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PRACTICE REVIEW

The Multicultural Orientation Framework: A Narrative Review

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After several decades of slow progress, researchers are beginning to make advances in linking constructs based on the multicultural competencies tradition—especially those focused on qualities of the therapist—to therapy outcomes. The multicultural orientation framework was developed in response to several trends within the multicultural competencies tradition, with a particular emphasis on integrating the multicultural competencies tradition into research on psychotherapy process. We provide a narrative review of studies that include one of the three constructs (i.e., cultural humility, cultural opportunities, and cultural comfort) articulated by the multicultural orientation framework. Results indicate initial evidence linking multicultural orientation constructs to therapy outcomes (e.g., perceived improvement, racial/ethnic disparities in termination, and therapy alliance). Results also supported the social bond and social oil hypotheses from theorizing on humility. Implications for future research and therapy practice are discussed.

Keywords: multicultural orientation, multicultural competence, cultural humility, cultural opportunities, cultural comfort

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The multicultural movement has been described as the fourth major force in psychology—following psychoanalysis, behaviorism, and humanism (Pederson, 2002). The movement grew in response to research demonstrating mental health disparities among racial and ethnic minority (REM) populations in the United States (American Psychological Association, 2003). Emphasis on multicultural competencies (MCC) are now included in accreditation requirements and guidelines for all areas of psychological science (American Psychological Association, 2003). Similar emphasis on MCCs have occurred across several disciplines, including education, social work, counseling, law, and medicine (Suh, 2004).

Prior literature has documented the need for training related to MCC. For example, a series of studies demonstrated that many therapists have better outcomes with White clients than with REM clients (Drinane, Owen, & Kopta, 2016; Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Owen, Imel, Adelson, & Rodolfa, 2012). Additionally, the prevalence of racial/ethnic microaggressions in therapy is relatively high, with 53% to 81% of clients reporting experiencing at least one microaggression (Hook, Farell et al., 2016). However, key propositions of the MCC theory have struggled to find consistent support in existing empirical literature. The MCC theory implied three ideas: (1) there are a set of competencies that predict therapy outcomes, which can be clearly articulated and then acquired by trainees; (2) one can reliably differentiate therapists who are competent from those who are not; and (3) the competencies are characteristic of the therapist across

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clients. Nearly 30 years after these ideas were proposed (Pederson & Lefley, 1986), they remain largely unevaluated.

Challenges to linking MCCs with therapy outcomes have been thoroughly reviewed elsewhere (Huey, Tilley, Jones, & Smith, 2014; Sue, Zane, Nagayama Hall, & Berger, 2009). They include the assertions that therapists' self-reports of MCCs are unrelated to client ratings (Fuertes et al., 2006; Worthington, Mobley, Franks, & Tan, 2000). The link between client-perceived MCCs of the therapist and outcomes has been shown in some studies (see Tao, Owen, Pace, & Imel, 2015 for review); however, there are concerns with the current MCC measures (Drinane, Owen, Adelson, & Rodolfa, 2016). Additionally, there is weak support for the proposition that MCCs are a stable characteristic of the therpist, given that studies have not demonstrated sufficient convergence across client ratings of the same therpist (Owen, Leach, Wampold, & Rodolfa, 2011).

Attempting to evaluate the link between the constructs derived from MCC theories to therapy outcomes, Owen and colleagues proposed the multicultural orientation (MCO) framework (Owen, Tao, Leach, & Rodolfa, 2011; Owen, 2013). MCO can be viewed as an extension of the MCC model designed to examine how cultural dynamics can influence the process of psychotherapy. In particular, MCO is concerned with how the cultural worldviews, values, and beliefs of the client and the therapist interact and influence one another to cocreate a relational experience that is in the spirit of healing. After several decades of limited empirical progress, researchers are beginning to make strides toward better understanding the association between MCC constructs and therapy as studies on the MCO framework accumulate.

The purpose of the present article is to evaluate initial findings, refine hypotheses, clarify priorities, and articulate a research agenda for evaluation of the MCO framework. Our hope is that this article will lay a conceptual foundation for other scholars within the MCC tradition to translate their work into studies of psychotherapy process. Therefore, in the current article, first, we provide a brief overview of the MCO framework and some of the historical trends that informed its development. Second, we present a systematic review of the empirical literature on the MCO framework; we review measures, as well as key findings. Finally, we discuss implications for research and practice.

Trends That Informed the MCO Framework

One of the primary motivations for developing the MCO framework was to provide a psychotherapy-specific explication of processes that can be applicable to any therapeutic orientation or approach. The MCO framework is not a new stand-alone therapeutic approach or a comprehensive therapeutic model that describes the nature of psychopathology/health, personality, and so forth. Rather, it compliments existing models of psychotherapy (e.g., cognitive-behavioral therapy, interpersonal, psychodynamic, or systems). Additionally, the MCO framework articulates a "way of being" in session for therapists (e.g., cultural humility), a way of identifying and responding to therapeutic cultural markers in sessions (e.g., cultural opportunities), and a way of understanding the self in these moments (e.g., cultural comfort). Moreover, the MCO framework challenges therapists to fully examine their motivation to have an "orientation" that guides their lived experiences around cultural dynamics. Accordingly, several trends within the theoretical and empirical literature within counseling psychology strongly informed the MCO framework.

First, the development of the MCO framework was influenced by the empirically supported psychotherapy relationships (e.g., empathy, working alliance, or real relationship) highlighted by Norcross (2011). It is a process-oriented approach to understanding how cultural dynamics can influence the therapeutic process. Thus, any attempts to "manualize" an MCO approach would likely run counter to the essence of MCO.

Second, we wanted to shift the language from competencies to orientation to more closely align with how psychotherapy is taught. That is, therapists are encouraged to develop a theoretical "orientation," which typifies how the therapist conceptualizes, understands client statements, and makes meaning of the world. Accordingly, MCO helps therapists develop a way of being or a cultural lens with which to understand their interactions with clients. MCC and MCO have aligned values but distinct priorities. Namely, original MCC theorizing occurred nearly 50 years ago and sought to initiate major structural changes within the mental health professions to begin to address disparities in the care of REM people. This was very much needed for the field, as many of the studies did not include minorities or even address issues related to health and mental health disparities (Huey et al., 2014). The competency language is well-aligned with current trends in health service training programs. However, we wanted to move away from promoting the idea that a therapist can be "competent." The language of competence infers a "finish line" or "end goal," which does not align well with the processes of therapy, which are ever-evolving, incremental, and highly contextual (Owen, Tao, et al., 2011). In addition, others noted that behaviors indicative of constructs within the MCC tradition differ from other areas of psychotherapy competence (Foronda, Baptiste, Reinholdt, & Ousman, 2016). Namely, effective work with cultural differences often involves not only what one knows (or knows how to do) but also how one handles what one does *not* know (or know how to do).

Third, in the psychotherapy literature, the link between therapist competency and therapy outcomes is weak, accounting for less than 1% of the variance in therapy outcomes (Webb, DeRubeis, & Barber, 2010). Thus, we did not believe the psychotherapy competency approach would be an ideal way to frame a new method to understanding cultural dynamics in therapy. In doing so, we wanted to provide more clarity to what therapists should be focusing on in-session. Constructs tend to correlate most strongly with each other when assessed at a similar level of specificity (Fishbein & Ajzen, 1974). Rather than asking clients to make broad generalizations, MCO attempts to hone in on constructs that might indicate positive or negative developments in the client's relationship or working alliance with the therapist.

Fourth, MCCs often focus on one cultural identity at a time (Sue & Sue, 2016). Increasingly, the psychology field is acknowledging the work and assertions of intersectionality scholars (Cole, 2009) who argue that no identity, or experience(s) associated with identity, exists in isolation; rather, all identities, as well as their affiliated privileges and oppressions, are interlocking, coexisting, and fluid. Thus, the plausibility of articulating and measuring MCCs—particularly skills and knowledge—for the entirety of a client's salient and less salient identities becomes untenable. For example, how would a trainee attain competence in working with a queer Latina woman who emigrated to the United States to

pursue an engineering degree and was recently diagnosed with multiple sclerosis? Importantly, intersectionality asserts that one cannot understand these identities in the singular because they did not develop in the singular. Furthermore, the journey to developing competence with queer, Latina women immigrants in engineering major with a disability, if one was attempting to do so, would vary greatly depending on the identities of the therapist (and other potentially salient identities of the client not discussed [e.g., religion or social class while growing up]). Although MCC certainly does not argue for a one-size-fits-all approach to clients, the ability to explicitly integrate multiple identities simultaneously is limited by the language of competence. Put simply, basic competence for working with one identity (e.g., race and ethnicity) necessitates a high degree of competence in working with a multitude of other identities. Extending this line of logic to MCC research, there are clear practical challenges to measuring MCC when one begins to consider intersecting identities.

Overview of MCO Framework

The MCO framework emphasizes orientation language as a compliment to competence language. Competence language helped translate multicultural values into literatures focused on training and training standards; orientation language pragmatically aligns with language related to one's approach to conceptualization, treatment planning, and interventions in psychotherapy. For example, one's theoretical orientation refers to identification with and belonging to professional communities attempting to integrate various values and perspectives of how to interpret available scientific evidence into their approach to psychotherapy. It provides a lens through which the therapist views their professional role as they integrate the client's problems, personality, and life context into their understanding of the client's distress and a plan for promoting better functioning. Similarly, a MCO involves a way of understanding and relating to the cultural identities of clients. MCO language implies "a way of being with clients," particularly when one detects cultural dynamics that may require enhanced awareness, knowledge, and skills. The language of humility primes therapists to focus all resources within their grasp toward optimizing attentiveness and responsiveness to the client's needs (i.e., being other-oriented), including regulation of ego involvement that might enhance self-consciousness. Sometimes competence language—focused more on an endpoint or destination—can cause therapists to attend to self-presentational concerns rather than the client's needs.

In the initial formulation, the MCO framework detailed three constructs (Owen, 2013). The overarching value or virtue of the MCO framework is *cultural humility*. A distinctive of the MCO framework is the attempt to delineate specific constructs that indicate potentially positive or negative processes within intercultural therapy relationships. First, culturally humble therapists strive to take advantage of *cultural opportunities* that arise in session. Second, culturally humble therapists strive to develop *cultural comfort* for engaging various cultural identities of clients. We elaborate on each of these three pillars of the MCO framework.

Cultural humility. The organizing virtue of MCO is cultural humility. A variety of health and mental health disciplines have converged on conversations about humility as a complementary or alternative language to competence (see Foronda et al., 2016, for a review; Tervalon & Murray-García, 1998). Humility is defined as having both intrapersonal and interpersonal aspects (Davis et al., 2011). Intrapersonally, humility involves having an accurate view of oneself, particularly about one's limitations. Interpersonally, humility involves being other-oriented rather than self-centered, marked especially by a lack of superiority. This definition is based on the theory of relational humility, which conceptualizes humility from a personality judgment perspective (Davis, Worthington, & Hook, 2010; Funder, 1995). These theories call for multimethod studies that assess virtues through triangulating other-reports, observation of behavior, and self-report (viewed as a complex type of other-report in which the person is both the target person and judge; Davis et al., 2011).

Cultural humility is a subdomain of humility that involves "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client" (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354). For people to accurately judge a character strength, they must have ample opportunity to observe relevant behavior, especially reactions to situations that make practicing that virtue especially difficult. For example, to truly know someone's degree of courage, one would have to see how that person tends to respond to dangerous situations. Consistent with this logic, humility scholars have studied subdomains of humility that involve contexts theorized to evoke egoism and defensiveness and make it more difficult to display humility.

Based on this reasoning, several aspects of psychotherapy and intercultural relationships might make cultural humility more difficult to practice. First, negotiation of the tasks and goals of therapy can challenge therapists' ability to maintain a collaborative and nondefensive stance. Theoretical perspectives in psychotherapy have developed within a cultural context that reflects Eurocentric, patriarchal, and middle- to upper-social-class values (to name a few privileged identities). Thus, clients belonging to marginalized groups may perceive misalignment in the values and culturally endorsed narratives about pathology and health often used by psychotherapists. Perceiving that one's therapist does not share one's worldview assumptions can cause clients to anticipate difficulty forming a strong relationship or working alliance, which can make premature termination more likely (Worthington, 1988). Therapists and clients, alike, vary in their tolerance for differences in worldview assumptions, and distress can attenuate this tolerance (Worthington, 1988).

Second, therapists invariably seek to satisfy competence needs through their work with clients (Ryan & Deci, 2000). Without appropriate awareness, fear of being evaluated poorly (e.g., by clients or supervisors) may cause lapses in therapists' emotional responsiveness to clients. Indeed, competence needs are a natural motive for professional growth, but must be skillfully managed or else they may interfere with therapists' ability to respond to cultural situations in therapy that threaten therapists' sense of confidence or self-efficacy. Cultural dynamics can cause aversive emotional states that interfere with expressions of cultural humility (i.e., cultural comfort and opportunities).

Third, therapists are not neutral, and therapy is inherently culturally laden. Prior relational history and context affect how therapists and clients experience each other and the process of therapy. Therapists with more privileged identities (e.g., White, male, heterosexual) cannot afford to minimize or deny the fact that psy-

chology, as a field, has strained trust with the members of many marginalized communities. Alternatively, therapists with marginalized identities may face challenges associated with a paradox of power. Namely, the therapist has power in their role as a therapist, but their ways of interacting in session are impacted by the broader social and cultural norms that might cede power to clients. Regardless of the variegated dynamics associated with the relative privilege of the therapist and client, clients often begin therapy vigilant to threats to trust (e.g., value differences), and therapists vary in their ability to tolerate the pressure that this places on the therapy relationship.

Fourth, cultural differences in therapy can cause therapists to experience value conflicts. Value conflicts reflect an incongruence between one's personal values and either (a) the values of the client or (b) the values of one's perceived professional roles and obligations. Therapists may be particularly vulnerable to this type of conflict when a core personal value they hold diverges from a core value of their client(s). For example, a therapist who is strongly committed to feminism may feel ambivalence about how to engage a heterosexual couple in which both partners want to maintain traditional gender roles. This circumstance could create a conflict for some therapists between their personal values of equity and fairness (and how traditional values threaten to violate those values and may disadvantage women) and their professional obligation to support the couple in their goals, which may or may not necessitate a focus on the gender dynamics within their relationship.

Cultural opportunities and comfort. Now that we have described cultural humility as an organizing virtue of MCO, we now turn to the two other pillars of the framework, which can be thought of as behavioral expressions of cultural humility within the therapy context. First, cultural humility ought to motivate therapists to consistently take advantage of opportunities to engage the client's salient cultural identities. *Cultural opportunities* are "markers that occur in therapy in which the client's cultural beliefs, values, or other aspects of the client's cultural identity could be explored" (Owen et al., 2016). They occur when clients mention their beliefs, values, or other details that provide an opportunity for the therapist to explore the client's cultural identities in more depth. Alternatively, at any time, therapists can initiate cultural conversations when they feel it is warranted, and therapeutically wise. The challenge is to do so naturally and without abrupt transitions that feel forced or inauthentic. Cultural opportunities are always present; MCO helps therapists orient themselves to clients in such a way that they recognize and seize upon these ever-present potentialities.

For example, during an intake, a White, heterosexual woman in her 30s mentions that she was born and raised in Tennessee by a single mother, and her presenting concern centers around depressive symptoms that have been persistent for over 4 months. A MCO therapist may explore what being "born and raised in Tennessee" means for the client. Another direction could be to explore how being raised by a single mother has impacted the client's views of gender roles, societal norms related to traditional views of family, and issues of social class. These are but a few of the possible directions for discourse, and as with other areas of exploration, some will be more fruitful than others. These areas of exploration are notably different than focusing on her depressive symptomology, which is also important and can be addressed through fully understanding the client's cultural values. The critical piece is to view this information through a cultural lens—not just a diagnostic lens.

Second, for therapists who have consistently worked to develop cultural humility in all aspects of their life, they ought to experience greater ease and less reactivity when leaning into conversations and deepening relationships surrounding the client's cultural identities. As such, c*ultural comfort* refers to the therapist's thoughts and feelings that emerge before, during, and after conversations about the client's cultural identities or culturally focused content (Owen et al., 2017). Cultural comfort is characterized by feeling at ease, open, calm, or relaxed with diverse others. It is important to note that there is a place for cultural discomfort, and in many ways that might be a good indicator for therapists to gain perspective. At the same time, a general sense of cultural competence and confidence is likely needed to navigate cultural similarities and differences. Here, the language of cultural transference and countertransference may provide a familiar language for therapists to understand and explore their own areas of cultural discomfort (Comas-Diaz & Jacobsen, 1991).

For example, consider a therapist (Latino, lesbian woman) treating the female client in the prior example. The therapist may fear exploring the client's religious identity because the therapist may worry that the client will express heteronormative ideas that may interfere with a fruitful therapy relationship. To effectively explore the potential importance of the client's religious identity, the therapist may need to seek consultation or supervision to process fears, potential countertransference, and prior painful experiences with Christians or southern culture.

Taken together, the three pillars of MCO describe the orienting virtue and attitude (cultural humility) and context-specific behaviors associated with creatively exploring the client's salient identities (cultural opportunities) and maturing in one's ability to self-regulate while doing so (cultural comfort). These three constructs, based on the ethos of the MCC tradition, work to contextualize these theories within the process of psychotherapy.

Purpose of Narrative Review

In our narrative review of the MCO framework, we focused on three research questions. First, consistent with the intention of MCC literature, we evaluated preliminary evidence linking MCO constructs to better therapy outcomes (*Hypothesis 1*). The other two hypotheses examine the degree to which the relational benefits of humility found in prior research replicate in the context of psychotherapy. These hypotheses are called the social bond (*Hypothesis 2*) and social oil hypotheses (*Hypothesis 3*), which we describe in turn.

The *social bond* hypothesis asserts that perceptions of humility regulate social bonds (and commitment, which is the psychological experience of a social bond). A social bond is an affinity for a person or group that causes one to act in a relationship-oriented way—that is, to prioritize the needs of the relationship. Social bonds require regulation because they involve costly, unselfish behavior, which makes people vulnerable to exploitation unless these behaviors are reciprocated (Ashton, Lee, & de Vries, 2014). According to the relational humility theory (Davis et al., 2013), perceptions of humility serve this purpose of regulating social bonds. Humility judgments help people predict how another per-

son is likely to treat them in the future. For example, observing arrogant behavior makes one view a target person as less humble and weakens one's social bond with that person. Alternatively, observing other-oriented behavior makes one view a target person as humbler and strengthens one's social bond with that person. In this way, humility perceptions help individuals regulate risk of exploitation in relationships.

In psychotherapy, we might think of the working alliance as a key indicator of the social bond. Indeed, one element of the working alliance is the relational bond between the client and therapist (Bordin, 1979). Accordingly, when clients view the therapist as safe, other-oriented, emotionally engaged, and responsive in regard to the client's cultural identities, they are likely to view the therapist as more culturally humble, which ought to lead to a stronger working alliance. When clients perceive less safety (e.g., microaggressions) or indicators of arrogance (e.g., defensiveness or unwillingness to collaborate on decisions about the course of therapy), they may view their therapists as less culturally humble, which in turn weakens the working alliance (Hook, Farrell, et al., 2016).

The *social oil* hypothesis asserts that humility buffers relationships from the deterioration that typically occurs due to traits or qualities that tend to erode relationships (e.g., competitiveness or relational power). As such, humility acts like a social lubricant, protecting relationships from "heating up" too much when there is a potential for conflict to erupt and intensify. For example, in a sample of entrepreneurial leaders, narcissism was correlated with negative outcomes (i.e., lower job engagement and performance) but expressed humility (i.e., as rated by coworkers) buffered this effect (Owens, Wallace, & Waldman, 2015).

In psychotherapy, this hypothesis suggests that cultural humility can mitigate the relationship between various therapist factors that would generally put the therapy alliance at risk of poorer outcomes (e.g., negotiation of goals and tasks, need to appear competent, historical contexts of therapist and client identities, and value conflicts). Thus, there are personal or contextual factors that can generally increase wear and tear on the working alliance, and the application of this hypothesis to psychotherapy would examine cultural humility as a buffer.

In summary, we expected cultural humility to correlate with better therapy outcomes, to correlate with process variables such as therapy alliance or perceived microaggressions, and to buffer the relationship between ruptures and negative therapy outcomes. As expressions of cultural humility, we expected cultural comfort and cultural opportunities to show a converging pattern of relationships.

Method

We used several methods to find empirical articles based on the MCO framework. First, we conducted searches on PsycINFO and Google Scholar. We used the following search terms: "multicultural orientation," "cultural humility," "cultural comfort," and "cultural opportunities." Second, we examined articles that cited the papers that reported the development of measures for each of the MCO constructs. Finally, we emailed the corresponding authors for any existing articles that met inclusion criteria to ask for additional studies. Studies were included if they were empirical and included a measure of one of the three constructs within the MCO framework. We excluded studies that were not focused on psychotherapy. Overall, nine articles (11 samples) were identified by the search. The method and primary findings of these studies are included in online supplemental Table 1. Furthermore, an expanded table that includes detailed sample information is available from Don E. Davis upon request.

Results and Discussion

Overview of Samples

All but one (i.e., Hook, Boan, et al., 2016) of the studies was conducted with either college students or Mechanical Turk participants. Samples tended to be predominately female ($n = 9$), and most studies ($n = 7$) focused primarily on White therapists. Three studies reported participants' spirituality.

Overview of Measures

Cultural humility. The Cultural Humility Scale (CHS; Hook et al., 2013) was used in eight studies. In terms of content validity, items focus on the interpersonal aspect of humility and align most squarely with definitions of humility that emphasize being other-oriented, rather than self-focused, and expressing openness, rather than interpersonal superiority. The CHS has two subscales (i.e., Positive and Negative), based on exploratory factor analyses that replicated in a second study. As yet, no studies have reported evidence pertaining to measurement invariance. The CHS has demonstrated adequate reliability across studies (Cronbach's α coefficients ranging from .83 to .95). Furthermore, although evidence of construct validity was limited within the initial publication (i.e., it correlated very strongly with therapy alliance and client perceptions of therapist MCC), it continues to gain evidence of construct validity with additional use.

Cultural comfort. The Cultural Comfort Scale (Owen et al., 2017) was used in two studies. It consists of 10 items (e.g., comfortable, awkward, nervous, or calm) designed to assess the degree to which clients viewed their therapist as comfortable with an aspect of their identity. Subsequently, Owen, et al. (2016) reported an exploratory factor analysis that supported a one-factor structure. Cronbach's αs have ranged from .93 to .94. Furthermore, the measure has shown initial evidence of construct validity, being related to working alliance, alliance behaviors, and therapy outcomes (Slone & Owen, 2015).

Cultural opportunities. Missed cultural opportunities were assessed in two studies with the four-item Cultural Opportunities Scale (Owen et al., 2016). The authors adopted a pragmatic approach to scale development by first creating a brief set of items designed to assess the construct and then having several experts provide ratings and feedback. Cronbach's α coefficients have ranged from .83 to .86. In terms of construct validity, the cultural opportunities scale has correlated positively with cultural humility, therapy outcomes after controlling for cultural humility, and number of sessions.

Taken together, although measures exist for each of the MCO constructs, the CHS is currently the only measure that was developed and validated with a more traditional scale-development approach. The other two measures were created using a pragmatic strategy within papers in which the construct was not the primary

focus. Initial use has demonstrated evidence of divergent validity and incremental predictive validity. However, only limited work has begun to situate these three constructs within the larger array of measures within the multicultural field.

Overview of Primary Findings

MCO constructs and therapy outcomes. Results have consistently linked MCO constructs to therapy outcomes (Table 1). Most early studies used client-reports of improvement. Importantly, two studies have documented the link between therapist effects (i.e., aggregates across MCO constructs across clients) and better therapy outcomes (Owen et al., 2016, 2017). In the study by Owen et al. (2016), 247 clients (of 50 therapists at a university counseling center) completed measures of cultural humility, missed cultural opportunities, and improvement in therapy. Cultural humility (therapist effect aggregated across clients) predicted better therapy outcomes and buffered the relationship between perceived missed opportunities and worse therapy outcomes. Only one study used a behavioral outcome (i.e., premature termination; Owen et al., 2017). Clients (N = 177; seen by 33 therapists) recently ending treatment at a university counseling center completed measures of the cultural comfort (a residual derived from regressing racial and ethnic minority comfort scores on White comfort scores). As predicted, cultural comfort predicted racial discrepancies in first session termination. Taken together, these findings provide promising evidence linking MCO constructs to both perceived improvement in therapy and premature termination. An important next step is to examine the degree to which these findings replicate across diverse clinical settings.

Social bond hypothesis. Several studies provided the initial evidence for the social bond hypothesis in psychotherapy. Cultural humility was positively related to the therapy alliance in two initial cross-sectional studies (Hook et al., 2013). In a large community sample collected on Mechanical Turk, cultural humility was negatively related to perceived microaggressions in therapy; cultural humility also correlated with fewer microaggressions, and clients rated microaggressions as less severe, even after controlling for general and multicultural competence (Hook, Farrell, et al., 2016). The race of the therapist did not influence the perception of microaggressions or other MCO constructs. In contrast, in a sample of women of color, clients reported more racial microaggressions (and rated them as more severe), and the relationship between microaggressions and cultural humility was more negative when clients had a White therapist rather than an REM therapist (DeBlaere et al., 2018). In a sample of undergraduates who had received therapy within the past year, cultural humility mediated the relationship between negative emotion due to a microaggression and therapy outcomes (i.e., therapy alliance and perceived improvement; Davis et al., 2016). Building on these cross-sectional designs, Owen et al. (in press) examined the causal direction of the relationship between microaggressions and the subsequent declines in the degree to which clients saw their therapist as culturally humble. Namely, therapists were assigned to either a microaggression condition, in which they viewed a role play where the therapist committed several microaggressions, or a control condition, in which the therapist enacted basic counseling skills. Therapists detected microaggressions around half the time. As predicted, the presence of microaggressions predicted the degree to which participants viewed the therapist in the video as culturally humble, culturally comfortable, and able to take advantage of cultural opportunities. Taken together, across several initial studies, theorizing on how humility perceptions affect relationships generalized well to constructs within the psychotherapy process literature.

Social oil hypothesis. Within our reviewed studies, the prediction that humility can protect relationships against the potential for deterioration from cultural conflict has received minimal attention—only one study considered this hypothesis (Owen et al., 2016). Clients at a university counseling center retrospectively rated their therapist on the number of missed cultural opportunities, cultural humility, and perceived outcome (Owen et al., 2016). Results indicated that cultural humility (therapist effect) mitigated the relationship between client perceptions of missed opportunities and therapy outcomes. Namely, missed opportunities were related to more negative therapy outcomes, but cultural humility buffered this deleterious relationship. Should this finding replicate, it would constitute a crucial insight into the potential importance of humility for intercultural relationships. Therapists can strive to prevent offenses, but given that conflict arises in all relationships, effective work with diverse clients requires recognizing and effectively repairing cultural ruptures.

General Discussion

The purpose of the current review was to take stock of the initial work on the MCO framework to refine priorities for theoretical development and testing. Perhaps one of the more promising developments is that studies are successfully linking MCO constructs with therapy outcomes—even when assessed as therapist effects aggregated across clients. This is a noteworthy step forward for research building on MCC theorizing because studies using other measures have failed to show sufficient convergence of client ratings to evaluate therapist effects. These findings also raise the possibility that other constructs drawn from various counseling psychology literatures could be translated into the therapy context and successfully measured as therapist effects (e.g., ethnocultural empathy; Wang et al., 2003).

Research on the MCO framework draws on converging trends within psychotherapy process research and investigations of personality judgments in personality and social psychology to suggest multimethod strategies. The framework especially prioritizes client perspectives of how therapists approach identity and culture within session. These research traditions shed light on why prior work may have failed to observe evidence that MCCs (as a therapist effect) predict better therapy outcomes. From the perspective of prior theory on humility (Davis et al., 2010), the best test of this hypothesis would contextualize MCC from the client's perspective of specific interactions with the therapist. In this regard, the current MCO measures ask clients to make generalizations about their relationship with the therapist.

The initial MCO measures are just one way of capturing the construct, and there are many possible ways to operationalize the three domains of MCO. For example, cultural comfort could be measured through biomarkers during a session. Considering lessons learned from the initial studies on the MCO framework, we expect to see more studies that seek greater specificity in contextualizing measurement to what is occurring within actual therapy

sessions, such as the studies examining whether therapists are able to detect microaggressions. It also might be fruitful to explore other constructs within multicultural literature (e.g., ethnocultural empathy; Wang et al., 2003) within an MCO framework. For example, researchers could use a similar strategy of (a) creating a client report measure, (b) narrowing the specificity of measurement, and (c) aggregating across clients to estimate therapist effects.

Researchers might also conceptualize and measure other possible expressions of cultural humility within psychotherapy. Treating cultural humility as a foundational construct provides an opportunity to explore a variety of process variables within the overarching domains of cultural opportunities and cultural comfort. The existing studies contextualize these constructs to psychotherapy process, but there is room for even greater contextualization. To do so, researchers might refine theory (and measurement specificity) of cultural comfort and cultural opportunities; qualitative or mixed-method studies (e.g., identifying therapists based on therapy outcomes and then using qualitative methods to explore their ways of thinking about MCO constructs during sessions) on positive and negative exchanges in psychotherapy would help refine our understanding of the specific skills that are fundamental to MCO.

Implications for Future Research

A crucial next step involves replication, particularly across clinical settings. One important question to address is the degree to which the privileged identities of the therapist affect MCO constructs. Hook, Farrell, et al. (2016) found null effects, but DeBlaere et al. (2018) found that women of color with a White therapist reported frequent microaggressions and a stronger negative relationship between microaggressions and perceptions of cultural humility. Thus, it will be helpful to understand when and how the identities of the therapist and client may interact with each other to influence MCO constructs and thereby therapy outcomes. Importantly, this research could inform our understanding of how to support therapists with both privileged and marginalized identities to cultivate cultural humility and other aspects of MCO in their practice.

Measurement work is also needed. The CHS assesses the interpersonal, but not intrapersonal, aspect of humility. This gap is noteworthy because both MCC and MCO emphasize qualities aligned with the intrapersonal aspect of humility (i.e., accurate view of one's limitations as a cultural being and taking appropriate ownership for cultural biases). Furthermore, it may be worth exploring various ways to assess cultural comfort and opportunities, and studies are needed to situate the MCO constructs within a broader nomological network of related constructs within counseling (ethnocultural empathy; Wang et al., 2003) and social psychology (e.g., linking MCO to colorblind ideology; Owen et al., in press).

In addition to shoring up conceptual and measurement concerns, a particular focus should be on examining the antecedents or sequelae of MCO constructs. For example, which therapist characteristics (e.g., agreeableness and open-mindedness) are related to cultural humility and its expression through cultural comfort and opportunities? How can cultural humility be incorporated into the supervisee–supervisor relationship as a means of fostering MCO constructs in training? Do MCO constructs increase with experience or training? What responses to cultural ruptures are viewed as most culturally humble? Researchers might also explore client factors that affect how MCO constructs are perceived, such as religious/spiritual involvement, attachment style, severity of symptoms, and mental health stigma. Finally, researchers can examine the specific relationship dynamics that most strongly affect perceptions of MCO constructs.

Researchers also might begin to test more speculative theorizing about humility within the context of psychotherapy. One promising—but currently untested—idea is the span hypothesis (masked citation). According to this hypothesis, cultural humility helps people fairly negotiate ideas even with people committed to ideologically opposed values and perspectives. It supports an epistemic style that allows people to change their mind when confronted with new and stronger evidence. Furthermore, it motivates people to put themselves at the crossroads (i.e., a configuration of relationships) of receiving new and strong evidence from opposing perspectives. Having greater ideological span involves the ability to negotiate ideas fairly and form collaborative relationships with individuals or groups who are committed to ideologically different, and perhaps competing, perspectives. Span helps people manage conflict effectively in relationships, which usually involves seeking shared interests rather than resorting to less effective strategies such as avoidance, accommodation, or compromise. Should these ideas hold up to empirical scrutiny, they might inform the priority and focus of psychotherapy training related to cultural diversity.

Although many of these questions begin with basic science, researchers should always remain focused on the mission of improving outcomes for marginalized groups and improving training of psychologists. The traditional approach has been to gather thought leaders in a cultural domain (e.g., race, gender, sexual orientation, ability, or spirituality) and have them articulate pragmatic competencies for training. This strategy was a necessary starting point, but the MCO research program illustrates the potential for a research program within psychotherapy to test, inform, and develop such clinical intuitions. There is a large gap between limitations in research and substantial contextualization required in therapy with clients with a variety of intersecting identities. Our hope is that research on the MCO framework will help reduce this research–practice gap.

Implications for Practice

Although work on the MCO framework is in an early stage, we hope the theorizing and initial empirical results can instigate professional conversations about how the MCO might inform various parts of the therapy process. We attempt to begin this discussion in the subsequent section, with two caveats. First, our ideas are heavily influenced by interpersonal process models, so we hope readers and future authors will consider implications within their own theoretical traditions.

Second, before we consider (and envision) how MCO may refine or create distinct strategies, we first want to reiterate the heavy alignment of MCC and MCO. Like MCC theorizing, the MCO framework begins with values of multiculturalism, such as humility and openness to the other (Fowers & Davidov, 2006). Thus, it should not be a surprise that many of our practical suggestions align with prior theorizing on how to infuse multicul-

tural values into the therapy process. The priorities of the MCO framework are distinct (i.e., focus on a "way of being with clients" rather than articulation of standards). Thus, MCO language may help remind (or prime) people of multicultural values, which in turns affects attitudes and behaviors during various aspects of the therapy process.

Intake. During the intake process, MCO can involve attending to the many assumptions embedded within this process. These assumptions may include fundamental elements of the intake process that are culturally encapsulated, such as believing that (a) clients trust the therapy process just because they are present; (b) the primary purpose of an intake is for the therapist to learn about the worldview, values, and experiences of the client (rather than the reverse or some combination of these two perspectives); or (c) the intake should follow a particular format, include only the client (individual, couple, or family), and take place within a particular context (e.g., office). Thus, a culturally humble therapist may begin therapy by questioning these assumptions and checking in with the client about these norms.

Similarly, cultural humility requires that therapists explore their cultural assumptions. Although assumptions are often automatic, and sometimes necessary and helpful in the process of generating clinical hypotheses, they are harmful if not scrutinized based on evidence. For instance, in the previous example of the woman in her 30s from Tennessee, a therapist may assume that the client has a strong Christian identity based on her Tennessean roots. However, rather than proceeding based on this assumption, the therapist could inquire as to whether spirituality or religion is an important identity to the client. This exploration of assumptions might prevent the rupture that would likely occur if the assumption is false (i.e., client identifies as spiritual but not religious or atheist). During the intake stage, the therapist may want to be particularly attuned to cultural opportunities, as this can communicate to the client that the therapist is willing and interested in the client's cultural background and experience.

The concept of cultural humility also aligns with debates about the use of formal assessments with marginalized groups (Caplan & Cosgrove, 2004; Owen, Tao, & Rodolfa, 2010) and the emphasis on assessing strengths and not just pathology. By having a strong MCO, therapists should challenge the assumptions and norms of all aspects of therapeutic work, especially assessments. Inertia in the field of psychology is not a valid rationale for carrying forward inappropriate practices.

Informed by the MCO framework, the therapist might also use the intake process to orient the client to the various processes and phenomena they are likely to experience throughout therapy. For example, it is common for therapists of various therapeutic orientations to mention that part of therapy includes talking about and processing painful stories and information that in turn can make the client feel worse. This prepares the client for an experience that might otherwise lead to premature termination if they were not properly informed about the phenomenon. Therapists might familiarize their clients with cultural concepts and issues that may arise in therapy. For example, a therapist can create a culturally inclusive setting by overtly discussing the importance of cultural identities and experiences in helping both client and therapist develop a more complex understanding of the issues that bring the client to therapy. Additionally, therapists can briefly educate clients about the pervasiveness of microaggressions and other forms of bias and how they can manifest in the therapeutic relationship. The therapist can further express their humility by proactively inviting the client to give feedback to the therapist if the client feels that a cultural rupture has occurred. Orienting the client to issues that might cause cultural ruptures can aid in building cultural trust from the outset of therapy.

Conceptualization. Cultural humility during conceptualization calls for a collaborative approach. Psychologists and clients may hold discrepant narratives (Frank & Frank, 1991) about why the client is distressed and what may help improve functioning. Forming a strong therapy alliance involves blending these narratives with each other, and doing this requires the therapist to accept influence from the client's cultural worldview and perspective. Failing to accept influence from the client in the conceptualization process is tantamount to cultural arrogance. Therapists should assess salient identities and integrate themes from these identities into the conceptualization. Identities provide a window into the client's values, beliefs, and potential consequences of nonconformance. For example, in many communities, therapy is not an ideal way to address problems, and going to therapy is stigmatizing (Owen, Thomas, & Rodolfa, 2013). Collaborating to understand the client's illness narrative can enhance treatment outcomes with clients from marginalized groups (Benish, Quintana, & Wampold, 2011).

Again, we highlight the importance of acknowledging the intersecting nature of identities. As therapists work with clients to develop a conceptualization, not only should they consider, name, and honor the client's multiple identities but also give equal importance to the contexts in which those identities were experienced and developed (Watson, DeBlaere, Langrehr, Zelaya, & Flores, 2016). Importantly, such explorations should not occur in a vacuum. For therapists with more privileged identities, it is critical that patterns of oppression are not repeated in the therapy space, particularly with clients with marginalized identities. Although it is likely impossible to negate all of these dynamics, by naming their own salient identities in a manner that acknowledges their social location within the matrix of power, therapists can begin to place ways of approaching conceptualization in context. For therapists with more marginalized identities, a similar naming process is needed, as it will assist the therapist in identifying interactions in which their identities may be particularly salient with diverse clients.

Treatment plan. Cultural humility during treatment planning might call for a transparent style in which the therapist shares decision-making power with the client. Clearly, therapists do not automatically adopt, in their entirety, the illness narratives and preferred interventions of clients. At the same time, therapists can remain aware of the power differential between themselves and their clients and seek therapeutic ways to share their power with clients. It harms the therapy alliance when therapists do not remain responsive to client's wishes regarding the approach to therapy. Ideally, therapists will introduce diverse narratives (i.e., environmental, biological, psychological, and cultural expectations) in the ongoing process of helping the client articulate their illness myth and plan for directing energy during therapy.

Indeed, a potent intervention worth considering is presenting one's conceptualization and treatment plan to the client. This description should be simple and concrete and must include

minimal jargon. Clarity and simplicity is especially important when clients are distressed because their cognitive resources are strained, and thus they may have limited energy to learn and understand professional jargon. One might share a simple graphic that communicates the theorized causal connection between the problem, target intervention, and affected outcome. For example, within interpersonal therapy, the problem involves assessing several interpersonal problems (e.g., loss of a loved one, role conflicts, or transitions such as moving); the targeted intervention involves awareness of emotions and using these problems for pragmatic problem-solving; and the affected outcome involves greater self-efficacy, which reduces a sense of interpersonal helplessness (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016).

As therapy progresses, cultural humility should affect the expression and monitoring of interventions and techniques. Therapists ought to remember that their preferred interventions may not work with all clients, so ongoing assessment of progress is required. They can attend to how their values interact and intersect with those of the clients and avoid imposing their values on the client in a coercive manner. Furthermore, an expression of cultural humility may involve a willingness to work systemically. Effective interventions may require consulting with family members or spiritual leaders in the client's life to negotiate a culturally acceptable way of addressing the client's presenting problem.

Strengthening and repairing the working alliance. Culturally humble behaviors are hypothesized to help strengthen, maintain, and repair the social bond with clients. For some therapists, competency language can evoke perfectionist strivings and self-preoccupation with how one is measuring up. Fear of making mistakes can also distract therapists from positive behaviors, such as emotional attunement and exploration of cultural opportunities. These positive behaviors set the stage for the work of therapy (e.g., sharing vulnerable emotions and tolerating challenging feedback), which requires high trust. We know from theory in positive psychology (Fredrickson, 2004) that cultivation of interest and curiosity may provide a more powerful context for exploring salient identities than an undercurrent of fear and self-monitoring.

Along similar lines, training might help therapists notice when they experience greater cultural discomfort and help them use strategies to quiet the ego (Chancellor & Lyubomirsky, 2013), such as mindfulness, self-affirmation, or self-compassion. Similarly, therapists can be intentional about maintaining a "here-and-now" frame throughout the therapeutic relationship, which can help the therapist remain present and allow for greater attention to process issues that can either exacerbate or alleviate cultural ruptures. In a similar vein, the therapist can regularly illuminate and reflect upon the interpersonal process of therapy, which might ease cultural discomforts by recognizing that they occur and can be spoken about without negative repercussions. Therapists may also want to learn and practice mental habits that return their focus to the fundamentals of forming a social bond. Our minds may drift to focusing on our fears or insecurities, which make it harder to attend to the moment and remain emotionally responsive to our clients. Other fundamentals include setting clear boundaries and expectations and then honoring these commitments. Therapists can learn to remain positively engaged and responsive, even when they may feel insecure. The essence of a strong emotional bond involves clients learning that the therapist will consistently attune and respond to their needs.

Therapists can also use interventions to increase hope and establish early "wins" to relieve distress. A strong relationship sets the stage for opportunities to explore salient identities of the client, which abound at any given time in therapy (e.g., noting and exploring when clients make risky cultural disclosures). We can also initiate cultural conversations through linking current themes to questions about the client's salient identities. When initiating cultural opportunities, an important skill involves using smooth transitions that link the new direction to what was happening in therapy. Without sufficient trust and bridging language, shifting to cultural topics can feel abrupt and invasive.

Even when therapists do good work, sometimes therapists may need to act decisively to repair cultural ruptures. Cultural offenses are common in therapy and can undermine a working alliance if not addressed (Hook, Farrell, et al., 2016). As with other regularly occurring therapeutic phenomena, the therapist can include these concepts during intake, which should serve as both data gathering and orienting functions. When therapists work to earn trust early in the relationship, this provides potential flexibility for addressing major challenges in attending to cultural ruptures: Many clients do not disclose offenses or wait until right before terminating to do so (Ridley, Mollen, & Kelley, 2011). When therapists talk with clients about cultural offenses and how they might be addressed, this intervention might allow clients to express these issues more freely throughout the therapeutic process. When offenses occur, culturally humble therapists express a commitment to understanding and validating the client's perspective of what happened and to making amends in a way that is culturally meaningful to the client. A culturally humble stance makes it likely that one can tolerate and validate the client's perspective. Likewise, cultural humility helps therapists engage in more effective conciliatory behaviors, including offering effective apologies and making amends.

Growing through value conflicts. Value conflicts pose a fundamental threat to the expression of cultural humility. They undermine therapists' ability to maintain a sense of integrity; no matter what they do, therapists actions will not fully align with values from one or more of their identities. We have a few suggestions for learning to deal with value conflicts and cultivating greater ideological span.

A first step involves naming (verbalizing) the nature of the value conflict to oneself. Therapists can clarify the conflicting values, relevant identities (i.e., who might be disappointed by various courses of action), and moral emotions. Moral theories—although culturally situated themselves—can at least provide a language for discussing the conflicting values. An example is the moral foundations theory (Graham & Haidt, 2010), which describes five foundations people use when making moral judgments. Does a behavior seem potentially wrong because it is (a) harmful (harm/care), (b) unfair (fairness), (c) undermines commitment to one's social group (loyalty), (d) shows disrespect for social hierarchies (authority), or (e) causes physical or social contamination (purity)?

Discussions of morality may require some of the most challenging conversations in therapy. Accordingly, value conflicts require

therapists to express cultural humility to moderate the degree to which clients feel morally judged. To manage expression of unconscious feelings, therapists will need to regularly explore prior cultural experience (e.g., cultural countertransference; Roysircar, 2004) that may amplify or mute their emotional responsiveness to their clients. An expression of cultural humility is realizing that we need other people to help us see our limitations. Consultation and supervision from individuals with both similar and different values can also provide perspective and support. Consultation can be especially helpful in deciding whether it might be helpful to explicitly discuss when, if ever, it might be appropriate to discuss the value conflict with the client. We think it would be imprudent to suggest any easy shortcuts or truisms. The role of a therapist is a value-laden process; value conflicts are difficult and will truly test a therapist's maturity and cultural humility.

Owning limits. An expression of cultural humility is having an accurate view of one's strengths and weaknesses. This is notoriously tricky, due to the capacity for self-deception. The less expertise one has, the more likely one is to overestimate one's degree of expertise (Kruger & Dunning, 1999). So, having less expertise working with an area of diversity might make it harder for one to see one's limitations in that area. This bias, combined with self-enhancement tendencies, make it challenging for individuals to perceive and appropriately take responsibility for their limitations.

Despite this difficulty of achieving an accurate view of oneself, we can offer a few practical suggestions. As therapists, not allowing others to see who we really are is a fundamental barrier to growth and learning. Without accurate feedback, we will have difficulty asking for and receiving appropriate help. Thus, even though concealing one's weaknesses may have short-term benefits (e.g., supervisor evaluations of competency), this behavior can severely stunt professional development. Culturally humble therapists make a professional and personal rhythm out of acknowledging, owning, and taking steps to address their limitations.

Conclusion

For several decades, several challenges have plagued the MCC tradition, especially the gap in research grounding training strategies in psychotherapy process research. The small set of studies that attempted to bridge this gap ran into practical problems that required innovation in theory and greater specificity in measurement. The MCO framework emerged in response to some of the converging trends and challenges. The first fruits of this work are in, and the future looks bright. The MCO framework draws on the virtue language of the MCC tradition but adopts a pragmatic strategy focused on client experiences associated with cultural interactions that strengthen or weaken the therapy alliance. We hope to see counseling psychologists translate a variety of MCC constructs into the context of the psychotherapy process so that we can bolster the evidence base for decisions about the structure and emphasis of training.

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