

Using an Attachment-Informed, Emotion-Focused Lens to Strengthen Therapists' Diversity Practice: A Clinical Opinion and Conceptual Model

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1. Abstract

Psychotherapists increasingly work with clients whose identities, social locations, and experiences of marginalization differ from their own. Training in diversity, equity, and inclusion (DEI) is necessary, but recent syntheses indicate that it improves knowledge and attitudes more reliably than sustained clinical behavior, and few studies examine the emotional processes that may interrupt the translation of learning into practice. This opinion article proposes that an attachment-informed, emotion-focused lens can complement conventional diversity training. Drawing on Emotionally Focused Therapy (EFT), it conceptualizes defensiveness, over-explaining, withdrawal, and premature problem-solving as secondary reactions that may conceal primary emotions such as shame and fear when therapists encounter difference, feedback, or their own errors. We present a refined conceptual model (Figure 1) in which psychologically safe but accountable learning conditions and reflective supervision support the awareness, regulation, reflection, and transformation of emotion; these processes are hypothesized to strengthen emotional security, cultural humility, empathic curiosity, and accountability, and to improve rupture repair, collaborative formulation, and client-reported respect and safety. Organizational context, therapist and facilitator characteristics, and feedback loops are specified as boundary conditions and moderators. Existing evidence on diversity training, cultural humility, therapist attachment, and rupture repair is related but indirect, and it does not show that EFT training is superior to other approaches. The framework is therefore offered as a clinically plausible, testable model rather than a proven intervention, accompanied by five testable propositions and a multilevel evaluation plan.

2. Introduction

Psychotherapists do not meet clients outside culture or power. Race and ethnicity, language, religion, gender, sexuality, disability, socioeconomic position, migration, and community history can shape how distress is expressed, how help is sought, and whether a clinical setting feels safe. A therapist may be technically skilled yet overlook how their assumptions, institutional norms, or emotional reactions influence assessment and treatment. Professional development must therefore go beyond memorizing cultural facts and include the capacity to reflect on one's position, tolerate uncertainty, repair relational ruptures, and adapt care collaboratively.

Psychotherapy research suggests that this relational capacity matters. In a recent meta-analysis of 13 studies, therapist cultural humility, as perceived by clients, correlated strongly with alliance quality ($r = .66$) and more modestly with psychotherapy outcomes ($r = .39$) [1]. An earlier meta-analysis of client-rated multicultural competence showed a similar pattern: associations were large for process measures such as alliance and satisfaction ($r = .75$) but much smaller for symptom improvement ($r = .29$), and there was evidence of publication bias [2]. These data are correlational and describe therapists as they are, not training as it is delivered; they do not show how clinicians can be helped to become more culturally humble. That is the question this article addresses.

Training has been studied more often as a means of changing knowledge and attitudes than of changing what therapists do in the room [3,4]. One plausible but little-studied reason is that learning about bias, privilege, and inequity is emotionally charged. Qualitative work with health professionals reports that

reflecting on racism and white privilege can evoke denial, anger, guilt, shame, fear, anxiety, and perfectionism [5]. If such reactions are not recognized and worked with, they may narrow the learning that training is meant to produce.

This article develops an attachment-informed, emotion-focused lens for therapist training. It draws on two related but distinct traditions that are both abbreviated “EFT” in the literature: Emotionally Focused Therapy, an attachment-based approach developed by Johnson [6], and Emotion-Focused Therapy, an experiential approach developed by Greenberg and colleagues

[7]. To avoid confusion, we use EFT for the former and EmFT for the latter. We do not suggest that diversity-related harm can be reduced to individual emotions: discrimination and inequity also arise from organizational policies, resource allocation, and structural power [8,9]. Instead, we argue that attention to emotion and to attachment-related security may be one component within a broader, accountable DEI strategy. The article is an opinion and conceptual contribution. Sources were selected for conceptual relevance rather than through a systematic search, and the model proposed here has not been empirically tested.

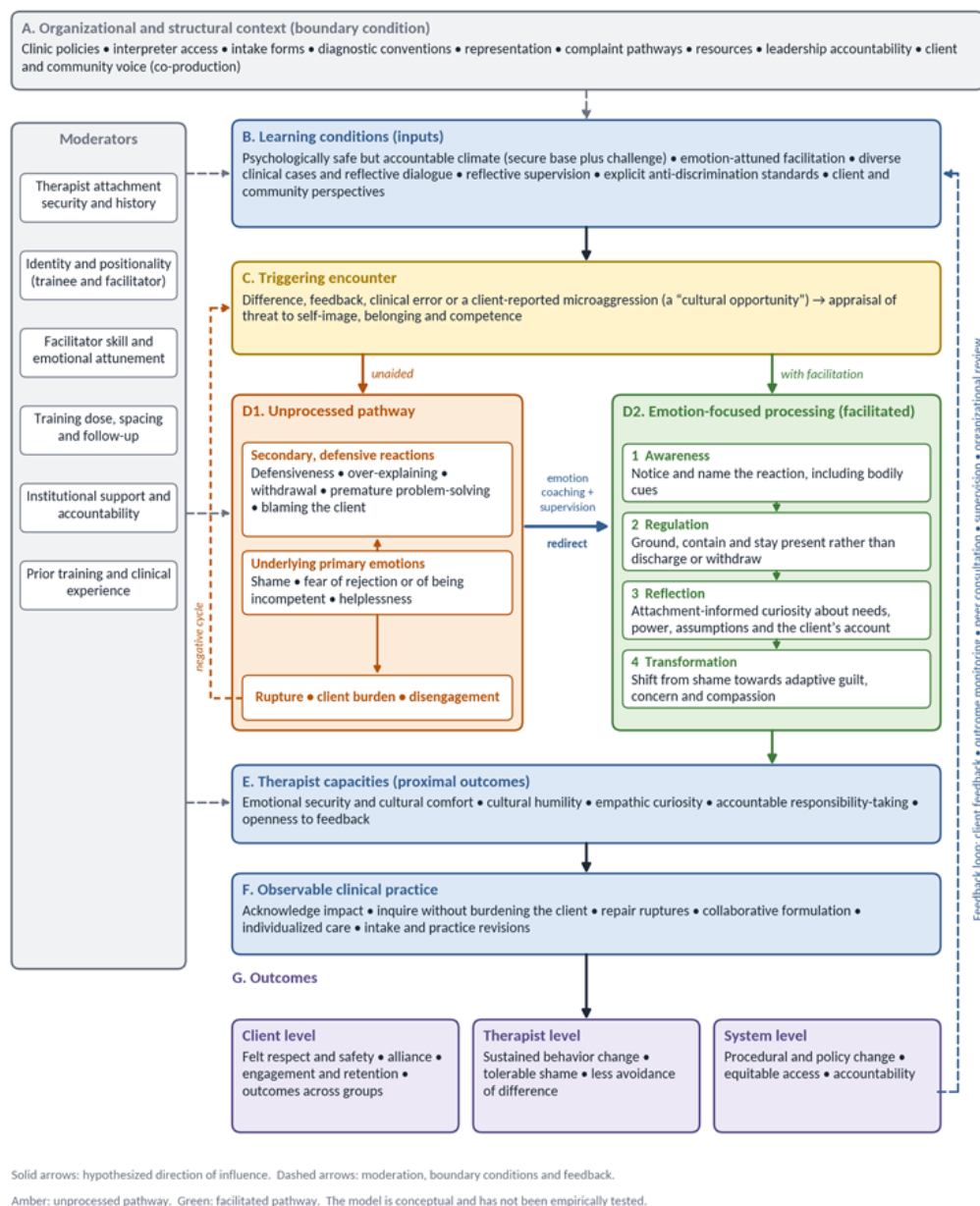


Figure 1: Proposed attachment-informed, emotion-focused model for strengthening therapists’ diversity practice. Emotion coaching and supervision are hypothesized to redirect therapists from the unprocessed pathway (D1) to the facilitated pathway (D2). Arrows indicate hypothesized relationships, not established causal effects.

2.1. What The Evidence Shows, and Does Not Show, About Diversity Training

Conventional diversity education can provide essential knowledge about inequity, bias, and culturally responsive care. However, knowledge acquisition is not equivalent to behavioral change [3]. A meta-analysis of 260 samples found an overall effect of $g = 0.38$, with the largest effects on reactions to training and cognitive learning and smaller effects on behavioral and attitudinal or affective learning. Effects on reactions and attitudes decayed over time, whereas cognitive learning remained stable, and training worked better when it was complemented by other diversity initiatives, addressed both awareness and skills, and was delivered over a significant period [4].

Recent syntheses in health care point in the same direction. A 2025 systematic review of strategies to address racism experienced by healthcare professionals included 17 studies; EDI training interventions may improve knowledge, awareness of racial inequalities, and cultural competence, but evidence was insufficient to show that they reduce the racism experienced by minoritized staff [10]. A 2026 systematic review of 21 studies of inclusion training for practicing healthcare professionals found that most reported short-term improvements in knowledge or attitudes but few demonstrated sustained behavior change; only six studies assessed outcomes beyond the immediate post-train-

ing period, four used comparison groups, and about half did not clearly report a theoretical underpinning. Interactive, reflective, and tailored programs were more consistently associated with positive short-term outcomes [11].

Reviews of education and mental health practice add context. A 2024 scoping review found that EDI-related interventions were associated with improved professionalism among healthcare trainees and workers while calling for standardized assessment tools [12]. A 2025 scoping review of the foundational and conceptual literature on cultural humility training in mental health services (publications from 2007 to 2018) concluded that cultural humility principles may foster self-awareness of racial bias and negative cultural stereotypes at practice and organizational levels; because it mapped concepts rather than testing effectiveness, it does not establish training outcomes [13]. A 2024 scoping review of 42 sources on the multicultural orientation framework in psychotherapy and supervision described the framework as still in its infancy, with cultural humility its most studied component [14].

These findings support a cautious conclusion: training can be useful, but outcomes depend on design, context, and what is measured, and few studies follow clinicians over time, observe what they do with clients, or test mechanisms. Table 1 summarizes the main sources that inform the model, with their limits.

Table 1: Principal evidence informing the proposed model, with design, main finding, and limits of inference.

Source	Design and scope	Main finding relevant to this article	Limits and use in the model
Bezrukova et al. 2016 [4]	Meta-analysis; 260 samples of diversity training	Overall $g = 0.38$; largest for reactions and cognitive learning; smaller for behavioral and attitudinal outcomes; attitudinal effects decayed over time	Mostly non-clinical samples; supports multi-component, sustained designs
Okeahialam et al. 2025 [10]	Systematic review; 17 studies; healthcare professionals	May improve knowledge, awareness, and cultural competence; insufficient evidence of reduced racism experienced by minoritized staff	Outcome is staff experience, not client care
Beeston et al. 2026 [11]	Systematic review; 21 studies; practicing healthcare professionals	Short-term gains common; sustained behavior change rare; six studies with later follow-up; four with comparison groups	Mostly self-report and heterogeneous; supports interactive, reflective formats
Orlowski et al. 2025 [1]	Meta-analysis; 13 studies; therapist cultural humility	$r = .66$ with alliance; $r = .39$ with outcomes	Correlational and client-rated; does not show that training raises humility
Tao et al. 2015 [2]	Meta-analysis; 18 studies; client-rated multicultural competence	$r = .75$ with process; $r = .29$ with outcome; publication bias evident	Older competence construct; client-rated
Marín-Cavestany et al. 2025 [15]	Systematic review (9 studies) and meta-analysis (12 studies); therapist attachment	Therapist attachment may influence alliance; the one systematic association was anxious attachment with therapist-rated alliance ($r = -0.31$)	Small literature; imprecise measures
Hallmann-Perez et al. 2025 [16]	Study of clients in German psychotherapy; racial microaggressions	Most participants reported therapist microaggressions; these related negatively to alliance and improvement, and less so when addressed	Observational and self-reported
Prince 2024 [5]	Qualitative interviews; 11 allied health professionals	All described strong emotions when reflecting on racism and white privilege	Small, context-specific; hypothesis-generating
Spengler et al. 2024 [17]	Meta-analysis; EFT for couples	Supports EFT as an evidence-based couple therapy; greater therapist fidelity linked to stronger gains	Concerns clinical efficacy, not therapist training

2.2. Conceptual Foundations: Attachment and Emotion-Focused Perspectives

2.2.1. Attachment-Informed Perspective

Attachment theory understands close relationships as a source of safety and proposes that perceived threat activates attachment-related emotions and strategies. EFT applies this view to relational distress, emphasizing attachment needs, vulnerability, and the interactional cycles through which protective reactions can perpetuate disconnection [6]. A comprehensive 2024 meta-analysis supports EFT as an evidence-based couple therapy and reports that greater therapist fidelity to the model is associated with stronger gains [17]. That evidence concerns clinical outcomes for couples, not the training of therapists in diversity practice.

Outside psychotherapy, social-psychological research links attachment security to intergroup attitudes. Perceived outgroup threat is theorized to activate the attachment system, leading to fear and prejudice among people high in attachment anxiety and to distancing among people high in attachment avoidance; attachment-priming experiments suggest a causal role for security in reducing prejudice, with empathy and negative emotions among proposed mediators [18]. More broadly, experimentally boosting security has been associated with better emotion regulation, compassion, and prosocial behavior [19,20]. These studies mostly involve non-clinical samples and brief manipulations. They motivate, but do not confirm, the idea that therapists who feel more secure when challenged may stay more open to difference. Therapist attachment is plausibly relevant to the alliance: a 2025 meta-analysis concluded that it may influence alliance quality, although the only systematic association was between anxious attachment and alliance when the alliance was rated by therapists, and the authors called for more precise measurement [15].

2.2.3. Emotion-Focused Perspective

EmFT is an experiential approach built on the view that emotions are adaptive sources of information about needs and values and that emotional change is central to enduring change. It emphasizes the awareness, acceptance, understanding, and transformation of emotion within a safe relationship [7]. A key distinction is between primary emotions (direct responses to a situation, which may be adaptive or maladaptive, such as an old, global shame), secondary emotions (reactions to other feelings, such as anger that covers hurt or shame), and instrumental emotions (expressed to influence others). EmFT proposes that working with the underlying primary emotion, rather than the secondary reaction, opens new possibilities for change, and models of emotional processing in experiential therapy describe how global distress can be differentiated into more specific emotions and needs when emotion is attended to rather than bypassed [7,21].

Applied to professional learning, this taxonomy offers a way to describe what happens when a therapist is told that a question was culturally presumptive. Defensiveness, over-explaining,

withdrawal, or rapid problem-solving can be understood as secondary, protective reactions. Beneath them may lie primary emotions such as shame (a global negative evaluation of oneself as a therapist or person), fear of rejection or of having caused harm, and helplessness. Research on moral emotions distinguishes shame from guilt: shame, with its focus on the self, is more often associated with defensive responses such as withdrawal or blaming others, whereas guilt, with its focus on a specific behavior, is more often associated with empathy and reparative action [22]. An emotion-focused training task is therefore not to eliminate shame or to reassure participants, but to help them notice and regulate the reaction, understand what it protects, and reach the adaptive concern for the client that can support repair.

Emotion regulation research adds that strategies can be deployed at different points in the emotion-generating process, from the situations people select to how they modulate their responses once emotion has arisen [23]. This matters for training because the moment of challenge, being told that one has caused harm, is when regulation is hardest and the quality of the response most consequential.

2.4. Integrating The Two Traditions

EFT and EmFT share a humanistic-experiential emphasis on emotion and on the therapeutic relationship as a vehicle for change, but they differ in focus and technique. EFT foregrounds attachment needs and interactional cycles; EmFT foregrounds emotion schemes, the differentiation of primary and secondary emotion, and the transformation of maladaptive emotion. The integration proposed here is conceptual and selective. From the attachment tradition we take the ideas that threat, security, and relational safety shape how people respond to challenge, and that trainers, supervisors, and colleagues can function as a secure base. From the emotion-focused tradition we take a vocabulary for what happens inside the therapist (primary versus secondary emotion; shame versus adaptive guilt) and a sequence for working with it (awareness, regulation, reflection, transformation). This is an extrapolation from therapy models to professional learning. It is not evidence that either model has been validated as a diversity-training protocol.

2.5. Why An Attachment-Informed, Emotion-Focused Lens May Help Therapists

1. Making Defensiveness and Shame Available For Reflection

Feedback about bias or a culturally unsafe interaction can evoke shame, fear of being judged, anger, or a wish to prove oneself well-intentioned. If those reactions are ignored, they may interfere with learning; in interviews with 11 allied health professionals, every participant described strong emotions when reflecting on racism and privilege [5]. In emotion-focused terms, the task is to help participants identify the secondary reaction, reach the primary emotion beneath it, and use that information to guide the next step.

A facilitated, non-humiliating training environment can help

therapists name their reactions without displacing responsibility. Psychological safety, the shared belief that one can take interpersonal risks, speak up, or make mistakes without being punished or humiliated, is widely regarded as a condition for learning [24,25]. A recent commentary applying a four-stage model of inclusion, learner, contributor, and challenger safety to health professions education offers practical strategies, although it is not itself an empirical test [25]. Safety here must not be confused with comfort. The trainer's task is not to reassure participants that they have done nothing wrong; it is to support accountability while keeping reflection possible.

2.6. Strengthening Cultural Humility Rather Than Claiming Cultural Mastery

Cultural humility treats understanding as an ongoing, relational process rather than a final state of expertise. It was introduced in medical education as lifelong self-evaluation and self-critique, combined with attention to power imbalances and institutional accountability [26]. In psychotherapy research it has been operationalized as an interpersonal stance of openness and lack of superiority, typically assessed from the client's perspective [27], and it forms one element, with cultural opportunities and cultural comfort, of the multicultural orientation framework [28]. For therapists, humility means asking rather than assuming, checking interpretations, inviting correction, and acknowledging the limits of one's knowledge. The client remains the authority on their own experience, while the therapist remains responsible for clinical judgment and ethical care.

The lens proposed here adds a hypothesis about what makes humility difficult in practice: it is hard to sustain when a therapist's sense of competence or goodness feels under threat. If so, the capacity to tolerate and regulate shame may be a precondition for humility rather than a separate attribute. This hypothesis is untested. It is also consistent with the cautious state of the evidence on training: reviews of cultural humility training in mental health emphasize self-reflection and attention to power but note the conceptual character of much of the literature and the need for stronger evaluation [13].

2.7. Attending To the Therapeutic Alliance, Rupture, and Repair

An inclusive stance is expressed through ordinary clinical actions: how a therapist asks about identity, responds to a client's account of discrimination, repairs a misunderstanding, and negotiates treatment goals. Alliance ruptures are common, and meta-analytic evidence links rupture repair to better outcomes [29]; therapists' management of their own reactions has likewise been associated with more effective treatment [30]. Racial microaggressions, brief everyday exchanges that communicate denigrating messages [31], are one source of rupture. In a study of psychotherapy clients in Germany, most participants reported microaggressions from their therapists; these were negatively related to working alliance and perceived improvement, and the associations diminished when therapists effectively addressed them [16].

Clients' accounts point to a related harm. LGBTQ+ clients of EFT described being "othered," including by having to educate the therapist, and believed this could be avoided when therapists intentionally bore witness to clients' experiences of marginalization [32]. Together these observations suggest that the therapist's response to being told they have erred, by acknowledging impact, staying engaged, and repairing, may be a clinically important and trainable behavior. The evidence is observational and largely self-reported, and none of it tests an emotion-focused training intervention.

3. Supervision As a Secure Base

Clinical supervision is a central method for training psychotherapists and a natural setting for this work. A 2024 scoping review identified multicultural orientation as an emerging process in supervision with potential benefits, though still at an early stage of study [14]. In an attachment-informed model, the supervisor functions as a secure base: attuned and consistent, able to hold support and challenge together, and willing to discuss their own cultural blind spots. In emotion-focused terms, supervision can attend to the supervisee's in-session emotion alongside technique. Because supervision carries power, supervisors should model humility, avoid requiring disclosure of sensitive personal information, and recognize that trainees from minoritized groups may carry different burdens than majority-group trainees.

4. Connecting Personal Reflection with Organizational Accountability

An attachment lens should not turn structural injustice into a problem of interpersonal discomfort. Therapists need to recognize how clinic policies, interpreter access, appointment systems, diagnostic conventions, confidentiality rules, and referral pathways may create unequal access or safety. Structural competency frameworks make this explicit by training clinicians to see how institutions and policies shape health and care [9], and reviews document structural racism as a driver of health inequities [8]. Training should therefore connect emotional and relational work to concrete practice changes, team procedures, and institutional accountability. It should also avoid treating any group as homogeneous, since identities intersect and experiences differ within as well as between groups [33]. Finally, programs that rely on minoritized staff to teach, absorb, or respond to colleagues' emotions risk reproducing a burden analogous to the "minority tax" described in academic medicine [34].

5. A Refined Conceptual Model

Figure 1 presents the proposed model. It integrates the elements of the original framework (learning conditions, mechanisms, practice outcomes, and a feedback loop) with the emotion-focused account developed above, and it does three things. First, it makes the mechanism explicit by adding an emotion-focused pathway: a triggering encounter can follow an unprocessed pathway, in which secondary defensive reactions mask primary emotions and tend to produce rupture, or a facilitated pathway, in which the awareness, regulation, reflection, and transformation of emotion are supported. Second, it separates therapist capac-

ities (proximal outcomes) from observable practice and from outcomes at client, therapist, and system levels. Third, it names boundary conditions and moderators, including organizational context and the characteristics of therapists, facilitators, and training. Letters below refer to the layers of Figure 1.

Learning conditions (B) combine support and challenge. Drawing on attachment theory, trainers, supervisors, and peers are intended to function as a secure base that is reliable, attuned, and non-humiliating, while explicit anti-discrimination standards and accountability prevent safety from becoming comfort. Case-based learning with diverse, de-identified clinical material and reflective dialogue tie the work to practice rather than to abstract attitudes.

The triggering encounter (C) is any moment in which difference, feedback, error, or a client's account of harm threatens the therapist's self-image, sense of belonging, or perceived competence. In multicultural orientation terms this is a "cultural opportunity" [28]. We propose that such moments activate emotional and attachment-related responses before they engage deliberate clinical reasoning.

Two pathways follow (D1 and D2). In the unprocessed pathway, secondary defensive reactions (defensiveness, over-explaining, withdrawal, premature problem-solving, or blaming the client) cover primary emotions such as shame, fear, and helplessness. They may protect the therapist in the moment but are hypothesized to produce ruptures, burden clients, and intensify the sense of threat, creating a negative cycle. In the facilitated pathway, trainers and supervisors help therapists to (1) become aware of and name the reaction, (2) regulate it so as to remain present, (3) reflect with attachment-informed curiosity on what it protects, including needs, power, assumptions, and the client's account, and (4) transform maladaptive shame toward adaptive guilt, concern, and compassion. The sequence is adapted from emotion-focused descriptions of emotional change [7,21]. It does not imply that shame should be eliminated: shame about harm may point to values worth keeping, and the aim is to prevent it from driving defensive behavior.

Therapist capacities (E) are the proximal outcomes: emotional security and cultural comfort when discussing culture, cultural humility, empathic curiosity, accountable responsibility-taking, and openness to feedback. These are expressed in observable clinical practice (F): acknowledging impact, inquiring without burdening the client, repairing ruptures, collaborative assessment and formulation, individualized care, and revising intake

and practice procedures. Outcomes (G) are conceptualized at three levels: client-reported respect, safety, alliance, engagement, and outcomes; sustained therapist behavior change with tolerable rather than disabling shame; and procedural, policy, and equity change at the system level.

Organizational context (A) is shown as a boundary condition because it can enable or undermine every other element: a clinic without interpreter access or protected supervision time limits what even well-trained therapists can do. Moderators include therapist attachment security and history, the identities and positionality of trainees and facilitators, facilitator skill, training dose and follow-up, institutional support, and prior experience. A feedback loop carries client feedback, outcome monitoring, peer consultation, supervision, and organizational review back into the design of learning conditions.

The model generates propositions that can be tested, and that could also falsify it:

1. Compared with information-only or generic reflective training, training that adds emotion-focused processing (awareness, regulation, reflection, transformation) produces larger and more durable reductions in defensive responding to standardized clinical vignettes at 3–6 months.
2. Reduced defensive responding and improved emotion regulation partially mediate the effect of training on client-rated cultural humility and on observed rupture repair.
3. Therapist attachment security and baseline shame-proneness moderate training effects; the direction of moderation is uncertain and should be estimated rather than assumed.
4. A climate combining psychological safety with explicit accountability is associated with more disclosure of errors in supervision and more observable repair than safety without accountability.
5. Organizational support (protected supervision time, procedural change, leadership accountability) moderates whether behavior change persists at 12 months.

6. Practical Implications for Therapist Training

Training should be experiential, repeated, and connected to real clinical work rather than delivered only as a one-off lecture. The components in Table 2 are proposed as an adaptable framework; they should be tailored to professional role, local context, and the communities served, and ideally co-designed with community and client representatives.

Table 2: Proposed components of an attachment-informed, emotion-focused diversity-development program for therapists.

Component	Suggested activity	Process target	Observable indicator
Reflective preparation	Private reflection on assumptions, identity, emotional triggers, and previous clinical misunderstandings.	Self-awareness without requiring public disclosure of sensitive personal information; early recognition of one's habitual defensive reactions.	Completed private reflection; triggers discussed in supervision by choice.
Secure and accountable learning climate	Co-developed group agreements that pair no-humiliation norms with explicit accountability; facilitators model acknowledging their own errors.	Psychological safety with challenge; willingness to take interpersonal risks and raise mistakes [24,25].	Climate ratings; frequency of errors and uncertainties raised.
Case-based dialogue	De-identified vignettes involving identity, discrimination, language, faith, disability, or power differences.	Notice assumptions; ask open questions; avoid premature interpretation.	Vignette responses coded by trained raters.
Emotion and attachment mapping	Identify the surface reaction (for example, defensiveness), the primary emotion beneath it (shame, fear), the underlying need, and the adaptive concern for the client; brief experiential exercises with grounding.	Awareness, regulation, reflection, and transformation; remain curious while accountable.	Reduced defensive responding in role-plays; self-reported regulation.
Skills rehearsal	Role-play responding to a client who reports bias, a microaggression, or a culturally mismatched intervention; practice a repair statement.	Validate impact, inquire without interrogation, apologize when appropriate, and collaboratively repair.	Observer or standardized-client ratings of acknowledgment, inquiry, and repair.
Supervision and feedback	Review actual practice examples, client feedback, and alliance ruptures; supervisors model humility and attend to supervisees' in-session emotion.	Translate insight into repeated clinical behavior; supervisor as secure base [14].	Supervisor-rated skills; client-rated cultural humility and alliance.
Organizational follow-through	Audit interpreter access, intake forms, referral processes, accessibility, and complaint pathways, and assign owners to changes.	Address structural barriers rather than relying on individual goodwill alone [9].	Documented procedural changes and their implementation.

7. Facilitation and Safeguards

Experiential work with emotion requires skilled facilitation and clear boundaries. Training is not therapy: trainees should control the depth of their participation, should not be required to disclose sensitive personal information, and should be able to be referred for further support if needed; facilitators should be trained in trauma-informed practice. Because trainees occupy different social positions, emotional processing may mean something different for a trainee learning about privilege than for one who has experienced discrimination. Optional parallel formats, including spaces led by and for minoritized trainees, can reduce the risk that colleagues' emotional work is placed on minoritized staff [34]. Facilitators should model the stance being taught by acknowledging their own errors and limits, and programs should avoid framing shame as something to be removed or reassured away.

8. Illustrative Clinical Application

Consider a client who says that the therapist's question about

family structure felt culturally presumptive. A defensive response might be to explain that the question is routinely asked or that no offense was intended. An attachment-informed and culturally humble response would begin by pausing, acknowledging the reported impact, and inviting the client to explain what felt presumptive, without demanding that the client educate the therapist. The therapist could say, "Thank you for telling me. I can see that my question made an assumption. If you are comfortable, I would like to understand what I missed, and we can decide together how to discuss family in a way that fits your experience." The therapist would then reflect on the interaction in supervision and consider whether intake practices need to change. This example illustrates a process, not a script that should be applied identically across contexts; clients differ in how much they wish to discuss a rupture, and the therapist should follow the client's lead.

In this scenario, the attachment-informed contribution is the therapist's capacity to stay engaged when feeling uncertain or criticized. The emotion-focused contribution is to recognize that

the urge to explain may be a secondary reaction covering shame or fear, so that regulation and reflection can precede the response. The cultural-humility contribution is to treat the client's account as meaningful and to avoid assuming that the therapist's intention cancels the impact. The ethical and organizational contribution is to repair harm and examine whether the same problem is built into routine practice.

9. Evaluation: What Should Be Measured?

If this model is implemented, evaluation should avoid relying exclusively on satisfaction surveys or immediate self-reported knowledge. Training evaluation frameworks distinguish reaction, learning, behavior, and results [35]; given the pattern of findings above, behavior and results deserve most attention. A feasible plan would measure outcomes at baseline, immediately after training, and at follow-up (for example, 3, 6, and 12

months). Table 4 aligns constructs and measures with the layers of the model. Where possible, evaluation should include perspectives from communities affected by inequity and examine outcomes across relevant groups without treating any group as homogeneous.

Implementation studies should compare the proposed model with an active comparator such as established multimethod training or usual continuing professional development, ideally in cluster-randomized or stepped-wedge designs with preregistered hypotheses and sufficient power to test mediators. They should account for training dose and organizational context and include mixed methods to examine not only whether change occurs but how participants interpret and sustain it. Because most existing studies rely on self-report [11], observed behavior and client-reported experience should be primary outcomes. Claims of effectiveness should be reserved until such studies are conducted.

Table 3: Walkthrough of the illustrative vignette through the proposed model.

Model element	Therapist's internal process	Observable response or organizational action
C. Triggering encounter	Hears that the question was culturally presumptive; appraises this as a threat to being a competent and caring therapist.	Client names the impact.
D1. Unprocessed pathway (for contrast)	Secondary reaction: "It is a routine question; I meant no harm." Beneath it: shame and fear of damaging the alliance.	Over-explaining or reassurance; the client may feel unheard or responsible for the therapist's feelings.
D2.1 Awareness	Notices heat, tension, and the urge to explain, and names it silently as defensiveness.	A brief pause.
D2.2 Regulation	Slows breathing, grounds, and re-orient to the client.	Steady, unhurried tone.
D2.3 Reflection	Asks: "What do I need right now? What does the client need? What did my question assume?"	Open question inviting the client's account, without requiring them to teach.
D2.4 Transformation	Shame about the misstep gives way to concern for the client and curiosity about their experience.	Acknowledgment of impact and collaborative decision about how to discuss family.
E-G and feedback loop	Takes the experience to supervision; examines own assumptions about family forms.	Revision of intake questions; client feedback and alliance monitoring in later sessions.

Table 4: Proposed multilevel evaluation plan aligned with the model.

Level	Constructs	Possible measures	Timing
Reaction and climate	Perceived psychological safety and accountability; acceptability	Brief climate and acceptability ratings; facilitator observation	During and after training
Learning	Knowledge and attitudes; emotional awareness and regulation; shame- and guilt-proneness	Validated self-report scales appropriate to the setting; reflective written responses	Baseline, post, follow-up
Behavior	Defensive responding, acknowledgment of impact, inquiry, and repair	Standardized-client or vignette simulations coded by blinded raters; supervisor ratings; consented session recordings	Post and 3–6 months
Client experience	Perceived cultural humility; alliance; felt respect and safety; microaggressions and whether they were addressed	Client-rated cultural humility [27]; alliance measures; client-reported microaggressions and repair [16]	Ongoing; 6 and 12 months
Organization	Procedural and policy change; interpreter access; complaint resolution	Documented changes; administrative data; staff retention	6 and 12 months
Unintended effects	Shame-driven avoidance; performative compliance; burden on minoritized staff	Qualitative interviews; anonymous feedback; stratified analysis	Throughout

10. Limitations and Cautions

This is an opinion article, not a systematic review, clinical trial, or validated training manual. Sources were selected purposively for conceptual relevance, so the account may be subject to selection bias, and the model has not been tested. The cited evidence concerns related but distinct areas (diversity and EDI education, cultural humility and multicultural orientation, therapist attachment, rupture and repair, and EFT as couple therapy). Much of it is correlational, self-reported, or qualitative, and part of it shows signs of publication bias [2]. It does not directly demonstrate that EFT- or EmFT-derived diversity training produces better clinical outcomes.

Several steps in the argument are extrapolations. EFT and EmFT have been studied as therapies, not as training methods; the distinction between primary and secondary emotion, and between shame and guilt, has not been validated as a framework for professional learning; and evidence on attachment security and prejudice comes largely from non-clinical samples and brief manipulations. The model also risks over-individualizing: emotional processing by therapists is not a substitute for structural change, and an emphasis on therapists' feelings could recentre majority-group comfort unless client harm and accountability remain central.

Attachment-based and emotion-focused models arose in particular cultural contexts, and their assumptions about emotional expression, autonomy, and relational needs may not hold uniformly. Even within the EFT literature, adaptation for LGBTQ+ clients has only recently been studied: an expert Delphi study generated 49 guidelines [36], and client-centered work has reported recommendations from 35 clients [37] and experiences of othering within EFT [32]. Adaptation of the proposed training for other communities should be community-engaged and evaluated for fit.

Finally, emotional safety must not be confused with freedom from challenge: training may need to confront harmful assumptions directly, and facilitators should not protect participants from accountability. Nor should clients be expected to manage therapists' distress or provide unpaid cultural education. Individual training cannot replace institutional policies that address discrimination, accessibility, representation, and equitable service delivery.

11. Conclusion

An attachment-informed, emotion-focused lens may offer therapists a useful way to examine the emotions and relational patterns that shape encounters across difference. By distinguishing defensive secondary reactions from the primary emotions beneath them, and by specifying how learning conditions and supervision can support awareness, regulation, reflection, and transformation, the refined model offers a mechanism through which diversity-related knowledge might become clinical behavior. When combined with cultural humility, skills rehearsal,

reflective supervision, client feedback, and organizational accountability, it may help bridge the gap between knowing and doing. The central proposal is not that EFT or EmFT is a proven diversity-training intervention, but that their attention to vulnerability, emotion, and relational safety provides a promising and testable framework for therapist development. The next step is to test the proposed model with transparent outcomes, active comparators, and sustained follow-up, while keeping equity and the client's lived experience at the center.

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