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The Multicultural Guidelines in Practice: Cultural Humility in Clinical Training & Supervision

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Abstract

The updated APA Multicultural Guidelines bring to the forefront many contemporary issues in clinical practice and supervision (APA, 2017). However, knowledge of recommended practices alone may not always create change in typical clinical practice. The application and implications of the multicultural guidelines will be explored from a supervisee perspective. In particular, the concept of cultural humility will be examined in relation to specific supervisory interactions and training standards dealing with race, culture, and identity. The role of power, privilege, and prejudice will also be discussed as relevant to clinical and supervision processes. A supervisee perspective of how the above topics may be relevant to clinical training more generally are presented. Finally, specific suggestions implementing a cultural humility perspective into clinical supervision and practice is discussed. The author's hope is that by examining common, current practices from an underutilized lens, further exploration and discussion of related practices will be stimulated.

Impact Statement

This study offers an examination of current practices towards culture in clinical training. Cultural humility is offered as a guiding principle that may inform current practices and offer solutions to contemporary issues in training.

Keywords

[Multiculturalism; Cultural Humility; Ethnic Minorities; Intersectionality, Cultural Competency]

The Multicultural Guidelines in Practice: Cultural Humility in Clinical Training & Supervision

One of the most influential experiences relating to my personal development as a trainee occurred in response to a simple prompt provided by my supervisor in the group supervision setting. I believe the excellent prompt highlights issues with multicultural training often not focused on:

> Consider that you knew you were soon going to be meeting a client for the first time who was from a cultural group you knew very little about. Also, imagine that you had access to a 1-page encyclopedia summary sheet that discussed many of the important aspects of that culture. The sheet would likely list common practices, beliefs, social norms, and taboos. Would you read the sheet before meeting with the client? Why or why not?

In response to this prompt the supervisees each offered reasons they might decide to read such an information sheet. The first offered that if we do not have information about a culture, it may be helpful to get a sense of the values and practices associated with a group. Another stated that learning about a culture is often discussed as a method to reduce engagement in culturally insensitive actions. Two separate students described how seeking expertise on a cultural group may give the therapist more power to assist the client. Finally, a student argued that if the therapist researches the client's culture on their own, it may ease the burden the client may feel in explaining cultural practices to a therapist. I thought the other supervisees offered a compelling argument of why researching a culture is a considerate attempt to learn more about a client's perspective.

Our supervisor then asked us to consider why we might reject such information, which seemed bizarre to many of the supervisees. In fact, my initial interpretation was very much the

same. However, as I sat there considering the other supervisee responses, some questions began to arise that I posed to the group. How well could a summary sheet accurately represent an individual member of that culture? How would I feel if my supervisor disclosed that they researched my ethnic culture before our first supervision appointment? Would my discomfort and concerns of stereotyping be valid? Would it not be reasonable for a client to feel similarly about a therapist conducting the same actions? How would a therapist of color researching “White Culture” be perceived? Our supervisor explained how our positions reflect ongoing debate among psychologists about contemporary cultural competency models.

Multicultural issues are complex, and the inclusion of the previous supervisory dialog is intended to highlight the difficulty in balancing well-intentioned information seeking with respect for the client’s individuality. After all, the client is the expert in their own worldview and context. As a trainee from a very different cultural context than others in my program, I was drawn to the notion of culture from the start of my clinical training. Being a cultural “other”, I was often assumed to have achieved a higher degree of “cultural competence” by supervisors. Instead, I believe that examining and questioning my personal and professional biases is what has made me a more culturally sensitive clinician. The above prompt was the catalyst for me developing many questions about best practices in clinical supervision. Even more central, it helped me reflect on my own confidence in dealing with cultural issues more broadly.

Multicultural Approaches in Training

It is easy to overlook that it was not until 2003 that the first APA Multicultural Guidelines (APA, 2003) were published. This was an essential step to move forward the field of psychology and clinical practice in particular. Prior to this, research findings that derived from a relatively unique population were often generalized to represent the human condition with little

question (Henrich, Heine, & Norenzayan, 2010). The multicultural guidelines helped to concretize the notion that multicultural approaches are necessary and may require consideration beyond a one-size-fits-all attitude. In contrast to past practices, multiculturalism countered the notion that western perspectives were the ideal in all circumstances.

Multicultural sensitivity is now one of the central skills expected of all students trained in clinical psychology. "Cultural Competence" is the term most commonly used to describe the skills associated with multiculturalism that trainees are expected to master. Cultural awareness, cultural knowledge, and an open attitude to individuals from other backgrounds are considered key proficiencies required of any capable clinician. Despite wide adoption, cultural competency has been criticized for increasing stereotyping, ignoring power dynamics, bolstering oversimplified static views on identity, and for focusing heavily on categorizing "others" rather than self-examination (Buchtel, 2014; Garran & Werkmeister Rozas, 2013; Tervalon & Murray-García, 1998). In many ways, cultural competence has not gone far enough to challenge white, middle class values and ways of being as the standard against which all behavior is evaluated. Cultural humility has been argued to be the successor of cultural competence, as it directly addresses these shortcomings of cultural competency (Hunt, 2001). Cultural humility can be defined as both an openness towards self-reflection about our personal existence as a culturally embedded being and a willingness to hear and strive to understand aspects of the cultural backgrounds and identities of others (Watkins & Hook, 2016). It relies upon non-paternalistic partnerships, mutual respect, unpresuming curiosity towards individual cultural identity, self-critique, and actions that equalize relational and societal power imbalances.

While many have proposed cultural humility to be a replacement for cultural competency, others have argued that cultural humility is already a component of cultural

competency. Nonetheless, even critics of replacing the term cultural competency acknowledge there are problems with cultural competence if only in the semantic implications and common misapplications of the concept (Danso, 2016). Whether cultural humility is destined to replace cultural competence or simply highlight an underappreciated aspect of current competence models has yet to become clear. However, there is wide consensus that multicultural work must be based on the core features of cultural humility, which centralize anti-oppressive practices more heavily than traditional applications of cultural competency have in the past. A cultural humility perspective can shed light on many common issues in multicultural training.

Limitations to Traditional Cultural Competency Approaches

In the United States, the vast majority of trainees and clinical supervisors come from the sociocultural backgrounds in which psychological science has historically been biased towards in research, practice, and foundational principles. While this lack of diversity may arguably not be a training issue in and of itself, a critical awareness of cultural bias in the profession becomes more difficult when our colleagues largely share that same cultural background. A key principle of clinical competencies is the constant need for assessment and growth. However, there does not exist any objective methods of measuring cultural competency. In general, accurate self-appraisals of competency have been argued to be lofty if not unrealistic (Johnson et al., 2014). In the case of cultural competency, the self-evaluative biases are not just personal. As a profession, we may share cultural blind spots that, in many cases, may underlie assumptions of how therapy (or supervision) should be approached.

Our focus on knowledge of the average individual in the realm of multiculturalism may be one example of a common shared professional blind spot. One danger of knowledge about cultural groups is that these categorical insights oversimplify the experiences of individuals

within that culture. As a current trainee, I have come to wonder if this is in fact an artifact of our statistical training, which is often used to describe average differences between groups. Awareness of group level differences can certainly inform, but it also carries risks. Research has demonstrated the danger of focusing too heavily on increasing such knowledge and exposure as it can counterproductively increase stereotyping (Buchtel, 2014).

If the focus on knowledge about the differences of other cultures is taken too heavily, individuals may grow to see themselves as inherently different from those groups and paint such a group with too broad a brush (Trimble & Dickson, 2005). On the other hand, several examples of consequential missteps have been published that demonstrate that practitioners may assume that principles that apply to their culture can be easily generalized to other groups (Christopher, Wendt, Marecek, & Goodman, 2014). Cultural competency has not completely overcome these issues. Cultural competency often focuses on predicting individual behavior based on a cultural label. This maintains a static view of culture where the majority culture is “normal” or the default, while other cultures have discrete deviations from the norm that can be accounted for (Hunt, 2001). While knowledge about other cultures is often pursued, putting that knowledge into practice unbiasedly may be difficult.

Applications of Cultural Humility

The above issues have no doubt influenced APA (2017) to recently identify humility as a cornerstone of multicultural practices. As reviewed previously, cultural humility normalizes the process of not knowing. In this perspective “not knowing” is a key part of self-awareness necessary for growth. Humble acknowledgement of unfamiliarity or bias is a strength, rather than a failure of the clinician (Hook, Davis, Owen, Worthington, & Utsey, 2013). No matter what cultural identities we have (or lack), we carry cultural baggage towards other identities.

Multiple recent articles have likewise argued the importance of integrating cultural humility as a necessary foundation of effective supervision (Hook et al., 2016; Watkins & Hook, 2016). Unsurprisingly, supervisory practices based upon humility may give supervisees more voice and strengthen supervisory alliance (Watkins, Hook, Mosher, & Callahan, 2018). In parallel to these benefits, the first APA multicultural guideline underwent the following change:

> APA (2003) Guideline 1:
>
> Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
>
> APA (2017) Guideline 2:
>
> Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

Regarding the guidelines as a whole, the updated version heavily de-emphasizes knowledge about different cultural groups in favor of an approach highlighting how such superficial knowledge about cultures may still be rooted in biases and lack an intersectional understanding. The language has changed from *whether* we may hold cultural beliefs that bias us towards others, to aspiring towards understanding *how* our cultural beliefs can affect our perceptions and professional judgements. The guidelines now acknowledge that attempts to educate ourselves about other cultures may increase our biases towards other groups. Culture is not something only had by those who are “different” from the norm. Holding a mirror to our

position as psychologists is central. This contrasts with attempting to formulate assumptions about how to interact with individuals who may represent a specific identity. While this issue has been clarified in the recent multicultural guidelines, the importance of this distinction does not yet seem to be infused within the perspectives of supervision practices. Consider one of the many personal examples from my own training.

Case example

The client was a 3rd generation Asian American bisexual atheist male in his early teens. The client presented to the clinic with concerns about anxiety, depression, and possible ADHD. In particular, the client described feeling anxious over his inability to focus on schoolwork and other tasks. His grades had declined greatly in the last year, which was associated with feelings of inadequacy. When presenting the recent intake assessment of this client my supervisor asked me to restate the background of the client. I interpreted my supervisor's request as asking for me to review the entire family background, schooling status, and community context. My supervisor interrupted this summary, by clarifying that he was instead just asking me to repeat the client's ethnicity. I responded with hesitation that the client was Chinese. I questioned the value of his ethnicity over and above other aspects of his background including family culture and beliefs, SES, and his other identities, especially given that the client himself never mentioned his ethnic identity. My supervisor responded. "It is essential to place our clients within a cultural context. In this case, it might give us some further insight into the family value on academics. Obviously, we can't be sure, but his background as an Asian-American can give us a working hypothesis of how his parents approach school, which would explain some of the client's anxiety over grades".

In the above example, the supervisor uses their previous experience and knowledge of a culture to make a hypothesis about the source of a specific client's anxiety. Research supports

the notion that, on average, Asian families place higher standards on academic achievement than other groups (Sy & Schulenberg, 2005). In the context of a positive cultural trait, it is not uncommon that cultural factors are presented as explanatory mechanisms for individual client behavior. While Asian-American identity or cultural factors may be underlying the presenting problem, is it the role of the therapist to create that hypothesis on behalf of the client? In the end, neither the clinician nor client may ever discover the cause of the behavior. Rather than investigating the “true” source of the behavior, training may be best served by emphasizing clinician humility and joining the client in “not-knowing”. Evidence suggests that therapist discussion of client culture and race can be beneficial to therapy, but only when these issues are salient to the client (Owen et al., 2016). In some ways, the current approach to multiculturalism in clinical training makes walking the thin line between implementing cultural knowledge and stereotyping even more difficult.

In most training programs, there exists an emphasis on gaining experience with distinct categorical cultural groups to improve our cultural competency. This brings to light several important considerations. What purpose should gaining experience with clients of a certain background serve if not to better understand members of that group in the future? In what manner should trainees generalize their limited experience with a few members of an ethnic group or religion as a demonstration that they are more competent at dealing with future members of that group? To be clear, that danger also exists in cases where clinicians share a sociocultural background with their client. Even when interacting with clients who share one of my identities, I try to remain mindful that my personal understanding of this identity may not reflect their unique experience. In all cases, clinicians should be wary of how they utilize pre-existing cultural knowledge to conceptualize client experiences.

To illustrate further, consider that the clinical internship process requires applicants to count off how many clients they have had of a particular racial group or sexual orientation. Students across many programs, who serve less diverse populations, often resort to competing to attain as many minority clients as possible as an attempt to bolster their applications for internship. We are effectively primed to view our clients as a representation of a single categorical identity. This is in contrast to their existence at the intersection of multiple identities that include gender, ethnicity, sexual orientation, country of origin, social class, and religion. To complicate the issue further, an individual's identity salience may vary greatly from situation to situation or session to session (Yakushko, Davidson, & Williams, 2009) Demographics may tell us very little about the respective salience of each identity or how they interact to produce the unique lived experience of that client. How does this training practice prepare students to effectively to follow the APA guidelines emphasizing the appreciation of social identity complexity and intersectionality? Perhaps even more poignant, how does such a practice fit with the guideline asking psychologists to "move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities" (APA, 2017). A paradigm shift is needed to overcome such categorical assessments of cultural competence. To consider alternatives, a cultural humility informed approach may instead ask applicants to count the number of cases in which a client's marginalized identity was addressed as a component of treatment or therapeutic process.

Power, Privilege, Prejudice & Humility

Clients with marginalized identities may be particularly vulnerable to power imbalances, which can threaten therapeutic process in clinical training. Members of marginalized groups may accurately lack trust towards mental health professionals, in particular when it comes to issues

relating to power, privilege, and prejudice. Minority attitudes towards mental health treatment is too often assumed to be an unchangeable idiosyncratic cultural difference, rather than as a potential product of systemic marginalization, blind spots, & biases in the field. Early findings suggest that most ethnic minority clients report experiencing at least one microaggression from their therapist (Owen, Tao, Imel, Wampold, & Rodolfa, 2014). One study found that Black Americans were actually more positive than White Americans towards seeking services, until they actually utilized such services, which caused significantly less positive attitudes than White clients (Diala et al., 2000). For ethnic minority clients who are unsatisfied with therapy, clinician lack of knowledge about racism, discrimination, other forms of oppression, and stigma are common factors. In fact, in one qualitative study, 3/4th of minorities dissatisfied with treatment provided specific experiences in which the therapist was ignorant to the role of power and privilege in relation to the client's concerns (Chang & Berk, 2009).

While a supervisor or trainee researching a client's assumed culture without the client's awareness may be problematic, gaining knowledge on the complexities of power, privilege, and prejudice in our society is likely essential for truly effective work with any client. Evidence supports this notion, as lesbian, gay, and bisexual (LGB) clients view a clinician's stance of openness and empathy towards LGB issues as essential in a desired therapist. However, assumption of LGB identity preeminence or evasion of sexual identity questions to avoid prejudice/offense are both viewed as factors that exclude a therapist from being desired (Burckell & Goldfried, 2006). To clarify, individuals from marginalized groups may find a therapist's knowledge about a specific group helpful, but that knowledge should not be applied without open discussion of its relevance and accuracy to the client's experience. The power imbalance between therapist and client may make such assumptions go uncorrected.

Case example

The clients were a Christian low-income rural White married couple. Therapy initially focused on anxiety psychoeducation and parent management training to treat their middle-school aged daughter's rising defiance and separation anxiety. The couple were low-income farmers and the husband, a former veteran. The wife complained her husband was insensitive and he complained that she micromanaged him. The husband engaged in very toughminded, concrete ways and often relied on disparaging humor when exploring the family's relationship or his own emotions. Given the husband's conservative perspective on gender roles (fathers should be stoic and peripheral), my supervisor advised that I assert my position as expert and make clear to the husband that his perspective was disrespectful and damaging. I expressed agreement with her as it seemed clear to us that his behavior was an obstacle towards treatment and hurtful to his wife. My supervisor expressed frustration at his stubbornness and joked that she knows she shouldn't say this, but she wishes the wife would just divorce him. I realized I agreed with my supervisor, and this made me question whether we were truly engaging unbiasedly with the family. I talked openly about this feeling with my supervisor and together we worked more mindfully in attempting to understand the husband's perspective. We realized we couldn't describe the husband's views without resorting to negative language and so we instead decided that I would ask the husband to convey his cultural perspective. In response he articulated that he is only here to help his daughter not to make him or his wife happier. He disclosed having a lot of traumatic events from his past, minimal chances for social development, and an abusive father which taught him a single way to move forward: stoicism not emotional engagement. Contrary to our assumptions, he felt powerless in his roles as father and husband. He expressed fear at being vulnerable in front of his wife, which he felt would cause her to be critical and respect him less.

As therapists, our bias may be to place blame towards the socially conservative, invalidating, or confrontational client. When a client's beliefs and actions are in conflict with best practices, it may be easy to reinforce the power differential by asserting ourselves as the expert and them misguided. In this case, my client was able to put effort into reexamining those practices once the role of low-income rural culture was neutrally considered. The privileged aspects of his identity conferred advantages and power in his family and community that made it easy for me and my supervisor to overlook the ways in which poor rural fathers may be marginalized, even in therapy. By allowing my client to teach me about his unique intersectional identity, I believe I became much more sensitive towards my own power and privilege as a therapist, while also challenging my notion of marginalized populations.

Despite the benefits of addressing culture, race, privilege, and marginalization, trainees often feel unprepared and uncomfortable discussing these topics in supervision and therapy. This discomfort is especially common among White trainees, who may even develop a distorted identity in response to discussions about potential instances of their own prejudice (Spanierman, Poteat, Beer, & Armstrong, 2006). Rather than viewing this as a problem of specific individuals, it is important to examine the societal context underlying this discomfort. Even supervisors & educators have difficulty broaching these topics due to concerns about displaying personal biases and prejudices (Wing Sue, Torino, Capodilupo, Rivera, & Lin, 2009). As many underrepresented students experience, cultural bias is systemically embedded within training programs (Smith, 2016). One recent study found that the majority of students applying for internship were asked at least one potentially inappropriate question; Ethnic minority candidates were 3.4 times as likely to be asked a potentially inappropriate question (Parent, Weiser, & McCourt, 2015). If we want

our supervisees to feel open with these topics, it is essential for supervisors and educators to address their own discomfort with acknowledging their position as cultural beings with biases.

An environment in which most supervisors and trainees feel uncomfortable and unprepared discussing topics that are central to the experiences of many clients may prove unsustainable for the field. The conversation on multiculturalism needs reframing from learning about “the other”, to learning about the role culture and identity plays in shaping the beliefs of all individuals. Clinical supervision and training may benefit considerably from proactive and consistent discussions of power, privilege, & prejudice based on a foundation of cultural humility. Too often is our own relationship to power, privilege, and prejudice unexamined. Consistent supportive exposure to these topics may normalize the conversations and even the discomfort with acknowledging our own personal biases.

Summary and Conclusion

This article is purposed at examining how cultural humility may inform new practices and perspectives towards supervision and training. To summarize the arguments presented: (a) any cultural information pertinent to treatment is gained with the most specificity and accuracy through direct discussion with clients from a perspective of cultural humility; (b) applying “cultural insights” without openly discussing their relevance to clients often relies upon stereotyping; and (c) personalized explorations of culture, power, privilege, and prejudice should be considered a foundation of both supervisory and therapeutic relationships.

Integrating cultural humility into all aspects of professional psychology may better prepare trainees and supervisors alike to engage with marginalized populations. Considering the power differential and discomfort around such explorations, I offer one example of an approach that I have applied to clients, which may also be appropriate for supervisees: (a) Ask “Are there

any aspects of your personal identity or cultural background that might be important for me to know about?"; (b) Provide a humble self-assessment of your familiarity with the identities mentioned and ask if they would tell you more about what those identities mean to them; (c) Acknowledge any discomfort and thank them for helping you to understand their personal experience; and (d) Ask them to please make you aware if you ever make any inappropriate statements or assumptions about their experience or identity. Whether or not an individual identifies any relevant identities or experiences, such an approach sets a frame of appreciation and respect towards these sensitive topics. Perhaps more importantly, an approach built on humility normalizes our fallibility. Afterall, the heart of cultural humility may well be the dedication to lifelong reflection and growth that we owe ourselves and our clients.

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