ABSTRACT

Title of Master's Thesis: CULTURAL HUMILITY, THERAPUETIC RELATIONSHIP, AND OUTCOME: BETWEEN-THERAPIST, WITHIN-THERAPIST, AND WITHIN-CLIENT EFFECTS

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The present study longitudinally examined the association between client-perceived cultural humility (CH) of the therapist, dyadic working alliance (WA), and dyadic session evaluation (SES). We analyzed cultural humility scores at three levels: a) between therapist b) within-therapist and c) within-client. Using a sample of 79 clients, 15 therapists, and 231 time periods, we conducted two multilevel analyses using dyadic WA and dyadic SES as predictors. We found that high between-therapist, within-therapist, and within-client CH yielded higher dyadic WA scores. We also found that within-therapist and within-client CH yielded higher dyadic SES scores. However, importance of client identity did not act as moderator as predicted for CH and dyadic WA; nor did importance of client identity moderate the relationships between within-therapist and within-client CH and dyadic SES. We did find that importance of client identity moderated the relationship between-therapist CH and dyadic SES. Implications for future research will be discussed.

Keywords: cultural humility, working alliance, session evaluation, psychodynamic, HLM

CULTURAL HUMILITY, THERAPUETIC RELATIONSHIP, AND OUTCOME: BETWEEN-THERAPIST, WITHIN-THERAPIST, AND WITHIN-CLIENT EFFECTS

by

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Cultural humility, therapeutic relationship, and outcome: Between-therapist, within-therapist, and within-client effects

The ability to work with culturally diverse clients is a growing concern, as the current mental health system is not sufficiently meeting the needs of our multicultural population. Further, examination of mental health services demonstrates that services are underutilized, not easily accessible, and not effectively delivered to minority populations (Agency for Healthcare Research and Quality, 2016, U.S. Surgeon General, 2001; Sue, 1998; Smedley et al., 2003; Alegria et al., 2008; Harris, Edlund, & Larson, 2005; Marques et al., 2011; Wang et. al., 2005). Despite the collective aim of training programs to ensure multicultural competency of therapists (Heppner, Leong, & Gerstein, 2008), the gap in utilization and outcomes persists. The disparity in effectiveness and quality of service to marginalized identities has highlighted the need for improving the current multicultural training of psychotherapists.

Gaining multicultural competence (MCC) has become a key goal of the field of psychology. In fact, APA's initial version of the Multicultural Guidelines was centered on the most commonly accepted definition of MCC (Sue, 1998). Sue (1998) defines three aspects of MCC: self-awareness, knowledge, and skills. APA's (2002) multicultural guidelines call therapists to reflect on their own unconscious problematic beliefs and attitudes toward cultural groups, recognize therapists as ethically responsible for learning as much as possible about the various values, norms, and expectations of the cultural identities of clients, and challenges therapists to develop the skills necessary to effectively work with diverse cultures (APA, 2002).

However, researchers have critiqued the MCC framework, highlighting that emphasis on gaining knowledge of differing cultures can be dangerous; some scholars have argued that instructing therapists to familiarize themselves with the specific cultural norms of clients is inadequate, as complete knowledge of differing cultures is impossible (Weinrach & Thomas, 2004). Furthermore, critical feedback on the MCC framework highlights the dangers this approach may have in encouraging an overreliance on stereotypes and biases of cultural groups, suggesting that advocates of this framework may be operating from a stance that is racist, prejudicial, and divisive (Herman et al., 2007, Hwang, 2006; Weinrach & Thomas, 2004). This approach may not take into account the nuances of culture, more specifically the evolution, fluidity, and intersectionality as individuals often do not fit into one prescribed identity (Weinrach & Thomas, 2004; Kumagai & Lypson, 2009; Phinney & Ong, 2007).

Cultural humility offers an alternative approach to addressing cultural differences. Cultural Humility, attributed to Tervalon and Murray-Garcia (1998), is a process of 'committing to an ongoing relationship with patients, communities, and colleagues' that requires 'humility as individuals continually engage in self-reflection and self-critique' (p. 118). Cultural humility takes into account the complex and subjective nature of culture. It challenges therapists to actively engage in a lifelong process with clients, organizational structures, and themselves (Tervalon and Murray-Garcia, 1998). Therefore, on the intrapersonal level, cultural humility involves an accurate view of one's self, including awareness of one's own limitations when understanding the cultural experiences of others. On the interpersonal level, cultural humility involves an other-oriented rather than a self-focused stance. It involves openness and a desire to learn from

others in a respectful and non-superior manner. Individuals with high levels of cultural humility are open to the idea that others differ in their beliefs, and aim to accept worldviews that are culturally different from their own.

Cultural Humility in Counseling

In an effort to target the potential dangers of the MCC framework (i.e. overreliance on assumptions and "expertise") and move toward a framework that underlines a culturally humble approach to cultural differences, Owen (2013) created the multicultural orientation (MCO) model; this model identifies cultural humility, cultural opportunities, and cultural comfort as the three pillars necessary to effectively work with multicultural populations. This framework focuses on being "oriented" toward thinking "multiculturally" rather than achieving "competence." Therefore it moves away from the "expert" role and emphasizes a "way of being" with clients. This new framework aims to neutralize the inevitable imbalance of power between the therapists and clients by empowering clients to not only identify their own culture but to define what it means to them.

This power and autonomy given to clients is highlighted in the Cultural Humility Scale (CHS; Hook et al., 2013), which asks clients to report up to three salient cultural identities and rate their importance. This approach to operationalizing culture is different from previous MCC research, which limits the understanding of clients' cultural heritage; for example, many studies have used client reported race and ethnicity as a proxy for client's culture (Betancourt & Lopez, 1993). This method results in researchers assuming race and ethnicity as the most important identities for all their clients, which erroneously limits the definition of culture to racial identity when culture encompasses much more

than that.

Culture is defined as the shared beliefs, values, norms, and expectations within a group, community, or society (Betencourt and Lopez, 1993; Triandis, 1980). These shared beliefs are influenced by many different factors outside of one's racial identity. Hays (1996) highlights culture as a multidimensional combination of identities through her ADDRESSING framework, which encourages therapists to recognize how the client is culturally influenced by age, developmental and acquired disability, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Therefore, it's unsuitable to favor one identity over others, in this case racial identity, as the definition of culture. The CHS, instead, acknowledges the individuality, fluidity, and intersectionality of culture by allowing clients to report multiple identities. Ashmore, Deaux, and McLaughlin-Volpe (2004) review of group identity aimed to identify the most important aspects of group identity. Ashmore et al., (2004) considered that self-categorization is the basic element of group identity. Therefore, allowing individuals to self-report their own identities rather than rely on assumptions is important to ensure that the individuals actually identify as members of a particular group (Phinney & Ong, 2007).

Recent research utilizing the CHS has made important strides in helping us understand the value of cultural humility in the context of psychotherapy; Cultural humility has been found to not only be distinct from cultural competency, but also to be positively related to positive therapeutic processes and therapeutic outcome (Hook et al., 2013, 2016; Owen et al., 2014; 2016, Davis et al., 2016). Hook et al. (2013) recruited 120 self-identifying Black participants through Amazon's Mechanical Turk and asked

participants to retrospectively report their working alliance and perceptions of therapists' cultural humility. Findings indicate that therapist and client perceptions of therapist cultural humility were positively related to having a strong working alliance and positive client outcomes.

Using a university sample, Owen et al. (2014) also asked 45 self-identified religious and spiritual participants to recall and report the perceived cultural humility and the working alliance of their previous therapist. They replicated Hook et al. (2013) findings, noting a positive correlation between cultural humility and working alliance. Furthermore, they found that cultural humility might be more important for aspects of a client's cultural background that are particularly salient and important. Specifically, they found that therapist's cultural humility toward a client's religious worldview was positively related to client outcomes, finding that this association was stronger for clients with high levels of religious commitment. Therefore, the importance of a client's salient identity may significantly influence the client's perception of their therapist's cultural humility; it is possible that a client's perception of their therapist's cultural humility may differ if the client perceives their therapists as arrogant or superior when discussing an identity that is very important to them compared to an identity that isn't as important.

Using an undergraduate sample of 128 participants, Davis et al. (2016) examined whether cultural humility mediated the relationship between perceived racial microaggressions and client-rated working alliance. Participants were asked to think of a microaggression experienced in therapy and write about it. They subsequently were asked to complete a working alliance and cultural humility measures. Previous research found that racial microaggressions, brief and common daily verbal slights toward a member of a

target racial group, was negatively correlated with the client-rated working alliance. Davis et al. (2016) found that cultural humility mediated this relationship, demonstrating that racial microaggressions are negatively associated with perceived cultural humility of the therapist.

Hook et al. (2016) extended Davis et al. (2016) findings. Using a sample of 2,212 participants recruited through Amazon's Mechanical Turk, Hook et al. (2016) asked clients to retrospectively complete measures about their past therapy experiences to examine the relationship between cultural humility and racial microaggressions. Perceptions of cultural humility were associated with lower racial microaggression frequency in counseling and lower negative impact of those racial microaggressions. Therefore, cultural humility's focus on introspection and open-mindedness may help prevent therapists from becoming overly influenced by stereotypes and making critical mistakes that may harm the therapeutic relationship.

Owen et al. (2016) study of 50 therapists and 247 clients from a university center providing brief term therapy examined the relationship between the perception of therapists' cultural humility and the perception of therapists' missed opportunities to discuss cultural issues. Clients were asked to retrospectively report their perceptions of therapists' cultural humility at the end of the academic term. Findings indicate that cultural humility moderates the relationship between cultural missed opportunities and client outcome. Although missed cultural opportunities were related to poor client outcome, this relationship was not significant for clients who perceived their therapist as culturally humble. This suggest that cultural humility acts a buffer, and may indicate that

cultural humility allows therapists to know the right time to address cultural experiences that may be too vulnerable to disclose for the client in the moment (Owen et al., 2016).

Based on the collection of studies, it is clear that cultural humility results in clients who feel heard by the therapist, and may help build a trusting relationship between the client and therapist. This is important, as establishing a firm therapeutic alliance is one of the main goals in the field of psychotherapy (Taber, Leibert, & Agaskar, 2011).

Working Alliance

Across theoretical orientations and in all treatment modalities, the therapeutic alliance remains a crucial component in yielding favorable therapeutic outcome (Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Bedi, 2002). One important aspect of the therapeutic alliance is the working alliance, which is defined as the agreement between the therapist and client on the emotional bond between client and therapist, the goals for treatment, and the ways to reach those goals (Bordin, 1979). The working alliance measures the strength of collaboration between the client and therapist, which is fundamental to the success of therapy. Working alliance significantly impacts treatment outcome (Flückiger et al., 2018; Flückiger Del Re, Wampold, Symonds, & Horvath, 2012).

Studies have found that the WA score from an early session is predictive of client outcome (Flückiger etl al., 2018; Horvath et al., 2011). Furthermore, a meta-analyses of 201 studies demonstrated that a strong working alliance is related to successful treatments outcomes, across the different measurement of WA, perspective of evaluating WA, time points assessed, the type of therapy utilized, client characteristics, and countries (Flückiger et al., 2018; Horvath et al., 2011). Given that a strong working alliance is

related to outcome, it is important that we continue to examine the working alliance in the context of culture, as cultural discussion can harm or enhance the working alliance. Lee's (2009) study demonstrated the importance of effectively addressing culture in psychotherapy. This study examined how therapists addressed cultural issues with clients and it's effect on the working alliance. Findings demonstrated that specific interactions when the therapists addressed culture were associated with the working alliance. Furthermore, studies on racial and sexual orientation microaggressions, "subtle, stunning, often automatic, and non-verbal exchanges which are 'put downs' (Peirce, Carew, Peirce-Gonzalez, & Willis, 1978, p. 66)" found microaggressions to be negatively related to client outcome and working alliance (Constantine, 2007; Sue et al., 2008). Therefore, cultural misunderstandings and errors between the therapist and client may lead to a weakened working alliance, which may influence treatment outcome.

Cultural humility has been shown to be a significant factor that the working alliance. However, one important problem with the current research examining cultural humility is that all of the studies are limited because of single-rater bias; client responses may only explain part of the relationship between cultural humility and working alliance or treatment outcome. There are also limitations in how the working alliance is conceptualized and measured. Theorists describe the working alliance as a joining together, co-creation, partnership, and collaboration and a co-creation of the client and therapist (for a review see Kivlighan, 2007); however, researchers have operationalized the working alliance as an individual construct. Kivlighan (2007) argued that because the working alliance is a shared creation of the client and counselor it is best measured as a dyadic construct-- a shared perception. As noted by Kivlighan (2007), using separate

alliance ratings from the client or counselor misses the dyadic and interactional nature of the working alliance. Unfortunately, most researchers have continued to assess the working alliance just from the client's perspective. Kivlighan (2007) demonstrated a dyadic analysis, the latent group model (also referred to as the common fate model; Ledermann & Kenny, 2012) that can be used to operationalize a dyadic working alliance. In the present study, we build on a small number of studies (Kivlighan, 2007; Kivlighan et al., in press) that use a dyadic approach to modeling the working alliance.

Another important limitation includes the reliance on single ratings of the working alliance as indicators of the strength of the working alliance. Research by Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, and Gallop (2011, p. 267) shows that "very good" dependability for working alliance scores can only be achieved when four or more working alliance ratings are aggregated to obtain a working alliance score. Similar arguments can be made about the importance of using a dyadic operationalization of session evaluation and combining multiple ratings of session evaluation to increase the dependability of a session evaluation measure. Therefore, in the present study, we aggregated eight sessions of working alliance and session evaluation ratings to obtain dependable longitudinal assessments of the working alliance and modeled working alliance and session evaluation as dyadic variables.

The Present Study

While previous studies have begun to examine the relationship between cultural humility, and working alliance, session, and treatment outcome (Hook et al., 2013, 2016; Owen et al., 2014; Davis et al., 2016; Hook et al., 2016), the present study aims to address several limitations. As described above, the present study combines multiple

working alliance and session evaluations ratings to achieve more dependable scores and models of working alliance and session evaluations as a dyadic constructs. Previous research on cultural humility used cross-sectional methodology in which participants were asked to reflect on their past counseling experience and complete the cultural humility scale at one specific time point. Not only does this approach give a limited number of data points, it also asks clients to answer questions about the therapist after significant time has passed—which may compromise the accuracy of the completed measures.

Second, cross sectional measures of cultural humility are inherently problematic because these measures contain an unknown mix of information about the therapist, the client and the time of measurement. For example a cultural humility score could be high because: (a) the therapist is culturally humble across all of her clients; (b) the therapist is especially culturally humble with a particular client; or (c) the therapist was especially humble, with the client, in the session when cultural humility was assessed. Recently, researchers have used partitioning of longitudinal data to address this problem by examining between-therapist, within-therapist (client) and within-client processes. Research suggests that between-therapist and within-client processes may be particularly important. For example, Baldwin, Wampold, and Imel (2007) found between-therapists differences in the working alliance and Kivlighan, Gelso, Ain, Hummel, & Markin (2015) found between-therapists differences in the real relationship to be stronger predictors of client outcome than between-client differences in these variables. Referring to the within-client processes, Ulvenes et al., (2014, p. 323) stated that: "…key processes in psycho-therapy might well exist primarily at the within-person level, which

emphasizes the experience of the particular patient rather than comparisons of the patient to other patients." Previous studies examining cultural humility did not disaggregate cultural humility into session, client, and therapist level. Given the research of Baldwin et al. (2007), Kivlighan et al. (2015), and Ulvenes et al., (2014) and the fact that the therapeutic context innately involves the therapist, client and time, it is crucial that each component is included in the data analysis, as this will give a more nuanced understanding of cultural humility.

This study aims to rectify the limitations identified in previous studies. The present study will contribute to the current body of literature by examining whether the relationships found in previous research remain present in the context of open-ended therapy, variance partitioning, and dyadic analysis. The purpose of the present study will be to longitudinally examine the association between client-perceived cultural humility (CH) of the therapist, and client-rated and therapist-rated working alliance (Cl-WA, Th-WA) and session evaluation (Cl-SES, Th-SES).

Therefore, we hypothesize the following: 1) that within-client cultural humility will be positively related to dyadic working alliance, 2) within-therapist cultural humility will be positively related to dyadic working alliance, 3) between-therapist cultural humility will be positively related to dyadic working alliance, 4) within-client cultural humility will be positively related to dyadic session evaluation, 5) within-therapist cultural humility will be positively related to dyadic session evaluation, 6) between-therapist cultural humility will be positively related to dyadic session evaluation.

Finally, based on Owen et al.'s (2014) finding that identity importance moderated the relationship between cultural humility and working alliance, we hypothesize the

following: 7) the self-reported importance of the clients' primary salient identity will moderate the relationship between dyadic WA and between-therapist cultural humility 8) the self-reported importance of the clients' primary salient identity will moderate the relationship between dyadic WA and within-therapist cultural humility, 9) the self-reported importance of the clients' primary salient identity will moderate the relationship between dyadic WA and within-client cultural humility, 10) the self-reported importance of the clients; primary salient identity will moderate the relationship between dyadic SES and between-therapist cultural humility, 11) the self-reported importance of the clients' primary salient identity will moderate the relationship between dyadic SES and within-therapist cultural humility, 12) the self-reported importance of the clients' primary salient identity will moderate the relationship between dyadic SES and within-client cultural humility. More specifically, we hypothesize that the self-reported importance of the clients identity will moderate the effects of cultural humility such that: a) when importance is high, high client-perceived cultural humility of the therapists will be related to a stronger dyadic working alliance and greater dyadic session evaluation, b) when importance is low, however, high client-perceived cultural humility of the therapists will unrelated to dyadic working alliance and dyadic session evaluation.

Method

Data

The sample for the current study was drawn from archival data collected at a university clinic providing low-cost, open-ended, psychodynamic-oriented, individual therapy to the surrounding community. Based on the data pool, 79 clients, 15 therapists, 270 time periods were included in the data analysis. Each time period consisted of 8

sessions.

Participants

Clients. There were seventy-nine clients [39 female, 33 male, 1 transgender male; 141 European American, 141 REM (75 African Americans, 3 Hispanic Americans, 20 Latino/a Americans, 20 Asian Americans, 10 Biracial/Multiracial, 1 Middle Eastern, 1 Greek International, 2 Pakistani International, 1 Brazilian International, 1 Cameroonian International, 1 Nigerian International, 1 Russian International, 1 Slovakian International, 1 South African International; 1 Jewish American); mean age = 33.07, SD = 13.50]. The average treatment length number of time periods per client was 3.42 and the average number of clients seen per therapist was 4.94 (*SD = 3.34).* Six clients were missing demographic data.

Therapists. Fifteen therapists were included in the study [11 female, 3 male; 1 transmale; 11 White and 5 REM (3 Asian students, 1 African American, 1 Hispanic, 1 Chinese international]; age M = 29.94, SD = 8.33). The therapists were counseling psychology students in, at least, their 3rd year of doctoral study, who received weekly individual supervision and participated in biweekly group supervision with experienced, psychodynamic oriented licensed psychologists.

Measures

Cultural identities (CHS; Hook et al., 2013). Following Owen et al., 2016, participants were asked to identify aspects of their cultural background that are 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." Participants had the option to list up to three identities. For each identity, they rated how important their identity was to them on a 5-point scale, 1 (not at all) to 5 (very important). Following Owen et al. (2016), we utilized the importance rating of the primary identity as a control variable in our analysis.

Cultural Humility Scale (**CHS**; Hook et al., 2013) Clients' perceptions of their counselors' level of cultural humility will be measured with the 12-item CHS. The scale asks clients the extent to which they agree with statements related to how their therapist addresses their cultural background. Example items include the following: "Is superior," "Is open to explore," and "Is a know-it-all." Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher mean scores indicate higher levels of clients' perceived cultural humility of their counselors. The CHS showed evidence of reliability, with Cronbach's alpha values ranging from .86 to .93 (Hook et al., 2013).

Session Evaluation Scale (SES; Hill & Kellems, 2002). The SES assesses client and therapist perceptions of session quality. The original measure had a total of four items, however, an additional item ("Rate the overall effectiveness of this session") was added as suggested by Lent et al., (2006) to increase score variability. Items were rated on a 5-point scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Example client items include the following: "I am glad I attended this session," and "I did NOT feel satisfied with what I got out of this session." Example therapist items include the following: "My client is glad s/he attended this session," and "My client did NOT feel

satisfied with what s/he got out of this session." Two items are reverse coded, so that higher scores reflect higher perceptions of session quality. Hill and Kellems 2002) reported adequate internal consistency (a= .89 and .91 for client and therapist).

Working Alliance Inventory-Revised Short Form (WAI-SR; Hatcher & Gillaspy, 2006). The working alliance reported by both clients and the therapists will be assessed by the WAI-SR. The WAI-SR is a 12-item, client-rated version of the original 36-item WAI (Horvath & Greenberg, 1989) that assesses tasks, goals, and bond in therapy. Example items include the following: "My therapist and I collaborate on setting goals for therapy," "What I am doing in therapy gives me new ways of looking at my problem", and "I feel that my therapist appreciates me." Items are scored on a 5-point Likert scale from 1 (seldom) to 5 (always). The short version was developed using factor analysis and item response theory based on the original WAI (Hatcher & Gillaspy, 2006). The measure had adequate internal consistency (a > .85) and showed good construct, convergent, and predictive validity, (Hatcher & Gillaspy, 2006).

Procedure

Clients in the data pool were recruited to the clinic through newspaper and online advertisements as well as through local physicians, therapists, and community agencies. Clients were screened to meet eligibility standards; requirements included being over 18 years old, not suicidal or reporting psychotic symptoms, and not enrolled in other psychotherapy. Clients who were not eligible for clinic services were offered referrals to other service providers. All clients went through an intake session where they completed a demographic questionnaire before beginning therapy. Clients gave consent for the video recording and data from all sessions to be collected for research purposes. Clients

were able to withdraw consent at any time, and paid up to $50 per session for services. At each session clients and therapists completed several process and outcome measures, including the Working Alliance Inventory Short Revised (WAI-SR) and Session Evaluation Scale (SES). The therapists were recruited from a doctoral program that sponsors the clinic.

Data Analysis

Because the data is nested, such that client and therapist ratings of working alliance and session evaluation are nested in sessions, sessions are nested in clients and clients are nested in therapists, we conducted a 4-level Hierarchical Linear Model (HLM) with dyadic working alliance and session evaluation ratings at level 1, time periods at level 2, clients at level 3, and therapists at level 4. With this model, we were able to examine within-client cultural humility at level 2 (differences between time periods), within-therapist cultural humility at level 3 (differences among clients in therapists' caseload), and between-therapist cultural humility at level 4 (differences between therapist's aggregated across clients).

We used two 4-level models to examine dyadic WA and dyadic SES. In each of the models, the predictors are between-therapist, within-therapist, and within-client cultural humility. Following Owen (2016), we controlled importance of central aspects of cultural identity, which was reported by the client on the CHS. However, we controlled for the importance of the primary salient identity, instead of an aggregate of the 3 reported identities by the client as done by Owen (2016). Unlike Owen (2016) we did not control for session number, as the model did not support this. However, because we are looking at the data longitudinally, we are in accordance with previous scholars assertions

that when examining the influence of time, it's best to not include time in the model (Wang & Maxwell, 2015).

The initial model for dyadic working alliance is:

Level-1 Model

Dyadic Working Alliance = $P_0 + P_1$*(Source: client (-1) or therapist (1)) + ε

Level-2 Model

$P_0 = \beta_{00} + \beta_{01}$*(Within-Client Identity Importance) + β_{02}*(Within-Client Cultural Humility) + β_{03}*(Within-Client Cultural Humility * Importance) + ρ_0

$P_1 = \beta_{10}$

Level-3 Model

$\beta_{00} = \gamma_{000} + \Gamma_{001}$*(Within-Therapist Identity Importance) + Γ_{002}*(Within-Therapist Cultural Humility) + Γ_{003}*(Within-Therapist Cultural Humility * Importance) + μ_{00}

$\beta_{01} = \Gamma_{010} + \mu_{01}$

$\beta_{02} = \Gamma_{020} + \mu_{02}$

$\beta_{03} = \Gamma_{030} + \mu_{03}$

$\beta_{10} = \Gamma_{100} + \mu_{10}$

Level-4 Model

$\Gamma_{000} = \Delta_{0000} + \Delta_{0001}$*(Between-Therapist Identity Importance) + Δ_{0002}*(Between-Therapist Cultural Humility) + Δ_{0003}*(Between-Therapist Cultural Humility * Importance) + ν_{000}

$\Gamma_{001} = \Delta_{0010} + \nu_{001}$

$\Gamma_{002} = \Delta_{0020} + \nu_{002}$

$\Gamma_{003} = \Delta_{0030} + \nu_{003}$

$\Gamma_{010} = \Delta_{0100} + \nu_{010}$

$\Gamma_{020} = \Delta_{0200} + \nu_{020}$

$\Gamma_{030} = \Delta_{0300} + \nu_{03}$

$\Gamma_{100} = \Delta_{1000} + \nu_{100}$

Results

The average dyadic WA rating was 3.95 (*SD =. 61*) and the average dyadic SES rating was 4.29 (*SD = .51)*. The average number of time periods per client, when CH was assessed was 3.42 (*SD* =2.97*)* and the average number of clients seen per therapist was 4.94 (*SD = 3.34)*.

Reported Cultural Identities

Clients reported their primary salient identities at multiple time points (at every 8th session). Of the reported identities, 18 % were related to ethnicity (e.g. Brazilian, Hispanic, Indonesian-American, Indian, Irish), 10% related to religious/faith/spiritualitity, 11% was related to race (i.e. blackness, white, race), 9% was related gender, 7% related to education, 6% none (did not know, or "continued to reject this question), 6% was related to socioeconomic status (class, growing up in a lower class background and living a middle-class life), 5% related to sexual orientation (queer identity, pansexual, mostly heterosexual), 6% was related to a disability (i.e. ADHD), 4% related to an intersectional/multicultural identities (i.e. being an African-American female or a Middle-class Jewish New Yorker), 4% related to gender (Male, Female), 4% related to personality traits and behaviors (working hard, honor, honesty), 3% related to Nationality (The United States, nationality), 3% related to family, 2 % related to challenging experiences (sexual violence survivor, being limited by race, growing up as a

minority), 2% related to History, 2 % related to regional identity (Maryland, West Virginian), 2% related to age, 1 % related to hobbies/interests (music, politics, knowledge).

Observations of self-reported identities across time points revealed that while some clients remained consistent in the report of their primary salient identity at each time point, about thirty clients had fluctuations in their primary identities at certain time points. For example, one client's primary salient identities were "African-American" at the end of time point one, "ADHD" at the end of time point two, "age" at the end of time period three, "gender" at the end of time period four, and "race" at the end of time period five.

Cultural Humility and Dyadic WA

The standardized fixed effects for the two HLM models are displayed in Table 1and Table 2. Cohen's guidelines were used to determine effect sizes (small, r = 0.10; medium, r = 0.30; large, r = 0.50). We predicted that that within-client cultural humility would be positively related to the dyadic WA (Hypothesis 1). As predicted, the dyadic WA was higher during time periods that clients reported higher perceived CH of the therapist compared to other time periods for that client (Γ_{0200} =356, p <. 001), a medium effect. We also predicted that within-therapist cultural humility would be positively related to the dyadic WA (Hypothesis 2). As predicted, clients who perceived therapist to be higher in CH compared to other clients in the therapist's caseload have a stronger dyadic WA, a large effect (Γ_{002} =. 548, p <. 001). Finally, we predicted that between-therapist cultural humility would be positively related to the dyadic WA (Hypothesis 3). As predicted, therapists with higher overall CH compared to other therapists have a

stronger dyadic WA, a large effect (Γ_{000} =. 610, p =. 016). Additionally, results indicate that client ratings of the WA were higher overall compared to therapist ratings of the WA (Γ_{100} =-.253, p =. 001).

We predicted that level of importance of salient identity reported by the client would moderate the relationship between cultural humility for each level (between-therapist, within-therapist, and within client) and dyadic WA (Hypothesis 7, 8, and 9). However, there were no significant interactions between the various levels of cultural humility, the client level of reported importance of salient identity, and the dyadic WA. However, within-therapist level of importance of salient identity reported by the client significantly predicted dyadic WA, (Γ_{0010} =-.120, p =. 006), a small effect. When a client of a therapist rated his or her salient identity as high in importance, compared to the therapist's other clients, they had a lower dyadic WA.

Cultural Humility and Dyadic SES

We predicted that between-therapist cultural humility would be positively related to dyadic SES (Hypothesis 6). However, this relationship was not found to be significant (Γ_{000} =. 195, p =. 321). We also predicted that within-therapist cultural humility would be positively related to dyadic SES (Hypothesis 5). As expected, clients who perceived therapist to be higher in CH compared to other clients in the therapist's caseload have a stronger dyadic SES (Γ_{002} =. 418, p <. 001), a medium effect. Finally, we predicted that that within-client cultural humility would be positively related to dyadic SES (Hypothesis 4). As predicted, the dyadic SES was higher during time periods that clients reported higher perceived CH of the therapist compared to other time periods on average (Γ_{020} =.

177, $p <. 05$), a small effect. Additionally, results indicate that client ratings of the SES were higher overall compared to therapist ratings of the SES (Γ_{100} =-.289, $p <. 001$).

The relationship between within-therapist importance of salient identity and dyadic SES was significant (Γ_{001} = -. 050, p =. 010). This indicates that clients who reported high importance of primary salient identity had lower dyadic SES compared to other clients in the therapists' caseload—this may indicate that for some clients, level of importance of their identity may influence the strength of the SES. We expected level of importance of salient identity to moderate the relationship between: between-therapist cultural humility and the dyadic SES (Hypothesis 10), within-therapist cultural humility and the dyadic SES (Hypothesis 11) and within-client cultural humility and the dyadic SES (Hypothesis 12). We expected cultural humility to be a significant factor for clients who report high identity importance, but not a significant factor for clients who report low identity importance. Our results indicated that there was only a significant two-way interaction between identity importance and between-therapist cultural humility in predicting dyadic SES (Γ_{003} = 1.06, p =. 001). Figure 1 illustrates this 2-way interaction.

As seen in the figure, there was positive slope for the relationship between cultural humility and dyadic SES when there was a high level of identity importance. The simple slope for high level of identity importance was significant (gradient =. 845, t = 13.4172, $p <. 001$); therefore when the level of identity importance of therapists' clients was generally high, as therapists trait (CH across all of the therapist's clients) cultural CH was higher, dyadic SES was higher. However, the relationship had a negative slope when there was a low level of identity importance (gradient = -.539, t =-13.58, p = < .001) was significant; therefore when the level of identity importance of therapists' clients was

generally low, as therapists trait (CH across all of the therapist's clients) cultural CH was higher, dyadic SES was lower.

Discussion

The ability to create a therapeutic environment that fosters growth in the therapeutic relationship satisfies the needs of clients, and produces successful outcomes continues to be our major goal as psychotherapists. Cultural humility has been recognized as a central component to influencing successful process and outcome factors such as the working alliance and client improvement with diverse clientele (Owen et al., 2016). The present study is the first to expand on previous cultural humility research findings, by examining cultural humility at the three levels of analysis (between-therapist, within-therapist, and within-client) and examining working alliance and session evaluation as dyadic constructs. Our assessment of WA and SES as dyadic constructs conceptually aligns with the understanding that the therapist and client perceptions and ratings are not independent, but rather inevitably dependent upon the other.

Previous research has found a relationship between cultural humility and working alliance, indicating that high-perceived cultural humility of the therapist is positively related to client-rated WA; however, they did not identify the source of this relationship. Was the relationship due to therapists' trait-cultural humility (CH level across all clients), client specific cultural humility (more CH for some clients and less for others) or therapists' state-cultural humility (changes in CH across time with the same client). The present study shows that trait, client-specific, and state cultural humility are all-important predictors of dyadic working alliance.

Trait Cultural Humility

As predicted, therapists with higher CH compared to other therapists have stronger dyadic working alliances. We also predicted that therapists higher in CH compared to other therapists would have stronger dyadic session evaluations. Contrary to our prediction, this relationship was not found to be significant.

However, the between therapist effects for dyadic working alliance indicates that there are some therapists, who are overall higher in cultural humility (high trait CH), and therefore, subsequently have higher dyadic working alliances with their clients than other therapists. This finding is supported by cultural humility previous research, which found a positive association between cultural humility and working alliance at the between-therapist level. The findings suggest that some therapist naturally have characteristics of CH imbedded in their personality or behavior, which is consistently perceived by many of their clients and results in a stronger WA.

Trait characteristics of therapists have been observed in previous studies. Some therapists can consistently produce better outcomes than other therapists; these therapists have been labeled as "superstrinks" (Ricks, 1974). Studies have found that some therapists are generally successful across all clients regardless of race or additional cultural factors; specifically, some therapists produce better outcomes, have more general competence, and multicultural competence compared to other therapists (Constantine, 2007; Imel et al., 2011; Morales et al., 2018). For example, Owen et al., (2014) found that some therapists had more unilateral terminations than other therapists—while he found that for some therapists unilateral terminations was influenced by client racial ethnic minority (REM) status—other therapists had similar patterns of unilateral terminations for both their white and REM clients. Therefore, some therapists' competence varied in

relation to client REM status, whereas other therapists seemed to retain or lack general competence regardless of the client. Morales et al., (2018) specifically examined therapist disparity in developing a strong WA based on client REM status, and found similar results to Owen et al., (2014).

Morales et al. (2018) study examining therapist effects in the strength of WA found that some therapists had stronger WA with their White clients than REM clients, some had stronger WA with REM clients than White clients, some had strong WA with both REM clients and White clients, and some had poor WA with both. These findings were not influenced by the race of the therapist, indicating that other factors influenced the strength in relationship between the therapist and client. These studies suggest that therapists, who remain consistent in their outcomes and performance, have trait qualities that are beneficial for the therapeutic process. Likewise, our study suggests another beneficial trait for therapists- cultural humility.

Client-Specific Cultural Humility

As hypothesized, clients who perceived therapist to be higher in CH compared to other clients in the therapist's caseload (client-specific CH) had a stronger dyadic WA. Similarly, clients who perceived therapist to be higher in CH compared to other clients in the therapist's caseload have a stronger dyadic SES.

The significant within-therapist effect indicates that therapist may behave more culturally humble with certain clients compared to others. It is possible that certain identities may more well-known or comfortable for therapists to work with than other identities. This is supported by previous research, which indicates differing ability among

therapists to cultivate a strong WA with their clients or produce successful outcomes. Studies on therapist effects, or therapist variability in outcomes, found that some therapists' outcomes are influenced by client characteristics. Morales et al. (2018) study examining therapist effects in the strength of WA found that some therapists had stronger WA with their White clients than REM clients and some had stronger WA with their REM clients than White clients. This pattern was also reflected in previous studies examining racial disparities in unilateral termination and treatment outcome (Owen et al., 2014; Imel et al., 2011).

Similarly, some therapists may be more culturally humble with certain cultural backgrounds than others. For example, a therapist may feel more comfortable and open to discussing a client's race or racial experiences, but may struggle with discussing an identity that is less-known to them like sexual orientation or religion. It is also possible that therapists may struggle being culturally humble with clients who hold identities that conflict with their own identities and beliefs (e.g. an atheist therapist with a religious client). Future research should explore the factors that influence client factors that may influence therapists' cultural humility. Examining a single therapist with several clients in his or her caseload would give insight into the factors that influence the varied views of a therapist's cultural humility.

State Cultural Humility

Finally, results indicated that the dyadic WA is higher during time periods that clients report higher perceived CH of the therapist, compared to the average time period (High State CH). Furthermore, within-client cultural humility was positively related to

dyadic SES, suggesting there is a higher dyadic SES time periods where clients rate their therapist as higher in cultural humility than the average time period.

The significant within-client effect suggests that perception of therapist CH can vary with time. The variation in perception of therapist cultural humility from time point to time point suggests that in certain sessions therapists may be exhibiting behaviors that are more culturally humble than in the average session/time period. This suggests that the quality of interaction and discussion on these sessions are different than the average session.

It is possible that during certain time periods, clients discussed more culture specific content compared to the average session and time period, which allowed clients to view the therapist as more open to discussing their culture (culturally humble). Furthermore, therapists may have taken advantage of opportunities to discuss culture with their clients compared to other time periods, which may not have only produced more cultural discussions but made clients feel that their therapist finds value in their culture or deems it important. Taking advantage to discuss culture when the opportunities arise is important. Owen et al. (2016) study on cultural humility and opportunities to discuss culture found that cultural humility moderated the relationship between missed opportunities and therapy outcomes, for therapists who were perceived as low in cultural humility. This study found that the higher the missed opportunities the poorer the outcome for therapists with low cultural humility. Therefore, taking advantage of opportunities to discuss cultures when they occur may be a factor in the fluctuation in perceptions of therapist cultural humility at the session level.

Importance of Primary Salient Identity as a Moderator

Results indicate that level of identity importance did not moderate the relationship between cultural humility and the dyadic working alliance, at any of the levels (between-therapist, within-therapist, and within-clients). Additionally, identity importance did not moderate the relationship of within-therapist cultural humility in predicting dyadic SES, or within-client cultural humility in predicting dyadic SES.

However, we did find a two-way interaction of identity importance and between cultural humility predicting the dyadic SES. Figure 1 shows this two-way interaction, and supports our moderation hypothesis. The figure indicates that for clients who have high identity importance as therapist trait CH is higher dyadic SES is higher This suggests that trait cultural humility, the ability to non-judgmentally and openly address cultural differences, is especially important when working with clients who care more about their culture(s). Furthermore, as predicted, clients who had low level of identity importance had lower dyadic SES scores with higher therapist trait CH. In fact, this match (low client importance and low therapist cultural humility) had higher dyadic SES than clients with low level of identity importance who were matched with therapists who were perceived as high in cultural humility (high client importance and high therapist cultural humility). This suggests that it may not be helpful to talk about culture with clients who do not care about discussing their culture or may not be ready for this type of exploration. Thus, while being open to discussing culture is important, therapists must assess whether discussing culture is relevant or important to clients.

These findings have important implications for student training, as evidence suggests that therapist can develop skills to become culturally humble. Previous research focused solely on between-therapist effects, which suggested that some therapists are

inherently more culturally humble than other therapists. This finding can be deflating for therapists who aspire to become more culturally humble and improve their ability to work with diverse client identities. The within-therapist and within-client effects suggest the existence of client-specific CH and state CH. These are hopeful findings, as it suggests that clients can learn to develop cultural humility with certain clients and identities. If client-specific cultural humility is related to therapist comfort or knowledge of certain cultural identities, than one could expect cultural humility to grow the more experience or knowledge of culture a therapist acquires.

If state CH is influenced by therapists' ability to introduce more cultural discussions and take advantage of opportunities to discuss culture, than with practice and time a therapist can increase their cultural humility by being attuned to their clients each session. These findings suggest that development of cultural humility can start small, even at the session level, and with more experience, a therapist can enhance their cultural humility.

Limitations and Future Research

The present study has several limitations. The use of a university-based clinic may draw a particular type of client compared to a community-based clinic, and may not produce a sample that is generalizable. Additionally, our use of only therapists-in-training may restrict our findings; a sample of counselors with a broad range of counseling experience may produce different results. Furthermore, the therapists in our study will provide mainly interpersonal or psychodynamic treatment; Given that psychodynamic therapists emphasize talking about past experiences, emotions, and family dynamics, we believe the conversations regarding culture and how it influenced the client's upbringing

will inevitably occur. However, this may not necessarily be true with therapeutic approaches that are more behaviorally focus.

Future studies should include a diverse range of treatment approaches, which may yield more generalizable results. Furthermore, while this study addresses a few limitations of previous studies, it is still limited in providing specific understanding on what interventions lead to being perceived as culturally humble. Identifying specific techniques and interventions that are used by therapists who are perceived as culturally humble is important for informing current training approaches. Future studies should incorporate observer raters and coding to identify specific interactions that communicate cultural humility to clients.

To increase our understanding of the factors influencing cultural humility, it would be important to examine if client perception of cultural humility is influenced by the therapist's comfort or length of experience working with particular identities. Although we reported the important cultural identities of the clients, this study did not examine or analyze the various important cultural identities of the clients is related to perceived cultural humility of the therapist.

Furthermore, it would be important to examine what influences change in primary reported identity. Is the change in primary identity influenced by the content explored in the therapy session, or by factors outside of the therapy room? Are reported primary identities influenced by the therapist's identities? It would be interesting to examine clients who transfer to a therapist of a noticeably different culture than their previous therapist to observe whether client reported identities changes depending on the perceived cultural identities of the new therapist.

Additionally, one could imagine that cultural humility can look different across cultures. For example, the value of humility varies across cultures; in eastern cultures subordinates are encouraged to be submissive, never to question authority, and emulate the authority figure. However, in Western nations like the U.S., subordinates are encouraged to ask questions and engage in discussion with their teachers in a relationship that is based on mutuality (Akhtar, 2018). Therefore, someone can be viewed as humble in the U.S. while still exhibiting behavior that may seem arrogant from another cultural perspective (Akhtar, 2018). Examining cultural humility traits across cultures would be beneficial, so that we can begin to understand how to communicate cultural humility to individuals from diverse cultural backgrounds.

Chapter II: Review of Relevant Literature

"...It is the counsellor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while he is doing so, and to communicate something of this empathic understanding by doing so (Rogers, 1959, p. 29)"

While Rogers does not directly reference culture, it is hard to imagine one's "external frame of reference" as independent of one's cultural frame of reference. In fact, Wohl (1989) offered pertinent thoughts on culture's influence. His concept was very simple: culture is always a factor. Wohl (1989) highlighted that even psychotherapy is cultural, as anything created by humans have embedded within them values, rules, assumptions, myths, and rituals of a particular culture; therefore psychotherapy, individuals, relationships, institutions, are inevitably and always, working within a cultural framework.

Roger's call that therapist must remove themselves from their frame of reference to reach true empathic understanding of the client highlights the importance of being aware of one's own culture and the culture of the client. To achieve this, one must undergo deep introspection, as the influences of culture may be hard to disentangle or identify.

Power and Privilege

For many individuals of marginalized identities, Wohl's (1989) statement, 'Culture is always a factor,' is an obvious one. Marginalized individuals have spent their lives being singled out as different and as "less than" due to their differing cultural identities. The visibility of culture is very much influenced by the power and privilege

one holds. Being able to ignore culture is a consequence of privilege—this is made possible when a member of a privileged identity frequently occupies spaces that are similar to his/her identity, and are subsequently, not forced to navigate spaces outside their social norms, values, and beliefs. In the U.S. for example, a White individual may not feel that they have a culture because Western European values dominate the cultural norms of the Unites States, which is a consequence of White privilege (McIntosh, 1988).

Privilege and oppression affects both privileged and subordinate groups (Sisneros, Stakeman, Joyner, & Schmitz, 2008). However, consequences for members of oppressed groups are often more destructive as oppression silences marginalized people and prevents them the opportunity to fully participate in society (Sisneros et al., 2008). Oppression directly stems from privilege. Oppression exists because others obtain some advantage from it. In the context of white privilege, the advantages of white people maintain the oppression of people of color. Furthermore, oppression does not require intent by the oppressor; even when unintentional, the pain and harm of the oppression are still present. Finally, oppression can occur at various levels: individual, institutional, and cultural levels (Hardiman, Jackson, & Griffin, 2007)

Individuals of marginalized identities face a oppression constantly at the individual, instituational, and cultural levels; in fact, studies have found that the social oppression persistently endured such as racism, sexism, homophia, classism, ableism, and transphobia cause negative psychological effects on individuals of marginalized identities (Altman, 2010; Comas-Diaz, 2011; Greene, 2007; Jefferson, Neilands, & Sevelius, 2013; Tummala-Narra, 2007). Therefore, therapists need to be able to effectively treat diverse cultural groups and bear in mind that each person will bring with them different

experiences of privilege and oppression.

Health Disparities

Health disparities persist among many marginalized identities including race, class, sexual orientation, and ability status (National Academies of Sciences, Engineering, and Medicine, 2017). Psychotherapy continues to be difficult to access, underutilized, and of lesser quality for racial-ethnic minorities; Furthermore, racial-ethnic minorities tend to prematurely terminate treatment at a higher rate than their white counterparts (Sue, 1998; Fortuna, Alegria, & Gao, 2010). Premature termination, especially in the early phases of therapy, is associated with poor client outcomes (Archer, Forbes, Metcalfe, & Winter, 2000; Klein, Stone, Hicks, & Pritchard, 2003). Racial ethnic minorities have higher dropout rates than Whites. Furthermore, research on therapist effects in premature termination rates demonstrated that therapists can vary in their ability to retain clients, and that this variability can be influenced by the client's racial/ethnic status. For example, some therapists achieve poorer outcomes with racial ethnic minority (REM) clients compared to White clients in their caseload. (Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Owen et al., 2017).

It is clear that there is a significant gap in the quality of care received by members of marginalized identities. A number of theories including aversive racism, microaggressions, implicit bias and cultural mistrust have been proposed to further explain the disparities in client outcome (Sue et al., 2007; U.S. Department of Health and Human Services, 2001).

Implicit Bias

Research has indicated that unconscious thoughts and behaviors rooted in

discrimination and prejudice as an important factor that can influence therapy outcomes. Therapists are not immune from internalizing the prejudicial attitudes and beliefs embedded in our social context. In fact, Boyson's (2009) review on studies examining therapist implicit and explicit biases found that explicit racial bias was not generally present among counselor; however, implicit bias was found to be very common. Explicit biases are negative beliefs and stereotypes that are conscious, while implicit bias refers to negative beliefs that occur without conscious intention. This research suggests that therapists can hold subtle prejudicial beliefs about their clients, which can affect how therapists relate and treat their clients (Boyson, 2009). Dovidio and Gaertner (2004) highlight that aversive racism is a result of holding negative beliefs and attitudes toward racial minorities while also concealing the racist beliefs from others or even themselves, which suggests that individuals who deem themselves as "not prejudice" can unconsciously commit the expression of racist beliefs.

Microaggressions

The term racial microaggression was first used by Pierce et al. (1978) and defined as "subtle, stunning, often automatic, and non-verbal exchanges which are 'put downs' (p. 66)." A recent definition describes them as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group (Sue et al., 2007, p. 273). These insidious acts of discrimination have been found to be pervasive in the lives of marginalized communities, particularly in the lives of Hispanics, Asian Americans, and African Americans (Nadal, 2011; Nadal, Escobar, Prado, David, & Haynes, 2012; Rivera, Forquer, & Rangel, 2010;
Sue, Bucceri, Lin, Nadal, & Torino, 2009; Sue et al., 2008).

Research demonstrates that racial microaggressions also occur in counseling and can impede the therapeutic process with racial minority clients; Studies have found that racial microaggressions are associated with poorer treatment outcomes, lower intention to seek counseling in the future lower client psychological well being (Constantine, 2007; Crawford, 2013; Morton, 2012; Owen et al., 2011; Owen, Tao, Imel, Wampold, & Rodolfa, 2014).

Sue et al. (2008) highlighted that sexual minorities also face daily subtle discrimination, referring to these experiences as sexual orientation microaggressions. Like racial microaggressions, studies have indicated that sexual orientation microaggressions occur in counseling context and are associated with both a weakened therapeutic alliance and decreased effectiveness of treatment (MacDonald, 2014; Shelton & Delgado-Romero, 2011). These negative experiences faced by individuals of marginalized identities can lead to further marginalization and distrust of medical professionals.

Cultural Mistrust

Research has shown that individuals of marginalized identities have a mistrust of institutions and constructs that are controlled by the dominant culture. REMs, for example, have been found to distrust White medical professionals (Whaley, 2001). For example, Nickerson et al. (1994) found a relationship between cultural mistrust and attitudes toward counseling for Black clients, especially when the therapist is White. In addition, research shows that Blacks with high levels of cultural mistrust also hold more negative views and expectations of White therapists and have more negative health-seeking attitudes (Whaley, 2001)

Moreover, members of the LGBT community may also harbor distrust of medical professionals. Research into mental health services showed that while gay men and lesbians are more likely than heterosexuals to use mental health services (King and McKeown 2003), they are fearful for their safety, of a breach of confidentiality, and the consequences of coming out to health practitioners.

It is important to acknowledge that cultural mistrust develops as a result of a history of mistreatment from those in power. For example, the Tuskegee study of untreated Syphilis in Black American males is a prime example of the mistreatment of racial minorities. In this study, doctors wanted to observe the impact of untreated syphilis at the expense the Black males who believed they were receiving genuine medical treatment. The historical evidence for cultural mistrust suggests that Blacks in America, and throughout the world, have a valid reason to mistrust systems controlled White people (Terrell & Terrell, 1981).

Homosexuality has also historically been stigmatized in society. Individuals who identifies as LGBT faced extreme isolation and stigma from the rest of society, who saw their sexual identity as sexual perversion, or pedophilia. Homosexual behavior was seen as a criminal behavior and was deemed a severe mental disorder in the DSM (D'Emilio, 2012). The long history of mistreatment and prejudice toward LGBT community in the field of psychology may make seeking therapy difficult for LGBT members.

The Current Chapter

More than ever, there is a significant obligation to appropriately service individuals of all diverse cultural backgrounds—and with this responsibility therapists must acknowledge how power and privilege intersect with the cultural identities of their

clients. With the increasing need for mental health support by individuals of marginalized identities, it is abundantly clear that psychotherapy has a significant responsibility to assess its approach to addressing culture and the cultural experiences of clients within treatment.

The current chapter attempts to examine the effectiveness of our treatment of diverse backgrounds and explore the integration of culture in psychotherapy. More specifically this paper aims to critically examine how culture is conceptualized in psychology and examine the two currently proposed multicultural frameworks: the multicultural competency framework and the multicultural orientation framework.

‘Culture’ Defined

The definition of culture in psychology has varied---illustrating the complex nature of studying culture within the context of psychotherapy. Rohner (1984) defined culture as highly variable systems of meaning that are learned and shared by an identifiable group of people. Others have conceptualized culture to include both “physical” and “subjective” aspects, in which physical culture refers to buildings, roads, tools, and other “cultural” objects while subjective culture includes values, social norms, and roles, and beliefs (Triandis, 1980).

Unfortunately, measuring culture in psychotherapy research is a difficult process as culture is complex and multidimensional. Ethnicity and race have been used widely in research as a proxy for culture (Betancourt & López, 1993). Race, previously characterized as biological and genetic group differences, has evolved to be considered socially constructed and rooted in assumptions prescribed to features such as skin color and phenotype (Quintana, 2007). Ethnicity, considered distinct from race by some

scholars, is related to culture and refers to groups or "tribes" who share social and cultural traditions, language, and communication styles (Betancourt & López, 1993; Quintana, 2007). However, this practice assumes race and ethnicity at the primary source of culture and ignores other cultural identities that may be more salient for the client or therapist; for example, age, disability, religion, social class, sexual orientation, indigenous populations, language, and gender (Hays, 1996). Furthermore, it focuses on differences between racial-ethnic groups and neglects the within group variability that may be present. This may lead to interpretations of findings that reinforce racist beliefs (Zuckerman, 1990). Furthermore, the intersectional component of culture is ignored. For example, an affluent Jewish female living Brooklyn is not only influenced by her Jewish culture and religion, but by her experience as a woman and even her life in Brooklyn. This woman's understanding of the world may be very different if she moved 12 hours away to a Midwestern state in the U.S. or another part of the world.

Betancourt and Lopez (1993) highlighted this limitation in cultural research, acknowledging that demographic variables do not sufficiently measure culture and therefore, cannot be an assumed substitute. Instead, they underscored Triandis (1980) definition of "subjective" culture, defining culture as the shared beliefs, values, norms, and expectations within a group, community, or society. Betancourt and Lopez (1993) intentionally focused on the subjective elements of culture, characterizing them as more psychologically relevant.

Like Betancourt and Lopez (1993), APA (2002) multicultural guidelines definition focuses on the subjective elements, defining culture as "the belief systems and value orientations that influence customs, norms, practices, and social institutions,

including psychological processes (language, care taking practices, media, educational systems) and organizations (Fiske, Kitayama, Markus, & Nisbett, 1998). Inherent in this definition, similar to Wohl (1989), is the view that everything is influenced by culture and working within a cultural framework, as everything is impacted by cultural norms and values.

Integrating Culture into Psychotherapy

Incorporating culture in the conceptualization of and treatment of clients has been shown to be beneficial for clients. Research shows that even just engaging in discussion about a client's cultural background can be beneficial not only for the client, but for the therapist. Tsang, Bogo, and Lee (2011) analysis of nine cases determined that therapists who actively and positively engaged in cross-cultural discussions with their clients expressed a better understanding of their client's goals and needs, appeared more emotional attuned with the clients, and appropriately addressed cultural issues raised by the client in session. These results demonstrate that when therapists acknowledge the cultural values and experiences of the client, they are better therapists. They are more attuned to the clients needs, and may therefore, have a stronger empathic understanding of their clients than therapists who do not engage in cultural discussions.

Scholars have also highlighted that psychological concepts and theories have been predominantly developed in a Euro-American context, and therefore may be limited in its application to the diverse cultures in the United States (Sue & Sue, l999; Wampold, 2007;). In order to provide treatment that better fits the cultural values of a client, psychotherapists have adapted treatments to better fit the needs of the clients. Smith, Rodriguez, and Bernal (2011) found that culturally adapted treatments for clients of color

are more effective when compared to traditional treatment procedures. Results indicated that when mental health treatments were designed targeting one particular cultural group in mind, these treatments outperformed other treatments serving clients from a variety of cultural backgrounds. Furthermore Benish, Quintana and Wampold (2011) meta-analysis of studies measuring the effectiveness of cultural adapted treatments found that culturally adapted psychotherapy treatment was more effective than unadapted psychotherapy treatment for racial-ethnic minority clients.

Understanding the fundamental values of a client's culture can be the first step to understanding the client, and being open to viewing the world from a lens other than your own. Scholars have highlighted the importance of gaining knowledge about cultures and suggest that therapists learn from multiple sources including literature, cultural immersion experiences, as well as peer and supervisor consultation (Ponterotto & Potere, 2003; Sue & Sue, 2008).

Despite the effectiveness of culturally adapted treatment, scholars have pointed out the importance of not assuming one's cultural framework based on racial-ethnic status. This is particularly important in the United States, which is high in diversity and has a high quantity of individuals that have multicultural identities. Wohl (1989) warned against assuming that a particular treatment has to be adapted based on cultural group membership of the client. He stressed that clients need to be treated as individuals, who are also a member of a cultural group. His recommendations highlight that psychotherapy is not black and white, where people can fit into boxes created just for them. Instead, psychotherapy should be fluid, flexible, and adaptable in order to receive the client's needs, values, norms, and more. Wohl (1989) states that effectively addressing culture

requires more than knowledge; he states that clients will not react in ways that are expected, and therefore flexibility is vital when working with clients, not only when working with clients who exhibits higher cultural differences than the therapist. This highlights that a rigid view and understanding of culture that emphasizes broad generalizations and stereotypes of cultural groups will not be effective in working with clients.

However, although there is significant evidence of the benefit of effectively addressing culture in psychotherapy, the number of practicing therapists that are engaging in cross-cultural conversations is low. A survey of 689 APA-licensed psychologists found that therapists reported having discussions about cultural issues with less than half of their racial ethnic minority clients (Maxie & Arnold, 2006). This causes one to wonder whether psychologists feel prepared to address cultural differences within therapy, and what may be contributing to the feeling of lack of ability. Some scholars have critiqued that cultural competency framework, emphasizing the demand for therapists to reach an unattainable task of being familiar with the cultural background of all clients.

Cultural Competency Framework

Sue, Arrendondo, and McDavis (1992) highlighted the need for multicultural competence based on the growing diversity of the U.S. and the socio-political realities of prejudice and discrimination. They proposed a model of 9 competencies with 31 skill areas in 3 dimensions of cross-cultural competencies: (a) counselors' awareness of their own cultural values and biases, (b) their awareness of the client's worldview, and (c) initiation of culturally appropriate intervention. These dimensions were connected with three major components: attitudes and beliefs, knowledge, and skills (Sue et al., 1998);

these three major components have become the most commonly accepted conceptualizing of multicultural competence.

Sue highlighted significant consequences to not having adequate competence with culturally diverse clients like committing racial microaggressions, which have been shown to have negative psychological effects on the "target" (Sue, 2007). Multicultural competency has also been linked to working alliance, so that therapists who were perceived as culturally competent reported stronger working alliances (Maxie & Arnold, 2006; Constantine, 2007). Perceived multicultural competence was also negatively correlated with racial microaggressions indicating that multicultural competence may be linked to making less harmful mistakes rooted in racist attitudes and beliefs that make the client feel further marginalized.

However, Sue et al. (1998) three-dimensional model for multicultural competence has been criticized for its emic approach. Emic refers to its culturally specific approach, which has the potential to place individuals in categories. Critiques of this framework believe that operating from a knowledge acquisition stance has the potential to perpetuate stereotypes and microaggressive behavior, as individuals will operate from a limited and generalized understanding of cultural groups that does not apply to every individual.

Another limitation of the multicultural competency literature is its focus on ethnicity and race as sources of culture, ignoring other important identities. For example, Sue's (2001), Multiple Dimensions of Cultural Competence (MDCC) offers a conceptual framework for organizing important dimensions of cultural competence. Although Sue (2001) briefly acknowledges the cultural influences of gender, disability, ability, age, education, and socioeconomic status in his paper, he focuses primarily on race and

ethnicity. Sue justifies his decision to focus on race and ethnicity over other cultural identities, stating, “Because group identities, such as race and ethnicity have historically occupied a tangential role in psychology, the focus of my model on cultural competence operates from a group perspective that is race-based (Sue, 2001, p. 795.)”. Therefore, for Sue (2001) race and ethnicity are the major cultural identities influencing individuals and their view of psychotherapy. However, race and ethnicity are not the only identities that have occupied important roles in psychology.

Not only is this framework itself vulnerable to perpetuating stereotypes and assuming race is important to the client, but the way scholars have approached measuring cultural competency has ignored the multidimensionality of culture. Kumas-Tan, Beagan, Loppie, MacLoed, and Frank (2007) systematically reviewed the most frequently used cultural competence measures and identified several problematic assumptions of current measures. They found that measurements usually equated culture with ethnicity and race and largely ignored other components of culture such as gender, class, geographic location, country of origin, or sexual preference. Kumas-Tan et al. (2007) further highlights that cultural competence measures operate through an assumption that culture is possessed by the client or the ‘other,’ not acknowledging the culture of the therapist. Furthermore, whiteness is understood and represented as the norm in some measures. Kumas-Tan conclude that the cultural competence measure assume that culture is a confounding variable that white providers must control for when they care for people of different races than themselves (Kumas-Tan et al., 2007).

Wohl (1989) highlights the fundamental mistake often made by individuals when thinking about culture. This mistake is rooted in the conceptualization of culture as

something only present in the “exotic” other, rather than all individuals living in systems influenced by cultivated values and beliefs—which is everyone. Although culture feels most relevant and visible between two people of dissimilar backgrounds, the cultural context does not disappear between two people from more similar cultural backgrounds (Wohl, 1989). In fact, Wohl (1989) boldly claims that all psychotherapy, all interactions, are cross-cultural, as every individual navigates their culture and internalizes their culture differently despite identifying with the same cultural group. Therefore, within-group differences are just as significant as between-group differences. One could argue even more so because it’s inconspicuous nature can make therapists forget or disregard the cultural differences present between him/her and the client, and over rely on assumptions based on one’s own personal preference and experiences.

Emphasizing culture for REMs further “exoticizes” them, rather than declare that everyone has embedded within them beliefs, values, and norms that shape their lives. Culture is not limited to racial-ethnic minority identity; however, studies have often conflated race and ethnic minority identities with culture, even though demographic variables do not adequately measure culture (Betancourt and Lopez, 1993). Furthermore, race and ethnicity may not be the most important cultural identities to a client. Assigning race and ethnicity as the cultural identity of the client denies clients the autonomy and power to claim their own cultural identities and importance.

The assumptions embedded in the cultural competency framework’s approach to measuring and conceptualizing culture further perpetuates the cycle of oppression by endorsing assumptions of racial ethnic group identity. Moreover, it operates from a very ethnocentric and superior view—allowing white individuals to operate from the

assumption that culture is only relevant for racial ethnic minority clients.

Cultural Humility Framework

In 1998, Tervalon and Murray-García suggested that cultural competency be distinguished from cultural humility. They summarized that "cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123).

Therefore, cultural humility has the prerequisite of 'cultural neutrality' (Akhtar, 1999). Cultural neutrality means that the therapist does not assume any particular culture to be inherently superior to another.

Tervalon and Murray-Garcia (1998) emphasized that cultural humility was a more appropriate goal than cultural competence in multicultural education. Cultural competence emphasizes the importance of knowledge as crucial to achieving the ability to successfully address and integrate culture, while cultural humility acknowledges that one will never attain enough knowledge to truly understand the client's culture. It requires constant reflection about one's own cultural views and beliefs, in order to understand how one's cultural framework may impact their understanding of the client. It also aims to learn cultural views and beliefs from the worldview of the client, rather than through preconceived ideas. Clients are given power and autonomy to define their cultural identity and experiences.

In this way, the therapist allows the client to be the expert in his or her own cultural views. Therefore, the therapist does not operate from his or her worldview, but

instead tries to understand the client through the client's perspective. Cultural humility involves being open to learning about the client's cultural background without displays of arrogance, superiority, and stereotypical assumptions.

Foronda, Baptiste, Reinholdt, and Ousman (2015) concept analysis of the term cultural humility identified specific traits associated with cultural humility. They uncovered attributes of openness, self-awareness, egoless, supportive interaction, self-reflection and critique. The antecedents to cultural humility were diversity and power imbalance. The consequences of cultural humility were respect, mutual empowerment, partnerships, and lifelong learning. Antonyms identified were prejudice, oppression, intolerance, discrimination, stereotyping, exclusion, stigma, inequity, marginalization, misconceptions, labeling, mistrust, hostility, misunderstandings, cultural imposition, judgmental, undermining, and bullying.

Cultural Humility Studies In Psychotherapy

Hook et al. (2013) recruited 120 self-identifying Black participants through Amazon's Mechanical Turk and asked participants to retrospectively report their working alliance and perceptions of therapists' cultural humility. Findings indicate that therapist and client perceptions of therapist cultural humility were positively related to having a strong working alliance and positive client outcomes. This study had several limitations. It's use of an M-Turk sample limits access to important information that may influence data analysis, for example: number of sessions completed, quality of the therapist, type of setting, and type of treatment. Second, the primary measures used in the present were retrospective self-report measures, which introduces the possibility that clients are misremembering their experiences. Clients may struggle to remember their experiences

in therapy accurately due to the lapse their time in therapy to completing the self-report measures. Furthermore, while a cross-sectional design gives us insight into the relationships between the factors, it does not give insight into the stability (or variability) of the relationship throughout therapy. A longitudinal design with multiple clients for each therapist will allow us to examine whether cultural humility is a state or trait characteristic.

Using a university sample, Owen et al. (2014) also asked 45 self-identified religious and spiritual participants to report the perceived cultural humility of the therapist and the working alliance of their previous therapy experience. The found a positive correlation between cultural humility and working alliance. Furthermore, they found that cultural humility might be more important for aspects of a client's cultural background that are particularly salient and important. Specifically, they found that therapist's cultural humility toward a client's religious worldview was positively related to client outcomes, finding that this association was stronger for clients with high levels of religious commitment. Limitations to this study include the small sample size, the cross-sectional design, and the lack of generalizability of the sample.

Using an undergraduate sample of 128 participants, Davis et al. (2016) examined whether cultural humility mediated the relationship between perceived racial microaggressions and client-rated working alliance. Participants were asked to think of a microaggression experienced in therapy and write about it. Davis et al. (2016) found that cultural humility mediated this relationship, demonstrating that racial microaggressions are negatively associated with perceived cultural humility of the therapist. A cross-sectional design did not allow them to examine the causal relationship implied by their

mediation model. A longitudinal design that assessed microaggressions, cultural humility, working alliance, and outcomes at multiple points throughout the course of counseling would have allowed them to test their mediation model.

Furthermore, clients were asked to think of past therapy experiences. Like (Hook et al., 2013; Owen et al., 2014; 2016) this study did not examine this relationship among individuals who were currently in therapy. Therefore, retrospective self-reports of the clients may not be accurate as clients may be remembering their experiences differently. It is possible that they may not remember moments of racial microaggressions or may remember their experience more positively than it was in the moment.

Hook et al. (2016) examined the relationship between cultural humility and racial microaggressions. Using a sample of 2,212 participants recruited through Amazon's Mechanical Turk, Hook et al. (2016) asked clients to retrospectively complete measures about their past therapy experiences to examine the relationship between cultural humility and racial microaggressions. Perceptions of cultural humility were associated with lower racial microaggression frequency in counseling and lower negative impact of those racial microaggressions. Like Hook et al. (2013) study, this study's use of Mechanical Turk does not make it possible to control for factors that may influence the data like type of setting, number of sessions completed and type of treatment. The retrospective self-reports also introduce the possibility of inaccurate accounts from the client.

Owen et al. (2016) study of 50 therapists and 247 clients from a university center providing brief term therapy examined the relationship between the perception of therapists' cultural humility and the perception of therapists' missed opportunities to

discuss cultural issues. Clients were asked to retrospectively report their perceptions of therapists' cultural humility at the end of the academic term. Findings indicate that cultural humility moderates the relationship between cultural missed opportunities and client outcome. Although missed cultural opportunities were related to poor client outcome, this relationship was not significant for clients who perceived their therapist as culturally humble. The retrospective self-reports also introduce the possibility of inaccurate accounts from the client. Furthermore the use of university sample is not generalizable. Future studies should examine cultural humility in a diverse community sample for more generalizable results.

Cultural Humility Scale

The Cultural Humility Scale (Hook, 2013) aims to improve the limitations in the current approach to measuring culture psychotherapy. By allowing clients to report their three salient identities, the scale is acknowledging the individuality and intersectionality of identity. It does not assume that one's racial-ethnic identity is the primary identity for the client; for example a lesbian African American woman may find her sexuality to be the most salient cultural identity for her, not her race. It also allows for a client to report an intersectional identity as equal, by being able to report " African American Woman," both race and gender as equally important intersectional identities.

The scale also asks questions directly related to the concepts of openness and lack of arrogance, which clients can easily identify through their experiences with the client. However, it is important to note that the Cultural Humility Scale only measures the interpersonal aspects of cultural humility. The intrapersonal component involves the therapist's continual reflection in his or her own cultural identities, biases, and awareness

of the cultural issues of others. The intrapersonal component of cultural humility is an especially important aspect of the construct, as major critiques to the multicultural competency framework is aimed at the lack of understanding of the fluidity and evolution of culture.

The introspective nature of cultural humility allows therapists to constantly be attuned to the evolution and nuances of culture. This introspective component also holds therapist's accountable for acknowledging themselves as cultural beings who are influenced by their own set of values and norms, rather than solely focus on the client as a cultural being. Given that this introspective component of cultural humility is a defining factor, it is important that future studies uncover methods to measure and foster the reflective nature of cultural humility.

While research has not uncovered whether cultural humility is a trait or state construct, a few scholars seem to believe it is possible to become more culturally humble and have suggested certain strategies to develop more cultural humility. Yeager and Bauer-Wu (2013) emphasizes the importance of being reflective and mindful in a culturally humble stance. To be culturally humble, it is imperative that one examines personal values, beliefs, and biases that are derived from one's own culture. Therefore, Yeager and Bauer-Wu (1993) suggest that practicing mindfulness can help clinicians and researchers become more reflective, and thus, more culturally humble. Mindfulness has shown to help clinicians be more mindful and aware in the clinical setting and other aspects of everyday life (Galantine, Baime, Maquire, Szapary, & Farrar, 2005). Mindfulness has also been suggested as a tool to help increase concern and consideration for others (Boellinghaus, Jones, & Hutton, 2014). Through this practice, therapist can

increase their reflexivity, and be able to practice cultural humility. Schussler, Wilder, and Byrd (2012) also emphasize the importance of improving self-awareness when developing cultural humility. They suggest the use of reflective journaling as a teaching strategy to help students cultivate this important aspect of cultural humility. Using this method in psychotherapy training may be beneficial for helping to develop cultural humility. Future studies should examine whether the introduction of journaling or mindfulness is related to increase in perceived cultural humility.

Conclusion

Finding ways to approach culture from a culturally humble stance is imperative to improve our current approach to addressing culture in research and clinical practice. It is important to teach cultural humility not only in the context of the therapeutic relationship, but also in the relationship between researcher and participants (Yeager & Bauer-Wu, 2013). A glance at the current research that has been conducted on diverse populations show that most research studies are focused on racial-ethnic identities, resulting in identities like religion, disability, sexuality, gender identity and age being significantly under-examined. Despite the APA's definition of culture emphasizing the belief and value systems that influences norms and practices, in the applied setting we are equating race and ethnicity with culture. Our over emphasis on racial-ethnic identity ignores the cultural values embedded in other types of cultural identities.

It is imperative that as field, we change our perspective of culture and what it means. It should no longer be applied solely to minorities. For example, often times the cultural differences within white racial group are disregarded. It is important to acknowledge and understand white clients within their cultural context; for example, a

client raised in an Italian-American family may hold different values and ways of being compared to a client raised in a Jewish or Swedish household. The concept of power and privilege does not disappear in the context of White Americans, but may operate differently than in the lives of racial ethnic minorities. By focusing on how culture applies to all clients and therapists, the importance of reflecting on the dynamic of culture between client and therapist becomes necessary for all therapeutic interactions. This will remove the implication that minority populations are different because they are influenced by culture.

Furthermore, as scholars, we must start to acknowledge the complexity of culture through our operationalization of culture in research. The concept of cultural humility brings us one step closer to examining culture through a multidimensional and intersectional approach. By allowing clients to report their own identity and define what their culture means to them, we are also given clients power and autonomy over their own identity. This is important as it reduces the power imbalance, and removes the therapist from the role of expert.

While evidence suggests that cultural humility is positively associated with client outcome and a strong therapeutic alliance, there is more work to do to understand how to provide culturally humble treatment. Future studies should focus on understanding what specific interventions are related to perception of cultural humility in therapists. Specific understanding of interventions used by therapist to promote a culturally humble approach is important for training purposes. Additionally, researchers should examine whether cultural humility is a trait or state construct, or a combination of both. This will inform

training practices, as we would know what aspects of cultural humility can be learned and improved through training.

Appendix A

Table 1

Fixed Effects of Dyadic Working Alliance (WA) on Cultural Humility (CH) Model

Variable	Coefficient (Standardized)	Standard Error	*t*-ratio	*df*	*p*-value
Between-therapist					
Identity Importance	.026	.105	.253	104	.800

Cultural Humility	.610	.252	2.420	104	.016
CH * Identity Imp.	.643	.420	1.53	104	.126
Within-therapist					
Identity Importance	-.119	.043	-2.795	517	.006
Cultural Humility	.548	.138	3.988	104	<.001
CH * Identity Imp.	.073	.114	.637	104	.524
Within-client					
Identity Importance	-.006	.033	-.194	13	.849
Cultural Humility	.356	.077	4.592	104	<.001
CH * Identity Imp.	..038	.168	0.223	104	.823
Type	-.254	.057	-4.452	13	001

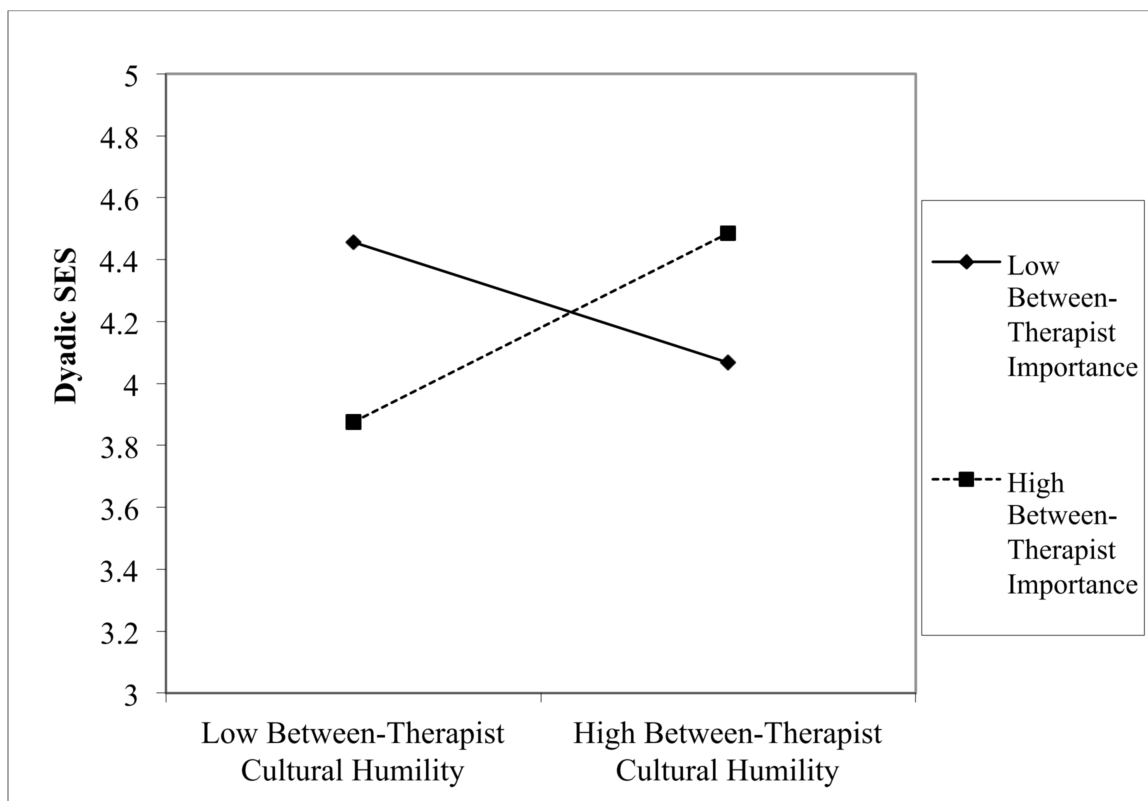
Table 2

Fixed Effects of Dyadic Session Evaluation Scale (SES) on Cultural Humility (CH) Model

Variable	Coefficient (Standardized)	Standard Error	*t*-ratio	*df*	*p*-value
Between-therapist					
Identity Importance	-.009	.072	-.132	104	.896
Cultural Humility	.195	.197	.994	104	.321
CH * Identity Imp.	1.06	.325	3.271	104	.001
Within-therapist					
Identity Importance	-.053	.020	-2.582	517	<.010
Cultural Humility	.418	.064	6.543	104	<.001
CH * Identity Imp.	-.020	.111	-0.181	104	.856
Within-client					
Identity Importance	.008	.025	.302	13	.768
Cultural Humility	.178	.056	3.147	104	.002
CH * Identity Imp.	-.080	.172	-.468	104	.640

Appendix B

Figure 1. Two-Way interaction: Dyadic SES on Between-therapist CH and Importance



Appendix C

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

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

Appendix D

Outcome Rating Scale

Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right represent high levels.

Overall:
(General sense of well-being)
Low High

Individually:
(Personal well-being)
Low High

Interpersonally:
Family, close relationships)
Low High

Socially:
(Work, school, friendships)
Low High

Appendix E

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe___likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ___and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ___and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that___appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Note: Items copyright © Adam Horvath. Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12;

Bond Items: 3, 5, 7, 9

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