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Cultural Humility: A Therapeutic Framework for Engaging Diverse Clients

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Therapists and mental health professionals strive to provide competent treatment to increasingly diverse populations, but can struggle to effectively engage with clients from different cultural backgrounds. Cultural humility is an approach and process that can help facilitate strong working alliances between therapists and diverse clients, leading to better therapy outcomes. In this article, we first consolidate definitions of cultural humility and work to better operationalize the construct. Next, we provide a brief review of empirical studies examining the role of cultural humility in therapy. Then, we offer a 4-part framework for applying cultural humility in therapy by (a) engaging in critical self-examination and self-awareness, (b) building the therapeutic alliance, (c) repairing cultural ruptures, and (d) navigating value differences. Finally, we illustrate what cultural humility looks like in the therapy room with two case studies.

Clinical Impact Statement
This article advances the idea that therapists who engage diverse clients with cultural humility may be better able to develop strong therapeutic bonds, work through cultural ruptures, and navigate value differences. In addition, it highlights empirical research on cultural humility and therapy and provides a practical guide and framework of cultural humility for therapists.

Keywords: cultural humility, multicultural, therapy

Psychologists have increasingly worked to attend to the mental health needs of marginalized groups (e.g., racial/ethnic minorities, sexual minorities, individuals with disabilities). This intention is critical given the continued diversification of the United States. For instance, a national polling agency reported that the United States population went from about 15% racial/ethnic minority in 1960 to about 36% in 2010, with an expected sustained increase in the growth of racial/ethnic minority populations in the future (Taylor, 2015). As a result, initiatives within the field of psychology have included prioritizing the development of competent clinical treatment approaches for clients from a variety of cultural backgrounds, as well as approaches related to racial/ethnic diversity, other marginalized identities, and the intersectionality of cultural identities (APA, 2003; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012).

Effectively treating the various needs of diverse clients can be a daunting task for any

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therapist (Sue, Zane, Nagayama Hall, & Berger, 2009). Value differences, cultural biases, or hesitations to engage in culturally meaningful dialogues can impede a genuine connection, and at worst, create ruptures in the therapeutic relationship. Struggling to understand or relate to the client's culture could limit the therapist's understanding of the client's inner world and hinder effective therapeutic work. Moreover, a client's cultural background can be complex, with the intersectionality of cultural identities overlapping with interdependent systems of privilege and oppression, which can make it difficult for therapists to attend to and comprehend all the various aspects of a client's culture in the therapy room.

In response to these challenges, many mental health professionals have adopted cultural competency guidelines and practices to remedy these issues and address the mental health disparities observed among various marginalized cultural groups (APA, 2003; Schulman et al., 1999). These guidelines and practices often draw on a model of cultural competence that seeks to promote (a) cultural awareness and beliefs, (b) cultural knowledge, and (c) cultural skills (Sue et al., 1982, 1992). Cultural competence forms the foundation for many of the multicultural guidelines adopted by the American Psychological Association *Ethics Code* (APA, 2003, 2007, 2014, 2015), the American Counseling Association *Code of Ethics* (ACA, 2005; Corey, Corey, Corey, & Callanan, 2014), and the National Association of Social Workers *Code of Ethics* (Reamer, 1998; NASW, 2000, 2007, 2008).

However, the concept of cultural competence has been a source of controversy because of issues with its definition, inconsistent empirical support in regard to culturally adapted interventions, and concerns about the effectiveness of the cultural competency model with culturally diverse clients (Johnson & Munch, 2009; Kirmayer, 2012; Renzaho, Romios, Crock, & Sønderlund, 2013; Tervalon & Murray-Garcia, 1998; Whaley & Davis, 2007). For example, models of cultural competence often emphasize a priori knowledge about cultural characteristics and values, which can potentially devolve into drawing inappropriate generalizations about an individual or group. Furthermore, these generalizations are often understood in relation to dominant or privileged group values and norms, which is inherently problematic. Although this strategy may provide a framework for attempting to avoid making false assumptions, additional strategies for helping therapists engage with diverse clients are likely needed to cultivate an accurate view of self and empathetically align with the client's lived experience. Furthermore, the utility of competence-based models may be limited when addressing the intersectionality of marginalized identities.

In response to these critiques, some psychologists have proposed the construct of *cultural humility* as a complement to competency-focused approaches. Cultural humility focuses on the process, values, and interactions between the therapist and client (Hook, Davis, Owen, & DeBlaere, 2017; Hook, Davis, Owen, Worthington, & Utsey, 2013). Foronda, Baptiste, Reinholdt, and Ousman (2016) described cultural humility as "a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals" (p. 213). Whereas cultural competence focuses more on ways of doing multicultural work (i.e., knowledge and skills), cultural humility is an important part of a therapist's multicultural orientation toward his or her client (Owen et al., 2016; Owen, Tao, Leach, & Rodolfa, 2011) and focuses on ways of *being with* clients that prioritize and value diverse cultural identities.

Cultural humility involves both intrapersonal components (e.g., critical self-examination of cultural biases) and interpersonal components (e.g., being other-oriented and open to another person's cultural background and experience), while cultivating respect and a mutual partnership (Hook et al., 2013). Given the growing need for effective mental health treatment for an increasingly diverse population, cultural humility could provide a framework to help therapists more comfortably and confidently engage with clients from differing cultural backgrounds. In the present article, we focus on defining cultural humility, briefly reviewing the empirical research on cultural humility in therapy, and offering practical applications concerning how to integrate cultural humility into therapy.

Defining Cultural Humility

What might cultural humility actually look and feel like in the therapy room? Myriad definitions have been offered to operationalize cul-

tural humility, and the lack of agreement on how to best define this construct has limited therapists' ability to identify clear applications in clinical practice. However, in a recent review of the literature, a consensus of definitions began to emerge. Across studies, cultural humility involved (a) a lifelong motivation to learn from others, (b) critical self-examination of cultural awareness, (c) interpersonal respect, (d) developing mutual partnerships that address power imbalances, and (e) an other-oriented stance open to new cultural information (Mosher, Hook, Farrell, Watkins, & Davis, 2017).

The intrapersonal components of cultural humility focus on the dynamic process of in-depth self-reflection by critiquing one's cultural biases and promoting cultural exploration and growth. This might occur through a number of avenues, including supervision experiences and personal therapy. For example, when I [DM] first started working with racial/ethnic minority students as part of a student-diversity program at a university, I gave little thought to how my cultural identity as a White, cisgender man would influence my interactions with students. I saw my Black coworkers connect with students easily and I felt frustrated and confused as to why I was having more difficulty connecting. Finally, I asked a Black student about his perceptions of our relationship, and the student said he questioned my motivation for working with minority students and thought I was there just to prove something as a White male, instead of being sincere in my efforts to offer help. His perspective shocked me as I had not critically reflected on how my cultural background might be affecting my relationships with students. I had to realize that from this student's perspective, I was seen as the oppressor who did not really care about racial inequalities or justice, but instead was there to make myself look and feel better. It was through supervision that I began to see my interactions differently after facing the difficult realities of the privilege I held because of my skin color. By confronting and critically reflecting on my own privilege, I came to the conclusion that I had a responsibility to work toward justice and make racial inequalities my problem as well.

Dynamic, in-depth self-reflection is not only needed because of the vast possible pairings of different-race dyads that could occur in therapy; research has also suggested it is important to reflect on same-race dyads and how other intersecting identities that may be less visible (e.g., socioeconomic status, religion, sexual orientation) could impact the therapeutic relationship (Ferguson, 2006; Goode-Cross, 2011; Goode-Cross & Grim, 2016). For instance, in a study of 36 Black therapists' experiences working with Black clients, results revealed that therapists within same-race dyads often perceived their experiences to have some advantages (e.g., better understanding of the context of Black clients' lives, creating easier and faster therapeutic connections) and some disadvantages (e.g., insufficient boundaries from feeling especially committed to these clients; Goode-Cross & Grim, 2016). Besides race and ethnicity, a lesser researched area in cross-cultural counseling explores how intersecting identities impact therapy, as well as how nonwhite therapists could benefit by being more aware of their privilege statuses (e.g., education level, socioeconomic status, heterosexuality; Ferguson, 2006). In this regard, intrapersonal components of cultural humility could help therapists to reflect on and recognize all of their cultural identities that could influence the therapeutic relationship and working alliance.

As therapists, developing in an environment without shame or fear is a cornerstone of cultivating cultural humility. This process is theorized to lead to greater cultural self-awareness, which reduces implicit cultural biases and increases sensitivity to the power dynamics in multicultural interactions (Yancu & Farmer, 2017). Addressing implicit cultural biases in therapists is crucial because research has demonstrated that a client's cultural background and identity (e.g., race, social class, gender, sexual orientation) influence therapists' psychodiagnoses, rating level of adjustment, prediction of a client's behavior, and treatment planning (Garb, 1997; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Wisch & Mahalik, 1999). For example, therapists have been found to judge lower-class clients as having more severe mental illness than upper-class clients, as well as female clients as being more distressed than male clients presenting with identical problems (Garb, 1997).

Interpersonal components encourage the culturally humble individual to focus on the other person rather than on him- or herself, which could diminish ethnocentric tendencies and lead to a deeper understanding of the uniqueness of

the other. As discussed earlier, cultural competence emphasizes awareness, knowledge, and skills for working effectively with different cultural groups. The requisite behaviors required in therapy involve complex metaskills of drawing from prior cultural experiences to optimize responsiveness to a particular client's needs. Generalized "knowledge about" various identities (Weinrach & Thomas, 2002) can promote stereotypes if decisions within sessions are not informed by appropriate levels of cultural humility.

As a counterbalance to cultural competency's focus on a priori knowledge of culture, cultural humility encourages a particular attitude toward orienting to the client's needs in the moment. Arrogant or insensitive behavior is characterized by various forms of difficulty connecting and attuning to the client. For instance, one might worry about how one is doing, feel overly sure of one's perspective of the situation, or misread how one's own and the client's cultural identities are affecting the situation. Cultural humility orients the therapist to the uniqueness of each client and relies on learning from the client while empowering them to become an equal partner in treatment decisions (Hook, 2014). For example, a culturally humble therapist might consider questions such as the following.

> What is it like to be this client? What is it about this person in front of me that makes him or her culturally unique? What aspects of this client's cultural background are important to him or her? How does this person's culture impact his or her reasons for attending counseling? How might this client's cultural context serve as a strength or support when working toward goals? How might this client's—and my own—cultural background impact our interaction and our ability to meaningfully connect and work together?

These orienting skills have always been present in competency focused models, but the language of humility sharpens the focus on precisely what is needed. What you "know" or "do not know" may be less important than having an accurate view of your limitations and responding effectively to those limitations. Indeed, one faulty assumption of counseling is that competent therapists are the ones with the most knowledge, skills, or techniques. Patterson (2004) argued that competent therapists are actually the ones who are able to facilitate the most effective therapeutic relationship with their clients. Further, the most consistent and powerful predictor of positive therapeutic outcomes in psychotherapy, across various theoretical orientations, is the quality of the client–therapist relationship (Lambert, 2013; Norcross & Lambert, 2011). Whereas cultural competency practices may enhance treatment, cultural humility may work toward building a real relationship (e.g., being genuine, viewing the client as a fellow person) in therapy with strong emotional bonds, agreement on goals and tasks, and a collaborative experiential process.

Cultural humility focuses the therapist on the goal of developing a strong therapeutic bond through a greater appreciation of what cultural values and beliefs add to the healing process. It affects how the therapist connects with clients, as well as the ongoing relational interactions. Cultural understandings provide opportunities for therapists to deepen the therapeutic process through adopting an other-oriented stance. This, in turn, creates the potential for psychological healing. We might recognize therapists who are higher in cultural humility because these individuals consistently execute several things in their work with clients. Culturally humble therapists (a) intentionally self-reflect and make a consistent effort to reduce their limitations and biases; (b) focus on learning from their clients' cultural backgrounds and experiences; (c) search for opportunities to build respectful, mutual partnerships with their clients; and (d) are motivated throughout their lives to learn more about various cultural beliefs.

Review of Research on Cultural Humility

Most of the writing on cultural humility has been theoretical in nature, with relatively few empirical studies exploring cultural humility in therapy (Mosher et al., 2017). Hence, caution should be used when interpreting these findings. However, the few studies that have explicitly focused on the effects of cultural humility in therapy show promising benefits of adopting a culturally humble stance in therapy. Most of this research has involved the Cultural Humility Scale (CHS; Hook et al., 2013), which is a quantitative measure that employs a client-report design, allowing clients to report perceptions of their therapists' cultural humility.

Cultural humility is strongly associated with therapy alliance. In the initial scale-develop-

ment study of the CHS, researchers found that clients who perceived their therapists to be higher in cultural humility also reported stronger working alliances with their therapists and greater improvements in therapy (Hook et al., 2013). Indeed, cultural humility predicted working alliance over and above the effects of multicultural competence.

Other studies have replicated and extended these findings. For example, some initial work suggested that cultural humility may be especially important for a client's most salient identities. In a study of clients who reported religion/spirituality to be a salient identity, cultural humility was related to stronger working alliances and better counseling outcomes, but only in clients with higher religious commitment (Owen et al., 2014).

Having low cultural humility has been linked to committing cultural mistakes or microaggressions (i.e., a statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination) that cause ruptures in the therapeutic relationship. For example, a study using a large racial/ethnic minority sample found that 81% of clients experienced at least one racial microaggression in counseling, including slights such as bias, denial/lack of awareness of stereotypes, and avoiding the discussion of cultural issues (Hook et al., 2016). Further, clients who perceived their therapists to be more culturally humble also reported that their therapists committed fewer microaggressions over the course of the therapeutic relationship (Hook et al., 2016). Relatedly, another study demonstrated that when cultural offenses occur, they are associated with unforgiving emotions that cause the client to view their therapist as less culturally humble, which in turn weakens the therapy alliance and leads to poorer therapy outcomes (Davis et al., 2016).

Cultural humility may also help therapists recover from cultural mistakes. Therapy is replete with opportunities to deepen one's connection and responsiveness to clients' core cultural identities, and a line of work has begun to explore variability in clients' perceptions of whether therapists miss opportunities to explore their important cultural identities. For example, a therapist seeing a gay couple for marital discord may be uncomfortable asking about the couple's intimacy behaviors or refrain from asking how the current sociopolitical landscape might be affecting stress levels in the marriage. In a study of 247 clients at a large university counseling center, the more clients reported that their therapists missed cultural opportunities, the worse their therapy outcomes were. However, cultural humility served as a protective factor: This negative association was weaker (i.e., buffered) for therapists perceived to be higher in cultural humility (Owen et al., 2016).

Practical Application of Cultural Humility in Therapy

In the following section, we offer a framework for how cultural humility can be integrated within therapy across four areas: (a) engaging in critical self-examination and self-awareness, (b) building the therapeutic alliance, (c) repairing cultural ruptures, and (d) navigating value differences.

Engaging in critical self-examination and self-awareness. Establishing a working definition of cultural humility and seeing some of the benefits it can have for therapy leads us to the question, "How does cultural humility show up practically in the therapy room?" We suggest that this question is best answered by first exploring and understanding one's own cultural perspective and biases. Although cultural self-awareness is not a new concept, cultural humility strives for a deeper understanding of one's cultural identities and the intersectionality between various self-aspects, rather than just simple recognition. Also, cultural humility encourages reflection on salient cultural similarities and differences between the therapist and client.

The culturally humble therapist delves deeper into his or her own cultural worldview and perspective by intentionally trying to achieve an in-depth understanding of how their own cultural identities (e.g., gender, race, ethnicity, religion, sexual orientation, ability, social class) are linked to their experiences of power, privilege, and oppression. In other words, cultural humility encourages us to go deeper than noticing differences (e.g., "I'm White, you're Black" or "How does it feel to work with a therapist from a different racial/ethnic background?"), and delve into what those differences mean (e.g., "How is my experience as a White male linked to power and privilege?" or "Given my position, what is my responsibility to work toward justice and equality?").

Culturally humble therapists also look deeply at how their cultural backgrounds and worldviews impact a wide array of decisions, both professionally and personally. For example, professionally, how does our cultural background affect our (a) theoretical orientation, (b) how we think change occurs, or (c) how we try to connect with others and develop relationships? Personally, how does our cultural background impact decisions such as (a) where we choose to live and socialize, (b) who we choose to befriend on social media, or (c) the kinds of movies or documentaries we watch?

The goal is to understand how our own cultural identities influence our perspectives, worldviews, and lived experiences, as well as how these cultural identities can affect our clients. When culturally humble therapists more clearly sense their cultural worldviews and perspectives, they commit to intentionally work to reduce their cultural biases and use their power and privilege to work toward justice. The goal to reduce bias is not unique to cultural humility, but at the same time, we encourage therapists to embrace the discomfort felt when they challenge their biases to truly explore and own them. If we can arrive at a place of welcoming and looking hard at our cultural discomfort, then perhaps new insights can arise that will bolster our courage to (a) seize culturally meaningful opportunities when interacting with clients and (b) work to make a real difference in the world, despite our discomfort.

When engaging with clients, it is important to recognize our limitations, remain self-aware, and remember that the client is the expert on their unique set of cultural identities and experiences. The culturally humble therapist engages with the client in a way that co-creates a relational experience. In doing so, the connection between clients' and therapists' cultural values and beliefs are part of the fuel for a deeper relational connection, with both positions adding to a new vision for healing. Throughout the process, therapists should be aware of their positionality in the relationship, and while being genuine and real, should take steps to mitigate their power and influence.

For example, a culturally humble therapist might actively listen to a client's story while being mindful not to make foreordained assumptions about the presenting problem. Instead of letting previous knowledge of culture foreclose the therapist's conceptualization of the client, the culturally humble therapist stays self-aware and uses their active listening and empathy skills to remain the learner rather than the expert of the client's situation. Thus, a deeper understanding of one's culture can lead to (a) a reduction of cultural biases, (b) opportunities to learn from clients, (c) stronger therapeutic bonds, and (d) opportunities to address power imbalances and work toward justice.

Building the therapeutic alliance. A core tenet of cultural humility theory and research has been that cultural humility can help build stronger therapeutic relationships with culturally diverse clients. In fact, this is perhaps the most strongly supported research finding thus far (Hook et al., 2013; Hook et al., 2017; Owen et al., 2014). This reasoning is built on a strong foundation of research that has revealed humility to be important in the development and maintenance of social bonds (Davis et al., 2013; Farrell et al., 2015).

For many clients, their cultural background is an important aspect of their identities, as well as how they see and move through the world. Communicating to clients, both implicitly and explicitly, that their cultural identities are important and will be respected within the therapy can be a key building block of the treatment alliance and set the stage for effective therapeutic work. The working alliance is thought to be comprised of three parts: bond, goals, and tasks (Bordin, 1979; Bordin, 1994). Cultural humility can positively impact all three aspects of the therapeutic alliance. For example, engaging a client with openness, curiosity, and respect can lead to positive feelings and closeness between the therapist and client (i.e., the bond). Culture often heavily influences one's view of what constitutes the "good life," and thus impacts the goals for therapy. Therefore, being open and humble toward the client's cultural background and experiences allows the therapist and client to come together and collaboratively create direction and focus (i.e., goals). Finally, culture often permeates many aspects of everyday life. Expressing openness and a desire to understand how the client views and interacts with the world can improve connection and cooperation about what actually happens in the therapy room (i.e., tasks).

Therapists can begin expressing cultural humility and working to build the working alliance even

before clients attend their first sessions. A therapist's or mental health organization's websites, materials, and intake forms can all be more or less culturally humble. For example, during the intake, the therapist can ask questions that communicate curiosity and respect for a client's cultural background and identity. Throughout treatment, therapists can be on the lookout for opportunities to connect with and bring culture into the therapy room if the client desires the integration.

An important part of cultural humility is being open to new information, and displaying curiosity to learn from the client. A therapist needs to be deliberate about integrating culture into therapy, if that is what the client desires, which requires the kind of therapist comfort when discussing culture that often develops over time. Many therapists feel anxious when discussing culture, for fear of saying the wrong thing or making a mistake. Thus, it can be easy to refrain from asking about the importance of culture, linking cultural issues to the presenting problem, or even using the client's culture as a source of support.

An orientation toward cultural humility views culture and the ability to help clients feel deeply known and accepted as cultural beings, as crucial dimensions to the therapeutic process. For example, a therapist might inquire about a client's cultural background and explore related values, such as the role of family and friends, views of mental health, any religious/spiritual influences, experience of gender and social class, and sexual beliefs and norms, just to name a few. This is intended to be done authentically and fluidly by expressing curiosity about the client's culture, exploring how culture may be linked to the presenting problem, and understanding cultural influences in the client's desired solutions and goals over the course of treatment. Engaging in cultural dialogue with a client allows the therapist to enter into the client's lived experience, which can help clients join with the therapy process and help align therapy goals by allowing culture to influence treatment focus. Essentially, this process of entering into the client's unique cultural experience helps build mutual partnerships in therapy founded upon respect.

Repairing cultural ruptures. Therapists can, and often do, make cultural mistakes (e.g., microaggressions) that could lead to a rupture in the relationship. The first step in repairing cultural ruptures is to be aware that the rupture occurred. For instance, Owen et al. (in press) found that approximately 50% of therapists were able to identify only one of three microaggressions. Thus, culturally humble therapists could set up a therapeutic environment that is culturally safe and alleviates client concerns about sharing a part of his or her cultural identity. Indeed, cultural concealment has been linked to weaker therapeutic outcomes (Drinane, Owen, & Tao, in press). Despite a therapist's best efforts to create a culturally safe environment, cultural mistakes can still occur. Thus, it is important to know what to do when a cultural mistake has occurred, which may be communicated through a client's body language or inconsistent attendance. Cultural humility can be an important foundation from which to repair such ruptures. When we make mistakes that involve cultural missteps as therapists, how do we work through this and repair our relationships with our clients?

Culturally humble therapists identify their limitations and are open to feedback from clients. Being humble toward a person's culture involves letting go of one's desire to remain the expert professional in exchange for a transparent relationship that invites clients to talk about their experiences when they feel offended by the therapist's words or behaviors. After making a mistake, the ultimate goal is to acknowledge our finite knowledge of the client's culture and work to rebuild the relationship, whether through an apology, owning our biases, or asking the client for corrective feedback. Not all therapists would agree with this approach, but the fundamental components of humility include having an accurate view of the self (including one's limitations) and adopting an other-oriented mindset. In light of this, cultural humility emphasizes validating the other person and the hurt they experienced as a result of the therapist's mistake, while also seeking to repair the rupture with an honest and genuine attempt to acknowledge and own our limitations. Supporting this point, research gives some evidence that cultural humility could buffer against ruptures in the therapeutic relationship (Hook et al., 2016; Owen et al., 2016). In other words, a strong connection can weather the storm of a misstep.

For example, suppose a therapist made an incorrect assumption about the client based on

their racial/ethnic background, which leads to feelings of anger and frustration from the client. The culturally humble therapist notices a change in the client's emotional countenance and asks for feedback about the exchange. Upon hearing the client's frustration, the therapist might internally feel defensive, but moderates this reaction. Instead, the therapist is open to the idea that he or she may have made a cultural mistake, and welcomes feedback from the client. This exchange may lead to the therapist apologizing and working to reconnect and rebuild the relationship with the client. Thus, cultural humility may act as both a buffer to ruptures in the relationship as well as a means to reconnect with a client who was hurt by a therapist's mistake.

Navigating value differences. Another common source of conflict and difficulty occurs when there are major value differences between a therapist and client, particularly on emotionally charged topics (e.g., politics, sexual orientation, religion). These value differences can affect the goals and tasks associated with therapy, and thus impact the therapeutic bond between therapist and client. Values often operate unconsciously and underlie our beliefs about therapy itself (e.g., how people change, what constitutes mental health, etc.).

The culturally humble therapist understands his or her own cultural values and worldview, as well as the cultural background and experiences that underpin these values. Also, the culturally humble therapist acknowledges that there are multiple cultural lenses through which individuals and groups view the world. The ultimate goal of therapy is to strive to do work that fits within the scope of the client's cultural lens, rather than force the client to operate out of the therapist's lens, which can lead to feelings of frustration on both sides.

When struggling to navigate value differences, culturally humble therapists remain other-oriented in that they focus on clients' values more than their own, as well as embrace the dyadic process of co-creating the work of therapy together in a collaborative partnership. This is also why critical self-examination and self-awareness of one's own cultural values and worldview is necessary, because value differences are likely at some point and can affect treatment goals and the interventions used during therapy. If the therapist has not examined her or his own cultural values and worldview, these values are likely to operate unconsciously and may negatively impact the therapeutic relationship and the work done in therapy (e.g., an individualistic therapist who encourages a collectivistic client to "find herself" and break free from the pressures and constrictions of her family).

If a therapist continues to struggle with a value conflict, it is important that he or she seek guidance through consultation and supervision. During therapy sessions, the goal of navigating value differences should be to remain respectful and focus on what is most important to the client, while asking questions to learn more about the client's values when they are unclear. Outside of session, a therapist may need to seek supervision, consultation, or readings that inform the therapist's awareness of the potential value differences present. Personal therapy may also be needed. For example, a therapist who grew up viewing gender as binary may have difficulty understanding and supporting a transgender client. Consultation, supervision, and personal reading can be tremendously helpful in navigating this value difference in a way that promotes the client's well-being.

Case Examples

To further illustrate how cultural humility may appear in counseling, we provide two case examples. The first case example illustrates the therapist acting in a nonculturally humble way, whereas the second case example illustrates the therapist acting in a culturally humble way.

Case #1: Low cultural humility. After checking in with the receptionist, Dana walks in for her third session and sits down in the chair across from Jane, her psychologist, who works from a family-systems orientation. In terms of identities, Dana (age 20) is a Mexican, cisgender female college student; Jane (age 55) is a White, cisgender woman who works in the counseling center. To open the session, Jane asks Dana about her previous week.

Jane: How have you been this week?

Dana: (Shakes her head.) Not too good. I have been arguing with my mom, which is really stressful,

and I have been having really bad headaches the past few days.

Jane: I'm sorry to hear that. What's going on with your mom?

Dana: She keeps asking me for money, which I do not really have. This has been getting on my nerves for a while, but last week I found out that she was using some of the money I had given her for online shopping to decorate her house. I barely have enough money for myself—it's just really frustrating.

Jane: Oh no, that is not good.

Dana: No! Not good at all. I am the youngest in our family and mom has always expected me to be the one that takes care of her as she has gotten older. I want to do it. But at the same time, some of her expectations make it really hard for me to manage my own life. It's hard to take care of my bills and other responsibilities when I am always having to give some of my money to mom, especially when she isn't always the best with her money.

Jane: Yes, that makes a lot of sense to me. I wonder if part of the problem has to do with your difficulty in setting appropriate boundaries with your mom. What would it look like for you to say "no" when she asks for money?

Dana: Well, I guess I could do that, I do not know. (She sits back in her chair and is mostly quiet for the rest of the session.)

What went wrong? It may be that Jane made some cultural mistakes associated with low cultural humility. From an individualistic lens, Jane views Dana's difficulties as arising from being too enmeshed with her mother. To have a healthier relationship, Jane believes that Dana needs to be able to set limits, tell her mom no, and tolerate the distress caused by maintaining these boundaries. She assumed her client would easily align with these goals, but this assumption may not be accurate. Dana did not respond well to the intervention, as evidenced by her withdrawing and becoming quiet for the remainder of the session. In fact, the therapist repeated a behavior that caused Dana a lot of pain in the past—adopting a judgmental perspective of her relationships within her family.

If Jane were to follow-up this exchange and engage with cultural humility, she might try to repair the relationship with Dana. For instance, Jane could start the next session by acknowledging that she may have made a quick and inaccurate judgment about Dana's family relationships (e.g., "I realized after last session that I made an assumption about you"), reflect the importance of Dana's viewpoint in therapy (e.g., "The last thing I want to do is suppress your voice in therapy"), and ask Dana to clarify her experience for Jane (e.g., "If you are willing, could you help me understand what you experience when around your family?"). However, without cultural humility, the therapist cannot recover. Later on in their work together, Dana tried to address the issue indirectly by disclosing difficulties with her White friends who do not understand her view of family. The therapist did not pick up on these cues and ignored the opportunity to understand more about her client's struggles with her friends (and related difficulties within the therapy relationship). Eventually, Dana got discouraged about talking with Jane about her relationship with her mother and decided to stop coming to therapy.

Case #2: High cultural humility. In what follows, we describe an alternative dialogue example in which Jane has cultivated an orientation of cultural humility in her work with Dana.

Jane: How have you been this week?

Dana: (Shakes her head.) Not too good. I have been arguing with my mom, which is really stressful, and I have been having really bad headaches the past few days.

Jane: I'm sorry to hear that. What's going on with your mom?

Dana: She keeps asking me for money, which I do not really have. This has been getting on my nerves

for a while, but last week I found out that she was using some of the money I had given her for online shopping to decorate her house. I barely have enough money for myself—it's just really frustrating.

Jane: Oh no, that is not good.

Dana: No! Not good at all. I am the youngest in our family and mom has always expected me to be the one that takes care of her as she has gotten older. I want to do it. But at the same time, some of her expectations make it really hard for me to manage my own life. It's hard to take care of my bills and other responsibilities when I am always having to give some of my money to mom, especially when she isn't always the best with her money.

Jane: Ah, I see. That does sound difficult. On the one hand, you want to be a good daughter and show your mom that you love her. You feel this sense of responsibility as the youngest daughter. But on the other hand, sometimes your mom's expectations and behaviors with money are causing you stress.

Dana: Exactly! It's like I'm being pulled in two directions and I do not know how to move forward.

What went better in this dialogue? The differences are subtle. Higher cultural humility allowed the therapist to respond more collaboratively to the client. Jane, leading with cultural humility, was able to respect and honor the client's cultural background and perspective, and consider how the client's cultural worldview might be impacting her presenting problem and goals for therapy. Jane did not quickly rush to solve Dana's problem before understanding the various contextual factors that may have led to her struggles.

In ongoing therapy with Dana, Jane might continue to demonstrate and cultivate cultural humility by (a) intentionally reflecting on her cultural background, intersecting identities, and experiences; (b) striving to adopt a stance of a curious learner about Dana's culture; and (c) searching for opportunities to build a mutual, respectful partnership. First, Jane might examine how her various salient cultural identities (e.g., White, cisgender) are connected to experiences of power and privilege, as well as how these identities might impact her view and relationship with Dana. In thinking about what this could mean for her relationship with her client, Jane would see some similarities with Dana, as well as recognize how their experiences might differ, which could lead Jane to think about how she wants to relate to Dana or approach the power differential in the therapy room. Second, Jane could strive to be a curious learner of Dana's culture by specifically thinking about what Dana expressed as being important to her in their session together and how she could inquire further about Dana's experiences that are still unknown to her, rather than assuming she understands. Jane might also spend time reflecting on her clinical mistakes or times she made a wrong assumption to remind herself of her limitations in understanding Dana's experiences. In addition, Jane could recommit herself to be a lifelong learner by continuing to explore the complexities of culture and its role in therapy. Finally, Jane might invite Dana in future sessions to take charge in directing time spent in therapy, while partnering with her to come up with mutually beneficial therapy goals and processes. For instance, Jane might use collaborative language to partner with Dana in discovering their end goal of therapy.

Conclusion and Future Research Directions

In an ever-growing diverse and postmodern world, therapists need to be prepared to effectively treat diverse clients who present with intersecting cultural identities. Cultural competence has received significant attention in recent years, but therapists may also benefit by adopting a mindset of cultural humility to work in conjunction with a cultural competence framework. We postulate that building knowledge and skills, with a heavy dose of cultural humility, provides the best framework for working with diverse clients and developing strong therapeutic bonds. However, the concept of cultural

humility is still a fairly recent development in the field, and further research is needed to clarify empirical support and develop cultural-humility-based interventions.

To help with this goal, in this article we first consolidated the definitions of cultural humility and defined the construct as having both intrapersonal (e.g., critical self-examination of one's culture) and interpersonal components (e.g., other-orientation, openness, mutual partnerships). Cultural humility develops as a therapist (a) intentionally reflects on one's cultural background, identities, and experiences; (b) adopts a stance of curious learner rather than expert of the client's culture; (c) searches for opportunities to build respectful, mutual partnerships; and (d) embraces the mindset of a lifelong growth.

Second, we reviewed the empirical literature on cultural humility and therapy and found cultural humility to strengthen the working alliance, therapeutic bond, and treatment outcomes. Also, cultural humility may buffer the negative consequences of missed cultural opportunities and cultural missteps. It appears cultural humility works to bolster and protect the therapeutic relationship when the therapist navigates given cultural differences, and also gives the therapist more insight into him- or herself, thereby decreasing the likelihood of making cultural mistakes (e.g., microaggressions). Research has shown promising results when therapists engage clients through cultural humility, though there are currently relatively few empirical studies.

Future research could tease out more specific ways in which cultural humility might impact psychotherapy. First, investigations could build on the current empirical studies by examining various moderators between cultural humility and the therapeutic relationship (e.g., therapist personality factors, cognitive reflective ability, therapist values). Second, studies could explore how to foster and develop cultural humility in therapists and mental health professionals in training. Third, researchers could examine how cultural humility impacts therapy in various settings (e.g., rural, military, low and high socioeconomic environments).

Finally, we offered some practical applications of how cultural humility can provide a therapeutic framework for multicultural work through personal self-examination and awareness, building the working alliance, repairing ruptures, and navigating value differences. To illustrate these applications, we provided a case example with two client–therapist dialogues to show the potential consequences of struggling with cultural humility, as well as the benefits of engaging with cultural humility in session.

Throughout this paper, we have argued that cultural humility is a process rather than a destination. Instead of reaching an end goal of competence or expertise, cultural humility develops as therapists (a) become aware of and moderate their egos; (b) engage with diverse clients with respect, curiosity, and a desire to truly understand; and (c) critically reflect on their own cultures, values, and biases to improve future work. In other words, cultural humility gives therapists the flexibility to connect with diverse clients, a framework to build the therapeutic relationship over time, and the means to repair any ruptures that arise. Developing and practicing cultural humility will better equip therapists and mental health professionals in effective interactions with diverse clients, keeping in mind that we are all human beings of multiple intersecting cultural identities who constantly influence each other.

References

American Counseling Association. (2005). *ACA code of ethics: As approved by the ACA Governing Council, 2005*. American Counseling Association.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377–402. http://dx.doi.org/10.1037/0003-066X.58.5.377

American Psychological Association. (2007). Guidelines for psychological practice with girls and women. *American Psychologist, 62,* 949–979. http://dx.doi.org/10.1037/0003-066X.62.9.949

American Psychological Association. (2014). Guidelines for psychological practice with older adults. *American Psychologist, 69,* 34–65. http://dx.doi.org/10.1037/a0035063

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70,* 832–864. http://dx.doi.org/10.1037/a0039906

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16,* 252–260. http://dx.doi.org/10.1037/h0085885

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). New York, NY: Wiley.

Corey, G., Corey, M. S., Corey, C., & Callanan, P. (2014). *Issues and ethics in the helping professions with 2014 ACA codes* (9th ed.). Stamford, CT: Brooks Cole.

Davis, D. E., DeBlaere, C., Brubaker, K., Owen, J., Jordan, T. A., II, Hook, J. N., & Van Tongeren, D. R. (2016). Microaggressions and perceptions of cultural humility in counseling. *Journal of Counseling & Development, 94,* 483–493. http://dx.doi.org/10.1002/jcad.12107

Davis, D. E., Worthington, E. L., Jr., Hook, J. N., Emmons, R. A., Hill, P. C., Bollinger, R. A., & Van Tongeren, D. R. (2013). Humility and the development and repair of social bonds: Two longitudinal studies. *Self and Identity, 12,* 58–77. http://dx.doi.org/10.1080/15298868.2011.636509

Drinane, J. M., Owen, J., & Tao, K. (in press). Cultural concealment and therapy outcomes. *Journal of Counseling Psychology*.

Farrell, J. E., Hook, J. N., Ramos, M., Davis, D. E., Van Tongeren, D. R., & Ruiz, J. M. (2015). Humility and relationship outcomes in couples: The mediating role of commitment. *Couple and Family Psychology: Research and Practice, 4,* 14–26. http://dx.doi.org/10.1037/cfp0000033

Ferguson, A. (2007). Intersections of identity: Navigating the complexities. *Forum on Public Policy: A Journal of the Oxford Round Table, Winter,* no pagination.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27,* 210–217. http://dx.doi.org/10.1177/1043659615592677

Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4,* 99–120. http://dx.doi.org/10.1111/j.1468-2850.1997.tb00104.x

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist, 46,* 964–972. http://dx.doi.org/10.1037/0003-066X.46.9.964

Goode-Cross, D. T. (2011). Same difference: Black therapists' experience of same-race therapeutic dyads. *Professional Psychology: Research and Practice, 42,* 368–374. http://dx.doi.org/10.1037/a0025520

Goode-Cross, D. T., & Grim, K. A. (2016). "An unspoken level of comfort:" Black therapists' experiences working with Black clients. *The Journal of Black Psychology, 42,* 29–53. http://dx.doi.org/10.1177/0095798414552103

Hook, J. N. (2014). Engaging clients with cultural humility. *Journal of Psychology and Christianity, 33,* 277–281.

Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: A guide to engaging diverse identities in therapy*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000037-000

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60,* 353–366. http://dx.doi.org/10.1037/a0032595

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63,* 269–277.

Johnson, Y. M., & Munch, S. (2009). Fundamental contradictions in cultural competence. *Social Work, 54,* 220–231. http://dx.doi.org/10.1093/sw/54.3.220

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine, 75,* 249–256. http://dx.doi.org/10.1016/j.socscimed.2012.03.018

Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy, 50,* 42–51. http://dx.doi.org/10.1037/a0030682

Mosher, D. K., Hook, J. N., Farrell, J. E., Watkins, C. E., & Davis, D. E. (2017). Cultural humility. In E. L. Worthington, D. E. Davis, & J. N. Hook (Eds.), *Handbook of humility: Theory, research, and applications* (pp. 91–104) New York, NY: Taylor & Francis.

National Association of Social Workers. (2000). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

National Association of Social Workers. (2007). *Indicators for the achievement of the NASW Standards for Cultural Competence in Social Work Practice*. Washington, DC: Author.

National Association of Social Workers. (2008). *Code of ethics*. Washington, DC: Author.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work: II. *Psychotherapy, 48,* 4–8. http://dx.doi.org/10.1037/a0022180

Owen, J., Jordan, I. I., Terrence, A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology and Theology, 42,* 91–98.

Owen, J., Tao, K., Drinane, J., DasGupta, D., Zhang, D., & Adelson, J. (in press). An experimental test

of microaggression detection in psychotherapy: Therapist multicultural orientation. *Professional Psychology: Research and Practice*.

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47,* 30–37. http://dx.doi.org/10.1037/pro0000046

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48,* 274–282. http://dx.doi.org/10.1037/a0022065

Patterson, C. H. (2004). Do we need multicultural counseling competencies? *Journal of Mental Health Counseling, 26,* 67–73. http://dx.doi.org/10.17744/mehc.26.1.j7x0nguc7hjh545u

Reamer, F. G. (1998). *Ethical standards in social work*. Washington, DC: National Association of Social Workers Press.

Renzaho, A. M. N., Romios, P., Crock, C., & Sønderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care: A systematic review of the literature. *International Journal for Quality in Health Care, 25,* 261–269. http://dx.doi.org/10.1093/intqhc/mzt006

Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., . . . Escarce, J. J. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine, 340,* 618–626. http://dx.doi.org/10.1056/NEJM199902253400806

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Reed Meldrum, C. D. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science & Medicine, 75,* 2437–2445. http://dx.doi.org/10.1016/j.socscimed.2012.09.023

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70,* 477–486. http://dx.doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10,* 45–52. http://dx.doi.org/10.1177/001100008210202008

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60,* 525–548. http://dx.doi.org/10.1146/annurev.psych.60.110707.163651

Taylor, P. (2015). *The next America: Boomers, millennials, and the looming generational showdown*. New York, NY: Public Affairs.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9,* 117–125. http://dx.doi.org/10.1353/hpu.2010.0233

Weinrach, S. G., & Thomas, K. R. (2002). A critical analysis of the multicultural counseling competencies: Implications for the practice of mental health counseling. *Journal of Mental Health Counseling, 24,* 20–35.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62,* 563–574. http://dx.doi.org/10.1037/0003-066X.62.6.563

Wisch, A. F., & Mahalik, J. R. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling Psychology, 46,* 51–60. http://dx.doi.org/10.1037/0022-0167.46.1.51

Yancu, C. N., & Farmer, D. F. (2017). Product or process: Cultural competence or cultural humility. *Palliative Medicine and Hospice Care, 3,* e1–e4. http://dx.doi.org/10.17140/PMHCOJ-3-e005

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