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Cultural competence and cultural humility: a complete practice

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ABSTRACT

Diversity is a complex concept comprised of many intersecting positions an individual may hold in society (e.g., gender, sexuality, (dis)ability, age, religion). Social work practitioners need culturally-responsive skills and knowledge to work with clients from diverse populations. They also need to apply professional humility to learn and analyze the cultural nuances of each population to avoid potential stereotype and personal bias. Some critics have championed cultural humility over cultural competence. This article presents an argument that both are necessary for practice.

KEYWORDS

Diversity; culture; competence; professional humility; self-awareness; unintentional injustice

Introduction

Working with diverse populations can be complex and challenging. Combining cultural competence and cultural humility can guide practitioners to effectively work with clients. Having prior knowledge about clients and their culture prepares practitioners to work with unfamiliar populations. Practitioners have to consciously keep this prior knowledge in check and avoid assuming or stereotyping. At the same time, practitioners need to have the humility to be a learner, rather than an expert, and start where the client is. Thus, having cross-cultural skills and knowledge and at the same time being open and adapting to clients from diverse populations can lead to a strong therapeutic alliance and positive outcomes. By expanding on the definitions and details of each concept, we assert that cultural competence and cultural humility need not compete with each other and not be mutually exclusive. Instead, diversity should be addressed using cultural competence *and* cultural humility to yield comprehensive treatment that is effective and, more importantly, sensitive to clients.

Cultural competence and cultural humility

As the world population grows and technology advances, boundaries and borders blur, making diversity prominent in everyday life. Often, race/

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ethnicity is an initial variable identified with diversity. However, diversity is also comprised of many other identities, such as socioeconomic status, (dis) ability, sexuality, age, religion and global citizenship, with each associating a unique context and culture. Practitioners must be aware of how these various identities intersect and give rise to complexities in their work and interactions with clients. Social work practitioners must have the appropriate knowledge and skills to account for diversity as part of a practice formula to effectively address each client's unique situation. Therefore, practitioners need to have professional humility to learn from and work with various clients.

By definition, ***cultural humility*** is the helping professional's consciousness toward an understanding of their potential blind spots that can interfere with the "other-oriented" perspective in analyzing their client's problems (Hook et al., 2013; Sloane et al., 2018). Cultural humility is not solely about openness, but also being intentional of the intersection between what the professional's experience has been and what other people consider the most important aspects of their cultural identity (Shaw, 2016).

Cultural competence is defined as "a set of attitudes, skills, behaviors, and policies enabling individuals and organizations to establish effective interpersonal and working relationships that supersede cultural differences" (Cross, Bazron, Isaacs & Dennis, 1989, p. 3). Kools, Chimwaza, and Macha (2014) similarly assert that

> Cultural competence encompasses knowledge about diverse people and their needs, attitudes that recognize and value difference, and flexible skills to provide appropriate and sensitive care to diverse population. Cultural competence has been described as the achievement of a particular skill or ability, implying its completion; however, it is a lifelong commitment to learning about oneself and others. (p. 52)

With the intent to work with the culturally diverse population, the main components of cultural competence are self-awareness and cultural awareness. Furthermore, practice knowledge and skills to be responsive to clients' cultural backgrounds are required for competent practice.

Current practice and standards

Cultural competence as the standard of practice has evolved in many helping professions. Medicine is now using a client-centered, rather than diseased-based approach, to validate and treat patients. Psychology has been focusing on cross-cultural skills, awareness of diversity, and providing effective care across lines of difference. In social work, terms such as *ethnic sensitive practice, cultural awareness, cross-cultural social work*, and *ethnic competency* have emerged (Fisher-Borne et al., 2015). The National Association of Social

Workers (NASW) emphasizes cultural awareness and social diversity as ethical responsibilities. Specifically, the Code of Ethics (2017) states that "social workers should understand and have a knowledge base of their clients' culture and able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups" (p. 3). Further, NASW (2017) mandates

> Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability. (p. 3)

Although cultural competence has long been popular in professions and education venues, critics have pointed to several deficiencies and concluded that cultural competence alone is inadequate when working with diverse populations. Fisher-Borne et al. (2015) state that a "core critique of cultural competency frameworks involves the explicit goal of competence itself" (p. 170). They suggest that "knowing broad descriptions of various group identities can translate into knowing the life experiences of an individual client" (Fisher-Borne et al., 2015, p. 170). This can lead practitioners to believe they are experts by having *mastered* the knowledge and skills to work with a particular population without considering their own biases. In other words, mastery and competence connote an "end point where one is sufficiently proficient" (Hook, 2014, p. 278). As a consequence, practitioners may approach clients with a false sense of confidence regarding the knowledge, assumptions, hypotheses, and stereotypes of a particular population (Ortega & Faller, 2011). Furthermore, practitioners may neglect to pay close enough attention to intergroup and intragroup differences and the unique characteristics and circumstances of their clients. In talking about this, Tervalon and Murray-Garcia (1998) describe the case of a nurse who had partaken in a course on cross-cultural practice. Having learned that Hispanics may overexpress their experience of pain, she interpreted a patient's moaning as exaggeration, rather than indication of real pain. Thus, her efforts to gain insight and learn more about a different culture, led to a misinterpretation of a person's expressed feelings.

Cultural competency emphasizes awareness and mastery of knowledge and skills. Critics argue that this approach treats culture as monolithic and mastery as simplistic, linear, static, and reductionist, as if knowing about certain populations is sufficient (Fisher-Borne et al., 2015). Acquiring and mastering knowledge and skills of a client culture suggests it is only adequate that practitioners (dominant culture, in power, privileged) learn about the clients to treat them, rather than consider the clients' culture. This causes the therapeutic relationship to be unidirectional and further deepen the power dynamic, create a wider gap in the already existing

hierarchical relationship, and potentially make clients feel less than or inferior and finally, create the "other" (DasGupta, 2008). Clients may be hesitant to address a discrepancy given the power differential between them and a practitioner. Ortega and Faller assert that "cultural competence training has not gone far enough in holding workers accountable for the privileged and power position their role entails" (2011, p. 30). As such, a power imbalance can skew decisions in a treatment plan when coupled with assumptions and hypotheses that are practitioner-centered or from a dominant perspective. This leads practitioners to neglect important facts and fail to solicit input from clients. Overall, the power imbalance of practitioner-as-expert does not facilitate trust and rapport during the helping process when clients do not believe that they are heard or validated. The aforementioned case example illustrates well how such efforts to be culturally competent can lead to less competent practice.

The social work profession commits to working with clients as well as seeking social justice in the macro arena. In this context, cultural competence does not go far enough to address systemic and institutionalized oppressions (Abrams & Moio, 2009). Rather, it places a focus on individual clients and culture but pays little attention to the macro practice that includes considerations of the cultural environment where institutions and organizations work toward combating inequalities.

Cultural humility as emerging framework

An emerging concept for competent practice is cultural humility. Tervalon and Murray-Garcia (1998) state that "cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123). Foronda et al. (2016) performed a concept analysis of the peer-reviewed medical literature to find words associated with cultural humility. The concepts they identified were: *openness, self-awareness, egoless, supportive interactions, self-reflection and critique*, and *life-long process*. In short, cultural humility emphasizes ongoing self-reflection, mutual understanding, and mutual respect between practitioner and client.

Recently, some have started to advocate for prioritizing cultural humility over cultural competence (Hook et al., 2013). Others champion replacing cultural competence with cultural humility (Fisher-Borne et al., 2015).

Cultural humility emphasizes a lifelong self-reflection and critique where one never achieves competence. It demands practitioners have more than just knowledge, but change their attitudes and behaviors. This requires a deep awareness of self by examining existing biases and the origins or factors that influence a practitioner's point of view and thoughts. In addition to examine

internal factors that affect their worldview, practitioners need to be cognizant of the external structural forces that shape their position in society, whether in positions of privileges, powers, or oppressed. Moreover, findings from the self-examination exercise can contextualize and identify a client's position in relation to a practitioner's. This helps practitioners understand and empathize, leading to a stronger therapeutic alliance with a client. In sum, cultural humility encourages practitioners to embark on an endless journey of learning and self-reflection.

A central tenet of cultural humility requires practitioners not to assume knowledge of clients, but to enter the therapeutic relationship as learner/student. This removes the onus of a practitioner to be the expert. It neutralizes biases, presumptions, or stereotypes of a client. Instead, practitioners are immersed in learning and respecting the experience of clients from their perspectives. Acting as a learner also reduces the hierarchical power dynamic where practitioners and clients enter the therapeutic alliance together to collaboratively solve the presenting challenge. This is similar to Freire's (1996) concept that teachers must be students to engage in a *mutual process* to work *with* clients, rather than *for* clients. The relationship between practitioner and client is now less authoritative and paternalistic. It takes on a sense of *we and us together* instead of *me fixing you*. This dynamic creates an environment that engenders trust, rapport, and sense of safety. Thus, it empowers clients to work on the presenting situation. Research has shown that cultural humility is positively associated with a working alliance and improvement in therapy (Hook et al., 2013).

In addition to keeping practitioners from making assumptions from their perspectives, a benefit of the client-centered philosophy of cultural humility is its consistency with the social work tenet of starting where the client is. It allows clients to shape the narrative through a lens congruent with relevant aspects of their world and context. This eliminates the *epistemic privilege* of practitioners (Ortega & Faller, 2011), i.e., being a learner and relinquishing control of the narrative keeps practitioners from automatically infusing their bias. It is worth noting that being a learner and relinquishing control does not mean that a client receives no guidance. Rather, a client works in a framework provided by a practitioner. For example, if the purpose of a session is to conduct a biological, psychological, and social assessment, a practitioner would provide a client themes and guide the interview. However, it is a client who gives the unvarnished content to complete the assessment.

With an open mind and starting from a position of not knowing, a client now dictates the narrative and fills in the information. The practitioner, not having to be preoccupied with assumptions or the pressure of being perceived as an expert, is free to receive the rich and complex contents through the lens of a client. In addition to discerning the immediate concerns

affecting a client, cultural humility includes an assessment of the organizational environment, policies, procedures, knowledge, and skills connected to micro practices (Tervalon & Murray-Garcia, 1998). Put differently, "cultural humility offers social work an alternative approach that focuses on knowledge of self in relation to others, acknowledges the dynamic nature of culture, and challenges barriers that impact marginalized communities on both individuals and institutional levels" (Fisher-Borne et al., 2015, p. 171).

Practicing cultural competence and cultural humility

Using the tenets of cultural humility builds rapport and trust with clients. This strong relationship helps gather as much information as possible to create a comprehensive treatment plan. Further, with the hierarchical power dynamic neutralized clients have the freedom to provide input and tailor treatment goals. They may even feel safe to correct or interject if practitioners are off-course to ensure the accuracy of information. Finally, practitioner humility, flexibility, and openness allow for adjustments during treatment to optimize outcomes. The end result is motivated clients who are heard, validated, and empowered. As such, advocates of cultural humility have called for it to be "an alternative rather than 'complement' cultural competency" (Fisher-Borne et al., 2015, p. 173). However, we argue cultural competency and cultural humility complement one another, rather than one or the other.

Cultural competence emphasizes practitioners should have an understanding and some knowledge base of a client's culture. Critics argue practitioners may believe they are the experts, leading to assumptions and stereotyping of a client. However, having some knowledge about a certain culture can also build rapport, prepare culturally-responsive skills, and avoid cultural pitfalls. To avoid the deficits listed by the critics of cultural competence it is of utmost importance practitioners have the *awareness* to avoid biases and *humility* to learn from clients. Ultimately, awareness is the common element shared by cultural competence and cultural humility.

Practice example

Jamila is a social worker assigned to work with Mr. Castillo, a man who recently arrived from Cuba. Her role is to ensure that he receives the mental and physical health services to help him acclimate to the United States. From his records, she knows he is in his late 70's, widowed, and has a chronic heart condition. She has worked with some Cuban clients in the past, but this was the oldest individual to date. She felt comfortable with her knowledge but to be more culturally competent, she wanted to quickly research trends of older adults in Cuba. From previous research and interactions with clients, Jamila

learned that the African slave trade heavily influenced Cuban culture (e.g., music, food, traditions). Articles online emphasize the importance and popularity of music and dancing. Previous experiences with clients affirmed her research that the majority of Cubans are Catholic.

Jamila was using the help of an interpreter to conduct her intake since Mr. Castillo only spoke Spanish. Using a standard intake form, she would assess what mental and physical health resources necessary to support Mr. Castillo. To begin, Jamila introduced herself, her role, and what he could expect from this first meeting. She used the intake form as a guide but conducted it more like a conversation. She began by asking him to share a bit about his medical history and experience in the healthcare system in Cuba. Mr. Castillo shared that he has high blood pressure and a chronic heart condition. Given her experience with other Cuban clients, she knew it would be helpful to provide a brief, high-level overview of the U.S. healthcare system. She explained some of the big differences, what to expect moving forward, and how she would assist him through the process. Her cultural competence made her aware of differences between the two healthcare systems and she was prepared to explain the differences to Mr. Castillo.

To gauge the state of his mental and emotional wellbeing, she wanted to determine if he had been able to engage in activities he enjoyed and that connected him to Cuba. Jamila asked if he had been able to communicate with his loved ones, Mr. Castillo said he had not been able to speak with his daughter. She made a note of this and assured him that they would promptly help him communicate with her. She asked Mr. Castillo if he had found the Spanish language radio stations so that he could listen to music. Mr. Castillo explained that as a Jehovah's Witness, he prefers to not listen to most mainstream music. Jamila realized she over relied on her research and previous experience with clients and needed to learn more directly from her client. Jamila thanked Mr. Castillo for mentioning his religious beliefs and engaged her cultural humility by asking if he would tell her more about it. After learning about his beliefs, Jamila asked if he would like to connect with the local Jehovah's Witness community. Mr. Castillo was thrilled by Jamila's offer. By engaging cultural competency and cultural humility, Jamila was prepared and able anticipate some of Mr. Castillo's need while still learning about his unique experiences and beliefs.

Conclusion

Cultural competence is the ongoing process of building skills, ability, and knowledge about cultures (Kools et al., 2014) whereas cultural humility is rooted in openness and understanding the intersectionality of professional wisdom and an individual's cultural identity (Shaw, 2016). Cultural competence is the standard in practice; however, many have pointed to its pitfalls,

particularly the assumption that competence itself is attainable (Fisher-Borne et al., 2015). Critiques of competence have led to cultural humility emerging in practice given its focus on self-reflection, mutual understanding, and mutual respect. Although some support using cultural humility instead of competence (Fisher-Borne et al., 2015), these concepts are not mutually exclusive and each serves a critical role in practice. Cultural competence and cultural humility work in unison to maximize a practitioner's knowledge and skills while encouraging they be open to learn from clients. Incorporating both concepts in practice results in treatments and interventions that are effective and responsive to the unique needs of clients.

Disclosure statement

No potential conflict of interest was reported by the authors.

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