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Cultural Humility: Measuring Openness to Culturally Diverse Clients

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Building on recent theory stressing multicultural orientation, as well as the development of virtues and dispositions associated with multicultural values, we introduce the construct of cultural humility, defined as having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience. In 4 studies, we provide evidence for the estimated reliability and construct validity of a client-rated measure of a therapist's cultural humility, and we demonstrate that client perceptions of their therapist's cultural humility are positively associated with developing a strong working alliance. Furthermore, client perceptions of their therapist's cultural humility were positively associated with improvement in therapy, and this relationship was mediated by a strong working alliance. We consider implications for research, practice, and training.

Keywords: humility, multicultural orientation, outcome

In recent years, psychologists have recognized the importance of developing multicultural competencies (MCCs) in the areas of education, training, research, and practice (American Psychological Association [APA], 2003). There are three main components of MCCs: attitudes/beliefs, knowledge, and skills (D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1982). APA MCCs guidelines encourage psychologists to (a) develop an understanding of their own cultural background and the ways that their cultural background influences their personal attitudes, values, and beliefs (i.e., attitudes/beliefs); (b) develop understanding and knowledge of the worldviews of individuals from diverse cultural backgrounds (i.e., knowledge); and (c) use culturally appropriate interventions (i.e., skills). This tripartite model has greatly influenced the research, practice, and training of psychologists.

Although the field of MCCs has received increasing research attention over the past 30 years, researchers have called for (a) innovations in the measurement of MCCs and (b) increased research linking MCCs to actual client improvement (Worthington, Soth-McNett, & Moreno, 2007). Measurement concerns in this field include (a) reliance on therapist-report measures (Worthington et al., 2007); (b) lack of association between therapist-reported MCCs, client-reported MCCs, and observer-rated MCCs (Constantine, 2001; Fuertes et al., 2006; Worthington, Mobley, Franks, & Tan, 2000); and (c) conflation of therapist-report measures of MCCs and therapist efficacy for conducting culturally sensitive counseling (Constantine & Ladany, 2001).

Some researchers have suggested a shift from measuring therapists' MCCs to measuring therapists' multicultural orientation (MCO; Owen, Tao, Leach, & Rodolfa, 2011). Whereas MCCs might assess how well a therapist has mastered specific knowledge or skills for working with a culturally diverse client, MCO might assess a therapist's "way of being" with the client, guided by the therapist's philosophy or values about the salience of cultural factors in the lives of therapists and clients. In contrast to MCO, MCCs can be conceptualized as "ways of doing" that assess how competent a therapist is at implementing cultural awareness, knowledge, and skills into therapy (Owen et al., 2011). Related to this shift from competencies to orientation, others have identified virtues or dispositions for therapists that align with the values of diversity in the field of counseling psychology (Winterowd, Adams, Miville, & Mintz, 2009). For example, Fowers and Davidov (2006) argued that the primary virtue necessary for multiculturalism is openness to the other.

This multicultural focus on openness to the other is closely related to the concept of humility. In their review of definitions of humility, Davis, Worthington, and Hook (2010) noted that definitions of humility generally included both intrapersonal and interpersonal components. On the intrapersonal dimension, humble individuals have an accurate view of self. On the interpersonal

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dimension, humble individuals are able to maintain an interpersonal stance that is other-oriented rather than self-focused, characterized by respect for others and a lack of superiority (Davis et al., 2011). In the present study, we focus on the interpersonal dimension, which we view as potentially more relevant to the therapy relationship and better able to be accurately perceived (and rated) by the client (Funder, 1995; Vazire, 2010). Furthermore, humility may be especially important in order to develop a strong bond in a situation in which relationship partners may have a strong tendency to value their own perspective (e.g., cultural differences; Davis et al., 2013). We posit that for a therapist to develop a strong working relationship and conduct effective counseling with a client who is culturally different, the therapist must be able to overcome the natural tendency to view one's own beliefs, values, and worldview as superior, and instead be open to the beliefs, values, and worldview of the diverse client.

The purpose of the present studies was to develop a client-rated measure of cultural humility as a component of MCO. Namely, we were interested in the degree to which clients perceived their therapists as expressing humility in regard to central aspects of cultural identity such as gender, race/ethnicity, sexual orientation, or religion/spirituality. Therapists have their own beliefs, values, and worldviews that likely guide how they understand psychological distress and how people make changes in their lives. Therapists who do not create a therapeutic environment that is open to different beliefs, values, and worldviews may struggle to work effectively with diverse clients. Cultural humility may help counteract and regulate the sense of superiority that may occur when cultural differences arise in therapy. As such, c*ultural humility* involves 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. Cultural humility is especially apparent when a therapist is able express respect and a lack of superiority even when cultural differences threaten to weaken the therapy alliance. Culturally humble therapists rarely assume competence (i.e., letting prior experience and even expertise lead to overconfidence) for working with clients just based on their prior experience working with a particular group. Rather, therapists who are more culturally humble approach clients with respectful openness and work collaboratively with clients to understand the unique intersection of clients' various aspects of identities and how that affects the developing therapy alliance.

The concept of cultural humility is not entirely new. Tervalon and Murray-Garcia (1998) contrasted the concept of cultural humility with MCCs in the field of health care. They noted that whereas MCCs have traditionally focused on building knowledge of multicultural content areas, cultural humility requires practitioners to engage in self-reflection and self-critique as lifelong learners. Similarly, S. Sue (1998) has encouraged therapists to develop scientific mindedness when working with clients from diverse backgrounds. Thus, therapists should make hypotheses rather than jump to premature conclusions when working with clients from diverse backgrounds. Ridley, Mendoze, Kanitz, Angermeier, and Zenk (1994) have encouraged therapists to develop cultural sensitivity, which involves seeking out, perceiving, and interpreting cultural information from clients. Ridley et al. note that it is impossible to understand an individual on the basis of his or her cultural background alone. Rather, therapists should accept their naiveté in regard to their assumptions about clients from diverse backgrounds.

Thus, although the idea of cultural humility has been previously discussed, models on the development of MCCs (and the existing instruments) have focused primarily on helping therapists build and develop competencies (i.e., self-awareness, knowledge, and skills). Rather than focusing on specific competencies, our conceptualization of cultural humility can be categorized as a virtue or disposition that comprises one's MCO. Paradoxically, therapists who are culturally humble not only strive to be effective but also cultivate a growing awareness that they are inevitably limited in their knowledge and understanding of a client's cultural background, which motivates them to interpersonally attune themselves to the client in a quest to understand the individual client's cultural background and experience.

Consistent with past theory and research, client perceptions of their therapist's cultural humility should be associated with strong working alliances as well as predict therapy outcomes. Past studies have found that client perceptions of their therapist's MCO are related to a strong working alliance (e.g., Constantine, 2007; Fuertes et al., 2006; Li & Kim, 2004), and working alliance has been found to mediate the relationship between MCO and therapy outcomes (Owen, Tao, et al., 2011). Cultural humility is likely to have a positive association with working alliance because the client is likely to develop a sense of trust and safety with a therapist who engages with his or her cultural background with an interpersonal stance of openness rather than superiority. Moreover, a strong alliance can serve as a buffer between therapists' missteps (e.g., microaggressions) and therapy outcomes (Constantine, 2007; Owen, Imel, et al., 2011; Owen, Tao, & Rodolfa, 2010).

The Present Study

In the present study, we first examined whether there is evidence for the importance of the cultural humility construct. We conducted an analogue pilot study that assessed the extent to which individuals believed that cultural humility was important when seeking a prospective therapist. We hypothesized that cultural humility would be rated as more important than other aspects of MCCs (e.g., knowledge, skills).

Second, we developed a brief measure of cultural humility. We hypothesized that our measure of cultural humility would show initial evidence of reliability and validity. Specifically, we hypothesized that our measure of cultural humility would have simple factor structure, internal consistency estimates above .70, concurrent validity with client reports of MCCs and working alliance, and predictive validity based on therapy outcomes.

Although there are a plethora of measures related to MCCs, we focused on the Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991) because it is widely used and is the only measure that assesses MCCs from the client's perspective (Constantine, 2002, 2007; Fuertes & Brobost, 2002; Fuertes et al., 2006; Li & Kim, 2004; Owen, Leach, Wampold, & Rodolfa, 2011; Owen, Tao, et al., 2011). The CCCI-R was originally developed as a measure to be completed by supervisors or other trained observers; however, it has also been used to assess client reports of a therapist's MCCs. The CCCI-R has some possible limitations as a client-report measure of MCCs. Namely, the content validity of the client-rated CCCI-R is not well

understood (Drianne & Owen, 2013). Furthermore, studies have generally analyzed the total score of the measure, and thus it is unknown whether the subscales reflect the tripartite model (e.g., Fuertes et al., 2006; Li & Kim, 2004; Owen, Leach, et al., 2011). In fact, Owen, Tao et al. (2011) argued that the CCCI-R is actually a better measure of MCO than MCCs. Beyond the CCCI-R, the only other client-rated measure related to MCCs or MCO are microaggression measures, which have limited data supporting their use and also have psychometric concerns (see Owen, Imel, et al., 2011; Owen, Tao, et al., 2011).

We also examined initial evidence for our primary theoretical hypothesis—namely, clients who perceive their therapists as more culturally humble will have better therapy outcomes, and this relationship will be mediated by working alliance. This hypothesis extends prior theory on the importance of humility for the strengthening of relationship bonds (Davis et al., 2013). In the context of therapy, cultural differences may make it more difficult to form a strong working alliance, but cultural humility may counteract this tendency for cultural differences to interfere with the formation of a working alliance. Related to this point, to provide evidence of incremental predictive validity, we hypothesized that cultural humility would be positively associated with working alliance, even when controlling for a measure of MCCs.

The Pilot Study

The purpose of the pilot study was to gather initial evidence that individuals perceive cultural humility as an important aspect of a therapist. Our main hypothesis was that participants would report that a therapist's cultural humility would be important to them in seeking a prospective therapist and that cultural humility would be more important to them than would other aspects of a therapist that have been associated with MCCs (e.g., similarity, experience, knowledge, and skills).

Method

Participants

Participants were 117 college students (31 men, 84 women, two indicated "other") from a large university in the southwestern United States. Participants ranged in age from 18 to 52 years (M = 23.4, SD = 6.4). Participants reported a variety of racial backgrounds (29.9% White, 38.5% Black, 7.7% Asian, 21.4% Latino, 0.9% Native American, and 1.7% multiracial). Participants were predominantly heterosexual (95.7%, 0.9% gay/lesbian, 3.4% bisexual). Of the participants, 8.5% were currently attending therapy, and 38.5% had attended therapy at some point in their lives.

Measures

Cultural background. Participants identified the aspect of their cultural background that was most central or important based on the following question: "Please identify the aspect of your cultural background that is the most central or important to you. If you do not feel comfortable disclosing this aspect of your cultural background, please write 'Not Comfortable.'" This question was an open-ended question.

Therapist characteristics. Participants rated a series of therapist characteristics that are associated with MCCs (i.e., similarity, experience, knowledge, skills, humility). We defined each characteristic for participants, and also provided participants with an example of each characteristic. For each characteristic, participants thought about the aspect of their cultural background that was most important to them and reported how important it would be that their therapist had that characteristic from 1 = *not at all important* to 9 = *very important.* For example, if participants had reported that race was the aspect of their cultural background that was most central and important, participants would rate how important it would be that their therapist (a) was similar in race, (b) had a large amount of experience working with other individuals from that race, (c) had a large amount of knowledge about issues related to that race, (d) had developed specific skills for working with individuals from that race, and (e) was humble in regard to the client's race. These five ratings were analyzed separately.

Therapy scenario. Participants were asked to imagine they were attending therapy and were given a description of a therapist. The descriptions of the therapist were created by the first author and varied in level of knowledge (high/low) and humility (high/low) toward the client's cultural background (see Appendix A for a description of the four scenarios). Participants then completed three items regarding their expectations for therapy. First, participants rated their confidence that they would be able to develop a good relationship with the therapist from 1 = *not at all confident* to 9 = *very confident.* Second, participants rated the expected effectiveness of therapy at resolving their problems from 1 = *not at all effective* to 9 = *very effective.* Third, participants rated the likelihood they would continue therapy with this therapist from 1 = *not at all likely* to 9 = *very likely*.

Procedure

We recruited participants from undergraduate courses, who participated in exchange for a small amount of course credit and a gift card. The questionnaires were completed online via SurveyMonkey. Participants read a consent form that explained the procedures of the study and their rights as a participant. Participants then indicated consent and completed the questionnaires. Participants were randomly assigned to one of four conditions. The four conditions were identical except for the therapy scenario. Specifically, participants first rated the importance of the therapist characteristics. Next, they read the therapy scenarios and answered questions about the hypothetical therapy scenario. After completing the questionnaires, we debriefed participants and gave them course credit and a gift card for their participation.

Results and Discussion

Prior to conducting the primary statistical analyses, we checked the data for assumptions. There were no problems with outliers or normality. Participants reported a variety of aspects of culture that were most central or important to them (18.8% race, 7.7% nationality, 4.3% gender, 1.7% sexual orientation, 15.4% religion, 2.6% socioeconomic status, 0.9% language, 17.1% family, 16.2% other, 13.7% did not wish to share, 1.7% none).

Our main hypothesis was that participants would report that cultural humility was important to them when seeking a prospec-

tive therapist and that cultural humility would be more important than other therapist characteristics typically associated with MCCs (e.g., similarity, experience, knowledge, and skills). We tested this hypothesis using participants' ratings of therapists and responses to therapy scenarios. For these analyses, we excluded participants who said the most important aspect of their cultural background was their family, other, did not wish to share, or none. We made this decision because some of the questions may not be applicable for these participants. For example, it may not make sense for participants to expect that their therapist would have a large amount of knowledge about their particular family. We excluded 57 participants, leaving 60 participants for the primary analyses (cell sizes ranged from 11 to 19 participants per condition). Participants in this subsample of 60 were 83.3% female and 26.7% White.

Using ratings of therapist characteristics, participants reported that the cultural humility of a therapist was very important (M = 7.33, SD = 2.01). Participants rated cultural humility as more important than similarity (M = 5.15, SD = 2.81, t = 5.67, $p <$ .001, d = 0.75), experience (M = 5.97, SD = 2.41, t = 3.51, p = .001, d = 0.45), knowledge (M = 6.43, SD = 2.35, t = 2.63, p = .011, d = 0.34), and skills (M = 5.57, SD = 2.52, t = 4.76, $p <$ .001, d = 0.62). Ratings of cultural humility were not different based on participants' past experience in therapy (p = .332), race (white vs. racially/ethnically diverse, p = .135), or gender (p = .174).

For responses to the hypothetical scenarios, we conducted a series of analyses of covariance (ANCOVAs), with knowledge (high/low) and humility (high/low) as the independent variables and confidence in developing a good relationship, expected effectiveness, and likelihood to continue as the dependent variables. We also controlled for past experience in therapy, race, and gender. For each dependent variable, there was a large main effect for humility (all ps $<$ .001), indicating that compared with participants who rated a therapist low in cultural humility, participants who rated a therapist high in cultural humility (a) reported a higher likelihood of developing a good relationship with the therapist, (b) expected therapy would be more effective, and (c) reported a higher likelihood of continuing therapy with the therapist. In contrast, for each dependent variable, there was not a statistically significant main effect for knowledge (all ps $>$ .100), indicating that having a therapist with a high or low amount of knowledge about the participant's cultural background did not influence expectations for developing a good relationship, effectiveness, and continuing therapy. The interaction between humility and knowledge was also not statistically significant (all ps $>$ .640), indicating that humility affected the dependent variables regardless of the level of knowledge.

This study provided initial support for the hypothesis that perceptions of a therapist's level of humility in relation to an individual's cultural background are important and may affect the therapy relationship. However, this study relied on an analogue design, was somewhat underpowered, used single-item measures of therapist characteristic ratings, and the therapist's actual level of cultural humility was not assessed. We addressed these limitations in the subsequent studies.

Study 1

The main purpose of Study 1 was to develop a client-rated measure of the cultural humility of a therapist. Our goal was to develop a measure that was brief and demonstrated initial evidence of estimated reliability and construct validity. A secondary purpose of Study 1 was to gather initial evidence that client perceptions of their therapist's cultural humility would be related to client outcomes. We hypothesized that client perceptions of their therapist's cultural humility would be positively associated with a strong working alliance.

Method

Participants. Participants were 472 college students (149 men, 323 women) from a large university in the southwestern United States who had attended therapy at some previous point in their lives. Participants ranged in age from 18 to 56 years (M = 21.0, SD = 4.4). Participants reported a variety of racial backgrounds (59.1% White, 12.6% Black, 6.6% Asian, 12.8% Latino, 0.9% Native American, and 8.1% multiracial). Participants were predominantly heterosexual (93.2%, 3.6% gay/lesbian, 3.0% bisexual, 0.2% "other"). No participants were currently attending therapy.

Measures.

Beginning severity. Participants rated the severity of their presenting problem for which they attended therapy at the time they began therapy from 0 = *absent* to 4 = *severe*. Perceptions of clients' pretherapy functioning have been used in prior studies (Moore & Owen, in press; Nielsen et al., 2004). Although these scores are not as viable as pre–post assessments, they do approximate the degree to which clients felt distressed prior to beginning therapy. Perceptions of pretherapy functioning are consistent with actual pretherapy assessments of psychological functioning (rs range = .57–.87; see Moore & Owen, in press). Some researchers have even argued that a clients' retrospective assessment of their pretherapy functioning are more valid than actual pretherapy assessments because the client's knowledge of functioning at intake was less sophisticated or essentially different than it is at posttherapy (Moore & Owen, in press; Seligman, 1995). Regardless, retrospective assessments of beginning severity provide a rough estimate of the amount of distress that clients were experiencing prior to beginning therapy, which has been shown to approximate pretherapy scores in previous studies (e.g., Nielsen et al., 2004; Owen, Leach, et al., 2011; Owen, Wong, & Rodolfa, 2009).

Working alliance. Participants completed the short form of the *Working Alliance Inventory* (WAI-SF; Tracey & Kokotovic, 1989). The WAI-SF consists of 12 items that measure three aspects of a strong working alliance with the therapist: task (e.g., "What I was doing in counseling gave me new ways of looking at my problem"), goal (e.g., "My counselor and I were working towards mutually agreed upon goals"), and bond (e.g., "My counselor and I trusted one another"). Participants rated the degree to which they agree or disagree with each statement on a 7-point rating scale from 1 = *strongly disagree* to 7 = *strongly agree.* High scores indicate a strong perceived working alliance with the therapist. Tracey and Kokotovic (1989) found evidence supporting the estimated internal consistency and the factor structure of this subscale. For the present sample, we used the total working alliance score. The Cronbach's alpha coefficient was .96 (95% CI [.95, .96]).

Cultural humility. Participants were asked to identify the aspect of their cultural background that was most central or important to them using the following prompt:

> There are several different aspects of one's cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation, religion, disability, socioeconomic status, and size. Some things may be more central or important to one's identity as a person, whereas other things may be less central or important (see Appendix B).

Because participants may have more than one aspect of their cultural background that is important to them, participants were also given the opportunity to identify a second and/or third aspect of their cultural background that was important to them. We created a list of 36 items that corresponded with our theoretical conceptualization of cultural humility (e.g., "My counselor is open to explore"). We first pilot tested these items with 12 experts in the field of MCCs. Experts had published at least one peer-reviewed article in the field of MCCs. On the basis of feedback from the experts, we removed four items. We gave the remaining 32 items to participants. Participants rated the degree to which they agreed or disagreed with each statement from 1 = *strongly disagree* to 5 = *strongly agree*, considering the core aspect(s) of their cultural background. Specifically, the instructions were: "Please think about your counselor. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your counselor. Regarding the core aspect(s) of my cultural background, my counselor . . ."

Procedure. We recruited participants from undergraduate courses. Participants were eligible for the study if they had been in therapy at some point in the past (median number of months since termination was 13). Students participated in exchange for a small amount of course credit. Participants completed the study online. Participants read a consent form that explained the procedures of the study and their rights as a participant. Participants then indicated consent and completed the questionnaires. After completing the questionnaires, we debriefed participants and gave them course credit for their participation.

Results and Discussion

The main purpose of this study was to develop a brief measure of the perceived cultural humility of the therapist. We aimed to develop a scale that had evidence of estimated reliability and validity. We first examined the cultural humility items for outliers and normality. All outliers fell within the expected range of values and were retained in the analyses. Five items showed slight deviations in normality (i.e., skewness or kurtosis values above one). However, exploratory factor analyses (EFAs) are relatively robust against violations of normality (Gorsuch, 1983).

To determine the optimal number of components to extract for the scale, we conducted a Scree test (Cattell, 1966) as well as a parallel analysis (Steger, 2006). Both tests suggested that we retain a two-factor solution. Thus, we analyzed all items using an EFA with principal components extraction first using a varimax rotation (for orthogonal factors) and second using a promax rotation (for oblique factors). The factors correlated with each other .59, which indicated that the two factors were not independent (Tabachnick & Fidell, 2007). Thus, we retained the promax-rotated solution for oblique factors. The two factors represented (a) positive other-oriented characteristics and (b) negative characteristics reflecting superiority and making assumptions. We dropped 12 items from the scale that either (a) did not have strong factor loadings on their primary factor (i.e., less than .70 on the primary factor) or (b) had moderate factor loadings on both factors (i.e., higher than .15 on the secondary factor). We also dropped eight items that were redundant with other items. We did this because we wanted to have a good spread of items rather than synonyms.

The final version of the Cultural Humility Scale (CHS) consisted of 12 items (see Appendix B), with two factors that represented positive (seven items) and negative (five items) aspects of cultural humility. Descriptive statistics and factor loadings for the CHS are listed in Table 1. The two factors accounted for 71.16% of the variance in items. The Cronbach's alphas for the full scales and subscales were .93 (95% CI [.92, .94]) for the full scale, .93

Table 1
Factor Loadings for the Cultural Humility Scale in Study 1

Scale item	*M*	*SD*	Positive	Negative
Positive				
Is respectful	4.40	.99	**.83**	−.05
Is open to explore	4.07	1.01	**.85**	−.03
Is considerate	4.12	.98	**.82**	.01
Is genuinely interested in learning more	3.89	1.02	**.87**	.01
Is open to seeing things from my perspective	3.91	1.05	**.83**	.08
Is open-minded	3.88	.99	**.81**	.10
Asks questions when he/she is uncertain	4.06	.92	**.84**	−.05
Negative				
Assumes he/she already knows a lot	3.54	1.24	−.08	**.89**
Makes assumptions about me	3.46	1.23	−.06	**.87**
Is a know-it-all	3.89	1.18	.11	**.76**
Acts superior	3.81	1.19	−.01	**.88**
Thinks he/she understands more than he/she actually does	3.71	1.22	.11	**.78**
Eigenvalue			6.81	1.73
Variance accounted			56.75	14.42

Note. Higher scores indicate higher cultural humility. The negative items are reverse coded such that higher scores indicate higher cultural humility. Values in boldface type are factor loadings at or above the criteria for selection.

(95% CI [.92, .94]) for the Positive subscale, and .90 (95% CI [.88, .91]) for the Negative subscale. Ratings of cultural humility did not differ on the basis of race ($p = .660$) or gender ($p = .592$).

Secondary analysis. The secondary purpose of this study was to examine whether clients who viewed their therapists as more culturally humble also tended to report stronger working alliances. Before conducting this analysis, we checked for the data for assumptions. There were no problems with outliers or normality. Means, standard deviations, and intercorrelations for all scales are in Table 2. We tested our hypothesis with a hierarchical regression with working alliance as the criterion variable. We entered beginning severity, race, and gender in Step 1 to control for these variables. Then we entered cultural humility in Step 2. Overall, the hypothesis was supported (see Table 3). Cultural humility was significantly associated with working alliance after controlling for the variance in the other variables ($\beta = .74$, $p < .001$). There was also evidence that each subscale of the CHS predicted unique variance in working alliance. We reran the regression analysis with the subscales entered separately. Both positive and negative cultural humility were associated with working alliance, although the Positive subscale was a stronger predictor ($\beta = .57$) than the Negative subscale ($\beta = .26$, both ps $< .001$).

This study resulted in the development of a brief measure of the client's perception of the therapist's cultural humility. We also provided initial evidence that clients who viewed their therapists as more culturally humble tended to report stronger working alliances. However, in the present study we used a retrospective design, making conclusions necessarily tentative. Thus, in the next study, we examined clients who were currently in therapy. We also wanted to see whether client perceptions of a therapist's cultural humility would predict developing a strong working alliance while controlling for other culturally salient variables used in previous studies (i.e., CCCI-R).

Study 2

The main purpose of Study 2 was to replicate and expand the findings from Study 1, using participants who were currently attending therapy. Specifically, we conducted a confirmatory factor analysis (CFA) to see whether the factor structure found in Study 1 would replicate on an independent sample. Also, one might argue that cultural humility is simply a proxy for developing cultural knowledge and skills. Thus, we aimed to show that client perceptions of a therapist's cultural humility would predict therapy outcomes, even while controlling for one measure of MCCs as they have been defined previously in the literature (i.e., CCCI-R). Our main hypothesis was that client perceptions of their therapist's cultural humility would predict developing a strong working alliance while controlling for the effects of client perceptions of their therapists' MCCs.

Table 2
Intercorrelations of the Cultural Humility Scale (CHS) With Therapy Variables (Study 1)

Variable	*M*	*SD*	1	2	3	4
1. CHS Total	50.15	10.28	—			
2. CHS Positive	28.33	5.86	.91*	—		
3. CHS Negative	18.40	5.11	.86*	.58*	—	
4. WAI-SF	61.31	15.93	.75*	.73*	.59*	—

Note. WAI-SF = Working Alliance Inventory, short form. The CHS Negative subscale is reverse coded such that higher scores indicate higher cultural humility.
* $p < .001$.

Table 3
Hierarchical Regression Analysis Predicting Working Alliance (Study 1)

Predictor	ΔR^2	β	sr^2
Step 1	.03		
Beginning severity		.18*	.03
Race		.02	.00
Gender		−.01	.00
Step 2	.54*		
Beginning severity		.11	.01
Race		.01	.00
Gender		−.02	.00
Cultural humility		.74*	.54

* $p < .001$.

Method

Participants. Participants were 134 adults (40 men, 92 women, two indicated "other") recruited from a university counseling center and department clinic, all of whom were currently in therapy. Participants ranged in age from 18 to 71 years ($M = 26.4$, $SD = 8.9$). Participants were predominantly White (70.1% White, 6.7% Black, 8.2% Asian, 6.7% Latino, and 8.2% multiracial) and heterosexual (76.1%, 9.7% gay/lesbian, 10.4% bisexual, 3.7% "other").

Measures.

Beginning severity. As in Study 1, participants rated the severity of the problem for which they attended therapy at the time they began therapy from 0 = *absent* to 4 = *severe*.

Working alliance. Participants completed the short form of the WAI-SF (Tracey & Kokotovic, 1989), as described in Study 1. For the present sample, the Cronbach's alpha coefficient was .93 (95% CI [.91, .95]).

Cultural humility. Participants completed the 12-item CHS, as described in Study 1. To provide further evidence for the factor structure of the CHS, we used a CFA with maximum likelihood estimation to test the extent to which a two-factor model with correlated factors fit the data. Fit indices suggested an acceptable fit, $\chi^2(53) = 81.11$, $p = .008$, comparative fit index (CFI) = .99, root-mean-square error of approximation (RMSEA) = .06, standardized root-mean-square residual (SRMR) = .04. All factor loadings were significant ($p < .001$) and ranged from .54 to .88. We also tested an alternate one-factor model, which did not show a good fit for the data, $\chi^2(54) = 377.90$, $p < .001$, CFI = .91, RMSEA = .21, SRMR = .09. The chi-square difference test revealed that the two-factor model was superior ($p < .001$). Thus, we retained the hypothesized two-factor model. For the present sample, the Cronbach's alpha coefficients were .92 (95% CI [.90, .94]) for the full scale, .90 (95% CI [.87, .92]) for the Positive subscale, and .90 (95% CI [.87, .92]) for the Negative subscale. There was a trend for clients who identified as racially/ethnically diverse to rate their therapists lower on cultural humility ($M =$

53.93, *SD* = 10.09) than clients who identified as White (*M* = 56.60, *SD* = 7.62, *p* = .096). Ratings of cultural humility did not differ on the basis of gender (*p* = .271).

Multicultural competencies. Participants completed the CCCI-R (LaFromboise et al., 1991). The CCCI-R consists of 20 items that measure a counselor's multicultural competence in regard to cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity (e.g., "My counselor demonstrates knowledge about my culture"). Participants rated the degree to which they agree or disagree with each statement on a 6-point rating scale from 1 = *strongly disagree* to 6 = *strongly agree.* High scores indicate that clients perceive their therapist to have high levels of multicultural competence. LaFomboise et al. (1991) found evidence supporting the estimated internal consistency and content validity for this scale. The CCCI-R was originally designed to be completed by a third-party observer; it was modified slightly so that it could be completed by clients (see Constantine, 2002). For the present sample, the Cronbach's alpha coefficient was .93 (95% CI [.91, .94]).

Procedure. We recruited participants from a university counseling center and department clinic using flyers. Participants were eligible for the study if they were currently attending therapy (median number of sessions was seven). Participants completed the study in exchange for a gift card. Participants completed the study online. Participants read a consent form that explained the procedures of the study and their rights as a participant. Participants then indicated consent and completed the questionnaires. After completing the questionnaires, we debriefed participants and gave them the gift card for their participation.

Results and Discussion

The main purpose of this study was to examine the relationship between cultural humility and the working alliance, controlling for MCCs. Before conducting this analysis, we checked the data for assumptions. There were no problems with outliers or normality.

Means, standard deviations, and intercorrelations for all scales are in Table 4. As in Study 1, we used a hierarchical regression to test the main hypothesis. We entered beginning severity, race, gender, and CCCI-R in Step 1. We entered cultural humility in Step 2. Overall, the hypothesis was supported (see Table 5). Client perceptions of their therapist's MCCs (i.e., CCCI-R) were a significant predictor of working alliance (β = .40, *p* < .001). Client perceptions of their therapist's cultural humility were also a significant predictor of working alliance, even when controlling for the CCCI-R (β = .35, *p* < .001). As in Study 1, there was also evidence that each subscale of the CHS predicted unique variance in working alliance. We reran the regression analysis with the subscales entered separately. Both Positive (β = .20, *p* = .058) and Negative (β = .20, *p* = .021) cultural humility were associated with working alliance, when controlling for the CCCI-R.

This study provided further evidence that client perceptions of a therapist's cultural humility are positively related to high-quality alliances with the therapist. Cultural humility appears to explain a modest amount of variance in the alliance over and above traditional measures of client perceptions of their therapist's MCCs. However, we did not assess in the present study client improvement in therapy, which was on a predominately White sample. Thus, in the next study we sought to address these limitations.

Table 4
Intercorrelations of the Cultural Humility Scale (CHS) With Therapy Variables (Study 2)

Variable	*M*	*SD*	1	2	3	4	5
1. CHS Total	55.80	8.49	—				
2. CHS Positive	31.28	4.30	.90*	—			
3. CHS Negative	20.88	4.60	.90*	.63*	—		
4. CCCI-R	98.60	13.68	.64*	.70*	.45*	—	
5. WAI-SF	69.84	11.00	.60*	.60*	.51*	.62*	—

Note. CCCI-R = Cross-Cultural Counseling Inventory—Revised; WAI-SF = Working Alliance Inventory, short form. The CHS Negative subscale is reverse coded such that higher scores indicate higher cultural humility.
* *p* < .001.

Table 5
Hierarchical Regression Analysis Predicting Working Alliance (Study 2)

Predictor	ΔR^2	β	sr^2
Step 1	.39*		
Beginning severity		−.06	.00
Race		.09	.01
Gender		.06	.00
MC competencies		.62*	.34
Step 2	.07*		
Beginning severity		−.07	.00
Race		.07	
Gender		.06	
MC competencies		.40*	.09
Cultural humility		.35*	.07

Note. MC = Multicultural.
* *p* < .001.

Study 3

The main purpose of Study 3 was to replicate and expand the findings from Studies 1 and 2 in two main ways. First, we incorporated a measure of client improvement in therapy. We hypothesized that client perceptions of their therapist's cultural humility would be positively related to client improvement and that this relationship would be mediated by developing a strong working alliance with the therapist. A gold standard for most process variables is the link between therapy process and outcomes. Given that cultural humility is a relational variable, linked to the alliance between the client and therapist (Studies 1 and 2), it is likely that the association between cultural humility and outcomes will be mediated by the alliance. That is, cultural humility has been theorized to help form, maintain, and repair social bonds, which in this case should be evident in the association between cultural humility and alliance. In turn, the alliance should be associated with positive therapy outcomes, a common and robust finding in the therapy literature (Horvath, Del Re, Flückiger, & Symonds, 2011). Second, the previous three studies used samples that were mostly White. In this final study, we wanted to confirm that cultural humility would be a useful construct among participants who identified as racially/ethnically diverse. Because individuals who identify as Black or African American experience disparities

in regard to using mental health services (Constantine, Kindaichi, Graham, & Watkins, 2008), we thought this population would be a good fit to test our construct of cultural humility.

Method

Participants. Participants were 120 adults (87 men, 33 women) recruited using Amazon's Mechanical Turk website, with the restriction that all participants must self-identify as Black and currently be attending therapy. Participants ranged in age from 18 to 55 years ($M = 27.8$, $SD = 7.7$). All participants identified as Black. Participants were mostly heterosexual (87.5%, 5.0% gay/lesbian, 7.5% bisexual). All participants were currently attending therapy.

Measures.

Improvement in psychotherapy. Participants completed the *Patient's Estimate of Improvement* (PEI; Hatcher & Barends, 1996). The PEI consists of 16 items that assess improvement during therapy across a broad range of client functioning (e.g., "To what extent have your original complaints or symptoms improved?"; response options vary). High scores indicate more improvement in therapy. Cronbach's alphas for the PEI in past studies have ranged from .89 to .94 (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Hatcher & Barends, 1996; Pesale, Hilsenroth, & Owen, 2012). Scores on the PEI have also been linked to symptom improvement during therapy (Owen & Hilsenroth, 2011; Pesale et al., 2012). For the present sample, the Cronbach's alpha coefficient was .95 (95% CI [.94, .96]).

Working alliance. Participants completed the WAI-SF (Tracey & Kokotovic, 1989), as described in Study 1. For the present sample, the Cronbach's alpha coefficient was .92 (95% CI [.89, .94]).

Cultural humility. Participants completed the 12-item CHS, as described in Study 1. For the present sample, the Cronbach's alpha coefficients were .86 (95% CI [.82, .89]) for the full scale, .88 (95% CI [.84, .91]) for the Positive subscale, and .84 (95% CI [.79, .88]) for the Negative subscale. Female clients rated their therapist to be higher in cultural humility ($M = 51.06$, $SD = 9.38$) than did male clients ($M = 44.86$, $SD = 7.48$, $p < .001$).

Procedure. We recruited participants using Amazon's Mechanical Turk website. Amazon's Mechanical Turk is a website through which individuals can complete tasks and receive compensation for their work (Buhrmester, Kwang, & Gosling, 2011). Participants were eligible for the study if they identified as Black and were currently attending therapy. Participants were compensated for their time via the Amazon Turk program. Participants completed the study online. Participants read a consent form that explained the procedures of the study and their rights as a participant. Participants then indicated consent and completed the questionnaires. After completing the questionnaires, we debriefed participants.

Results and Discussion

The main purpose of this study was to replicate and expand the findings from Studies 1 and 2, using a reliable and valid measure of improvement in therapy, and using a sample of racially/ethnically diverse participants. We hypothesized that client perceptions of a therapist's cultural humility would be positively associated with their perceived improvement to date in therapy, and this relationship would be mediated by working alliance. Before conducting this analysis, we checked the data for assumptions. There were no problems with outliers or normality.

Means, standard deviations, and intercorrelations for all scales are in Table 6. Controlling for beginning severity and gender, the direct association between the predictor variable (cultural humility) and the criterion variable (improvement) was significant ($\beta = .50$, $p < .001$; see Figure 1). Also, the direct association between the predictor variable (cultural humility) and the mediator variable (working alliance) was significant ($\beta = .74$, $p < .001$). Finally, controlling for the predictor variable (cultural humility), the association between the mediator variable (working alliance) and the criterion variable (improvement) was significant ($\beta = .71$, $p < .001$). In this final regression analysis, there was no longer a significant association between the predictor variable (cultural humility) and the criterion variable (improvement) ($\beta = -.03$, $p = .736$). To test whether the mediated effect of cultural humility on improvement through working alliance was significant, we used the bootstrapping procedure outlined by Preacher and Hayes (2008). Using a bias-corrected bootstrapping procedure based on 5,000 resamples, controlling for beginning severity and gender, we found that the indirect effect of cultural humility on improvement through working alliance was significant (est. = 1.17, $SE = .21$, 95% CI [.79, 1.64]). Using the R^2 effect size measure for mediation analysis (Fairchild, MacKinnon, Taborga, & Taylor, 2009), about 37.2% of the variance in improvement was explained by the mediated effect of cultural humility through working alliance (a large effect size).

General Discussion

The present set of studies created a brief client-rated measure of a therapist's cultural humility and provided evidence for the reli-

Table 6
Intercorrelations of the Cultural Humility Scale (CHS) With Therapy Variables (Study 3)

Variable	*M*	*SD*	1	2	3	4	5
1. CHS Total	46.57	8.47	—				
2. CHS Positive	27.58	5.36	.86*	—			
3. CHS Negative	15.42	4.83	.76*	.34*	—		
4. PEI	92.30	18.66	.59*	.73*	.17	—	
5. WAI-SF	60.47	13.17	.74*	.76*	.41*	.77*	—

Note. PEI = Patient's Estimate of Improvement; WAI-SF = Working Alliance Inventory, short form. The CHS Negative subscale is reverse coded such that higher scores indicate higher cultural humility.
* $p < .001$.

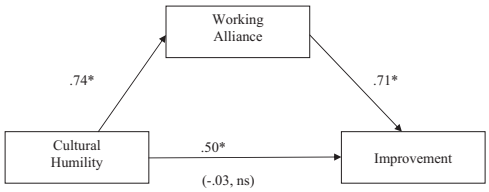

Figure 1. Mediator effects of working alliance on the relationship between cultural humility and improvement. The number in parenthesis is the effect of the predictor variable on the criterion variable with the mediator in the model. * $p < .001$.

ability and validity of this measure. Indeed, although the majority of theory and measurement of MCCs has involved the building or development of self-awareness, knowledge, and skills, we have conceptualized cultural humility as a virtue or disposition important to one's MCO that involves having an interpersonal stance that is other-oriented in relation to another individual's cultural background and experience, marked by respect for and lack of superiority toward another individual's cultural background and experience. We decided to focus on the interpersonal dimension of humility rather than the intrapersonal dimension (i.e., accurate view of self), because we felt it was more relevant to the therapy relationship and better able to be perceived (and rated) by clients. In the present set of studies, we found that client perceptions of a therapist's cultural humility could be assessed reliably using a brief measure. Client perceptions of a therapist's cultural humility were positively associated with both working alliance with the therapist and perceived improvement in therapy. The relationship between client perceptions of a therapists' cultural humility and perceived improvement appears to occur via a stronger working alliance with the therapist.

The results of the present study indicate that in addition to focusing on building self-awareness, knowledge, and skill, it may be important to address developing an interpersonal stance of humility when engaging with a client about his or her cultural background. This supports prior theory by Tervalon and Murray-Garcia (1998) as well as others (e.g., Fowers & Davidov, 2006; Ridley et al., 1994; S. Sue, 1998) that have emphasized the importance of humility and being open to the other in order to work effectively with diverse clients.

There are some notable limitations of the present set of studies. First, cross-sectional, correlational designs were used in all studies. Thus, it is impossible to infer causality between the variables in the present studies. Although the data are consistent with our theoretical model (e.g., perceptions of cultural humility affecting improvement via working alliance), there are other theoretical models that may also fit the data well, including a model that would suggest that all ratings of a therapist might be affected by improvement to date or by working alliance. Related to this limitation, we did not assess for temporal stability of the CHS. In the present article, we take an important first step of articulating our theory and hypotheses, developing a psychometrically supported measure to assess the key construct, and testing the hypotheses (albeit in cross-sectional studies). Longitudinal or experimental research is necessary to further elucidate our theoretical model. Second, the primary measures used in the present set of studies were self-report measures of a client's experience in therapy and perceptions of the therapist. Although this appears to be the most widely used measurement strategy in this area of research, it does have some limitations. For example, retrospective clients may struggle to remember their experiences in therapy accurately, or current clients may not wish to report negative experiences with their therapist. Furthermore, future studies could include measures of other types of constructs associated with MCCs (e.g., microaggressions; Constantine, 2007). Third, our samples were in some ways limited. Two samples consisted of college students, and two samples consisted of mostly White participants. Although we tried to minimize this limitation by designing our measure to allow participants to select the aspects of their cultural identity that were most important to them and using a sample of racially/ethnically diverse participants in one study (Study 3), future research should nevertheless examine other types of samples, particularly samples of racially/ethnically diverse participants, as well as community or older adult samples.

More research is needed on the subscales of the CHS (see Appendix B for the scale and Appendix C for a table of norms to date). Studies 1 and 2 showed high correlations between the two subscales, but Study 3 showed a more modest correlation. Furthermore, the pattern of relationships between the subscales and therapy outcomes were mostly consistent, although in some cases the Positive subscale showed slightly higher correlations with therapy outcomes than did the Negative subscale. This difference was most prominent in Study 3, which was also the study in whicha racially/ethnically diverse sample was used. It may be that for racially/ethnically diverse participants, the positive characteristics of cultural humility (e.g., openness to explore) are somewhat more important than the negative aspects of cultural humility (e.g., making assumptions) in predicting counseling outcomes. At present, we recommend using the total scale score, although future research may show important differences between positive and negative aspects of perceptions of cultural humility.

Our findings have several implications for therapy practice and training of therapists. First, therapists should be aware that humility appears to be very important to clients when addressing their cultural worldview. As much as a therapist can be an "expert" in a certain aspect of diversity, we encourage therapists to engage with each client with an attitude of humility in relation to the client's cultural background. Therapists should not assume that they understand the client's cultural background or experience based on therapists' prior knowledge, experience, or training. Rather, therapists should partner with the client to explore the client's cultural background and experience, in order to determine the aspects of the client's cultural background that may be helping or hurting the client. This attitude of humility may be especially important to the development of a strong working alliance with a client who is culturally different. Furthermore, engaging a culturally diverse client with an interpersonal stance of humility may attenuate the tendency for therapists to overvalue their own perspectives and worldviews, instead of joining with the client to explore the client's perspective and worldview.

Second, when training therapists to competently work with clients from diverse backgrounds, it may be important to focus on interpersonal behaviors such as expressions of humility (e.g., being open to explore the client's cultural background, asking questions when uncertain, expressing curiosity and interest about the client's cultural worldview) in addition to accruing a specific set of knowl-

edge or skills for working with a particular type of client. The present studies suggest that as a therapist is continually gaining new knowledge and skills to work with diverse clients, it is important for the therapist to also learn to engage with his or her clients in a humble manner.

Third, cultural humility may also play a role in guiding how counseling psychologists engage in activities aligned with social justice goals, such as advocacy, outreach, prevention programs, and psychoeducational interventions (Vera & Speight, 2003). These roles often involve partnering with community members and leaders, and it is likely important to engage in these relationships from an interpersonal stance of humility and openness to the other, rather than from a superior role as the "expert."

The push to develop MCCs has changed the face of counseling psychology over the past 30 years. Most therapists now acknowledge that they must address issues related to culture and diversity in the therapy session. Our hope is that as therapists develop greater self-awareness, knowledge, and skills for working with diverse clients, they will simultaneously engage diverse clients with cultural humility.

References

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

Buhrmester, M., Kwang, T., & Gosling, S. D. (2011). Amazon's mechanical turk: A new source of inexpensive, yet high quality data? *Perspectives on Psychological Science, 6,* 3–5. doi:10.1177/1745691610393980

Cattell, R. B. (1966). The scree test for the number of factors. *Multivariate Behavioral Research, 1,* 245–276. doi:10.1207/s15327906mbr0102_10

Clemence, A., Hilsenroth, M. J., Ackerman, S. J., Strassle, C. G., & Handler, L. (2005). Facets of the therapeutic alliance and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology and Psychotherapy, 12,* 443–454. doi:10.1002/cpp.467

Constantine, M. G. (2001). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology, 48,* 456–462. doi:10.1037/0022-0167.48.4.456

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49,* 255–263. doi:10.1037/0022-0167.49.2.255

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54,* 1–16. doi:10.1037/0022-0167.54.1.1

Constantine, M. G., Kindaichi, M. M., Graham, S. V., & Watkins, N. L. (2008). Strategies for reducing disparities in African Americans' receipt and use of mental health services. In B. C. Wallace (Ed.), *Toward equity in health: A new global approach to health disparities* (pp. 155–167). New York, NY: Springer.

Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 482–498). Thousand Oaks, CA: Sage.

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. doi:10.1080/00223891.2011.558871

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.

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. doi:10.1080/15298868.2011.636509

Drianne, J., & Owen, J. (2013). *A revision of the client-rated Cross Cultural Counseling Inventory-Revised*. Manuscript under review.

Fairchild, A. J., MacKinnon, D. P., Taborga, M. P., & Taylor, A. B. (2009). R^2 effect-size measures for mediation analysis. *Behavior Research Methods, 41,* 486–498. doi:10.3758/BRM.41.2.486

Fowers, B. J., & Davidov, B. J. (2006). The virtue of multiculturalism: Personal transformation, character, and openness to the other. *American Psychologist, 61,* 581–594. doi:10.1037/0003-066X.61.6.581

Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity and Ethnic Minority Psychology, 8,* 214–223. doi:10.1037/1099-9809.8.3.214

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43,* 480–490. doi:10.1037/0033-3204.43.4.480

Funder, D. C. (1995). On the accuracy of personality judgment: A realistic approach. *Psychological Review, 102,* 652–670. doi:10.1037/0033-295X.102.4.652

Gorsuch, R. L. (1983). *Factor analysis* (2nd ed.). Hillsdale, NJ: Erlbaum.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64,* 1326–1336. doi:10.1037/0022-006X.64.6.1326

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9–16. doi:10.1037/a0022186

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory—Revised. *Professional Psychology: Research and Practice, 22,* 380–388. doi:10.1037/0735-7028.22.5.380

Li, L. C., & Kim, B. S. K. (2004). Effects of counseling style and client adherence to Asian cultural values and counseling process with Asian American college students. *Journal of Counseling Psychology, 51,* 158–167. doi:10.1037/0022-0167.51.2.158

Moore, J., & Owen, J. (in press). Assessing outcomes in university and college counseling centers: Practical methods and evidence. *Journal of College Counseling*.

Nielsen, S. L., Smart, D. W., Isakson, R. L., Worthen, V. E., Gregersen, A. T., & Lambert, M. J. (2004). The *Consumer Reports* effectiveness score: What did consumers report? *Journal of Counseling Psychology, 51,* 25–37. doi:10.1037/0022-0167.51.1.25

Owen, J., & Hilsenroth, M. J. (2011). Interaction between alliance and technique in predicting patient outcome during psychodynamic psychotherapy. *Journal of Nervous and Mental Disease, 199,* 384–389. doi:10.1097/NMD.0b013e31821cd28a

Owen, J., Imel, Z., Tao, K., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research, 11,* 204–212. doi:10.1080/14733145.2010.491551

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58,* 1–9. doi:10.1037/a0021496

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

Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and women in short-term psychotherapy: Initial evidence. *The Counseling Psychologist, 38,* 923–946. doi:10.1177/0011000010376093

Owen, J., Wong, Y. J., & Rodolfa, E. (2009). Empirical search for psychotherapists' gender competence in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 46,* 448–458. doi:10.1037/a0017958

Pesale, F. P., Hilsenroth, M. J., & Owen, J. (2012). Patient early session experience and treatment outcome. *Psychotherapy Research, 22,* 417–425. doi:10.1080/10503307.2012.662607

Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods, 40,* 879–891. doi:10.3758/BRM.40.3.879

Ridley, C. R., Mendoze, D. W., Kanitz, B. E., Angermeier, L., & Zenk, R. (1994). Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology, 41,* 125–136. doi:10.1037/0022-0167.41.2.125

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965–974. doi:10.1037/0003-066X.50.12.965

Steger, M. F. (2006). An illustration of issues in factor extraction and identification of dimensionality in psychological assessment data. *Journal of Personality Assessment, 86,* 263–272. doi:10.1207/s15327752jpa8603_03

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. doi: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. doi:10.1177/0011000082102008

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53,* 440–448. doi:10.1037/0003-066X.53.4.440

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston, MA: Pearson Education.

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 Undeserved, 9,* 117–125. doi:10.1353/hpu.2010.0233

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1,* 207–210. doi:10.1037/1040-3590.1.3.207

Vazire, S. (2010). Who knows what about a person? The self–other knowledge asymmetry (SOKA) model. *Journal of Personality and Social Psychology, 98,* 281–300. doi:10.1037/a0017908

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31,* 253–272. doi:10.1177/0011000003031003001

Winterowd, C. L., Adams, E. M., Miville, M. L., & Mintz, L. B. (2009). Operationalizing, instilling, and assessing counseling psychology training values related to diversity in academic programs. *The Counseling Psychologist, 37,* 676–704. doi:10.1177/0011000009331936

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology, 47,* 460–468. doi:10.1037/0022-0167.47.4.460

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology, 54,* 351–361. doi:10.1037/0022-0167.54.4.351

Appendix A

Description of Counseling Scenarios (Pilot Study)

Scenario 1: High Knowledge, High Humility

Imagine you are attending counseling. Your counselor has a large amount of knowledge about individuals who share your cultural background. Your counselor is also humble in regard to your cultural background. Your counselor does not assume that he or she understands your particular cultural experience, but rather your counselor explores your cultural background with openness.

Scenario 2: High Knowledge, Low Humility

Imagine you are attending counseling. Your counselor has a large amount of knowledge about individuals who share your cultural background. However, your counselor is not very humble in regard to your cultural background. Your counselor makes assumptions about your particular cultural experience (which may or may not be accurate) based on his or her experiences with others who share your cultural background.

Scenario 3: Low Knowledge, High humility

Imagine you are attending counseling. Your counselor does not have much knowledge about individuals who share your cultural background. However, your counselor is humble in regard to your cultural background. Your counselor does not assume that he or she understands your particular cultural experience, but rather your counselor explores your cultural background with openness.

Scenario 4: Low Knowledge, Low Humility

Imagine you are attending counseling. Your counselor does not have much knowledge about individuals who share your cultural background. Your counselor is also not very humble in regard to your cultural background. Your counselor makes assumptions about your particular cultural experience (which may or may not be accurate) based on his or her experiences with others who share your cultural background.

(*Appendices continue*)

Appendix B

Cultural Humility Scale (CHS)

DIRECTIONS: There are several different aspects of one's cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation, religion, disability, socioeconomic status, and size. Some things may be more central or important to one's identity as a person, whereas other things may be less central or important.

Please identify the aspect of your cultural background that is most central or important to you:

_____

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

If there is a 2nd aspect of your cultural background that is important to you, please list:

_____

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

If there is a 3rd aspect of your cultural background that is important to you, please list:

_____

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

(*Appendices continue*)

Please think about your counselor. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your counselor.

Regarding the core aspect(s) of my cultural background, my counselor…	**Strongly Disagree (1)**	**Mildly Disagree (2)**	**Neutral (3)**	**Mildly Agree (4)**	**Strongly Agree (5)**
1. Is respectful.	1	2	3	4	5
2. Is open to explore.	1	2	3	4	5
3. Assumes he/she already knows a lot.	1	2	3	4	5
4. Is considerate.	1	2	3	4	5
5. Is genuinely interested in learning more.	1	2	3	4	5
6. Acts superior.	1	2	3	4	5
7. Is open to seeing things from my perspective.	1	2	3	4	5
8. Makes assumptions about me.	1	2	3	4	5
9. Is open-minded.	1	2	3	4	5
10. Is a know-it-all.	1	2	3	4	5
11. Thinks he/she understands more than he/she actually does.	1	2	3	4	5
12. Asks questions when he/she is uncertain.	1	2	3	4	5

Positive subscale items: 1, 2, 4, 5, 7, 9, 12

Negative subscale items: 3, 6, 8, 10, 11

(*Appendices continue*)

Appendix C

Normative Data for the Cultural Humility Scale (CHS)

Sample	Study	*n*	Total CHS	Positive	Negative
Past clients, college students (41% REM)	1	472	51.2 (10.3)	28.3 (5.9)	18.4 (5.1)
Current clients, college students and community (30% REM)	2	134	55.8 (8.5)	31.3 (4.3)	20.9 (4.6)
Current clients, community (100% REM)	3	120	46.6 (8.5)	27.6 (5.4)	15.4 (4.8)

Note. Values in three rightmost columns are means (and standard deviations). The Negative subscale is reverse coded such that higher scores indicate higher cultural humility. REM = racial/ethnic minority.

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