Cultural Humility in Psychotherapy Supervision

JOSHUA N. HOOK, Ph.D.*
C. EDWARD WATKINS, JR., Ph.D.*
DON E. DAVIS, Ph.D.#
JESSE OWEN, Ph.D.†
DARYL R. VAN TONGEREN, Ph.D.‡
MARCIANA J. RAMOS, MS*

As a core component of multicultural orientation, cultural humility can be considered an important attitude for clinical supervisees to adopt and practically implement. How can cultural humility be most meaningfully incorporated in supervision? In what ways can supervisors stimulate the development of a culturally humble attitude in our supervisees? We consider those questions in this paper and present a model for addressing cultural humility in clinical supervision. The primary focus is given to two areas: (a) modeling and teaching of cultural humility through interpersonal interactions in supervision, and (b) teaching cultural humility through outside activities and experiences. Two case studies illustrating the model are presented, and a research agenda for work in this area is outlined.

KEYWORDS: psychotherapy supervision; humility; culture; multicultural competence; cultural humility

"The supervision encounter is really an encounter between the supervisor's, the therapist's, and the client's . . . *cultural maps* . . ."

—(Falicov, 2014, p. 32, italics in original)

INTRODUCTION

During the past 30 years, multicultural competence has become a major theme in the mental health professions (e.g., American Psychological Association [APA], 2003). The multicultural psychotherapy/counseling movement grew as researchers persuasively documented that racial/ethnic

* University of North Texas, Denton, TX; # Georgia State University, Atlanta, GA; † University of Denver, Department of Counseling Psychology, Denver, CO; ‡ Hope College, Psychology Department, Holland, MI. ***Mailing address:*** Joshua N. Hook, Ph.D., University of North Texas, 1155 Union Circle #311280, Denton, TX 76203. e-mail: joshua.hook@unt.edu

minority clients were not getting their needs met in psychological treatment (Gonzales & Papadopoulos, 2010; Miranda, McGuire, Williams, & Wang, 2008; U.S. Department of Health and Human Services, 2001). Accordingly, mental health professionals began to explore how to adapt dominant models of psychotherapy—which arose from a White, male perspective—to be more compatible with the values and worldview of clients from different cultural backgrounds. Models for education, training, research, practice, and organizational change attuned to and respectful of clients' cultural background have since been developed (APA, 2003). These models of multicultural competencies emphasized three components:

(a) self-awareness, which refers to developing an understanding of one's own cultural background and the ways in which it influences personal attitudes, values, and beliefs;
(b) knowledge, which refers to learning about the worldviews of individuals from diverse cultural backgrounds, and
(c) skills, which refers to utilizing culturally appropriate interventions (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue & Sue, 2012).

This model has received a considerable amount of attention, and many applied training programs have implemented coursework based on this model (Collins & Arthur, 2010).

Supervision is provided by a more senior professional to one in a more junior position, for enhancing professional functioning, monitoring the quality of professional services, and serving as a gatekeeper for the profession (Bernard & Goodyear, 2014; Falender, Shafranske, & Falicov, 2014a; Milne & Watkins, 2014). Scholars have recognized the supervision process as an integral component of training and the central opportunity to evaluate and enhance practical implementation of self-awareness, knowledge, and skills (Falender, Shafranske, & Falicov, 2014b; Tsui, O'Donohue, & Ng, 2014). Multicultural supervision, which attends to culture and diversity issues as a core component of supervision, can have a number of positive impacts on supervisee growth and development, such as enhancing multicultural knowledge and perceptions of the supervisory alliance (Inman, Hutman, Pendse, Devdas, Luu, & Ellis, 2014; Inman & Kreider, 2013; Soheilian, Inman, Klinger, Isenberg, & Kulpe, 2014). The importance of multicultural and intercultural competence is recognized internationally and incorporated into supervision competency frameworks around the globe (e.g., Falender, Cornish, Goodyear, Hatcher, Kaslow, Leventhal, & Grus, 2004; Pilling & Roth, 2014; Psychology Board of Australia, 2013). As Falender and Shafranske (2012) indicated, the value of

a multicultural supervision perspective for contemporary practice cannot be overestimated.

In addition to an appreciation for multicultural competence, mental health professionals also focus on complementary factors, such as one's multicultural orientation (Owen, Tao, Leach, & Rodolfa, 2011). When fleshed out, multicultural competencies have focused on *mastery* of specific awareness, knowledge, or skills, regarding a particular aspect of culture. In contrast, multicultural orientation involves professional *engagement* with a client. *Multicultural competencies* can be thought of as a "way of doing" various tasks in the psychotherapy setting, whereas *multicultural orientation* can be thought of as a "way of being" with clients. While emphasis regarding multicultural orientation has exclusively been in the treatment situation, we believe that multicultural orientation is readily applicable to the supervision situation. How the supervisor engages with a supervisee is eminently important for the process and outcome of supervision. But attention to that attitudinal element of the supervision process has thus far been minimal. Falender et al. (2014a) recently captured that seeming reality well: "Generally, two components of competence, knowledge and skills, have been primarily addressed in the literature on multicultural supervision. However, increasingly, concern has been raised that attitudes, which are at the core of competence, have been given inadequate attention" (p. 5). It may indeed be that such attention to attitudes and values is the key to helping supervisees develop greater multicultural competence (Falender et al., 2014a).

In efforts to define the relevance of multicultural orientation for the supervision experience, the focus has recently been directed toward *cultural humility*. This construct, more commonly used in the context of family medicine (Falicov, 2014), has recently gained attention for its role in psychotherapy and supervision conceptualization. Owen (2013) identified cultural humility as the core component of and foundation for implementation of a multicultural orientation. Cultural humility is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client [or supervisee]" (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354). Culturally humble individuals have a more accurate view of the self and greater awareness of their limitations; they maintain a respectful, other-focused perspective (Davis et al., 2011; Davis, Worthington, & Hook, 2010). Cultural humility involves an open and aware mindset (Falender, Shafranske, & Falicov, 2014c) and a lifelong commitment to self-examination and the redress of power imbalances in the client-

therapist-supervisor dynamic (Falender & Shafranske, 2012; Patel, 2012; Tervalon, & Murray-Garcia, 1998).

Below, we accentuate the role of cultural humility in the supervision process. As supervisors, how can we better incorporate cultural humility into our conceptualization and conduct of supervision? How can we help supervisees practice cultural humility in their work with clients? Because cultural humility is a crucial training-relevant attitude that has only recently begun to receive supervision emphasis (cf. Falender & Shafranske, 2012; Falender et al., 2014a; Falicov, 2014; Hook et al., 2013), those questions are important to address. First, we consider some guiding conceptual and empirical considerations about cultural humility. Second, we consider how supervisors can deliberately emphasize cultural humility in their supervision. Third, we discuss ways to help supervisees practice cultural humility with their clients. We also provide two case examples that illustrate the importance of cultural humility in supervision.

CONCEPTUAL AND EMPIRICAL CONSIDERATIONS OF CULTURAL HUMILITY

There has been some initial research about the role of cultural humility in psychotherapy. Hook et al. (2013) theorized that developing a strong working alliance with diverse clients depends on one's willingness to cultivate openness to the other person by regulating one's natural tendency to view one's beliefs, values, and worldview as superior. Indeed, the culturally humble therapist strives to cultivate a growing awareness that one is inevitably limited in knowledge and understanding of clients' cultural backgrounds. Awareness of one's limitations ought to motivate therapists to attune themselves to their clients' cultural background and experience. In a series of four studies Hook et al. (2013) found that clients viewed cultural humility as desirable, and cultural humility related significantly to the clients' ability to develop a strong therapeutic alliance and their ultimate improvement. A follow-up study by Owen and colleagues found that the cultural humility of the therapist toward religious beliefs and values positively related to client improvement, and this effect was strongest for clients with high levels of religious commitment (Owen et al., 2014). Although this research is in a preliminary stage, it is useful for supervisors as they instruct supervisees about the value of a culturally humble therapeutic presence, treatment implementation, and development of an appreciation of cultural issues that relevant for each client (Falicov, 2014).

We believe that Hook et al.'s (2013) conclusions about cultural humility in psychotherapy can be extended to the psychotherapy supervision situation. They may may be used in concert with available multicultural conceptualizations (e.g., American Psychological Association, 2014; Ancis & Ladany, 2010; Falender et al., 2014a; Fouad & Chavez-Korell, 2014; Patel, 2012). We propose that for supervisors to be effective and to build strong relationships with culturally diverse supervisees, supervisors must

(a) overcome the tendency to view their beliefs, values, and worldview as superior, and be open to the beliefs, values, and worldview of their supervisees, and
(b) strive to cultivate an awareness that they are limited in their knowledge and understanding of supervisees' cultural backgrounds and develop the motivation to attune themselves to their supervisees to understand the impact of cultural background and experience (cf. Bernard & Goodyear, 2014; Falender et al., 2014b; Inman & Kreider, 2013; Inman & Ladany, 2014; Tsui et al., 2014).

CULTURAL HUMILITY OF THE SUPERVISOR

We propose that cultural humility is an important feature of the supervisors' multicultural competence for three reasons. First, a supervisory stance of cultural humility contributes to the development of a strong working alliance with the supervisee and serves as an antidote to issues of cultural difference or microaggression that may emerge (Constantine & Sue, 2007; Sue, 2010). Second, because it can be quite difficult to help supervisees work on issues that we ourselves are not willing to address, it would seem crucial for supervisors to prioritize the development of cultural humility in themselves. Third, when supervisors engage supervisees with a stance of cultural humility, this may help supervisees to engage their clients with cultural humility. Pawl and St. John (1998) refer to such engagement as following the Platinum Rule: *Do unto others as you would have others do unto others (*p. 7). Put differently, the supervisor models behavior for the supervisee to emulate.

Culturally humble supervisors view themselves as always being in the process of multicultural learning—acknowledging having been raised in a particular culture and having a particular cultural worldview that likely has a set of built-in biases and blind spots. Furthermore, they strongly value exploring other perspectives and working to reduce biases or blind spots (Hawkins & Shohet, 2012; Patel, 2012). This stance stands in stark contrast to the "supervisor as an omniscient expert," and it accentuates the need for the supervisor to be a cultural learner in the supervision process.

Such a stance reflects a fundamental, foundational, and orientational mindset in which *belief* in, *commitment* to, and *esteem* of multiculturalism and its value in treatment *and* supervision reign supreme.

Culturally humble supervisors develop several habits in their interpersonal interactions between supervisor and supervisee. First, they are aware of cultural differences that may exacerbate the existing power differential of the supervisory relationship and how those may be accentuated by social identities (e.g., white supervisor working with a racial/ethnic minority supervisee). Additionally, they need to regulate their sense of superiority to avoid assumptions that may lead to identity offenses (Patel, 2012). Instead, they cultivate an attitude of openness, curiosity, and interest in the supervisee's perspective (Corey, Haynes, Moulton, & Muratori, 2010; Tsui et al., 2014), including proactively checking in with the supervisee regarding his or her cultural perspective. Falicov (2014) suggests that supervisors adopt a stance of being "open to learning from the supervisee about his or her cultural location . . . [and not assuming] cultural knowledge based on preconceived identity labels" (p. 32).

When engaging with supervisees from a culturally humble perspective, supervisors adopt an initiate-invite-instill approach. Namely, they make culture a welcome part of the supervisory conversation, *initiating* conversations about identity and cultural diversity regarding psychotherapy and supervision. In addition to initiating conversations about culture with supervisees, supervisors *invite* supervisees to freely and fully engage in and consider the ramifications of ongoing cultural dialogue (Vargas, Porter, & Falender, 2008; Yu, 2013). Modeling cultural humility and providing a supervisory context that prioritizes respectful dialogue about culture *instills* this value in supervisees. Supervisees learn and grow when they are in a culture-friendly space (Inman & Kreider, 2013; Inman & Ladany, 2014). According to prior research, supervisees—while valuing cultural conversations—perceive any such conversations to be rare in supervision and, if occurring at all, to not be supervisor initiated (Inman et al., 2014). An initiate-invite-instill approach can prove a helpful mindset and antidote in countering those undesired possibilities.

When initiating and inviting conversations about culture with a supervisee, conversations could be direct: "You and I have different cultural backgrounds, how do you think that influences our supervisory relationship? (Vargas et al., 2008). Or conversations may be more closely connected to the processes of client work "How do you think this client's racial/ethnic background impacts her/his presenting problem of anxiety?" (Harrell, 2014). Cultural discussions would ideally be infused into various

aspects of supervision discussion. For example, discussion of the supervisee's theoretical orientation could explore cultural factors that influence one's beliefs about change processes (Patel, 2012). Discussion about case conceptualization could lead to exploring the connection between a client's socio-cultural contexts and presenting problem (Fouad & Chavez-Korell, 2014). Discussion about treatment planning could incorporate cultural elements, and choices of interventions could be evaluated for whether or not they are consistent with the supervisee's and client's cultural background and view of the world (Falicov, 2014). In these discussions about culture, supervisors should strive to engage the supervisee with humility, being open to the supervisee's cultural perspective rather than viewing one's own cultural perspective as superior.

Supervisors can communicate cultural humility in supervision by being honest about their continuing journey toward cultural humility and admitting personal limitations when not understanding certain cultural issues that arise. Supervisors can be forthright when they need to look into those matters further. Supervisors can openly acknowledge the validity of different cultural viewpoints and that their opinions reflect but one particular position. (For recent material supporting these ideas, see Bernard & Goodyear, 2014; Corey et al., 2010; Falender et al., 2014b, 2014c; Patel, 2012; Tsui et al., 2014). Thus, openness, honesty, and transparency would be the watchwords that ideally permeate every aspect of supervisor behavior. With culture, everything can always be different, and the culturally humble supervisor recognizes and embraces that reality as integral to effective supervision practice.

HELPING SUPERVISEES CULTIVATE CULTURAL HUMILITY

The supervisor can also help the supervisee develop cultural humility via outside experiences and activities. Therapists-in-training enter graduate programs in psychology with various levels of multicultural experience, values, and competence. For example, some trainees may have grown up in families and neighborhoods where they were exposed to individuals who were different from them on a regular basis, whereas other trainees may have grown up in families and neighborhoods in which most individuals were similar to them. Likewise, some trainees may have strong interests and values toward diversity and social justice whereas other trainees may not be interested in these topics nor understand the importance of multicultural issues to effective treatment. Furthermore, trainees vary in their degree of cultural self-awareness, knowledge, and skills. Even if the supervisee is an advanced student who has already gone through

some coursework and training, training programs vary in their attitudes toward multicultural issues and how well they train graduate students in cultural issues (Dickson & Jepsen, 2007; Holcomb-McCoy & Myers, 1999).

When helping supervisees develop cultural humility via outside experiences and activities, supervisors can implement an assess-build-connect (ABC) approach. Because cultural humility involves an accurate view of one's strengths, weaknesses, and limitations, first help supervisees *assess* their strengths and weaknesses in counseling culturally diverse clients, including the development of an awareness of limitations, possible biases, or blind spots in fully understanding clients' cultural backgrounds. Accurate assessment of a supervisee's cultural strengths, weaknesses, and limitations should involve a combination of self-evaluation, supervisor evaluation, and observation of counseling behavior.

For supervisee self-evaluation, one excellent training exercise is to have supervisees construct a cultural genogram (Hardy & Laszloffy, 1995) and autobiography, in which supervisees explore the cultural beliefs and values of their family of origin. In this exercise, trainees write down the first names of their family members to two or three generations, and also describe the cultural background of each family member (e.g., gender, age, race, ethnicity, language, sexual orientation, religion, disability, socioeconomic status). Trainees can also explore the beliefs, attitudes, and values of their families of origin, describing their family of origin's beliefs and attitudes on topics such as money, possessions, crises, fun, sex roles, education, work, religion, and diversity. Identifying the beliefs, attitudes, and values of their family of origin (and the degree to which the trainee has adopted the same beliefs, attitudes, and values) helps the trainee to acknowledge his or her cultural perspective rather than view one's worldview as universal. This exercise also helps supervisees identify experiences that may have contributed to positive or negative feelings toward particular cultural groups. When supervisees become aware of biases or blind spots they may hold, these biases or blind spots can be discussed and explored in supervision.

In addition to helping supervisees conduct a self-assessment of their cultural strengths, weakness, and limitations, supervisors will need to give direct feedback to supervisees about their strengths, weaknesses, and limitations in working with culturally diverse clients. Indeed, cultural humility may be a characteristic that is difficult for individuals to recognize and accurately self-report (Davis et al., 2010). Supervisors should establish norms early on in supervision that make both positive and negative

feedback a normal part of the supervision process. Ideally, such feedback would be framed as normative for a developing therapist, and shared within the context of a strong working relationship between supervisor and supervisee.

Finally, in addition to supervisee's self-assessment and supervisor's feedback about cultural humility, the assessment of cultural humility should involve observation (e.g., direct observation, videotape or audiotape review) of the supervisee's clinical work, to identify behaviors that indicate cultural humility (or not). Observation of the supervisee's clinical work may be especially important in assessing cultural humility because supervisees may be able to discuss cultural humility in supervision without being able to apply these principles effectively and appropriately with clients. Indeed, it has been our experience that trainees often feel pressure to present themselves as 'culturally competent' and hesitate to explore and admit limitations or biases in their work with diverse clients.

When observing a supervisee's clinical work, culturally humble behaviors might include: asking open-ended questions that aim to explore or better understand a client's cultural background and experience, explicitly acknowledging one's lack of understanding or desire to understand, and making responses that directly communicate respect for a client's cultural background and experience. Behaviors that indicate a lack of cultural humility might include: making a comment that communicates an assumption about a client's cultural background, failing to address a cultural issue when it comes up in therapy, and making responses that communicate a lack of respect for a client's cultural background and experience.

After the supervisor and supervisee work to assess the supervisee regarding cultural humility, the second area of focus is to work collaboratively to *build* a plan to work proactively on cultural humility. Building a plan is integral to cultural humility because it requires the supervisee to acknowledge limitations and areas for growth. The plan should be tailored to the specific cultural strengths and weaknesses identified in the assessment step. Ideally, the plan would involve both building on identified strengths and working to bring identified weaknesses up to an adequate level of competency. For example, to further enhance self-awareness, the supervisor could suggest additional exploration or understanding of the supervisee's own cultural background, beliefs, and values. The supervisor could recommend coursework or training to target particular areas of weakness. Personal therapy could be an avenue to help supervisees work through possible blind spots or biases.

The third area of focus, perhaps the most important aspect of building a plan to work on cultural humility, is broadly based on the contact hypothesis (Allport, 1954; Pettigrew & Tropp, 2006) and encourages the supervisee to *connect* with culturally different individuals and groups. The supervisor can help the supervisee improve cultural humility by encouraging supervisees to put themselves in situations where they can have positive contact with individuals who are different from them. This contact ideally can occur both inside and outside the context of the training program. Inside the context of the training program, supervisees could request diverse clients and participate in practicum settings in which there is a high percentage of diverse clients. Outside the context of the training program, supervisees could deliberately place themselves in situations where they are likely to learn and engage with people who are different from them. This may be especially important for cultural issues identified as weaknesses in the assessment phase. For example, if a supervisee has identified an aspect of diversity about which he or she knows little or has negative biases, the supervisee could make a commitment to learn about that particular cultural group by joining a group or activity focused on that culture or developing relationships with members of that cultural group. When engaging with members of different cultural groups, the focus should be on humble learning and positive engagement. The contact hypothesis works best when interactions are with typical group members of equal status, and considered to be positive. It may be especially important for trainees to engage with culturally different individuals and groups *from a position of equal status.* It is common for individuals to engage with culturally different individuals and groups from a position of 'helper' or 'expert.' This position of engagement often still regards one's cultural worldview as superior. Instead, trainees can be encouraged to approach these cultural encounters with humility, working to remain open to the possibility that others may have equally valid ways of perceiving and experiencing the world, especially regarding issues about which one feels the strongest convictions.

SUPERVISION CASE EXAMPLES

We now present two supervision case examples. The first example describes a supervision situation in which cultural humility was absent. The second example describes a supervision situation in which cultural humility was present. These examples are based on actual supervision events. However, case information has been modified to protect the

identities of the involved parties and to highlight the role of cultural humility.

Case I

Supervisor

The supervisor was a Caucasian female in her late 30s with a doctoral degree in clinical psychology. She identified with cognitive-behavioral theory, had supervised at a community mental health center for several years, and was held in high regard by colleagues for her treatment and supervision work.

Supervisee

The supervisee was an African American female in her late 20s. She was a fifth-year doctoral student in a clinical psychology program.

Client

The client was a married male in his 40s of Mexican ethnicity, with no previous mental health history. The client presented with symptoms of depression and stress. He attributed these to difficulty in protecting his family from what he termed "Americanization." He described this as dressing and acting in ways that conflicted with his conservative Catholic views and cultural values, and in their building strong friendships with people outside the family.

The Supervision Process

During initial supervision meetings, the supervisor and supervisee worked to conceptualize stresses related to issues of acculturation that the client described in session. Supervision focused on two goals: helping the client come to terms with the fact that his wife and daughters were changing and considering how he could better cope with that reality. As treatment progressed, however, the supervisee began to feel as if work with the client was stagnating. The client seemed less involved, had more difficulty talking in a session, and did not appear as emotionally invested. The supervisee increasingly reflected on her work with this client, wondered why treatment had taken this unfortunate turn, and considered how she might be contributing to that stagnation. Building a strong rapport, something that typically came naturally for her, had proven difficult with this client. But why? She also noticed that she and the client often held very different opinions about some treatment concerns (e.g., desirability/undesirability of social contact outside the family). In the process of this self-reflection, the supervisee wondered how her American cultural views and values might be affecting the work of treatment. Was she able to truly

understand the client's perspective and experience of the world? Was the cognitive therapy approach that she was using a good fit for the client?

The supervisee decided to discuss these issues in supervision and brought up the cultural concerns with her supervisor. But the supervisor was uninterested and dismissed the supervisee's cultural concerns, saying that "Your client is just being a man . . . and a Mexican man at that." The supervisor said that the client's behavior—lacking openness to others' perspectives, wanting to dominate and control, and believing that he was always right—was a reflection of why men, particularly men with a Mexican cultural background, did not go to therapy. Lack of therapeutic progress was attributed to the client's supposedly holding therapy-incongruent cultural values. When the supervisee raised some questions about "the Mexican man" reference and what specifically that meant, the supervisor became defensive, described progress with this client as ultimately being an unrealistic goal, and told the supervisee to do the best she could for the remaining sessions. From that point forward, the supervisee never brought up matters of culture with this supervisor.

Case I: Discussion/Comment

In this example, the supervisor lacked cultural humility in several ways. She (a) dismissed the importance of culture and the client's cultural background; (b) made automatic, negative assumptions about key features of the client's character; and (c) made negative presumptions about the client's goals for therapy and his ability to achieve those goals. She also relied solely upon personal beliefs/experiences as her preeminent data source rather than seeking material about providing culturally competent therapy to clients of Mexican heritage.

Furthermore, in disregarding the supervisee's cultural reflections and concerns, the supervisor modeled cultural arrogance. The supervisor did not support and value the supervisee in bringing up the cultural issues for discussion; rather, the supervisor negated the supervisee's concerns and viewed her own cultural perspective as superior. Furthermore, the supervisor did nothing to reinforce the supervisee's appreciation of the impact of culture on psychotherapy and, thereby, may have impeded the development and growth of both the client and supervisee.

Case II

Supervisor

The supervisor was a Caucasian male in his mid 40s with a doctoral degree in counseling psychology. He identified theoretically with psychodynamic therapy, had been supervising in a community mental health

center for about 15 years, and colleagues held him in high regard for his treatment and supervision work.

Supervisee

The supervisee was a Caucasian male in his late 20s. He was a fifth-year doctoral student in a counseling psychology program.

Client

The client was a single Asian American female in her early 30s. The client presented with symptoms of anxiety and depression that she attributed to difficulty keeping up with her college course work. She said that she wanted to "feel better" and hoped therapy would help her in doing that.

The Supervision Process

During the first supervision meeting, the supervisor brought up the matter of culture and asked the supervisee if he had any initial reactions to working with an Asian American client. The supervisee shared that he had very limited experience working with Asian Americans clients and wondered what his client would think of him as a Caucasian male. The supervisor empathized with the supervisee's concerns and then shared his experiences in working with Asian American clients. Specifically, he explained that he also had similar concerns and doubts about his abilities when he began working with people of cultural backgrounds different from his own. He emphasized the critical roles that awareness, consultation, and research play in helping practitioners to navigate cross-cultural therapeutic experiences. He stressed the importance of recognizing and acknowledging one's limitations and seeking help and assistance. Next, he provided the supervisee with some readings on culturally competent therapy with Asian American clients and asked for those to be read. The supervisor noted the importance of learning about the client's cultural background, but also balancing that knowledge with the realization that the client's specific cultural background and experience is unique. Throughout the supervision process, the supervisor made a point to keep multicultural concerns at the forefront of consideration and worked to help the supervisee tailor a treatment approach that would be most consistent with and sensitive to the client's cultural worldview. For example, the supervisor encouraged the supervisee to ask the client about her values, and how those values influenced her presenting problem and goals for therapy. The client's work ethic and values learned from her family and culture were woven throughout the therapy discussion about her aca-

demic, professional, and personal self-expectations. The open cultural dialogue was useful in helping the client gain better insight into her expectations and to identify ways in which her anxiety and stress could be de-escalated. The supervisor also asked the supervisee to consider his values, and how those values matched (or did not match) the client's values. The supervisee's process of reflecting on his values helped ensure the supervisee would not impose his values and worldview on the client.

Case II. Discussion/Comment

In this example, the presence of cultural humility can be observed in several ways. The supervisor (a) readily acknowledged the importance of culture and the client's cultural background; (b) encouraged the supervisee to equip himself through new learning experiences, such as reading materials about Asian-American clients in psychotherapy; and (c) discouraged making automatic character/ability assumptions about the client. He also (d) assigned supreme significance to understanding the client as a unique, culturally-embedded individual (i.e., understanding the other's perspective); and he encouraged (e) making the client and her perceptions, views, and experiences the preeminent data source for any and all treatment actions and interventions.

Furthermore, the supervisor modeled a culturally humble supervisory stance, made culture an integral part of both the treatment *and* supervision experiences and potentially contributed to the development and growth of both the patient and supervisee.

AREAS FOR FUTURE RESEARCH

Based on our theoretical framework, which suggests the importance of cultural humility in supervision, we believe a multifaceted research agenda is warranted. Indeed, although mental health professionals have begun to acknowledge that multicultural issues are relevant to the supervisory process, more research is clearly needed in this area (Inman et al., 2014; Watkins, 2014). First, researchers could explore the extent to which supervisors are culturally humble, and compare the possible differences in supervision outcomes between humble and less humble supervisors. There has been no existing research on this particular construct in the context of supervision. Based on research in psychotherapy, we predict that supervisors who are more culturally humble should be better able to form a strong working alliance with supervisees, especially when there are cultural differences between supervisor and supervisee. Furthermore, we predict that supervisors who are more culturally humble are less likely to engage

in microaggressions toward the supervisee, and are better able to repair the relationship with supervisees when it is damaged.

Second, researchers could explore how and in what situations a supervisor modeling process, where desired supervisor behaviors are displayed and come to be enacted in the therapist-client dyad, occurs regarding cultural humility and attitudes toward diversity. We predict that supervisors who engage supervisees with an interpersonal stance of cultural humility may help supervisees engage their clients with cultural humility because the interpersonal processes of supervision may be mirrored in the supervisee's work in psychotherapy.

Third, researchers could explore how supervisors engage in conversations with supervisees about culture and cultural humility. For example, researchers could explore the effectiveness of various strategies to discuss cultural humility with supervisees (e.g., direct discussion of culture and cultural differences, connecting discussions of culture to therapeutic or supervisory processes). Researchers could explore how supervisees respond when supervisors initiate conversations about culture and invite supervisees to engage in cultural discussions, and whether these strategies instill cultural humility in supervisees.

Finally, researchers could explore the efficacy and effectiveness of various strategies for helping supervisees develop cultural humility when working with clients. Our recommendations for intervention focused on an assess-build-connect (ABC) model. Research on the assessment step could focus on various strategies to help supervisees acknowledge and explore their limitations to understand a client's particular cultural background and experience, including possible biases or blind spots they may have in their particular cultural worldview (e.g., self-assessment, supervisor feedback, observation of clinical work). Research on the build step could focus on the effectiveness of various plans to improve cultural humility, as well as how such plans are developed (e.g., collaborative vs. unilateral). Research on the connecting step could focus on the contact hypothesis (Allport, 1954; Pettigrew & Tropp, 2006), which has shown that positive contact with culturally different individuals can improve attitudes toward those individuals. Researchers could assess the effectiveness of engaging in opportunities to broaden supervisee's network of interactions, both inside and outside the training program, to improve attitudes toward culturally different individuals. Single-case studies, as well as more in-depth experimental designs, could be developed to test the efficacy and effectiveness of various interventions designed to improve cultural humility in supervisees.

CONCLUSION

As Collins and Arthur (2010) indicated, "Culture must be located at the center of all work with clients . . ." (p. 204). It is important for therapists to become effective in helping all clients, especially those clients from diverse backgrounds. Thus, it is important to explore how training programs can help trainees develop a strong multicultural orientation that values diversity. To develop multicultural orientation in supervision, we posit that culture must also be located at the center of all work with supervisees. One important aspect of multicultural orientation is developing a sense of cultural humility. A multiculturally-informed supervision framework can be one important way that training programs help trainees develop cultural humility (cf. Soheilian et al, 2014).

Acknowledgment: We would like to acknowledge the generous financial support of Fuller Theological Seminary / Thrive Center in concert with the John Templeton Foundation (Grant No. 108), as well as the John Templeton Foundation (Grant No. 14979). The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Fuller Thrive Center or the John Templeton Foundation.

REFERENCES

Allport, G. W. (1954). *The nature of prejudice.* Reading, MA: Addison-Wesley.

American Psychological Association (2003). Guidelines for multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402.

American Psychological Association (2014). *Guidelines for clinical supervision in health service psychology*. Retrieved from: http://apa.org/ed/resources/index.aspx

Ancis, J. R., & Ladany, N. (2010). A multicultural framework for counseling supervision. In N. Ladany & L. J. Bradley (Eds.), *Counselor supervision: Principles, process, and practice* (4th ed., pp. 53-95). Philadelphia: Brunner-Routledge.

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Upper Saddle River, NJ: Merrill.

Collins, S., & Arthur, N. (2010). Culture-infused counselling: A fresh look at a classic framework of multicultural counselling competencies. *Counselling Psychology Quarterly, 23*, 203-216.

Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*, 142-153.

Corey, G., Haynes, R., Moulton, P., & Muratori, M. (2010). *Clinical supervision in the helping professions* (2nd ed.). Alexandria, VA: American Counseling Association.

Davis, D. E., Hook, J. N., Worthington, E. L., Jr., Van Tongeren, D. R., Gartner, A. L., Jennings, D. J., II., & Emmons, R. A. (2011). Relational humility: Conceptualizing and measuring humility as a personality judgment. *Journal of Personality Assessment, 93,* 225-234.

Davis, D. E., Worthington, E. L., Jr., & Hook, J. N. (2010). Humility: Review of measurement strategies and conceptualization as a personality judgment. *Journal of Positive Psychology, 5,* 243-252.

Dickson, G. L., & Jepsen, D. A. (2007). Multicultural training experiences as predictors of multicultural competencies: Students' perspectives. *Counselor Education and Supervision, 47*, 76-95

Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., Shafranske, E., & Sigmon, S. T. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60*, 771-785.

Falender, C. A., & Shafranske, E. P. (2012). *Getting the most out of clinical training and supervision: A guide for practicum students and interns*. Washington, DC: American Psychological Association.

Falender, C. A., Shafranske, E. P., & Falicov, C. (2014a). Diversity and multiculturalism in supervision (pp. 3-28). In C. A. Falender, E. P. Shafranske, E. P., & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falender, C. A., Shafranske, E. P., & Falicov, C. (Eds.). (2014b). *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falender, C. A., Shafranske, E. P., & Falicov, C. (2014c). Reflective practice: Culture in self and other (pp. 273-281). In C. A. Falender, E. P. Shafranske, E. P., & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falicov, C. J. (2014). Psychotherapy and supervision as cultural encounters: The multidimensional ecological comparative framework (pp. 29-58). In C. A. Falender, E. P. Shafranske, E. P., & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Fouad, N. A., & Chavez-Korell, S. (2014). Considering social class and socioeconomic status in the context of multiple identities: An integrative clinical supervision approach (pp. 145-162). In C. A. Falender, E. P. Shafranske, E. P., & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Gonzales, J. J., & Papadopoulos, A. S. (2010). Mental health disparities. In B. L. Levin, K. D. Hennessy, & J. Petrila (Eds.), *Mental health services: A public health perspective* (pp. 443-464). New York, NY: Oxford University Press.

Hardy, K. V., & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy, 21*, 227-237.

Harrell, S. P. (2014). Compassionate confrontation and empathic exploration: The integration of race-related narratives in clinical supervision (pp. 83-110). In C. A. Falender, E. P. Shafranske, E. P., & C. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Hawkins, P. & Shohet., R. (2012). *Supervision in the helping professions: An individual, group and organizational approach* (4th ed.). Berkshire: Open University Press.

Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling and Development, 77*, 294-302.

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.

Inman, A. G., Hutman, H., Pendse, A., Devdas, L., Luu, L., & Ellis, M. V. (2014). Current trends concerning supervisors, supervisees, and clients in clinical supervision. In C. E. Watkins, Jr., & D. Milne (Eds.), *Wiley international handbook of clinical supervision* (pp. 61-102). Oxford, UK: Wiley.

Inman, A. G., & Kreider, E. D. (2013). Multicultural competence: Psychotherapy practice and supervision. *Psychotherapy, 50*, 346-350.

Inman, A. G., & Ladany, N. (2014). Multicultural competencies in psychotherapy supervision. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology: Applications and training* (Vol. 2; pp. 643-658). Washington, DC: American Psychological Association.

Milne, D., & Watkins, C. E., Jr. (2014). Defining and understanding clinical supervision: A functional approach. In C. E. Watkins, Jr., & D. Milne (Eds.), *Wiley international handbook of clinical supervision* (pp. 3-19). Oxford, UK: Wiley.

Miranda, J., McGuire, T. G., Williams, D. R., & Wang, P. (2008). Mental health in the context of health disparities. *The American Journal of Psychiatry, 165,* 1102-1108. doi:10.1176/appi.ajp.2008.08030333

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*, 496-502.

Owen, J., Jordan, T. 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., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*, 274-282.

Patel, N. (2012). Difference and power in supervision: The case of culture and racism. In I. Fleming & L. Steen (Eds.), *Supervision and clinical psychology: Theory, practice and perspectives* (2nd ed.; pp. 96-117). London: Routledge.

Pawl, J. H., & St. John, M. (1998). *How you are is as important as what you do in making a positive difference for infants, toddlers, and their families*. Washington, DC: ZERO TO THREE Press.

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology, 90*, 751-783.

Pilling, S., & Roth, A. D. (2014). The competent clinical supervisor. In C. E. Watkins, Jr., & D. Milne (Eds.), *Wiley International handbook of clinical supervision* (pp. 3-19). Oxford, UK: Wiley.

Psychology Board of Australia. (2013). *Guidelines for supervisors and supervisor training providers*. Retrieved October 8, 2014 from http://www.psychologyboard.gov.au/Registration/Supervision.aspx.

Soheilian, S. S., Inman, A. G., Klinger, R. S., Isenberg, D. S., & Kulpe, L. E. (2014). Multicultural supervision: Supervisees' reflections on culturally competent supervision. *Counselling Psychology Quarterly*. (available online)

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477-486.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pederson, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Sue, D. W., & Sue, S. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

Tervalon, M., & Murray-Garcia, 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.

Tsui, M., O'Donoghue, K., & Ng, A. K. T. (2014). Culturally-competent and diversity-sensitive clinical supervision: An international perspective. In C. E. Watkins, Jr., & D. L. Milne (Eds.), *Wiley international handbook of clinical supervision* (pp. 238-254). Oxford, UK: Wiley.

U.S. Department of Health and Human Services (2001). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups.* Rockville, MD: U.S.

Vargas, L. A., Porter, N., & Falender, C. A. (2008). Supervision, culture, and context. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 121-136). Washington, DC: American Psychological Association.

Watkins, C. E., Jr. (2014). Clinical supervision in the 21st century: Revisiting pressing needs andimpressing possibilities. *American Journal of Psychotherapy*, *68,* 251-272.

Watkins, C. E., Jr., & Milne, D. (Eds.). (2014). *Wiley international handbook of clinical supervision*. Oxford, UK: Wiley.

Yu, A. (2013). *Stop erring on the side of caution: Begin addressing diversity*. Presentation given at the Ninth International Interdisciplinary Conference on Clinical Supervision, Adelphi University, Garden City, NY.