Received: 27 July 2021 | Revised: 4 October 2021 | Accepted: 7 October 2021
DOI: 10.1002/capr.12481

REVIEW

Cultural humility in psychotherapy and clinical supervision: A research review

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Abstract

Cultural humility, first introduced a quarter century ago, has increasingly emerged over the last decade as a concept of considerable importance: it has been touted as playing a crucial role in potentially enhancing the relationship in both psychotherapy and supervision, its practice being heartily embraced and roundly recommended. But are those recommendations and that hearty embrace justified? What do the empirical data say? We address those questions subsequently, taking a granular look at studies in which cultural humility vis-à-vis psychotherapy and supervision have been examined. Based on our review of 21 psychotherapy/cultural humility studies and seven supervision/cultural humility studies, we offer critique of the research work done thus far (e.g., it being decade delimited and landlocked) and propose recommendations for future treatment and supervision investigations (e.g., internationalising cultural humility research). Because cultural humility appears to be a durable and enduring concept, appears practically beneficial for both the therapy and supervision situations and is increasingly being pursued empirically, such a research report would seem particularly timely and potentially helpful in advancing research.

KEYWORDS
cultural humility, outcome, process, psychotherapy, supervision

1 | INTRODUCTION

When Tervalon and Murray-Garcia (1998), both renowned physicians, educators and activists (e.g., melanietervalon.com), first introduced the term, cultural humility, into the literature approximately 25 years ago (Tervalon & Murray-Garcia, 1998), they may well not have realised how impactful and far reaching their new concept would become. What was then new has now become a vital and integral part of a general ethic and culture of care (Foronda, 2020; Hook et al., 2017), increasingly recognised by, and practice affecting, across a host of varied professions and disciplines, including medicine, nursing, the allied health professions, business/management and religion/spirituality (Davis et al., 2020). That effect has been equally and powerfully felt in the areas of psychotherapy and clinical supervision as well.

Cultural humility has emerged as part of the broader study of humility, which has seemingly exploded across this past decade (e.g., Worthington & Allison, 2018). Although a host of possible forms of humility have been proposed, three have been most consistently identified and researched: relational, intellectual, and cultural.

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Because all psychotherapy and supervision can be deemed multicultural in nature (e.g., Chopra, 2013; Sue et al., 2019), cultural humility has accordingly proven of most interest to psychotherapy and supervision scholars and practitioners. We subsequently examine the cultural humility research in psychotherapy and supervision, providing an empirical status report and research resource for prospective cultural humility investigators.

2 | CULTURAL HUMILITY: DEFINITION, SIGNIFICANCE AND BEYOND

2.1 | Definition

Cultural humility, having both intrapersonal and interpersonal components, is defined as follows: a way of being that involves a willingness, an openness and desire to (a) reflect on *oneself* as an embedded cultural being and (b) hear about and strive to understand others' cultural backgrounds and identities (Foronda et al., 2016; Hook et al., 2017; Hook & Watkins, 2015). It foremost is a form of humility that is specific to all matters of culture (e.g., race/ethnicity, gender, sexual orientation, ability status) and, most fundamentally, involves being curious about and respectful of others and their cultural identities, not making automatic, foreordained assumptions about them (Foronda et al., 2016; Hook et al., 2013). Descriptors that seemingly best capture a sense of cultural humility include open-mindedness, curiosity, respectfulness, consideration, self-reflectivity, egolessness, other-empowerment and being a lifelong learner (Foronda et al., 2016; 2020; Hook et al., 2017).

2.2 | Significance

Cultural humility appears to matter and matter greatly in psychotherapy and supervision, some reasons being that it potentially: (a) increases the probability of cultural issues being introduced into the treatment/supervision conversations, then being further considered and discussed; (b) increases the likelihood of the deepening of any such cultural conversations; (c) increases the probability of more easily building and further fortifying the therapist/client and supervisor/supervisee working alliances; and (d) increases the likelihood that more favourable treatment/supervision processes and outcomes will be had (Davis et al., 2018, 2020; Hook et al., 2017). Because culture is inextricably intertwined in all facets of our being and becoming (Spector, 2017), and because both treatment and supervision encounters are recognised as being inexorably multicultural in nature (British Association for Counselling & Psychotherapy, 2018; Roth & Pilling, 2008; Watkins et al., 2019), it conceptually stands to reason that cultural humility would indeed have positive treatment/supervision effects. The conceptual has begun to be increasingly complemented by the empirical across this past decade (as evidenced in Appendices S1 and S2).

Implications for Practice

The reviewed studies suggest that cultural humility can positively impact therapy and supervision outcomes. Perhaps what can be most safely said now is this: psychotherapists and supervisors would do well to learn about and foster their cultural humility, consider how it potentially affects their professional practice and consider more deliberately incorporating it into their conceptualisation and conduct of psychotherapy and supervision. It may well come to pass that highly valuing cultural humility is viewed as both a professional necessity and as readily reflective of best practice (cf. Vandament et al., 2021).

2.3 | Measuring cultural humility

The measurement of humility has long proven to be a thorny problem, and the measurement of cultural humility has proven no exception in that regard (Davis et al., 2010, 2011; Hook et al., 2017). Worthington (2007) stated 15 years ago that "Science tells us precious little about humility" (p. 79); that, however, is no longer the case. Worthington and Allison (2018) now make clear that "…a science of humility has taken root" (p. 9); that science has taken root for cultural humility as well. With the advent of the Cultural Humility Scale (CHS) and its validation (Hook et al., 2013), the measurement of cultural humility as a construct became possible; the CHS has since proven promisingly heuristic, resulting in at least 21 psychotherapy studies and seven supervision studies (subsequently reviewed), and seemingly has contributed to other like measures being developed (e.g., Gonzalez et al., 2020).

The CHS, a 12-item, other-informant scale, involves an informant (rater) reporting on the cultural humility of the individual (ratee) in question. Although any measurement of humility ideally is pluralistic in nature (Hoyle & Mancuso, 2021; McElroy-Heltzel et al., 2019), other-informant scales are useful because they sidestep the modesty effect problem (whereby humble individuals have trouble accurately rating their own humility; Davis et al., 2010, 2017). It may well be that, when it comes to matters of humility, others can know us better than we know ourselves (or are better raters in that regard; Vazire & Carlson, 2011). Thus, the CHS reflects the fruitful melding of the conceptual and empirical, with cultural humility consequently becoming a researchable construct.

2.4 | Previous review where cultural humility/psychotherapy was addressed

One other narrative review, while focused more broadly on multicultural orientation, addressed cultural humility vis-à-vis psychotherapy as a part of its coverage (Davis et al., 2018). Primary findings of this review of nine articles (11 samples) were as follows: (a) positive

associations (as predicted) were found between (a^1) the therapeutic alliance and cultural humility and (a^2) psychotherapy outcomes and cultural humility; (b) negative associations (as predicted) were found between microaggressions and cultural humility; and (c) cultural humility was affirmed as a positive, enhancing treatment feature across all conducted psychotherapy studies.

Because cultural humility/supervision studies are a most recent phenomenon, a product of the last two years alone, no review attention has yet been given to those investigations.

3 | OUR GRANULAR REVIEW ABOUT CULTURAL HUMILITY

3.1 | Rationale

We wish to complement the cultural humility/psychotherapy portion of the Davis et al. (2018) review in two ways. First, whereas their review was narrative in nature (e.g., describing study results in but a few sentences), we take a more granular approach here: providing a highly detailed picture about each study, what was done and how, and presenting attending conclusions, strengths and limitations. That highly detailed study by study cultural humility/psychotherapy picture is provided in Appendix S1, with six areas—setting/sample, measures, procedure, analyses, findings/conclusions and limitations—being given focus. By taking this granular approach, we hope to provide a more complete view about: the specific features that, for better or worse, empirically compose each study; what can be safely inferred from the data; and what recommendations for future research can be made. Furthermore, we hope that the highly detailed nature of Appendix S1, in and of itself, could serve as a useful reference resource for investigators who may wish to pursue future cultural humility/psychotherapy study. Second, although the Davis et al. (2018) review was conducted but four years ago, the number of cultural humility/psychotherapy studies has since more than doubled; because of this rapid escalation of empirical work, an updated report would seem helpful in keeping pace with those fast occurring developments.

In addition to taking a granular look at cultural humility/therapy studies, we wish to also do the same for cultural humility/supervision studies. Although these studies are few, their findings and features still merit scrutiny and could also provide useful fodder for thinking in a more informed manner about future supervision investigations. Those studies are detailed in Appendix S2.

3.2 | Caution

For the sake of full disclosure, we acknowledge our strong investment in, and long-standing commitment to, the area of cultural humility, that we have been intimately involved in conducting cultural humility research across this past decade, and that we will be reviewing some of those very studies here. Thus, we well recognise the potential for reviewer bias (e.g., to guard against such bias, an outside author could have been added to this review). With our potential for bias acknowledged, we have remained most mindful and ever vigilant of that possibility throughout the entirety of this review process, have exercised a most critical eye towards each and every reviewed study (including our own) and hope that that most critical eye will clearly be on full display in all that follows (in both text and Appendices)—that the evidence itself will speak to our critical perspective applied.

4 | METHOD

Two primary inclusion criteria were employed for this review. First, all included studies were empirical, with theoretical articles and case studies being excluded. Second, all psychotherapy studies focused specifically on the relationship between cultural humility and treatment processes or outcomes; all supervision studies did the same, focusing specifically on cultural humility and supervision processes or outcomes. In locating studies for the current review, five steps—outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement guidelines—were followed so as to identify studies for examination (Page et al., 2021). We (a) conducted database searches (i.e., Google Scholar, PsycINFO, PROQUEST Dissertations and Theses) throughout June 2021, combining the search word “cultural humility” with “psychotherapy,” “counselling,” “supervision” and “therapy”; (b) examined reference sections of identified articles for studies that might have been missed; (c) examined psychotherapy and supervision journals, or journals that publish psychotherapy or supervision material, for recent studies; (d) examined recent cultural humility texts (e.g., Davis et al., 2020; Hook et al., 2017) to find further possible missed work; and (e) sent emails to corresponding expert cultural humility authors, when possible, to inquire about unpublished research that we may have missed. The PRISMA literature search process is diagrammed in Figure 1.

5 | RESULTS

Twenty-one cultural humility/psychotherapy studies and seven cultural humility/supervision studies were identified for review. The details of each study are presented in Appendices S1 and S2. Review findings for cultural humility/psychotherapy are presented first, organised into three areas: (a) methodology (e.g., setting/sample, measures), (b) overall relationship between cultural humility and psychotherapy outcomes, and (c) potential mediators and moderators of that cultural humility/psychotherapy outcomes relationship. Review findings for cultural humility/supervision are presented second, being organised in accordance with those same three areas (i.e., methodology, overall relationship and mediators/moderators).

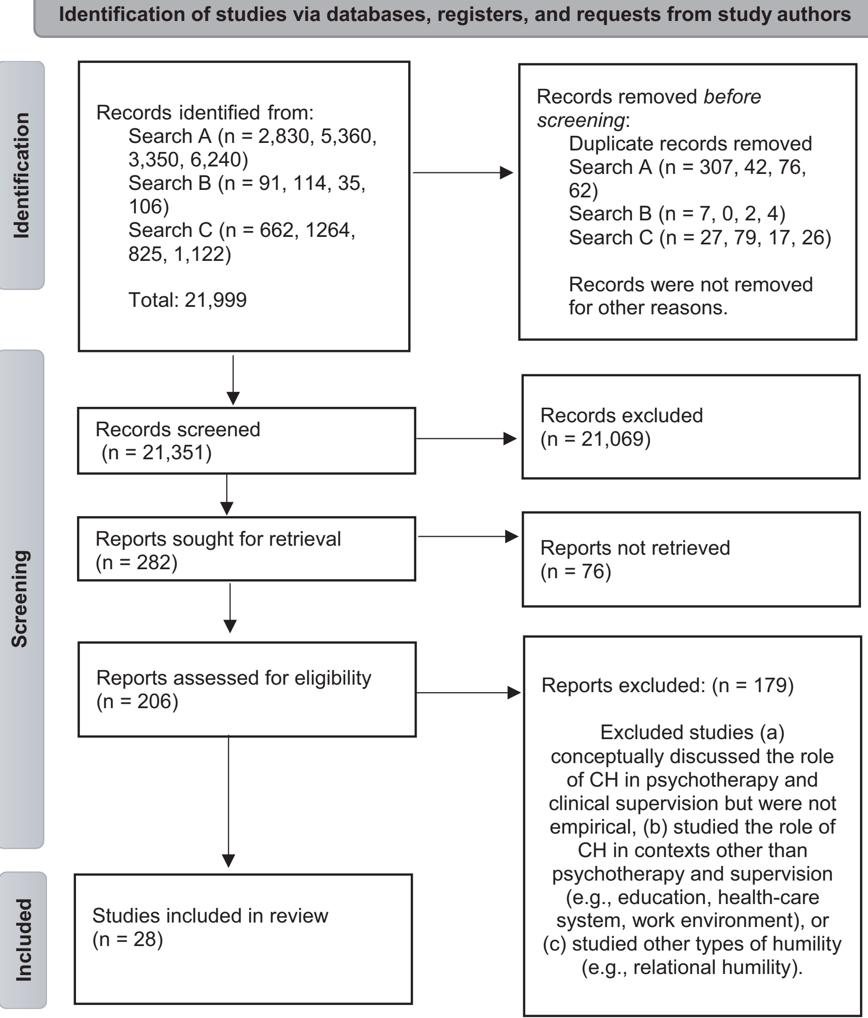

FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram. *Note*. Search A = Google Scholar; Search B = PsycINFO; Search C = ProQuest Theses and Dissertations. The three numbers corresponding with each search reflect the three searches conducted (e.g., Search A: cultural humility with "psychotherapy," "counselling," "supervision," "therapy")

5.1 | Cultural humility and psychotherapy

5.1.1 | Methodology

Setting/sample

The primary characteristics across the 21 studies (*n* = 6,542) on cultural humility/psychotherapy are as follows: first, regarding gender, 4,439 identified as cisgender women, 1,910 as cisgender men, 69 as gender nonbinary, 33 as transgender, and the remainder as "other" or declining to answer.

Second, regarding settings and sources of participants, 12 studies drew samples from a college/university setting (e.g., university counselling centre, department clinic, undergraduate research participant pool), eight recruited samples from online platforms (e.g., Amazon Mechanical Turk, social media posts, listserv of professional organisations) and one study recruited inmate participants from two county jails (i.e., two locations in Denver, CO.; Coleman et al., n.d.). The vast majority of participants across studies either had been or were now in psychotherapy.

Third, regarding age, the mean age across the 21 studies was 28.64 years. Specifically, 12 studies had a mean age in the 20s, seven studies had a mean age in the 30s, one study had a mean age above 40, and one study did not report the mean age. Fourth, where sexual orientation was reported, the majority of participants (*n* = 4,123) identified as heterosexual (the percentages across the 20 studies ranged from 47% to 96%), with one study specifically recruiting LGBTQ participants (Kangos, 2019); 405 participants identified as gay or lesbian, 603 as bisexual, 83 as pansexual, with the remainder identifying as "other" or declining to answer.

Fifth, regarding racial/ethnic identity, studies involved representation across several different racial/ethnic groups, including Black, White, Asian American/Pacific Islander, Hispanic/Latinx, Native American/American Indian, multiracial and "other." Specifically, 2,367 participants identified as White/European-American, 1,453 as Black/African American, 1,049 as Hispanic/Latinx, 645 as Asian American/Pacific Islander, 634 as Biracial or Multiracial, 166 as Native American/American Indian, with the remainder identifying as "other" or declining to reply. Approximately one-third to 100% of the participants in six out of the 21 studies were Black, and approximately one-third to 84% of participants in 15 out of 21 studies were White.

Although other racial/ethnic groups were typically represented, that representation was quite variable, with Asian American/Pacific Islander participants accounting for approximately

10%–20% of samples across nine studies, Hispanic/Latinx participants representing 10%–30% in eight studies, biracial or multiracial participants representing 10%–15% in four studies and Native American/American Indian participants representing 5% of the sample in one study.

Measures

With the exception of Hook et al.'s (2013) pilot study, the Cultural Humility Scale (CHS) was uniformly used across all investigations to measure cultural humility - that was the one measurement constant. Otherwise, based on the nature of the questions being researched, a host of other measures was employed to measure psychotherapy-related constructs, including psychotherapist cultural competency (Cross-Cultural Counseling Inventory-Revised, Counselor Comfort Scale, Cultural Missed Opportunities Scales, Color-Blind Racial Attitudes), general competence of the psychotherapist (Counselor Short Rating Form), therapeutic alliance (Working Alliance Inventory), therapeutic outcomes (Patient's Estimate of Improvement, Schwartz Outcome Scale, Clinically Adaptive Multidimensional Outcome Survey), factors contributing to psychological distress in psychotherapy (Racial Microaggressions in Counseling Scale, Microaggressions in Counseling Scale) and outside of therapy (Adverse Childhood Experiences), mental health symptoms (Negative Emotion subscale of the Positive and Negative Affect Scale), counselling approach (Feminist Approach to Therapy, The Attitudes Related to Trauma-Informed Care) and client religiosity (Religious Commitment Inventory, Perceived Religious Outlier Status).

Research design

Of the 21 studies, 18 used a quantitative research design, and three utilised a mixed methods research design that involved both qualitative and quantitative responses. Sixteen studies were cross-sectional in nature, two were longitudinal, and three used an experimental design.

5.1.2 | Overall relationship

Of the 21 studies, with but one exception (Coleman et al., n.d.), all studies demonstrated a positive relationship between cultural humility and positive psychotherapy constructs (as was predicted). Client-perceived therapist cultural humility was linked to positive working alliances, therapy continuance, expected treatment effectiveness (Hook et al., 2013), positive treatment outcomes (Kivlighan et al., 2019; Owen et al., 2014, 2016), higher psychotherapist competence ratings (DeBlaere et al., 2019), lower frequency and lower impact of racial microaggressions (Hook et al., 2016), lower colour-blind racial attitudes (Haywood Stewart, 2019), greater prosocial justice advocacy attitudes (Chase, 2021) and willingness to disclose and discuss one's religious beliefs (Judd, 2017). Conversely, lack of participant-perceived therapist cultural humility was associated with weaker working alliances and more therapeutic ruptures (Davis et al., 2016).

5.1.3 | Potential mediators and moderators

Given the low number of published studies where mediation or moderation was tested, the subsequent findings are, at best, suggestive, perhaps most useful as a heuristic reference point for future cultural humility studies.

Potential mediators

First, cultural humility was found to positively impact treatment outcomes through stronger working alliances (Hook et al., 2013). Kangos (2019) also found a partial mediating role of the working alliance on this cultural humility/outcome relationship.

Wright (2019) found that positive regard, empathy and congruence each had a mediating effect on the positive relationship between cultural humility and the working alliance. Cultural humility, perhaps acting through these facilitative therapist characteristics, leads to healthier working alliances, which in turn brings about positive treatment outcomes.

Potential moderator

Client cultural identity emerged as one potential moderator of the relationship between cultural humility and treatment outcomes. Owen et al. (2014) found that ratings of cultural humility about religion/spirituality were more strongly related to treatment outcomes for individuals with higher levels of religious commitment. Morales (2019) found that, for clients with high cultural identity importance, higher therapist cultural humility was associated with higher perceived session quality; however, for clients with lower cultural identity importance, higher therapist cultural humility predicted lower session quality ratings. Cultural humility may be most important when aspects of clients' cultural background are highly salient for them.

5.1.4 | Limitations and recommendations

The major limitations across these 21 cultural humility/psychotherapy studies, consistent with limitations noted by Davis et al. (2018), involve issues of research design, age and cultural background. First, although studies may have recently doubled in number, most studies still remain ex post facto, cross-sectional and correlational in nature. A dearth of studies ($n = 3$) employed causal designs; this remains a substantial gap in the literature, and any causal conclusions about cultural humility/psychotherapy cannot be drawn at this time. Furthermore, the role of mediators and moderators in the cultural humility/psychotherapy relationship has only begun to be tested.

Second, the mean age of virtually all participants placed in but two decades: the 20s and 30s. Although research on these age groups is still needed, research on cultural humility/psychotherapy needs to be explored in, and expanded to include, other age groups. What impact does cultural humility have in child/adolescent psychotherapy? How might cultural humility impact psychotherapy outcomes for those who are middle aged or older adults? These

questions remain unexplored. Our current empirical knowledge base about cultural humility/psychotherapy is decade delimited, lacking a life span perspective, and sorely needs an age expansion.

Third, all cultural humility studies have been conducted in the United States and involved predominantly American participants. How does cultural humility apply beyond the borders of the United States? Though cultural humility is purportedly a construct of international import, is that so? These questions also remain unexplored territory that are in need of investigation. Our current empirical knowledge base about cultural humility/psychotherapy is landlocked, lacking in international perspective, and sorely needs cross-country and cross-continent transport.

5.2 | Cultural humility and clinical supervision

5.2.1 | Methodology

Setting/sample

Primary setting/sample characteristics across these seven cultural humility/supervision studies are as follows: 804 participants were involved, with 658 identifying as cisgender women, 124 as cisgender men, 3 as transgender and 23 as gender nonbinary or "other." Most participants were drawn from a college/university setting, their mean age being in the 30s in four studies; three studies (Cook et al., 2020; Jadaszewski, 2020; King et al., 2020) had a mean age in the 20s. The majority of participants identified as heterosexual (percentages ranged from 62% to 84%). Participants were from several different racial/ethnic groups, including Black (*n* = 1,457), White (*n* = 2,444), Hispanic/Latinx (*n* = 1,055), Asian American/Pacific Islander (*n* = 647), multiracial/biracial (*n* = 636), American Indians/Alaskan Natives/First Nation (*n* = 166) and other (*n* = 138).

Measures

The Cultural Humility Scale (CHS; Hook et al., 2013) was adapted to measure supervisees' perceptions of supervisor cultural humility (with the word "counsellor" being replaced by the word "supervisor" in the instructions) across the seven studies. Wilcox et al. (2020) created two adapted versions of the CHS for supervision: one pertaining to the supervisee's identities and the other pertaining to the supervisee's clients' identities. Four quantitative measures were employed to assess supervision outcomes, including perceived agreement on supervision goals, tasks and bond (Supervisory Working Alliance), supervisees' degree of satisfaction with supervision (Supervisory Satisfaction Questionnaire) and supervisees' general psychological distress (the Negative Affect subscale of the Positive and Negative Affect Schedule). For the interview process exploring role transitions in counsellors, King et al. (2020) used two guiding questions to explore supervisors' transitions from the supervisee to supervisor role and challenges associated with that transition. The Critical Incident Analysis was used by Wilcox et al. (2021) to qualitatively identify themes of critical incidents related to multicultural competence.

Several quantitative measures were used to assess other supervision-relevant variables, including the degree of self-disclosure during supervision (Supervisee Nondisclosure Scale), empathy towards people of different racial/ethnic backgrounds other than one's own (Scale of Ethnocultural Empathy), supervisor responsiveness to cultural dialogue in supervision (supervisee-focused and client-focused versions of the supervision-adapted Cultural Missed Opportunities Scale), supervisors' and supervisees' in-session broaching behaviours (Cultural Behaviors Scales), counsellors' self-efficacy in counselling competence (Counselor Activity Self-Efficacy Scale) and supervisee's sense of esteem (the Collective Self-Esteem Scale).

Research design

Of the seven studies, five utilised a quantitative design, King et al. (2020) a mixed methods design, and Wilcox et al. (2021) a qualitative design. Six studies were cross-sectional in nature. King et al. (2020) used a longitudinal component as a part of their study, with one measure being given over time. No studies used an experimental design.

5.2.2 | Overall relationship

Overall, the seven studies revealed a positive relationship between cultural humility and clinical supervision processes and outcomes (as was predicted). Supervisee-perceived supervisor cultural humility was associated with, or predictive of, supervisee openness and disclosure, more favourably perceived supervisory working alliances, a greater sense of counsellor self-efficacy, and more satisfaction with supervision (Cook et al., 2020; King et al., 2020; Vandament et al., 2021; Wilcox et al., 2021). Perceived supervisor cultural humility was negatively associated with supervisees' negative affect caused by cultural ruptures in supervision (Jadaszewski, 2020).

5.2.3 | Potential mediator

The supervisory working alliance was the one potential mediator to emerge in the reviewed studies: Cultural humility appeared to exert a positive impact on supervisory outcomes (e.g., supervision satisfaction) via a stronger working alliance (Vandament et al., 2021; Wilcox et al., 2021). Akin to psychotherapy, cultural humility perhaps leads to stronger supervisory working alliances, which in turn bring about positive supervision outcomes.

5.3 | Limitations and recommendations

Similar to the studies on cultural humility/psychotherapy, most of the cultural humility/supervision studies featured ex post facto, cross-sectional, correlational designs. Studies involving experimental designs were absent, which has long been and generally remains

the case for supervision research (Watkins, 2020; Watkins et al., 2021). The role of mediators and moderators in the cultural humility/supervision relationship remains virtually unexplored.

Second, most studies featured only supervisees' perceptions of supervisor cultural humility. Although other-report measures have merit, it would be interesting to assess supervisors' own self-ratings of cultural humility to check for possible discrepancies between the two (similar to Jarvis, 2018), which may yield more nuanced information about the supervision dynamic. Furthermore, supervisees also experience varying degrees of cultural humility (Watkins & Mosher, 2020); yet, no studies have examined supervisors' perceptions of their supervisees' cultural humility. That form of assessment may also yield further important, nuanced, interactive information about the cultural humility/supervision dynamic.

Third, the samples in the supervision studies were again limited to younger participants, most in university settings, all from the United States. Once more, just as cultural humility/psychotherapy studies are decade delimited and landlocked, so too are cultural humility/supervision studies. International samples would indeed be a most welcome addition to the literature, as well as samples that utilise older supervisees. How cultural humility/supervision works outside the university setting remains largely uncharted territory.

Fourth, all studies included in the present review assessed the effects of cultural humility in individual supervision, but most supervisees also receive group supervision during their training (Bernard & Goodyear, 2019). Exploring the effect of cultural humility in group supervision seems highly important and another area much in need of empirical attention.

6 | DISCUSSION

The purpose of the current paper was to provide a granular picture of and update the empirical literature that explored the relationship between, first, cultural humility and psychotherapy and, second, cultural humility and clinical supervision. Virtually all of the 21 therapy studies revealed a robust, positive relationship between cultural humility and positive psychotherapy process/outcome; that same robust, positive relationship was also the case for the seven cultural humility/supervision studies as well. These findings seemingly provide further empirical support for the prosocial and practical value of cultural humility in the therapy and supervision contexts.

Perhaps what can be most safely said now is this: psychotherapists and supervisors would do well to learn about cultural humility, consider how it potentially affects their professional practice and consider more deliberately incorporating it into their conceptualisation and conduct of psychotherapy and supervision. It may well come to pass that highly valuing cultural humility is viewed as both a professional necessity and as readily reflective of best practice (cf. Vandament et al., 2021).

But with those positives acknowledged, cultural humility study is not without limitations. First, although consistent (and expected) positive cultural humility associations were found across these reviewed investigations, virtually all studies were correlational, ex post facto, and cross-sectional in nature. Causality cannot be inferred: "… future [psychotherapy and supervision] studies should use designs that allow for stronger causality inferences" (Davis et al., 2016, p. 490). Furthermore, there could be other variables (e.g., client or supervisee motivation) that also affect the reviewed data. Therapeutic and supervisory relationships are complex, impacted by a host of intersecting variables and not necessarily linear in nature. In that respect, cultural humility's relationship to treatment and supervision may not necessarily be linear either; that possibility should be borne in mind when considering our findings. Second, all 28 studies featured in this review utilised other-report (informant) measures of cultural humility. In future research, taking multiple forms of measurement across all engaged parties would seem to provide the most informed and complete assessment picture. Third, cultural humility—while showing much promise as a construct—appears to be decade delimited and landlocked: cultural humility/psychotherapy and cultural humility/supervision research are largely products of participants in their 20s and 30s, all of who reside in the United States. Primary challenges for cultural humility ahead would be these: Internationalising cultural humility research in psychotherapy and supervision and working to include other age groups that are fully reflective of the developmental life span. Until those challenges are met, the reach of cultural humility will forever remain in doubt. We strongly recommend that psychology as a field works to make cultural humility research more global, cross-cultural, and developmental and moves beyond the predominant study of what has been referred to as W(esternised), E(ducated), I(ndustrialised), R(ich) and D(emocratic) research participants (Henrich et al., 2010b). As Henrich et al. (2010a) have made clear, most people do not fit the WEIRD acronym, and they need to be researched as well. So it is for cultural humility.

7 | CONCLUSION

Cultural humility, a prosocial virtue, is thought to play a beneficial role in daily life; it also may play a highly beneficial role in psychotherapy and clinical supervision. Empirical study of the concept has begun in earnest, with 21 psychotherapy and seven supervision studies being conducted thus far. We have presented a detailed review of these 28 studies in an effort to (a) provide a current research update and status report about cultural humility vis-à-vis psychotherapy and supervision, (b) identify salient research issues that require attention going forward, (c) advance further investigation into the potential impacts of cultural humility on the treatment/supervision processes, and (d) provide a ready reference resource for use by future researchers (via Appendices S1 and S2).

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How to cite this article: Zhang, H., Watkins, C. E. Jr, Hook, J. N., Hodge, A. S., Davis, C. W., Norton, J., Wilcox, M. M., Davis, D. E., DeBlaere, C., & Owen, J. (2022). Cultural humility in psychotherapy and clinical supervision: A research review. *Counselling and Psychotherapy Research*, 22, 548–557. https://doi.org/10.1002/capr.12481