and consider appropriate coordination. The cultural explanation and the psychiatric differential must both remain open to assessment.

Three cautions apply. Cultural concepts of distress are not diagnoses and do not map neatly onto DSM categories; a client may meet criteria for a DSM disorder and also describe their experience in cultural terms. Not every member of a cultural group uses these concepts, and assuming that a client does is a form of the over-accommodation error described in Section 2. And clinicians should learn the term the client uses and ask what it means to them, instead of supplying a label from a glossary. "What do you call this?" and "What do people in your family say is happening?" are usually better questions than "Is this *susto*?"

Working With Interpreters and Language Access

Language is one of the most direct routes to misdiagnosis. Assessment conducted in a language in which the client is not fully proficient can distort what a clinician hears. A review of research on psychiatric care for patients with limited English proficiency found that evaluations conducted in a patient's nonpreferred language, or through ad hoc interpreters, could produce incomplete or distorted assessments of psychopathology (Bauer & Alegría, 2010). Clients may appear more disorganized, more flat, or less forthcoming when speaking a second language under stress. Thought content may be lost or simplified in translation, and untrained interpreters sometimes tidy up disorganized speech, omit material they find embarrassing, or answer for the client.

For programs covered by Section 1557, federal regulations require reasonable steps to provide meaningful access for individuals with limited English proficiency. Needed language assistance must be offered without charging the individual or requiring the individual to provide an interpreter. Restrictions apply to reliance on unqualified adults, minor children, or unqualified bilingual staff. Emergency use of a child or unqualified adult is a temporary measure while obtaining a qualified interpreter; an adult-companion exception requires specific safeguards, including confirmation of the individual's request in private with a qualified interpreter present (45 C.F.R. § 92.201, 2024; U.S. Department of Health and Human Services [HHS], 2024). Do not treat a client's preference as a blanket waiver of interpreter safeguards. Confirm the rule's coverage and current requirements for the setting. Qualified language support is also a clinical safeguard when a particular federal provision does not apply.

The evidence on interpreter-mediated psychotherapy is limited. A 2025 review of cognitive behavioral therapy delivered with spoken-language interpreters found 11 relevant articles and concluded that interpreter-mediated CBT appears feasible and may be effective, but that the evidence is not conclusive (Kunorubwe, 2025). A systematic review of interpreters working in refugee mental health care found high levels of stress, including secondary traumatic stress, along with reports of insufficient preparation, supervision, and support (Geiling et al., 2021). Interpreters are part of the clinical team, and the work affects them.

The following practices reflect professional consensus and clinical experience more than trial evidence (recommended practice):

- **Confirm the right language and dialect.** "Spanish speaking" in a referral may describe a client whose first language is an Indigenous language such as K'iche' or Mam, or a client who speaks a regional variety that differs from the interpreter's. Ask the client which language they prefer for talking about personal and emotional matters.
- **Brief the interpreter before the session.** Explain the purpose of the session, any sensitive topics, and the importance of rendering the client's words as closely as possible, including speech that seems disorganized, incomplete, or strange.
- **Speak directly to the client**, in the first person, and ask the interpreter to do the same. Seat the interpreter so that the client and clinician face each other.
- **Use shorter segments** and avoid idioms and jargon that do not translate well.
- **Watch for small-community concerns.** In some communities, the client and interpreter may know each other or share social networks. Ask the client privately whether they are comfortable with the assigned interpreter.
- **Debrief after the session.** Ask the interpreter about anything that did not translate well, cultural meanings the clinician may have missed, and how the interpreter is doing after difficult content.
- **Document** the language used, the interpreter's name or identification number, and any limitations in communication.

Bilingual practice requires attention to clinical language proficiency as well as conversational fluency. Ask which language the client prefers for sensitive topics, clarify unfamiliar expressions, and use qualified interpretation when needed. A change in language may affect expression without indicating a change in the underlying disorder.

Cautions on Standardized and Norm-Referenced Measures

Standardized instruments are valuable. They reduce reliance on clinical impression, make change measurable, and can catch symptoms that a conversation misses. They also carry cultural assumptions, and those assumptions can contribute to the disparities described in Section 3.

Professional standards address this directly. The *Standards for Educational and Psychological Testing* treat fairness as a foundational concern and call for evidence that test scores can be interpreted in the same way across the groups with whom a test is used, including attention to language, culture, and disability (AERA et al., 2014). The American Psychological Association's ethics code requires psychologists to use assessment instruments whose validity and reliability have been established for members of the population tested and, when that has not been established, to describe the strengths and limitations of the results (American Psychological Association, 2017a, Standard 9.02[b]), and to consider factors such as cultural and linguistic differences that might affect interpretation (American Psychological Association, 2017a, Standard 9.06). The *ACA Code of Ethics* similarly asks counselors to use caution with assessment techniques normed on populations other than the client's and to consider culture when diagnosing (American Counseling Association [ACA], 2014, Standards E.5.b, E.8).

Using a measure carefully means asking several questions before relying on its score (recommended practice):

- **Who was in the norming and validation samples?** If the client's group was absent or very small, the cutoff may not mean the same thing.
- **Is the translation validated, or was it improvised?** A translation produced for a single session, or by an untrained interpreter reading items aloud, is a different instrument from the validated version.
- **Do any items carry cultural assumptions?** Items about suspiciousness, religious experience, family involvement, eye contact, or somatic symptoms may be endorsed for culturally normative reasons.
- **Does the format fit the client?** Literacy, familiarity with rating scales, and comfort with written forms all affect responses.
- **What does the client say about their answers?** Reviewing endorsed items with the client often reveals that an item was understood differently than intended.

A score is one source of information, interpreted alongside the clinical interview, collateral information, and the client's own account. When a measure's validity for a particular client is uncertain, the documentation should say so.

Case 4 (Continued): Graciela

At the clinic's weekly case review, the bilingual social worker presented Graciela's intake. A colleague asked a question the social worker had not asked: what language Graciela spoke at home. The answer, obtained by phone through her daughter-in-law, was K'iche', a Maya language spoken in the highlands of Guatemala. Graciela spoke Spanish as a second language, learned as an adult, and used it mainly for errands.

The social worker arranged a second session with a qualified K'iche' interpreter through a telephone interpreting service. She briefed the interpreter first, asking her to translate as literally as possible and to note any expressions that carried meanings beyond their words. She used the core CFI, along with selected questions from the immigrants and refugees module.

The interview changed the picture. Graciela's older son had died in Guatemala two years earlier, after she had moved to the United States to help her younger son's family care for their children. She had not been able to travel for the burial, and she spoke about this with a grief that had not appeared in the first session. Since the robbery three months ago, she had been unable to sleep, startled at every sound, avoided the bus stop and the street where it happened, and felt that her spirit had left her body, a condition she and her family called *susto*. A woman in her community had performed a cleansing ceremony, which had helped a little. Her son appeared to her in dreams and, at dusk, she sometimes heard him call her name. In her family this was understood as a visit, and it comforted her more than it frightened her. She was not afraid of him. She was afraid of the men at the bus stop, of going out, and of what would happen to her family if she were sent to a hospital. She had told no one about this last fear because she worried that a hospital might involve immigration authorities.

The revised formulation included probable posttraumatic stress disorder following the robbery, clinically significant depressive symptoms, and bereavement-related concerns. Further assessment was needed to establish full diagnostic criteria, symptom course, functional impairment, and safety. Susto was recorded as Graciela's explanation for her illness. Experiences of her son were explored in relation to sleep, grief, community meaning, distress, and other possible psychotic symptoms; cultural familiarity alone did not rule out a disorder. The available account favored bereavement experiences over psychotic features, provisionally. Weight loss prompted coordination with primary care for further medical evaluation. The plan included interpreter-supported follow-up, assessment of trauma-focused treatment options, discussion of confidentiality and hospitalization fears, and respectful inquiry into healing practices she found helpful.

The first formulation was not careless. It rested on information gathered in a second language, under time pressure, with a referral label already in place. The second assessment changed what information was available, and it left real questions open: whether she met full criteria for PTSD, how her grief would evolve, and what the weight loss meant medically. It also changed the relationship. At the end of the session, Graciela asked the interpreter to tell the social worker that this was the first time anyone had asked her what she thought was wrong.

Clinical Practice Exercise

For Graciela, formulate one open question about the meaning of susto, one about help seeking, and one about concerns in the clinician-client relationship. Draft a cultural formulation note that includes a diagnostic uncertainty and a follow-up action.

Reasoning guide: Use her preferred language; ask what the term means to her instead of supplying a definition. Record the cultural explanation alongside trauma, depressive, bereavement, medical, and safety assessment. Note which CFI questions were used and which information remains unavailable. A culturally familiar experience should neither be pathologized automatically nor exempted from assessment.

Reflection Questions

1. Which three or four CFI questions could you add to your current intake without lengthening it significantly?
2. How does your agency determine a client's preferred language for clinical conversations, and how often does "Spanish" or another language on a form turn out to be incomplete?
3. Which standardized measures do you use most often, and what do you know about the samples on which they were normed?

Key Clinical Takeaways

- The DSM-5-TR outline for cultural formulation covers cultural identity, conceptualizations of distress, stressors and resilience, the clinician-client relationship, and an overall assessment.
- The core CFI's 16 questions, in four domains, begin with the client's definition of the problem and end with the client's view of help and of the clinical relationship.
- Field-trial, randomized, and review evidence supports the CFI's usefulness for gathering context, with important limits. It supplements diagnostic assessment and has not been shown to guarantee accurate diagnosis or improved outcomes.
- Cultural concepts of distress change the meaning of symptoms and can be mistaken for other disorders; learn the client's own term and what it means to them.

- Assessment in a nonpreferred language or through untrained interpreters risks diagnostic error; covered programs must offer qualified interpreters and generally may not rely on children or untrained companions.
- Standardized measures should be interpreted in light of their norming samples, translations, and item content, with any limits documented.

Section 5: Talking About Culture, Race, and Difference in the Room

Many clinicians were trained to wait for clients to bring up race, culture, or religion, on the theory that raising these topics first would impose the clinician's agenda. Clients often experience the waiting differently. To a client who has spent a lifetime noticing how others react to their race, accent, faith, or sexuality, a clinician's silence can say that the topic is unwelcome, uncomfortable, or irrelevant. Research on cultural concealment suggests the cost: clients who reported concealing aspects of their cultural identities from their therapists had poorer therapy outcomes (Drinane et al., 2018). This section covers how to raise culture and difference directly, how to notice and repair the ruptures that follow a cultural misstep, and how to respond to microaggressions, including the ones the clinician commits.

Naming Difference Versus Defaulting to Silence

Silence about culture is rarely neutral. In a survey of more than 2,000 racial and ethnic minority clients, the most commonly reported counseling microaggression was the therapist avoiding or minimizing cultural issues (Hook et al., 2016). Clients who are unsure whether their experiences of racism, religious discrimination, or immigration stress will be understood may test the clinician with a small disclosure and watch the response. If the clinician changes the subject, the client learns where the limits are.

Naming difference does not mean making every session about identity. It means letting the client know, early and in plain words, that these topics are welcome, and then following the client's lead. Clients vary widely in how central race, ethnicity, religion, or other identities are to the problems that bring them to therapy. Some will want to talk about them at length. Others will say, reasonably, that their identity has little to do with their panic attacks. The clinician's job is to make the conversation possible, not to require it.

Naming difference also matters for assessment, which is the focus of this course. Information about discrimination, cultural explanations of distress, family obligations, and religious practices often changes the formulation, as the cases in Sections 3 and 4 showed. Clients are more likely to share that information when they have reason to believe the clinician will receive it well. A recent article on suicide risk assessment argues that raising race, ethnicity, and culture proactively helps clinicians obtain more accurate information about risk and protective factors, which can be culturally shaped (Gabriel et al., 2025).

Broaching

Broaching is the term Day-Vines and colleagues use for the counselor's deliberate effort to raise race, ethnicity, and culture with clients and to invite exploration of how these factors relate to the client's concerns (Day-Vines et al., 2007). They describe broaching as an ongoing attitude of openness, something more than a single statement, and they proposed that clinicians vary in their broaching styles along a continuum. At one end, an *avoidant* clinician does not raise culture and may deflect it when the client does. An *isolating* clinician raises it once, superficially, and does not return to it. A *continuing/incongruent* clinician recognizes that culture matters but lacks the skill to explore it well. An *integrated/congruent* clinician weaves cultural exploration naturally into the work. An *infusing* clinician extends that commitment beyond the session into advocacy and social justice (Day-Vines et al., 2007).

A later model describes four dimensions that broaching can address (Day-Vines et al., 2020):

- **Intracounseling:** similarities, differences, and dynamics between clinician and client within the therapy relationship.
- **Intraindividual:** how the client's multiple identities intersect.

- **Intra-REC (race, ethnicity, and culture):** within-group concerns between the client and their own cultural communities.
- **Inter-REC:** the client's experiences of oppression and discrimination from outside their group.

The model is useful because it expands broaching beyond the question most clinicians think of first ("How do you feel about working with someone of a different race?"). That question addresses only the first dimension. Clients may care much more about the second, third, or fourth: the tension between being gay and being part of a religious family, a sense of not being "enough" of their own ethnicity, or the stress of being the only person of color in their workplace.

Research on broaching is still developing. In an experimental analogue study, potential clients evaluated White counselors' initial broaching statements about race and racism. Broaching showed therapeutic benefits, participants preferred counselors who broached, and the counselor's own positionality affected how cultural responsiveness was judged (King & Borders, 2019). The broader multicultural orientation research reviewed in Section 1 offers indirect support, since engaging cultural opportunities is associated with better outcomes (Owen et al., 2016). Most of the specific guidance below comes from clinical writing and experience, not from trials.

How to Broach

Broaching should make room for the client's priorities without presuming that identity explains the presenting concern. The examples below are suggested approaches, not validated scripts to use mechanically (recommended practice):

At intake, as part of the assessment: "I like to ask everyone about the parts of their background and identity that matter to them, like culture, religion, family, where they grew up. Some people find these connected to what brings them in and some don't. What feels important for me to know about you?"

Naming a visible difference in the relationship: "I'm aware that I'm a White therapist and you've mentioned some experiences with racism at work. I want you to know that you can talk about that here, including if anything I say doesn't sit right with you."

When the clinician and client share an identity: "We're both Cuban American, and that can make some things easier to talk about. It can also make me assume I understand things I don't. If I do that, I'd want you to tell me."

With a difference that is not about race: "I didn't grow up in a farming community. Help me understand what losing the farm means for you and your family." The question invites meaning without assuming what all farming families value.

When a client raises discrimination: "That sounds like it's been wearing on you for a long time. Can you tell me more about what it's been like?" The aim is to stay with the experience before moving to coping or reframing.

With an adolescent: "Some teens I work with talk about how things like race, religion, or being LGBTQ affect them at school or at home. If any of that is part of what's going on for you, I'm open to hearing it whenever you want."

Clients respond to broaching in many ways, and each response deserves respect. A client may say that identity is not relevant, and the clinician can accept that while leaving the door open. A client may engage readily, and the clinician follows. A client may respond with suspicion or irritation, perhaps because previous clinicians raised identity in clumsy ways, and the clinician can acknowledge that without retreating. What matters is that

the clinician does not use broaching as a ritual, a box to check at intake, and then never return to it. Day-Vines et al. (2007) would call that an isolating style.

When a Client Declines the Invitation

A Korean American graduate student referred for insomnia is asked at intake whether any part of her background or identity feels connected to what brings her in. She answers quickly: "Not really. It's just stress from my program." The clinician has several options. Pressing ("Are you sure? A lot of students of color feel isolated in graduate school") would turn an invitation into an assumption. Dropping the subject for good would make the question a ritual. A middle response keeps the door open without pushing: "That makes sense. If that changes, or if anything about your background turns out to matter more than it seems right now, you can bring it up anytime."

Six weeks later, the student mentions that her advisor keeps confusing her with the other Asian student in the lab and that she has stopped speaking in lab meetings. The earlier invitation made that easier to say. The clinician's task now is to follow her lead: to ask what the experience has been like, how it connects to her sleep and her sense of belonging, and what, if anything, she wants to do about it.

A client who declines has given the clinician information. Some clients decline because identity really is peripheral to their concern. Others are testing whether the clinician can accept a no, or are not ready yet. The clinician does not need to know which on the first day. A respectful acceptance and a later, natural opening are usually enough.

Broaching When the Clinician Holds Formal Power

Much of the broaching literature assumes a voluntary outpatient relationship. Many social workers practice in settings where the client did not choose the encounter and where the clinician's decisions carry legal weight: child protective services, emergency departments, inpatient units, court-ordered treatment, and school discipline processes. In these settings, broaching has to account for power as well as culture (recommended practice).

A parent being interviewed by a child welfare worker knows that the worker's assessment may affect custody of their children. If the parent belongs to a community that has reason to distrust child welfare, or has had prior contact with the system, that history is in the room whether or not anyone names it. A brief acknowledgment can help: "I know a visit from child protective services is stressful, and some families have had bad experiences with agencies like mine. I want to understand your family's situation accurately, and that includes hearing from you about anything you think I might misunderstand." The statement does not erase the power difference, and it should never be used to imply a promise the worker cannot keep. It does make the difference speakable, which allows the parent to correct the worker's assumptions before they reach the report.

In emergency and inpatient settings, clients may be evaluated during the worst hours of their lives, sometimes after arriving in handcuffs. A clinician who acknowledges how the client arrived, asks what the experience was like, and explains plainly what will happen next is practicing a form of broaching, even when culture is never mentioned by name. For a client who expects to be disbelieved, being asked for their account is information about the clinician.

Broaching in these settings has limits. Time is short, the clinician's role may constrain what can be offered, and some clients will not want to talk about identity with a person who has power over them. The goal is modest: to reduce the chance that unspoken assumptions on either side distort the assessment.

Cultural Comfort

The multicultural orientation framework includes a third element alongside cultural humility and cultural opportunities: *cultural comfort*, the clinician's ease and openness in cultural conversations (Davis et al., 2018). Clients notice discomfort. A clinician who rushes past a client's mention of racism, laughs nervously at a religious reference, or suddenly becomes formal when sexuality comes up is communicating something, whatever the clinician's intentions. Comfort is not the same as expertise. A clinician can say, honestly, "I'm less familiar with this, and I want to understand it," while remaining calm and interested. The discomfort itself is useful information. It belongs in supervision and self-reflection. Brought into the session, it can leave the client feeling responsible for managing it.

Rupture and Repair Across Cultural Difference

A rupture is a strain or breakdown in the working alliance. Ruptures often take the form of withdrawal, in which the client becomes quieter, more compliant, or less engaged, or confrontation, in which the client expresses anger or criticism (Eubanks et al., 2018). A meta-analysis found a moderate association between rupture repair and better outcomes ($r = .29$), a correlational finding consistent with clinical experience (Eubanks et al., 2018).

Cultural ruptures may appear as withdrawal or confrontation. A clinician's good intentions do not reliably indicate how an interaction was experienced. In Owen et al. (2014), approximately three quarters of clients who reported a therapist microaggression said it had not been discussed. Treat a change in engagement as a reason to inquire, not as proof that a cultural rupture occurred.

Signs of a possible cultural rupture include a client becoming briefer or more guarded after a session in which identity came up, missing the next appointment, being less willing to talk about family, faith, or community, or deferring to the clinician in a new way. None of these signs is specific. Each is worth noticing.

Repair follows the general principles of metacommunication: the clinician steps back from the content and talks with the client about what is happening between them (Eubanks et al., 2018). In cultural ruptures, the clinician also has to manage a particular temptation, which is to explain what they meant. The client's experience of the moment matters more than the clinician's intention, and explanations of intent tend to shift attention back to the clinician.

In Owen et al. (2014), clients who discussed a microaggression with their therapist rated the alliance about as highly as clients who reported none. The finding is correlational, but it points in a clear clinical direction: invite the conversation, then watch what happens next.

Responding to Microaggressions

Clinicians encounter microaggressions in three positions: when clients describe experiencing them outside therapy, when clients direct them at others or at the clinician, and when the clinician commits one.

When a client describes a microaggression from someone else, the first task is to listen and validate the experience before analyzing it. A common misstep is to move quickly to alternative explanations ("Maybe she didn't mean it that way"), which can feel to the client like one more person questioning their perception. After the client feels heard, the clinician can explore the impact, the client's options for responding, and how such experiences connect to the presenting problem. Sue et al. (2019) describe *microinterventions*, strategies that targets and allies can use in response to microaggressions, grouped around making the hidden message visible, disarming the microaggression in the moment, educating the person who committed it, and seeking external support. Clients may find it helpful to think through which strategies fit their situation and their safety.

When a client directs a microaggression at the clinician or at another group, the clinician has to decide whether and how to address it, considering the client's goals, the stage of the relationship, and the clinician's own reaction. Consultation and supervision are appropriate here, particularly when the clinician is the target.

When the clinician commits a microaggression, the work is harder, because it requires the clinician to recognize a mistake that was invisible to them at the time.

The Harder Case: Recovering From Your Own Microaggression

Clinicians can cause cultural harm without recognizing it at the time. The following sequence offers a practical response to a possible microaggression or cultural rupture. It draws on repair principles and the microaggression literature; it is not an experimentally validated protocol (recommended practice):

1. **Notice.** The signal is often indirect: a client's sudden quiet, a change in tone, a missed appointment, or a moment that replays in the clinician's mind after the session.
2. **Raise it.** Bring it up, preferably in the same or next session, without waiting for the client to do so. "I've been thinking about something I said last week, and I'd like to come back to it."
3. **Own the impact.** Name what was said and acknowledge how it might have landed, without extended explanation of intent. "I asked whether your husband supports you working, and I realized afterward that I was making an assumption about your marriage based on your religion. That wasn't fair to you."
4. **Invite the client's experience.** "I'd like to hear what that was like for you, if you're willing to tell me." Then listen without defending.
5. **Apologize simply** where it is warranted. A brief, sincere apology is usually more repairing than a long one, which can require the client to reassure the clinician.
6. **Adjust.** Show through later sessions that the feedback changed something.
7. **Learn outside the session.** Use supervision, consultation, or reading to understand what drove the assumption, so that the client does not become the clinician's teacher.

The client may accept the repair warmly, may need time, or may decide to end the relationship. Each response is legitimate. The clinician's job is to make repair possible, not to secure forgiveness.

Case 5: The Question About the Marriage

Amina, 34, began therapy for panic attacks that had started after the birth of her second child. She wore a hijab, had immigrated from Somalia as a child, and worked as a pharmacist. Her therapist was a White, secular social worker who had worked with many anxious new parents. In the third session, Amina described feeling overwhelmed by the demands of work, two young children, and caring for her mother-in-law, who lived with the family. The therapist, trying to understand the household, asked: "Do you feel like you have a say in how the work at home gets divided? Does your husband support you working?"

Amina paused and said, "Yes, he does." She answered the remaining questions briefly. She canceled her next appointment, citing a sick child, and was quieter than usual when she returned two weeks later.

The therapist had not noticed anything at the time. During a peer consultation meeting, she described the case as "stalled," and a colleague asked when Amina had started seeming less engaged. Going back through her notes, the therapist realized that the change followed the session with the question about her husband. She also realized that she had not asked any other client with a working spouse whether the spouse "supported" them working. The question had come from an assumption about Muslim marriages, and she had been confident that she held no such assumption.

At the next session, she raised it. "I want to come back to something from a few weeks ago. I asked whether your husband supports you working. I've realized I asked that because of assumptions about your faith and

your marriage, and I wouldn't have asked it that way of someone else. I'm sorry. I'd like to know how that question landed for you."

Amina was quiet for a moment. Then she said that she had been asked versions of that question her whole life, by teachers, coworkers, and once by a pharmacy customer, and that she had hoped therapy would be different. She said she had almost not come back. Her husband, she explained, had encouraged her to finish pharmacy school when her own parents had doubts. What she needed help with was her mother-in-law's expectations, her own perfectionism, and the panic that came when she felt she was failing everyone at once. Those were the things she had been trying to say.

The therapist thanked Amina and asked whether other concerns had been difficult to raise. Amina wondered whether a non-Muslim therapist would understand why asking her mother-in-law to leave was not a straightforward option. The therapist invited her account and checked her understanding. Subsequent work focused on perfectionism, family responsibilities, and limits consistent with Amina's values. The therapist also monitored panic symptoms and engagement and revisited the rupture in later sessions instead of treating the apology as the end of it.

Two details matter. The therapist's first awareness came from a colleague, not from her own observation; she had been sure she held no relevant bias. And the repair was specific and brief, then followed by real interest in Amina's account. It could have gone differently. Amina might have stayed hurt, declined to discuss it, or asked for another therapist, and each of those responses would have been hers to make.

Clinical Practice Exercise

Write a repair statement of no more than four sentences for Amina's therapist. It should identify the specific assumption, acknowledge its possible effect, invite her response, and leave room for her not to discuss it. Then identify one way to check whether the response helped over time.

Reasoning guide: Avoid defending intent, requesting reassurance, or assuming forgiveness. Ask what Amina needs from the work and monitor her experience, engagement, and presenting symptoms. A client's continued attendance alone does not demonstrate that a rupture has been repaired.

Reflection Questions

1. Where would you place your usual broaching style on the continuum from avoidant to infusing? Does it differ with different clients?
2. Which of the four broaching dimensions do you raise least often, and why?
3. Think of a time a client grew quieter after a session. Looking back, could a cultural rupture have been part of it, and what would repair have looked like?

Key Clinical Takeaways

- Silence about culture is not neutral; clients who conceal cultural aspects of themselves in therapy tend to have poorer outcomes, and avoidance of cultural issues is among the most commonly reported therapist microaggressions.
- Broaching is an ongoing stance of inviting clients to explore race, ethnicity, and culture, and it can address the therapy relationship, the client's intersecting identities, within-group concerns, and experiences of oppression.
- Effective broaching is early, brief, specific to the client, and followed by genuine interest in the client's response, including a response of "this isn't relevant."

- Cultural ruptures can appear as withdrawal or confrontation and are easy to miss, and microaggressions that are discussed appear less damaging to the alliance than those never addressed.
- When the clinician commits a microaggression, repair centers on raising it, owning its impact, inviting the client's experience, apologizing simply, adjusting, and doing further learning outside the session.

Section 6: Integrating Culturally Responsive Practice

A careful assessment only helps the client if it carries into what happens next: the treatment plan, the record, the referrals, and the systems the client moves through after the session. This section is about that carry-through. It covers treatment plans built around the client's values, documentation that shows the reasoning behind a diagnosis, the professional standards and licensing requirements that apply, the organizational side of cultural humility, and the limits of what one clinician can fix.

Because this section moves between ethics, law, and practice, statements are labeled by type where the distinction matters. **Code** refers to enforceable standards in professional ethics codes, which apply according to a clinician's profession, membership, and licensing rules. **Standard** refers to practice standards and guidelines from professional bodies. **Law** refers to statutes and regulations, which vary by jurisdiction and change. **Recommended practice** refers to this course's own clinically reasoned suggestions.

Culturally Responsive Treatment Planning

Treatment plans encode values. A goal such as "client will increase independence from family of origin" or "client will assert her needs with her mother-in-law" reflects assumptions about what a healthy life looks like, and those assumptions may or may not be shared by the client. Culturally responsive planning starts by asking what the client wants their life to look like when treatment is working, in their own words, and builds goals from the answer (recommended practice).

Several shifts follow:

- **Goals in the client's language.** "Be able to go to church again without leaving early" is a better goal for a client with panic disorder than "reduce avoidance behaviors," because it is meaningful to the client and measurable in their life.
- **Family and community involvement on the client's terms.** Some clients want family members involved in decisions; others want therapy to be a private space. The CFI questions about supports and help seeking (Section 4) help clarify which.
- **Integration of other sources of help.** Religious leaders, traditional healers, community organizations, and mutual aid groups can be part of a plan, with the client's consent and with appropriate coordination. A clinician does not need to share a client's beliefs to respect their role in the client's recovery.
- **Attention to practical barriers.** Work schedules, transportation, child care, cost, immigration-related fears, and past experiences with institutions affect whether a plan is realistic. These are often treated as logistics. They are also part of the client's cultural and structural context.
- **Adaptation of interventions.** Evidence-based interventions can often be adapted in language, examples, metaphors, and delivery to fit a client's culture without losing their core components. A meta-analysis of 99 studies found that culturally adapted interventions outperformed comparison conditions with an average effect size of $d = 0.50$, or about 0.35 after accounting for publication bias (Soto et al., 2018). The finding supports adaptation as a general strategy, though it does not specify which adaptations matter most for which clients.

Culturally responsive planning does not mean abandoning clinical goals that the client does not initially share. A client who wants to stop having panic attacks without facing feared situations still needs to know that facing feared situations, gradually and with support, is central to the most effective treatments. The clinician's task is to explain the reasoning, connect it to what the client values, and negotiate a plan the client can commit to.

Documentation That Captures Cultural Formulation

Clinical records outlast the clinician who writes them. A diagnosis, a descriptive phrase, or a risk label will be read by the next clinician, the next agency, the insurer, the court, and increasingly by the client. Section 2 described diagnostic momentum, in which a label gains authority as it travels. Documentation is how it travels.

In a study of 40,113 history and physical notes from 18,459 adult patients at an urban academic medical center, Black patients had 2.54 times the adjusted odds of having at least one negative descriptor in their records compared with White patients (Sun et al., 2022). The descriptors included "resistant," "noncompliant," "aggressive," and "combative." The study describes a pattern across records, not the intent behind any single note. Words like these record an interpretation as if it were an observation, and they can shape how later clinicians approach a client before meeting them.

Culturally responsive documentation does several things (recommended practice):

- **Records the client's own account** of the problem, its causes, and what help they want, using their words where possible.
- **Records cultural explanations as explanations.** "Client and family understand her symptoms as *susto* following the robbery" is accurate. "Client believes her soul left her body" without context may be read as a delusion.
- **Describes behavior, not character.** "Declined to give employer's name; asked who would have access to records" is an observation. "Guarded and paranoid" is an interpretation that should be supported by observations if it is used at all.
- **Documents the reasoning behind high-stakes diagnoses,** including alternative explanations considered and why they were ruled in or out.
- **Records language and interpreter use,** including the language used, the interpreter's identification, and any limits on communication.
- **Notes the limits of measures and observations** when instruments were used outside their validated populations or assessment conditions were constrained.

Table 4 shows how some common phrases can be revised to record what was observed and why the clinician concluded what they did.

Table 4. Revising Documentation to Reduce Bias

Instead of	Consider	Why
"Paranoid, guarded"	"Reports being followed by store security on several occasions; asked who would have access to records; declined to name employer"	Records observations and allows the reader to judge; does not label reasonable caution as a symptom
"Noncompliant with medication"	"Has not taken prescribed medication for 3 weeks; reports concern about weight gain and cost"	Describes behavior and the client's reasons
"Resistant to treatment"	"Declined referral to group; states she prefers individual sessions because of privacy concerns in her community"	Identifies the client's reasoning, which may be addressable
"Aggressive"	"Raised voice and stood up when told the appointment would be rescheduled; sat down when staff acknowledged his frustration"	Records specific behavior and context

Instead of	Consider	Why
"Poor historian"	"History limited; interview conducted in Spanish, client's second language; K'iche' interpreter requested for next session"	Locates the limitation in the assessment conditions
"Hallucinations" (for a bereavement experience)	"Reports hearing her deceased son call her name at dusk; experiences this as comforting; family understands it as a visit; no other perceptual disturbances reported"	Preserves cultural meaning and supports accurate diagnosis

Documentation should also record the cultural formulation itself, not only its conclusions. A brief cultural formulation note, organized around the DSM-5-TR outline from Section 4, gives the next clinician the context that made the diagnosis make sense. For example:

Cultural formulation: Client identifies as Maya K'iche' from highland Guatemala; K'iche' is her primary language and Spanish is secondary. She understands her current illness as susto following a robbery and reports some benefit from a traditional cleansing. Experiences of her deceased son are described as comforting and consistent with family beliefs; assess their timing, relation to sleep, functional impact, and any additional psychotic features. Stressors include the robbery, bereavement without attendance at the burial, and fear of immigration-related consequences of care. Supports include family and a community healer. Initial Spanish-language intake limited communication; arrange ongoing K'iche' interpretation. Current differential includes trauma-related and depressive conditions, with further assessment of full criteria and safety. Coordinate medical evaluation of weight loss with consent and document follow-up.

A Documentation Self-Audit

A brief audit of one's own notes can show whether these principles are reaching the record (recommended practice). A clinician can pull five recent intake notes, ideally for clients of different backgrounds, and read them as a stranger would, asking:

- Does each note record the client's own description of the problem, in their words?
- Do words such as "guarded," "resistant," "noncompliant," or "aggressive" appear, and is each one supported by a specific observation?
- Are cultural explanations recorded as the client's explanations, or have they been translated into symptoms?
- Are the language of the interview and any interpreter documented?
- For any serious diagnosis, does the note show which alternatives were considered?
- Would the notes read differently if the clients' names and demographic details were removed?

The last question is the most revealing. If two clients with similar presentations are described in noticeably different terms, the difference deserves a closer look. Supervisors and peer groups can run the same exercise across a team, which spreads the work and makes patterns easier to see. Clinical judgment still belongs in the note; the audit checks that the judgment is visible, supported, and fair to the person being described.

Professional Ethics

Each of the major mental health professions addresses culture in its ethics code and practice standards. The language differs, but the obligations converge.

Social work. The NASW *Code of Ethics* addresses understanding culture, culturally informed services, action against oppression and inequities, and acknowledgment of privilege (code; NASW, 2021, Standards 1.05[a] and 1.05[b]). Standard 1.05(c) explicitly names cultural humility, critical self-reflection and self-correction,

recognition of clients as experts on their own culture, lifelong learning, and institutional accountability. The competence standard requires social workers to practice within the boundaries of their education, training, and experience (code; NASW, 2021, Standard 1.04).

The NASW *Standards and Indicators for Cultural Competence in Social Work Practice* translate these principles into ten standards: ethics and values, self-awareness, cross-cultural knowledge, cross-cultural skills, service delivery, empowerment and advocacy, diverse workforce, professional education, language and communication, and leadership to advance cultural competence (standard; NASW, 2015). The language and communication standard is especially relevant to assessment, as Section 4 showed. In social work education, the Council on Social Work Education's accreditation standards include a competency on engaging anti-racism, diversity, equity, and inclusion in practice (standard; Council on Social Work Education [CSWE], 2022).

Counseling. The 2014 ACA *Code of Ethics* addresses the cultural definition and experience of problems (Standard E.5.b), historical and social prejudices in diagnosis and pathologizing (Standard E.5.c), and caution with assessments normed on other populations (Standard E.8; code; ACA, 2014). The Multicultural and Social Justice Counseling Competencies provide additional practice guidance (standard; Ratts et al., 2016). Because the ACA has been revising its code, counselors should confirm that these provisions and their numbering still apply.

Psychology. The American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* requires psychologists to use assessment instruments whose validity and reliability have been established for the population tested, or to describe the limitations of results when they have not, and to take cultural and linguistic factors into account when interpreting assessment results (code; American Psychological Association, 2017a, Standards 9.02 and 9.06). The American Psychological Association's multicultural guidelines describe an ecological approach to context, identity, and intersectionality in practice (standard; American Psychological Association, 2017b).

Across these sources, culturally informed assessment is part of competent professional practice. The codes and standards support the assessment, communication, and documentation skills developed in this course; they do not replace an individualized clinical formulation.

State Cultural Competency Standards in Practice

Some jurisdictions require continuing education in cultural competence, implicit bias, health equity, or related topics (law). Hours, topics, approval rules, and content standards differ by profession and change over time. This course does not claim to satisfy any particular board's requirement, and clinicians should check their own board's current rules, including whether a course must be approved by a particular body.

Whatever a board requires on paper, the evidence that culture was considered in a particular case is concrete: the client's own account in the record, a cultural formulation, qualified language support, measures interpreted within their limits, and a plan built on the client's goals (recommended practice).

Structural and Organizational Humility

Tervalon and Murray-García (1998) tied cultural humility to partnerships with communities and institutions, later writers framed this as institutional accountability (Fisher-Borne et al., 2015), and the NASW Code now asks social workers to hold institutions accountable for advancing it (NASW, 2021, Standard 1.05[c]). This is an acknowledgment that individual clinicians, however skilled, work within organizations and systems that shape what happens to clients.

Metzl and Hansen (2014) proposed *structural competency* as a complement to cultural approaches. They describe five skills: recognizing the structures, such as policies, institutions, and economic systems, that shape clinical interactions; developing a language for talking about those structures; rearticulating "cultural" presentations in structural terms; observing and imagining structural interventions; and developing structural humility, meaning awareness of the limits of one's own understanding of these forces. A client's missed appointments may be read as cultural ("this community doesn't value therapy") when they reflect bus schedules, shift work, or fear of immigration enforcement. Seeing the structure changes the response.

Organizations can build humility into their routines in ways that individual clinicians cannot (recommended practice):

- **Review patterns across client groups.** Examine diagnoses, access, outcomes, and coercive interventions by group, and investigate unequal patterns with attention to case mix, referral pathways, language, and illness burden. A numerical difference is a reason to look closer, never a reason for diagnostic quotas.
- **Build cultural assessment into intake templates,** including selected CFI questions and a field for preferred language for clinical conversations.
- **Ensure interpreter access** that does not depend on whether a bilingual staff member happens to be available.
- **Create review processes for high-stakes diagnoses,** such as a second look at first diagnoses of psychotic disorders, which Section 3 suggested deserve the extra checks given to other high-risk decisions.
- **Support a diverse workforce** and supervision that addresses cultural issues directly, consistent with NASW's diverse workforce and leadership standards (NASW, 2015).

Consider how this might look in one composite agency. A community mental health center noticed in its annual quality review that first diagnoses of psychotic disorders were assigned to Black clients at a much higher rate than to other clients, mostly during after-hours crisis evaluations. Leadership did not assume the diagnoses were wrong, and it did not set targets. It added a second-look review within two weeks for every new psychotic disorder diagnosis made in crisis, added three CFI questions to the crisis template, and arranged on-call interpreter access. A year later, the review had changed several diagnoses in each direction, and clinicians reported that it caught missing history more often than it caught bias. The agency kept the review.

Referral and advocacy are part of this work. Many of the stressors that surface in a cultural formulation, including housing instability, discrimination at work, and immigration-related fear, call for responses that therapy alone cannot provide. Social workers in particular are trained to connect clients with legal aid, housing resources, community organizations, and advocacy groups. A clinician who identifies a structural problem and does nothing with it has completed only part of the assessment.

There are also limits. An individual clinician cannot fix structural racism in psychiatry, unequal access to care, or the pathways that bring some clients into treatment through police and emergency departments. Shim (2021) argues that these require institutional and policy change. Recognizing the limits matters for two reasons. It prevents clinicians from blaming themselves for outcomes they do not control, and it keeps the focus on the changes they can make, in their own assessments, records, and organizations.

Scope of Practice: When to Consult or Refer

Cultural humility includes knowing when to bring in others (code, consistent with the competence standards cited above; recommended practice for the specific situations below). Consultation or referral is appropriate when:

- **Language cannot be bridged** with the resources available, for example when no qualified interpreter is available for the client's language and a clinician who speaks it can be found.

- **Cultural consultation would clarify a diagnosis**, particularly when a high-stakes diagnosis is being considered and the client's presentation includes experiences that may be culturally normative.
- **The client's needs exceed the clinician's competence**, such as specialized trauma work with refugees or survivors of torture.
- **Legal questions arise**, for example about immigration status, which belong with qualified legal services.
- **The clinician's own reactions** to a client's culture, beliefs, or identity are interfering with the work and are not resolving with supervision.

When consulting with cultural brokers, religious leaders, or community members, clinicians need the client's informed consent and must protect confidentiality in communities where the client may be known. Referral is not a failure of humility. Done thoughtfully, it is an expression of it.

Case 6: Rebuilding a Treatment Plan

Mr. Thanh Nguyen, 66, was referred to an outpatient clinic by his primary care physician for depression after a heart attack. He had come to the United States as a refugee in his twenties, worked for thirty years as a machinist, and lived with his wife near his adult daughter's family. His initial treatment plan, written by a clinician who had completed the intake quickly, listed three goals: "Client will verbalize feelings of sadness and loss at least once per session." "Client will increase independence from adult children by attending a senior center twice weekly." "Client will practice mindfulness meditation 10 minutes daily." After four sessions, Mr. Nguyen had attended each appointment, said very little, and done none of the homework. The clinician documented "limited engagement; possible cultural reluctance to discuss emotions."

At a supervision meeting, the supervisor asked what Mr. Nguyen himself wanted from treatment. The clinician realized she did not know. She had assumed he would want independence because many of her older clients did, and she had added mindfulness because she had read that it was helpful for depression after cardiac events and had thought it might fit a Buddhist client. She had never asked whether he was Buddhist.

At the next session, the clinician asked Mr. Nguyen whether he preferred English or Vietnamese for talking about personal matters. He said his English was fine for most things but that some feelings were easier to say in Vietnamese, so the clinic connected a Vietnamese telephone interpreter for the parts of the conversation where he wanted one. The clinician then used several CFI questions. Mr. Nguyen described his problem not as sadness but as uselessness. Since the heart attack, his doctors had told him not to lift anything heavy, and he could no longer repair things for his daughter's family or help his son-in-law with his small business, which had been the center of his days and his sense of being a good father. He was Catholic, not Buddhist, and his parish had been an important part of his life before the heart attack, though he had stopped attending because he was embarrassed to be seen tired and slow. He did not want more independence from his family. He wanted to be useful to them again. He also mentioned, when asked about sleep, that his heart racing at night frightened him, and that he had not told his cardiologist because he did not want to bother him.

The rebuilt plan looked different. Its goals, in his words, were: "Find work I can do with my hands that the doctor allows." "Go back to Mass on Sundays." "Sleep through the night without fear." The interventions included behavioral activation focused on meaningful, cardiac-safe activities, such as teaching his grandson to repair a bicycle and handling the bookkeeping for his son-in-law's business; coordination with his cardiologist about permissible activity and about the nighttime symptoms, with his permission; a referral to his parish's outreach for older members, which he chose to accept; and work on the shame of being seen as diminished. The clinician did not attempt to make him "verbalize feelings" on a schedule. She noticed that he spoke more about his sadness once the sessions were organized around what he valued.

The note about "possible cultural reluctance to discuss emotions" deserves a second look. It located the problem in Mr. Nguyen's culture when the problem was a plan built without his goals, and the next clinician to

read it might have started from the same assumption. The rebuilt plan still had to prove itself: his depressive symptoms, sleep, safety, and cardiac limits were reviewed at each visit.

Clinical Practice Exercise

Rewrite one of Mr. Nguyen's original goals using his stated priorities. Specify a feasible action, an observable indicator of progress, and a review plan that respects medical limits. Add one documentation sentence explaining how the goal was chosen.

Reasoning guide: A goal may involve returning to Mass or resuming a medically permitted family role. Agree on the activity and review interval with Mr. Nguyen and coordinate with his medical team when needed. Monitor depressive symptoms and safety as well as the chosen activity; cultural fit and clinical effectiveness both require follow-up.

Reflection Questions

1. Look at a recent treatment plan you wrote. Whose language are the goals in, and whose values do they reflect?
2. Which words in your own documentation might function as interpretations rather than observations? How would you revise them?
3. What is one change your agency could make in its intake, review, or tracking processes that would make culturally responsive assessment more likely, regardless of which clinician is on duty?

Key Clinical Takeaways

- Culturally responsive treatment plans are built from the client's own goals and values, involve family and community on the client's terms, and adapt interventions without losing their core components.
- Documentation carries diagnoses and descriptions forward; negative descriptors appear more often in the records of Black patients, so record observations and reasoning, and support any interpretation with them.
- A brief cultural formulation note preserves the context that makes a diagnosis understandable to the next reader.
- The NASW, ACA, and American Psychological Association ethics codes each address culture in assessment; the NASW Code explicitly names cultural humility and acknowledgment of privilege.
- Continuing education requirements in this area vary by profession and jurisdiction and change over time; check your own board's current rules.
- Structural humility means recognizing the institutional forces that shape clinical encounters, building safeguards into organizations, advocating where possible, and accepting the limits of individual practice.
- Consultation and referral, when language, culture, competence, or legal questions exceed what the clinician can provide, are expressions of cultural humility.

Conclusion

The course began with a three-line referral: "Guarded, paranoid, poor historian. Please evaluate for psychotic disorder versus anxiety." The social worker reading it had forty-five minutes and a client, Andre, who answered briefly, asked who would see his records, and described being followed by store security.

The social worker now has more to work with. She can read the referral as a hypothesis written by someone who had less time than she does, and she can notice that "guarded" and "paranoid" are interpretations, not observations (Sections 2 and 6). She can recognize the specific risk in this assessment: a possible first diagnosis of a psychotic disorder in a Black man, a decision known to be vulnerable to error (Gara et al., 2012; Olbert et al., 2018) and one that deserves the same extra care as any other high-stakes clinical judgment (Section 3). She can ask Andre, in plain words, what he calls the problem, what he thinks caused it, and what kind of help he wants, which are the opening questions of the Cultural Formulation Interview (Section 4). She can answer his question about records honestly, explaining who will see them and what the limits of confidentiality are, and she can tell him that his caution makes sense. She can say that he is welcome to talk about race, about the store, and about anything about her or the clinic that makes it harder to talk (Section 5).

So the referral settles nothing yet. Andre describes what sounds like repeated profiling, a frightening physical episode with a clean cardiac workup, months of feeling on edge, and poor sleep. That gives the social worker a list to work through: panic and other anxiety or stress-related conditions, substance and medical contributors, changes in functioning, mood, any psychotic experiences, and safety. Her provisional note might read: "Reports repeated store-security encounters; confidentiality concerns explored. Referral descriptions of guardedness and paranoia require further assessment in context. Current account does not independently establish delusional thinking. Working differential and follow-up discussed." She records only what she actually assessed. A symptom nobody asked about has not been ruled out.

If later sessions point toward a psychotic, mood, substance-related, or medical condition, she revises the formulation and arranges the right care. A credible account of discrimination and a mental illness can exist in the same person. Humility applies in both directions here: it means staying open to the clinical findings too, including the ones that challenge the interpretation she would prefer.

The tools in this course are mostly ordinary ones: an honest look at one's own assumptions, a question that could prove the first impression wrong, the CFI, a qualified interpreter, careful use of measures, a direct conversation about culture, and notes that keep observations and uncertainty separate from conclusions. They are easier to keep up when an organization builds in review and consultation.

None of these practices requires a clinician to know everything about every culture. They ask the clinician to stay curious about the person in the room, to remember that confidence is not the same as accuracy, and to treat the client as the authority on their own life. Andre's intake is forty-five minutes long either way. What changes is what the social worker does with those minutes.

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Glossary

Anchoring. The tendency to rely too heavily on the first information encountered, such as a referral diagnosis, and to interpret later information in its light.

Broaching. A clinician's deliberate, ongoing effort to raise race, ethnicity, culture, and other dimensions of identity with clients and to invite exploration of how these relate to the client's concerns.

Colorblindness. The belief that the fair or respectful response to race is not to notice it; in its color-blind racial ideology form, it includes denial or minimization of racism and its effects.

Cultural Formulation Interview (CFI). A semistructured interview in DSM-5-TR, with a 16-question core version organized in four domains, an informant version, and supplementary modules, used to gather culturally relevant information during mental health assessment.

Cultural competence. A framework emphasizing the awareness, knowledge, and skills clinicians need to work effectively across cultural difference; as commonly taught, it can imply mastery of knowledge about particular groups.

Cultural concepts of distress. Ways that cultural groups experience, understand, and communicate suffering, including cultural syndromes, cultural idioms of distress, and cultural explanations or perceived causes.

Cultural humility. A stance of lifelong self-reflection, attention to power imbalances, openness toward the client as the authority on their own culture and experience, and institutional accountability.

Cultural rupture. A strain in the working alliance that follows a moment in which the client felt stereotyped, dismissed, or misunderstood because of their identity.

Diagnostic disparity. A difference in diagnosis between groups that reflects error or inequity rather than a true difference in the underlying condition.

Diagnostic error. The failure to establish an accurate and timely explanation of a patient's health problem or to communicate that explanation to the patient.

Diagnostic momentum. The process by which a diagnosis or label is carried forward from one clinician or record to the next, gaining authority without being reexamined.

Implicit bias. Attitudes or associations that operate outside conscious awareness and can influence perception and behavior.

Intersectionality. The ways in which multiple social identities, such as race, gender, class, religion, and sexual orientation, combine to shape a person's experiences of privilege and oppression.

Microaggression. A brief, everyday verbal, behavioral, or environmental slight, intentional or not, that communicates a hostile, derogatory, or negative message about a person's group identity.

Multicultural orientation. A framework describing three related therapist processes: cultural humility, engagement with cultural opportunities, and cultural comfort.

Over-accommodation (cultural overattribution). Attributing a client's behavior or symptoms to culture without checking, which can lead to missed risk or pathology and to treating the client as a category.

Positionality. A person's location within social structures of identity and power, including the professional role, and how that location shapes what they see.

Structural competency. The capacity to recognize and respond to the policies, institutions, and economic systems that shape health and clinical encounters, including reframing apparently cultural presentations in structural terms.