CULTURAL HUMILITY, RELIGION, AND HEALTH IN LESBIAN, GAY, AND
BISEXUAL (LGB) POPULATIONS

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Thesis Prepared for the Degree of
MASTER OF SCIENCE

UNIVERSITY OF NORTH TEXAS
August 2017

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Mosher, David K. *Cultural Humility, Religion, and Health in Lesbian, Gay, and Bisexual (LGB) Populations.* Master of Science (Psychology), August 2017, 92 pp., 21 tables, 1 figure, references, 97 titles.

The purpose of this study was to explore the religion – health link in a sample of adults and undergraduate students (*N* = 555) that identified as lesbian, gay, or bisexual (LGB), and to explore how perceptions of cultural humility of religious individuals and groups toward LGB individuals affect the relationship between religion and health. First, I found religious commitment among LGB individuals was positively correlated with satisfaction in life, but it was negatively correlated with physical health. Second, I found that cultural humility moderated the relationship between religious commitment and satisfaction in life for LGB individuals involved in a religious community. The lowest levels of satisfaction with life were found for individuals with low religious commitment and perceived the cultural humility of their religious community to be low. However, cultural humility did not moderate the relationship between religious commitment and mental and physical health outcomes. Third, I found cultural humility did not moderate the relationship between religious commitment and minority stress (i.e., internalized homophobia). Fourth, I found that cultural humility was a significant positive predictor of motivations to forgive a hurt caused by a religious individual. I conclude by discussing limitations, areas for future research, and implications for counseling.
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ACKNOWLEDGMENTS

Had it not been for God’s providence, none of this would have been made possible and I am ever grateful for God’s countless blessings in all of this. I have much to thank my wonderful wife Monica for, including her never-ending support, love, and strength. I would not have been able to write this thesis without her. Thank you to Joshua Hook for always making the time for my needs and going out of your way to be a mentor to me. I owe so much of my achievements to you already, and I am truly grateful for your guidance and encouragement. I happen to have the best committee members in Ed Watkins and DC Wang, and I am grateful for their expertise and willingness to share their wisdom with me. I must thank my mom and dad for always believing in me and for all their love over the years. I have been blessed numerous times by the kindness and thoughtfulness of my friends and classmates. Lastly, I would like to thank my sons JD and Jase for showing me the beauty in life as well as for being my snuggle-buddies.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES AND FIGURES</td>
<td>vii</td>
</tr>
<tr>
<td>CHAPTER 1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 2. REVIEW OF THE LITERATURE</td>
<td>2</td>
</tr>
<tr>
<td>Purpose of Current Review</td>
<td>3</td>
</tr>
<tr>
<td>Method</td>
<td>3</td>
</tr>
<tr>
<td>Inclusion Criteria</td>
<td>3</td>
</tr>
<tr>
<td>Literature Search</td>
<td>4</td>
</tr>
<tr>
<td>Results</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical/Conceptual Papers</td>
<td>4</td>
</tr>
<tr>
<td>Empirical Studies</td>
<td>9</td>
</tr>
<tr>
<td>Discussion</td>
<td>15</td>
</tr>
<tr>
<td>Limitations and Directions for Future Research</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER 3. STATEMENT OF THE PROBLEM</td>
<td>18</td>
</tr>
<tr>
<td>Religion and Health</td>
<td>18</td>
</tr>
<tr>
<td>Religion and Health in LGB Individuals</td>
<td>22</td>
</tr>
<tr>
<td>Cultural Humility</td>
<td>25</td>
</tr>
<tr>
<td>Purpose of Current Study</td>
<td>27</td>
</tr>
<tr>
<td>CHAPTER 4. METHOD</td>
<td>29</td>
</tr>
<tr>
<td>Participants</td>
<td>29</td>
</tr>
<tr>
<td>Design</td>
<td>29</td>
</tr>
<tr>
<td>Measures</td>
<td>29</td>
</tr>
<tr>
<td>Demographic Questionnaire</td>
<td>29</td>
</tr>
<tr>
<td>Cultural Humility—Religious Community</td>
<td>30</td>
</tr>
<tr>
<td>Religious Commitment</td>
<td>30</td>
</tr>
<tr>
<td>Physical Health</td>
<td>31</td>
</tr>
<tr>
<td>Subjective Well-Being</td>
<td>32</td>
</tr>
<tr>
<td>Depression</td>
<td>33</td>
</tr>
</tbody>
</table>
LIST OF TABLES AND FIGURES

Table 1. Cultural Humility: Conceptual/Theoretical Journal Articles ............................................. 64
Table 2. Cultural Humility: Empirical Journal Articles .................................................................. 67
Table 3. Skewness, Kurtosis, and Range of Responses of Religious Commitment, Health, Minority Stress, Forgiveness, and Cultural Humility ................................................................. 70
Table 4. Intercorrelations of Religious Commitment, Health, Minority Stress, Forgiveness, and Cultural Humility ...................................................................................................................... 71
Table 5. Comparison of Religiously Involved vs. Non-Involved Participants ............................. 72
Table 6. Intercorrelations Based on Religiously Involved Versus Religiously Non-Involved..... 72
Table 7. Comparison of Outcome Variables In MTURK & Undergraduate (SONA) Samples .... 73
Table 8. Comparison of Sexual Orientation in MTURK & Undergraduate (SONA) Samples .... 74
Table 9. Comparison of Age in MTURK & Undergraduate (SONA) Samples ............................ 74
Table 10. Comparison of Religious Affiliation in MTURK & Undergraduate (SONA) Samples 75
Table 11. Preliminary Analysis of Gender on Outcome Variables ................................................... 76
Table 12. Multiple Regression Analysis Predicting Satisfaction with Life in Group 1 .......... 76
Table 13. Multiple Regression Analysis Predicting Depression in Group 1 ............................ 77
Table 14. Multiple Regression Analysis Predicting Anxiety in Group 1 ..................................... 77
Table 15. Multiple Regression Analysis Predicting Physical Health in Group 1 ......................... 77
Table 16. Multiple Regression Analysis Predicting Satisfaction with Life in Group 2 .......... 78
Table 17. Multiple Regression Analysis Predicting Depression in Group 2 ............................ 78
Table 18. Multiple Regression Analysis Predicting Anxiety in Group 2 ..................................... 78
Table 19. Multiple Regression Analysis Predicting Physical Health in Group 2 ......................... 79
Table 20. Multiple Regression Analysis Predicting Internalized Homophobia in Group 1 ....... 79
Table 21. Multiple Regression Analysis Predicting Internalized Homophobia in Group 2 ...... 79

Figure 1. Moderator effect of cultural humility on the relationship between religious commitment and satisfaction with life. ........................................................................................................ 80
CHAPTER 1

INTRODUCTION

A large body of research has documented the positive association between religion and physical, mental, and emotional health (Koenig, 2012). However, the association between religion and health could be different for various cultural groups, especially for groups that may have a history of conflict between religion and other aspects of one’s cultural identity. When individuals experience conflict between religious viewpoints and important aspects of their cultural identity, cultural humility may be an important variable that could buffer against conflict and preserve the health benefits of religion (e.g., less disease, less anxiety, better life satisfaction). In particular, LGB individuals could experience negative reactions from religious individuals and groups due to their sexual orientation (Hatzenbuehler, Pachankis, & Wolff, 2012). Cultural humility could be a key factor that buffers against negative outcomes (e.g., ruptured relationships, negative emotions, worse health) and leads to preserving the health benefits associated with religion for LGB individuals.

The purpose of this thesis seeks to fill a gap in the literature by exploring the associations among religion, health, and perceptions of cultural humility in LGB individuals. In Chapter 2, I present a review of the literature on cultural humility. Specifically, I reviewed all publications that explicitly focused on measuring, defining, or describing cultural humility. In Chapters 3, 4, and 5, I present an empirical study that explores the relationship between cultural humility and the religion-health link in LGB individuals. In Chapter 6, I discuss the findings from my empirical study in the context of the existing literature.
CHAPTER 2
REVIEW OF THE LITERATURE

With the rise of positive psychology near the turn of the 21st century (Seligman & Csikszentmihalyi, 2000), the study of virtues has flourished and rapidly expanded. However, due to definition and measurement problems, the study of humility got off to a slow start relative to other virtues (Davis, Worthington, & Hook, 2010). This has shifted in recent years, and researchers have begun to study humility in a variety of settings and situations.

The role of humility in the context of cultural factors that might strain a relationship, called cultural humility (Hook, Davis, Owen, Worthington, & Utsey, 2013), is one important area that has received increased attention in recent years. Cultural humility involves both intrapersonal and interpersonal dimensions. Intrapersonally, cultural humility involves an awareness of (a) limitations of one’s own cultural worldview and of (b) limitations in one’s ability to understand the cultural background and experiences of others. Interpersonally, cultural humility involves a stance that is other-oriented toward (or open to) another individual’s or group’s cultural background and worldview (Hook et al., 2013). Cultural humility prioritizes developing mutual respect and partnerships with others.

Because individuals and groups can be highly invested in their own cultural worldview, beliefs, and values, meaningfully infusing humility into dialogues about cultural differences can be difficult. Cross-cultural research supports the idea that culture and conflict are inextricably intertwined (Berry et al., 2002). Cross-cultural conflicts, often inspired by group belief and value differences, appear in a variety of contexts (e.g., politics, interfaith dialogue, and academia) and take a variety of forms (e.g., ruptured relationship bond or group competition over limited resources). In our current cultural context, examples abound of cultural differences being linked
with disagreement and conflict between groups (e.g., the Black Lives Matter movement and resistance toward it, attitudes toward immigration and illegal immigrants, attitudes toward Muslims, conflicts about abortion and LGBT issues, etc.). Cultural humility can be essential to working through such conflicts.

Purpose of Current Review

The purpose of this chapter is to provide a comprehensive literature review on cultural humility. In what follows, I (a) summarize what is known about cultural humility and (b) set an agenda for future research. Specifically, I (a) consolidate definitions of cultural humility and distinguish cultural humility from other similar concepts (e.g., cultural sensitivity, cultural competency), (b) consider the theoretical foundation of cultural humility, and (c) summarize the current empirical literature. By summarizing the current knowledge base, I hope to galvanize and chart direction for further work in this area.

Method

Inclusion Criteria

I included all publications from the present literature that explicitly focused on measuring, defining, or describing cultural humility (e.g., articles that contained the words, ‘cultural humility’ in the title or included cultural humility as a measured variable). I included both theoretical and empirical articles, published and unpublished. I excluded studies that involved only brief reflections about cultural humility.
Literature Search

First, I conducted the literature search by using the following computer databases: PsycINFO, PsycARTICLES, PubMed, Psychology and Behavioral Sciences Collection, Academic Search Complete, ProQuest Dissertations & Theses Global, and Google Scholar, up until February 5th, 2016. The search included the following key terms: ‘cultural,’ and ‘humility.’ Second, I searched the reference lists of the articles to identify any missed studies. Overall, a total of 65 studies were identified using our search criteria. Eleven articles did not focus specifically on cultural humility and were excluded, leaving 54 reviewable studies.

Results

Of the 54 reviewed studies, 33 were theoretical papers and 21 were empirical studies (Tables 1 and 2). The literature review is organized into two sections: (a) theoretical/conceptual publications and (b) empirical studies.

Theoretical/Conceptual Papers

Most cultural humility publications have been theoretical in nature. These theoretical papers were categorized into three main themes: (a) work that sought to spur research by defining and providing a conceptual framework for cultural humility; (b) work that sought to distinguish or differentiate cultural humility from other relevant terms (e.g., cultural competence); and (c) work that stressed the importance of cultural humility across a wide range of fields and domains.
Defining Cultural Humility

To identify core features and consolidate definitions of cultural humility, it is important to review definitional commonalities and differences. Some core aspects of cultural humility were found across almost all definitions. First, cultural humility has been viewed as a life-long learning experience rather than an end point. For example, in Borkan et al.’s (2008) model, the “L” in the Acronym H.U.M.B.L.E. stands for life-long learner. (The other letters in the acronym are H—Be Humble about the assumptions you make about knowing the world from your patients’ shoes; U—Understand how your own background and culture can impact your care of patients; M—Motivate yourself to learn more about the patient’s background, culture, health beliefs and practices, as well as the unique points of view of their families and communities; B—Begin to incorporate this knowledge into your care; and E—Emphasize respect and negotiate treatment plans). Similarly, Chang, Simon, and Dong (2012) suggested a life-long process of learning by fully engaging patients through active listening. This focus on life-long learning is especially important when contrasting cultural humility and other related constructs such as cultural competence, which implies that people will get to a certain place after training and experience where they are deemed ‘competent.’ Cultural humility, in contrast, is often conceptualized as a virtue or value that shapes one’s worldview, mindset, or way of being across the lifespan.

Second, most cultural humility definitions include a focus on cultural self-awareness and the importance of checking one’s cultural assumptions and biases via intrapersonal reflection. Cultural humility is considered to be anti-ethnocentric, emphasizing development of understanding others through exploration, active listening, and being mindful of one’s own assumptions and biases (Clark et al., 2011; Cruess, Cruess, & Steinert, 2010; Fahey et al., 2013;
Foronda, Baptiste, Reinholdt, & Ousman, 2015; Foronda & MacWilliams, 2015; Ortega & Faller, 2011; Schuessler, Wilder, & Byrd, 2012; Tervalon & Murray-Garcia, 1998). For example, Foronda et al. (2015) describe cultural humility as follows: “In a multicultural world where power imbalances exist, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals” (p. 4).

Third, most cultural humility definitions include a focus on interpersonal respect in cross-cultural interactions. While respecting others is not necessarily unique to cultural humility, it is an important component that helps individuals develop and maintain positive cross-cultural interactions and relationships. For example, Miller (2009) demonstrated the importance of cultural humility in fostering long-term partnerships of nurses from different countries. Similarly, Chang et al. (2011) theorized that culturally humble people engage others in conversations that foster mutual respect.

In addition to life-long learning, cultural self-awareness, and interpersonal respect, some writers also incorporated other constructs into their cultural humility definition. These are constructs that are not yet widely accepted as core to the definition of cultural humility, but they merit future thought and research. For example, cultural humility has been theorized to incorporate a fluid-thinking framework that requires personal accountability in navigating power differentials (Fisher-Borne, Montana, & Martin, 2015). Researchers who focus on constructs such as fluid thinking aim to explore the underlying cognitive processes of culturally humble people that set them apart from culturally arrogant or ethnocentric individuals. This focus aligns well with other humility research, which theorizes that humility is a governing force of internal processes that often leads to more positive social interactions (Lavelock et al., 2014). In other
cases, cultural humility has been defined as involving vulnerable authenticity and a willingness to adopt a non-expert stance. As Issacson indicated (2014), not being an expert requires the courage to be vulnerable, and vulnerable authenticity helps foster key elements of cultural humility (e.g., mutual respect, life-long learning).

**Cultural Humility vs Cultural Competence**

Many studies have compared and contrasted cultural humility with cultural competence. The first main point of comparison has been whether cultural humility is separate from cultural competence or an addition to the overall cultural competence model. Some authors argued that cultural humility is a completely separate concept, a different viewpoint, approach, or way of life that has not been included in cultural competence models. One example is Yeager and Bauer-Wu’s (2013) distinction that cultural humility is not defined by the end result of knowledge/skills acquisition, but rather as a life-long commitment to value others culturally and reflect on one’s own cultural background.

Others have suggested that cultural humility is actually an expansion of the original cultural competence focus on cultural knowledge, awareness, and skills. For instance, Ross (2010) conceptualized cultural humility as a strand within cultural competence that expands knowledge, attitude, and skills (e.g., knowledge of health disparities in treatment, recognition of privilege, and non-authoritarian communication skills).

The second main point of comparison has been on the extent to which cultural humility is an attitude versus a set of skills. In general, cultural humility is viewed more as an attitude, value, or way of being, whereas cultural competence has focused on skills or ways of doing. For example, Butler et al. (2011) suggested rebranding cultural competence as cultural humility for
medical multicultural education, emphasizing life-long learning rather than knowledge/skills acquisition. Most discussion has centered on cultural humility as a mindset, with far less attention being given to cultural humility ‘skills’ (c.f., active listening; Ortega & Faller, 2011).

It remains to be seen whether cultural humility will viewed as an independent model or be subsumed as part of the existing cultural competence framework. What appears to be clear is that the focus on cultural humility does offer something new and important that was perhaps not given adequate attention in existing models of cultural competence. There may be conceptual advantages to the cultural humility framework relative to the cultural competence framework, especially for training purposes. For example, it may be important to frame cultural training as a process rather than an end goal, which fits with the cultural humility framework. Also, models of cultural competence may imply that there is an agreed upon knowledge base and set of skills that must be mastered by trainees, which may not be true for all fields. Finally, cultural humility draws from pre-existing theory and research on humility as a character strength or virtue that promotes social bonds and facilitates the self-regulation of behavior, which may support the idea of cultural humility being key in buffering against cross-cultural conflicts (Davis et al., 2013).

Importance of Cultural Humility across Domains

The third major review theme to emerge is that the theoretical literature about cultural humility is quite diverse; spread across many fields and disciplines. Cultural humility appears to be highly important for the helping disciplines, such as medicine, psychology, and social work, but it could arguably apply to any profession that involves cross-cultural engagement (Cruess et al., 2010). For example, Groll (2014) contended that cultural humility, because it contributes to respect, understanding, and partnership, is important for engineering practice.
Moreover, cultural humility goes beyond occupational benefits. It is often seen as a way of life that enhances all relationships (Foronda et al., 2015). Humility may be the underlying variable that draws people closer together, buffers against relationship disruptions, and helps repair damaged relationships (Davis et al., 2013; Farrell et al., 2014; Van Tongeren, Davis, & Hook, 2014; Watkins, Hook, Ramaeker, & Ramos, in press). Cultural humility may be an important strategy for addressing cultural conflict, and likely applies to myriad cross-cultural relationships. For example, cultural humility could help improve relationships in a business setting, where individuals or groups from different cultures compete over limited resources. Culture can be a source of relational conflict; cultural humility may be its antidote. Although most existing research on cultural humility has been focused in the counseling and helping professions, it is clear that cultural humility may have applications across a wide variety of domains.

Empirical Studies

I first summarize the methods used in the reviewed empirical studies and, second, summarize the main empirical findings.

Research Design

Of the 21 reviewed empirical studies, the majority \((n = 11)\) were qualitative, with fewer studies using quantitative \((n = 5)\) or mixed-methods designs \((n = 5)\). This qualitative emphasis is likely because cultural humility is a relatively new research area. Studies of new concepts often describe and explore first, rather than testing specific hypotheses, which are goals that are perhaps better suited for qualitative inquiry. For example, one qualitative study was a cross-
sectional life history study of physical therapists; the primary research method was one-on-one semi-structured interviews about practicing cultural humility (Hillard, 2011). Most reviewed studies used cross-sectional research designs \((n = 18)\) (e.g., involving interviews, ethnographies, or surveys). However, two studies used a longitudinal research design (Schlusser, Wilder, & Byrd, 2012; Sheridan, Bennet, & Blome, 2013) and one used an experimental design (Kutob et al., 2013). One of the longitudinal studies examined 200 journal entries from 50 nursing students across two years of study (Schuessler et al., 2012). The second longitudinal study examined the effects of a cultural humility training program in three cohorts of social work students \((N = 100)\) across four years that were transitioning from working in Western countries to another cultural context (Sheridan et al., 2013).

**Participants**

Sample size was reported in 18 studies. The total number of participants was 2,129. Only eleven of the eighteen studies reported sample demographic characteristics; the majority of participants were female (60.9%). About half of the participants (50.2%) identified as White, with the rest identified as a racial/ethnic minority. Only eight studies reported participants’ mean age; the mean age was 31.7 years.

**Measures**

Three quantitative studies measured cultural humility using the Cultural Humility Scale (CHS; Hook et al., 2013). The CHS is a 12-item other-report measure of the extent to which a therapist was culturally humble toward the most important aspects of a client’s cultural background. It includes both positive (i.e., ‘Is open to explore) and negative (i.e., ‘Makes
assumptions about me’) items. Items on the CHS had strong factor loadings, and the scale showed evidence of internal consistency and construct validity, being significantly correlated with measures of cultural competence, working alliance, and client improvement. The CHS is a relatively recent scale, and more research on the CHS is needed. However, it appears to be a promising instrument for research on cultural humility moving forward.

A fourth quantitative study used the Cultural Competence Assessment Tool (CCAT; Kutob et al., 2013) to assess cultural competence and cultural humility. The CCAT is a 68-item self-report measure that was modified to include items specifically pertaining to American Indian and Asian racial groups, which resulted in a total of 81 items. There are six subscales, including (a) Cultural Self-Awareness, (b) Nonjudgmental Thinking, (c) Cultural Knowledge, (d) Nonverbal Communication, (e) Empowerment, and (f) Explanatory Model Elicitation. Although the CCAT was used in one study to assess cultural competency and cultural humility, the original purpose of the scale was to be a self-assessment tool for doctors in training courses on cultural competency, and the majority of items are focused on competency rather than humility.

One mixed methods study used the Intercultural Development Inventory (IDI; Hammer, Bennet, & Wiseman, 2003) and the Miville-Guzman Universality-Diversity Scale - Short (M-GUDS-s; Brown & Lent; 2008) to assess cultural humility. The IDI was based on Bennett’s developmental model of intercultural sensitivity and consists of a 50-item questionnaire that is administered and scored electronically. The IDI provides individual and group scores referred to as developmental orientation (DO) and perceived orientation (PO). The DO score indicates the primary orientation towards cultural difference, whereas the PO score represents how people rate their own capabilities in adapting to cultural differences (Hammer, 2012). The original IDI was developed from interviews with 40 culturally diverse participants; the researchers lifted verbatim
statements from the initial transcripts to create the original questions (Hammer, Bennett, & Wiseman, 2003). The M-GUDS-s is a 15-item questionnaire that was developed based on a theoretical, holistic notion of a universal-diverse orientation (UDO). Brown and Lent (2008) conclude that the instrument offers “significant research potential” as an etic instrument to understand individuals “cultural self-integration and multicultural interpersonal competence” (p. 123). Together, these two measures were a part of an assessment of first-year engineering student’s cultural humility.

None of the qualitative studies used the same method for assessing cultural humility. One study used home ethnography to assess cultural humility through stories told by participants. Four studies used various methods of interviews (e.g., semi-structured, life history method), and two studies created quantitative Likert-scale, self-report measures. Another four studies used various coding methods (e.g., hermeneutic phenomenology) of journals, videotapes, or observations. One exploratory study drew from a combination of theories and a postmodern form of inquiry associated with narrative therapy and collaborative therapy. One study did not report any measurements or observation methods.

Overall, the research designs of most studies appeared to lack rigorous methodologies found in established fields. This may be due to cultural humility being a relatively new area of research. Several of the studies utilized convenience samples, untested measures of cultural humility, and some studies did not report the characteristics of their sample at all. Relatively few studies utilized more sophisticated research designs or sampling techniques. Moving forward, there is ample opportunity for researchers to explore the topic of cultural humility using more sophisticated research designs and sampling techniques, and there is also an opportunity to improve the measurement of cultural humility.
Summary of Empirical Findings

The empirical findings can be grouped into three areas. First, seven studies described what cultural humility looks like in the helping professions and how it develops over time. Four of these studies interviewed helping professionals who were regarded as being culturally humble in their professional work. For example, Hilliard (2011) explored the life experiences of eight culturally humble physical therapists and identified five common themes for how cultural humility evolved: (a) being open-minded, (b) responding to client’s emotions, (c) focusing on client’s goals, (d) engaging and teaching empowerment, and (e) being aware of the community’s needs and assets. In two other studies, students engaged in a reflective journaling exercise so that their cultural humility development could be examined. Both studies concluded that cultural humility cannot be solely taught in classroom settings, and that reflective journaling can be useful in stimulating cultural humility development.

Second, ten studies implemented a training or education program to help participants improve their level of cultural humility. All studies found the programs contributed to the desired improvements. The improvements in cultural humility included both intrapersonal (e.g., increased self-awareness and confidence) and interpersonal characteristics (e.g., increased likelihood of eliciting client beliefs about treatment, enhanced client relationships). For example, Ross (2010) demonstrated that students could apply knowledge from cultural humility classroom lectures to a community practicum setting; graduate students reported higher levels of knowledge (e.g., underlying factors driving disparities), attitudes (e.g., awareness of bias), and skills (e.g., culturally humble communication) associated with cultural humility. Although most of these studies had promising findings, caution should be made when interpreting the effectiveness of these training programs. None of the studies were randomized controlled trials, and most of the
studies utilized a single-group pre-test/post-test design. More research is needed for firm conclusions to be made about the efficacy and effectiveness of these programs for improving cultural humility.

Third, three quantitative studies explored the links between cultural humility and counseling outcomes. The first study (Hook et al., 2013) created a measure to assess cultural humility (Cultural Humility Scale); favorable client perceptions of a counselor’s cultural humility were found to positively relate to a stronger working alliance and more improvement in counseling. The second study (Owen et al., 2014) explored cultural humility specifically in the context of a client’s religious and spiritual beliefs. Although favorable client perceptions of a counselor’s cultural humility toward religion related to stronger working alliance and better counseling outcomes, client religious commitment moderated that relationship. Associations between cultural humility toward religion and counseling outcomes were significant for clients with high levels of religious commitment, but not for clients with low levels of religious commitment. The third study (Owen et al., 2016) examined the effects of therapists’ cultural humility and their ability to create meaningful cultural dialogues in therapy on therapy outcomes. Therapists who missed opportunities to engage in cultural discussions with clients had worse therapy outcomes, but this negative relationship was buffered by therapist cultural humility. These studies point to an initial link between perceptions of cultural humility and positive counseling outcomes (e.g., working alliance, improvement). Again, caution is recommended when interpreting these findings. All of these studies were cross-sectional. Thus, causal conclusions should not be made. Longitudinal and experimental research would be a welcome addition to the field.
Discussion

In this thesis, I conducted a literature review of theoretical and empirical publications focused on cultural humility. Most papers were theoretical, with attempts being made to define and conceptualize cultural humility and lay the groundwork for future research. A smaller number of publications explored cultural humility empirically, mostly using qualitative research designs.

Overall, although this is a relatively recent topic of inquiry, there was quite a bit of consensus for how to define cultural humility. Definitions included key elements such as being a life-long learner, accurate cultural self-awareness, and interpersonal respect in cross-cultural engagement. The core components of the definition of cultural humility were similar to that of general humility (Davis et al., 2011) and intellectual humility (McElroy et al., 2014), which have usually incorporated both intrapersonal and interpersonal components. In general, it appears that definitions are consolidating, which is a positive development and bodes well for the future of cultural humility research.

There was less consensus about the relationship between cultural humility and cultural competence. Some researchers viewed cultural humility as a separate, stand-alone construct, whereas others considered cultural humility to instead be an expansion of cultural competence. It is likely that both the cultural humility and cultural competence models have something to offer as we move forward to consider best practices in cross-cultural training and education. Regardless of how some of these conceptual issues resolve over time, cultural humility is clearly now seen as being important in a wide variety of disciplines.

The empirical articles were mostly qualitative and covered three main areas. First, several studies painted a more detailed picture of what cultural humility looks like in practice and how it
might develop over time. Second, several studies tested educational intervention programs that
were designed to increase cultural humility; the initial results were promising, suggesting that
training interventions can positively impact both intrapersonal (e.g., increased self-awareness)
and interpersonal (e.g., enhanced client relationships) components of cultural humility. Finally,
the few quantitative studies mainly focused on the relationship between client perceptions of
cultural humility and client outcomes; the results again were promising, suggesting that
favorable client perceptions of cultural humility relate to better counseling outcomes (e.g.,
stronger working alliances). Caution is suggested when interpreting the empirical findings, as
most studies utilized cross-sectional designs.

Limitations and Directions for Future Research

There were several limitations in this literature review. First, most articles were
theoretical. If cultural humility theories are to be supported, more empirical research, both
quantitative and qualitative, is sorely needed. Specifically, there needs to be more longitudinal
and experimental research exploring cultural humility. In regard to training or educational
programs designed to promote cultural humility, future research should employ randomized
controlled trials to measure the efficacy and effectiveness of these programs. Also, relatively
little research has worked to provide reliable and valid measures of cultural humility. With only
one quantitative measure specifically measuring cultural humility, more research is needed to
explore multiple methods (e.g., self-report, other-report, behavioral observation measures, semi-
structured interviewing) of accurately assessing cultural humility.

Second, most studies focused on racial/ethnic cross-cultural exchanges, with little
attention given to other aspects of culture. Future research ideally will continue to include
participants from various racial/ethnic groups, as well as consider other important aspects of cross-cultural exchanges (e.g., religion, sexual orientation, politics, etc.).

Third, more research could explore the internal processes that occur when individuals are more or less culturally humble. Some researchers have begun to consider these internal processes, even noting characteristics such as fluid thinking as being part of the definition of cultural humility. It would be interesting to describe and assess the cognitive processes that occur when individuals are behaving in a culturally humble manner versus a culturally arrogant manner.

Fourth, applied research has begun to explore cultural humility in the context of counseling and psychotherapy with diverse clients. Other applied settings could be excellent settings for research on cultural humility. For example, research could describe culturally humble hospitals and doctors, culturally humble teachers and professors, or culturally humble religious leaders.
CHAPTER 3

STATEMENT OF THE PROBLEM

A large number of research studies have examined the relationship between religion and physical, mental, and emotional health (e.g., Koenig, King, & Carson, 2012; McCullough, Thoresen, & Koenig, 2000). In general, the majority of research examining the relationship between religion and health has found positive associations between religion and mental health outcomes (e.g., increased well-being, less depression, less anxiety) and physical health outcomes (e.g., less coronary heart disease, lower mortality rates) (Koenig, 2012).

Religion and Health

In regard to the relationship between religion and mental health, research has found that religion may boost mental health by promoting positive emotions, neutralizing negative emotions, and serving as a coping resource (Koenig et al., 2012). For instance, a review of qualitative and quantitative research found that religion and spirituality helped people deal with adversity, including both external (e.g., difficult environmental circumstances) and internal (e.g., genetic predisposition to mental disorder) stressors, in a positive way (Koenig, 2012). Furthermore, a review of 326 quantitative, peer-reviewed studies found that 256 (79%) of the studies reported significant positive correlations between religion and measures of well-being, whereas only 3 studies (<1%) reported a negative correlation (Koenig, 2012). Other examples of the religion—mental health link include positive correlations between religion and hope (73% of reviewed studies; $N = 40$) and religion and meaning/purpose (93% of reviewed studies; $N = 45$), as well as negative correlations between religion and depression (61% of reviewed studies; $N = 444$) and anxiety (49% of reviewed studies; $N = 299$) (Koenig, 2012).
In regard to the relationship between religion and physical health, similar results have been found. A review of literature on the relationship between religion and physical health found that 63% of studies \( (n = 19) \) reported a significant negative relationship between religion and coronary heart disease and 68% of studies \( (n = 121) \) reported a significant negative relationship between religion and mortality rates (Koenig, 2012). There have also been numerous studies that have reported a negative correlation between religion and physical health outcomes related to stress or tension. Some examples include negative correlations between religion and hypertension \( (57\% \text{ of reviewed studies}; \ n = 63) \), susceptibility to infection \( (67\% \text{ of reviewed studies}; \ n = 12) \), and poor endocrine system functioning \( (74\% \text{ of reviewed studies}; \ n = 31) \) (Koenig, 2012).

Relatively fewer research studies have attempted to explain the mechanisms that underlie the relationship between religion and health (Hall, 2004), but several theories suggest religion might lead to better physical and mental health through the many resources religion can offer. For example, religious communities can be a source of strong social support, which could in turn promote positive mental and physical health, and buffer against negative health problems and symptoms (Ellison & George, 1994; Koenig et al., 2012). Also, religion may help to promote the development of virtues (e.g., forgiveness, gratefulness, humility) (Davis et al., 2012; Schnitker, Felke, Barret, & Emmons, 2014), which in turn could promote better mental and physical health. Research has also found that religious individuals use their religion as a source of coping to deal with stressors (e.g., negative emotions, low SES, loss of loved one), which in turn could lead to better mental and physical health (Koenig et al., 2012; Pargament, Smith, Koenig, & Perez, 1998). Furthermore, many theorists believe religion can be a source of meaning and purpose in life, which could lead to positive mental and physical health outcomes (Galek et al., 2015). For
instance, Krause (2003) found that religious belief was associated with higher levels of meaning in life, life satisfaction, self-esteem, and optimism in a sample of older American adults. A final possible mechanism that could help explain the link between religion and positive mental and physical health is that religion promotes positive coping behaviors (e.g., meditation, rest, social support) and discourages negative coping behaviors (e.g., drug/alcohol abuse, risky sexual behaviors). Given the known connection between religion and mental and physical health, it is possible that religion influences health through psychological, social, and behavioral pathways.

Despite the abundance of research that reports a positive relationship between religion and health, there are some aspects of religion that may negatively affect health, particularly for certain cultural groups. Although the majority of research on the religion—health link has been positive, it is important to note that some research has found that religious communities can also contribute to negative mental health states through promoting authoritarian control, irrational fear, and neurotic fixations (Koenig et al., 2012). While religion can be an important source for positive coping mechanisms, there is evidence that certain religious ways of coping are linked to poorer mental health outcomes. For example, a study on survivors of an earthquake who met criteria for PTSD reported increased symptom severity and negative emotions when they felt punished by God for their sins or reported a lack of spirituality following the earthquake (Feder et al., 2013). Furthermore, while positive religious coping is associated with better mental health and social relations for hemodialysis patients dealing with End-Stage Renal Disease (ESRD), religious and spiritual struggle was positively correlated with both depressive and anxiety symptoms, even after controlling for clinical and socio-demographic data (Ramirez et al., 2012).

Also, some evidence from correlational and experimental studies has demonstrated a link between religiosity, religion, and prejudice (Rowatt, Carpenter, & Haggard, 2013). For instance,
a study of over 190 pairs of cultural groups at 97 sites around the world found that increased conflict between different cultural groups was predicted by the religious commitment (e.g., degree to which religion was infused into a group’s everyday life), resource-power differential, and value incompatibility of the cultural groups (Neuberg et al., 2013). While religion has been shown to promote the development of virtues, and often teaches love and kindness to others, some studies have found religious individuals are more prejudiced and intolerant of cultural out-groups than non-religious individuals, with religious motivations moderating the relationship (Jennings, 2014).

The religion-prejudice link has been demonstrated in multiple religions. For example, one study examining both Christianity and Buddhism demonstrated that religiously priming individuals indirectly increased negative attitudes toward cultural out-groups (i.e., gay/lesbian individuals) through the activation of associated cultural value systems (i.e., traditionalism, conservatism) (Ramsay, Pang, Shen, & Rowatt, 2014). A meta-analysis of the relationship between religious dimensions and prejudice found small, positive relationships between extrinsic religiosity (r = .17, k = 22), religious fundamentalism (r = .13, k = 14), and religious identification (r = .12, k = 20) to black-white racial prejudice (Hall, Matz, & Wood, 2010). Moreover, in 17 independent samples of more than 5200 participants, Whitley (2009) found a mean correlation of .45 between religious fundamentalism and sexual prejudice.

It is important to note that despite the evidence reporting a positive link between religion and prejudice, some studies have found the opposite effect, that greater religious commitment can increase tolerance towards a minority group, including a different religious group (Shaver, Troughton, Sibley, & Bulbulia, 2016). These mixed results were theorized to be due to (a) failure to assess and adjust for multi-level religious affiliation effects, (b) inattention to demographic
variables, (c) poor measurement, and (d) inadequate theories derived for the particular purpose in explaining mechanisms underlying prejudice and tolerance (Shaver et al., 2016). It is clear that more research on the link between religion, health, and prejudice is needed.

Religion and Health in LGB Individuals

One understudied cultural group that may be of particular importance when considering the links between religion, prejudice, and health are individuals who identify as a sexual minority (i.e., lesbian, gay, or bisexual [LGB]), because they may experience conflict with religious individuals or groups due to negative religious attitudes and behaviors toward LGB individuals (Nadal et al., 2015; Pew Research Center, 2013). Religion and sexual orientation are two cultural identities that are often strongly valued, and LGB individuals who experience conflict with religious individuals and groups around their sexual orientation may experience negative or mixed health outcomes from religious participation.

Conflict between religion and sexual orientation could be a source of minority stress for the LGB population. Several sexual minority stress models have been proposed (e.g., Hatzenbuehler, 2009; Meyer, 2003) that highlight the challenges of having an LGB identity. This minority stress (e.g., internalized homophobia, acceptance concerns) could be influenced by one’s religion and have negative effects on their health (Page, Lindahl, & Malik, 2013). It has been theorized that the positive development of a person’s LGB identity could serve as a moderator of this internalized minority stress and act as a buffer to the negative psychological effects of minority stress (Meyer, 2003), but other models have expanded the minority stress model to include external stressors related to religion (Page et al., 2013).
Furthermore, discrimination regarding one’s sexual identity could lead to lower levels of physical, mental, and emotional health (Mays & Cochran, 2001). For example, one study found that LGB individuals reported poorer mental health (e.g., higher levels of psychological distress, greater likelihood of being diagnosed with depression or anxiety) and were more likely to report experiencing a major occurrence of discrimination when compared to heterosexuals (Burgess, Lee, Tran, & van Ryn, 2008). Given that it has been theorized that religion could add to a person’s minority stress and that some research has found religion to be positively correlated with prejudice, it is possible that LGB individuals who are more religiously committed may be more likely to experience discrimination and its harmful effects.

However, while some research has focused on the possible negative effects on mental health for LGB individuals who have certain religious backgrounds and experiences (e.g., Schuck & Liddle, 2001), others have looked to examine the possible benefits of religion on LGB individual’s health. For example, one study of 583 LGB individuals by Lease, Horne, and Noffsinger-Frazier (2005) found that positive, affirming religious experiences were linked to positive mental health, and this effect was mediated by less minority stress (i.e., internalized homophobia) and greater spirituality in participants. In other words, affirming religious experiences positively impacted participant’s mental health by reducing internalized homophobia and increasing one’s spirituality. Their findings suggest that religion could be a resource for LGB individuals and coincide with other researching demonstrating a positive religion – health link.

The relationship between religion and health in LGB individuals may be complex. It is possible that high levels of religious commitment could buffer LGB individuals from the negative effects of discrimination. For example, one national survey found negative effects of
discrimination on mental health for LGB individuals, but attendance to religious services moderated this relationship for African Americans (Bierman, 2006). In the current culture, LGB individuals and groups may experience conflict and tension in religious communities due to differences in cultural beliefs or values. In turn, these cultural conflicts could possibly reduce or eliminate the health benefits religion may offer.

Little research has directly examined conflict between religion and sexual orientation in LGB individuals. While a few studies have looked at religious affiliation and their stance towards LGB issues (e.g., support gay marriage or gay clergy) (Herek, 1987; Finlay, & Walther, 2003), little research has looked further than religious affiliation to explore the conflict between religion and sexual orientation in LGB individuals. For example, Ream and Savin-Williams (2005) demonstrated how LGB adolescents and young adults ($N = 393$) with a Christian background negotiated conflicting emotions and experiences concerning religious beliefs and sexual orientation. Strategies for negotiating these conflicts were separated into six categories: (1) peacefully coexisting spiritual beliefs and sexual orientation; (2) altered spiritual beliefs while staying Christian; (3) disregarded any conflict; (4) left their religious affiliation; (5) renounced sexual orientation due to religious beliefs; and (6) did not experience a conflict. The results indicated that the rejection of either spiritual beliefs or sexual orientation could have possible negative consequences (e.g., depression, reduced self-esteem) (Ream & Savin-Williams, 2005). In another study, Dahl and Galliher (2009) examined the frequented assumption about the conflict between the intersection of a religious and sexual identity in a sample of LGB young adults ages 18 to 24 and found increased knowledge and self-acceptance to be key factors in fully integrating the two identities. While intrapersonal conflicts involving religion and sexual orientation may exist or exacerbate minority stress (e.g., internalized homophobia) for LGB
populations, it is possible that religion could also help this navigation of identities by promoting a safe space for knowledge gathering and self-compassion.

In addition to experiencing intrapersonal conflicts between one’s religion and sexual orientation, LGB individuals may experience interpersonal conflicts with other religious individuals and groups about their sexual orientation (Hook et al., 2015; Zhang et al., 2015). Since social support is an important mechanism of the religion—health link, LGB individuals may not be as likely to receive as much support from their religious communities as heterosexual religious individuals, and may experience increased levels of relational conflict with their religious communities. For example, the level of supportiveness of a religious community towards LGB individuals was negatively correlated with the degree of risk-taking behavior (e.g., greater alcohol abuse, more sexual partners) in adolescents (Hatzenbuehler et al., 2012).

Cultural Humility

The relationship between religion and health for LGB individuals may depend on certain aspects of the religious community. While conflict and discrimination could lead to negative health outcomes, the cultural humility of religious communities and individuals could buffer these negative effects and lead to more positive outcomes. Cultural humility, a sub-domain of humility, has been theorized to help individuals engage positively in the midst of cultural differences that might strain a relationship (Hook et al., 2013). Cultural humility involves a commitment to life-long learning, cultural self-awareness, and engaging culturally different individuals and groups with respect (Foronda et al., 2015). Cultural humility could serve as a buffer against negative outcomes (e.g., ruptured relationships, poor health outcomes) that may arise when individuals or groups experience conflict due to cultural differences. Cultural
humility could be an important factor to navigating these conflicts and disagreements. Specific to my study, the cultural humility of a religious group or individual toward LGB issues may help LGB individuals experience greater health benefits from their religious participation.

A religious community’s cultural humility towards a LGB individual’s sexual orientation could buffer against perceived conflict or discrimination that could negate the religion-health link for LGB individuals. The findings of the literature review (see Chapter 2) supported the theory that cultural humility may be linked to positive relationship outcomes when cultural differences might strain a relationship. Furthermore, one study demonstrated that client perceptions of a therapist’s cultural humility toward their religious background were linked to positive outcomes in counseling (e.g., stronger working alliances) (Owen et al., 2014).

Cultural humility is theorized to help buffer against and repair conflicts in cross-cultural interactions (Hook et al., 2016; Watkins, Hook, Ramaeker, & Ramos, 2016), so a religious community with high levels of cultural humility may have better outcomes in cross-cultural interactions with LGB individuals. Furthermore, high levels of cultural humility in religious individuals could lead to fewer incidents of perceived discrimination in LGB individuals and buffer against negative relational and health outcomes.

While LGB individuals have been found to have higher levels of depression or anxiety, and are more likely to experience a major incident of discrimination than heterosexual individuals (Burgess et al., 2008), higher degrees of religiosity have reduced the negative effects of discrimination on mental health in racial minority populations (Bierman, 2006). It is possible that higher religious commitment in LGB individuals can lead to better physical, mental, and emotional health outcomes while reducing the negative effects of perceived discrimination—if
one’s religious community (and the individuals that comprise it) have high levels of cultural humility.

Perceptions of another person’s humility may influence a person’s emotional attitude towards that individual (Davis et al., 2011). A more favorable perception of another’s ability to facilitate positive, other-oriented emotions along with regulating self-focused emotions in a modest and respectful way towards another’s culture can lead to an increased social bond between two individuals (Davis et al., 2013). Thus, it is theorized that LGB individual’s perceptions of their religious community’s cultural humility will lead to more positive relational outcomes and stronger social bonds, as well as buffer against negative effects of discrimination on physical, mental, and emotional health.

Purpose of Current Study

The present study has four primary aims. First, it will seek to expand previous findings regarding the relationship between religion and health by specifically examining the LGB population. Second, it will explore cultural humility as a moderator for the religion-health link among LGB participants. Specifically, I hypothesize that religion will be positively correlated with health for participants who perceive their religious community to be high in cultural humility, but religion will be negatively correlated with health for participants who perceive their religious community to be low in cultural humility. Third, it will explore cultural humility as a moderator between religious commitment and experiences of discrimination and minority stress on LGB individuals. Specifically, I hypothesize that higher levels of religious commitment will be associated with higher levels of discrimination and minority stress, but cultural humility will buffer this relationship. Fourth, it will explore how cultural humility at the interpersonal level
can predict forgiveness in LGB individuals towards religious individuals. Specifically, I hypothesize that cultural humility will be positively associated with forgiveness, even after controlling for the severity of the offense.
CHAPTER 4

METHOD

Participants

Participants (N = 555) were mostly female (66.5%), ranging in age from 18 and 66 years old (M = 27.28, SD = 9.65). Most participants were White (72.3%), with others identifying as Black (10.6%), Asian/Pacific Islander (5.4%), Latino/Hispanic (12.6%), Native American (4.0%), Multiracial (3.6%), or Other (0.9%). Regarding sexual orientation, participants identified as lesbian (9.4%), gay (12.1%), queer (6.8%), bisexual (62.2%) or other (9.5%). Regarding religious affiliation, about one-third of participants identified as Christian (30.9%), with others identifying as Agnostic (20.2%), Atheist (12.8%), Buddhist (3.9%), Hindu (1.3%), Muslim (1.3%), Jewish (1.8%), and Other (16.6%). There were 159 participants (28.6%) who responded “yes” in response to the question, “Are you currently involved with a religious community?”

Design

This study utilized a cross-sectional, correlational design.

Measures

Demographic Questionnaire

A 14-item questionnaire was used to collect demographic information from participants. Participants were asked to indicate their gender at birth, current gender identity, current sexual orientation, age, current and past religious affiliation, race/ethnicity, political views, and level of education, among others, both in multiple choice and short answer format. Also, the participants were asked to indicate the perceived political views of their religious community.
Cultural Humility—Religious Community

Cultural humility of one’s religious community was measured by the Cultural Humility Scale (CHS; Hook et al., 2013). This CHS is a 12-item measure designed to assess perceptions of another person’s humility towards one’s cultural background. Seven items reflect positive aspects of cultural humility, and five items reflect negative aspects of cultural humility. The CHS was modified to assess perceptions of the cultural humility of an individual’s religious community toward one’s sexual orientation. For participants who reported being involved in a religious community, the instructions were: “Please think about your religious community. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your religious community. Regarding my sexual orientation, my religious community…” For participants who reported not being currently involved in a religious community, the instructions were: “Please think about Christians in the United States of America. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about Christians in the United States. Regarding my sexual orientation, Christians in the United States…” Example items include “is respectful,” “acts superior” (reverse coded), and “is genuinely interested in learning more.” Participants rate each item on a 5-point Likert scale, from 1 (strongly disagree) to 5 (strongly agree). Scores on the CHS have evidence for internal consistency and construct validity (Hook et al., 2013). Scores on the CHS have been significantly associated with other measures of multicultural competency and therapy outcomes (Hook et al., 2013). For the CHS, the Cronbach’s alpha for the present study was .93.

Religious Commitment

Religious commitment was measured by the Religious Commitment Inventory—10
(RCI-10; Worthington et al., 2003). The RCI—10 is a 10-item measure designed to assess one’s commitment to their religion. Participants rate their agreement with each item on a 5-point rating scale ranging from 1 (not at all true of me) to 5 (totally true of me). An example item is “My religious beliefs lie behind my whole approach to life.” In a variety of samples, Worthington et al. (2003) found Cronbach’s alpha coefficients ranging from .88 to .98. Estimates of temporal stability (3 week and 5 month) were .84 to .87. The RCI-10 also demonstrated evidence of construct validity. The RCI-10 was significantly and positively correlated with a single item measure of religiosity, the frequency of attendance of religious activities, and self-rated spiritual intensity. Furthermore, when comparing Buddhists, Christians, Hindus, Muslims, and nonreligious participants on the RCI-10, the nonreligious group scored significantly lower on the RCI-10 than all religious groups. For the RCI-10, the Cronbach’s alpha for the present study was .95.

Physical Health

Physical health was measured by the MOS 36-Item Short Form Health Survey (SF-36; Ware Jr. & Sherbourne, 1992). The SF-36 is a 36 item measure designed to assess health status in eight different health concepts: (1) limitations in physical activities because of health problems, (2) limitations in social activities because of physical or emotional problems, (3) limitations in usual role activities because of physical health problems, (4) bodily pain, (5) general mental health, (6) limitations in usual role activities because of emotional problems, (7) vitality, energy, and fatigue, and (8) general health perceptions. Participants rate each item on a 5-point rating scale from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating higher physical and mental well-being. This instrument has evidence for internal
consistency with a Cronbach’s alphas above .80 for all SF-36 subscales (Lyons, Perry, and Littlepage, 1994). I will utilize the MOS SF-36 software to first convert the raw data into standardized scores, and then convert the standardized scores into T scores with a mean of 50 and a standard deviation of 10. In the manual of the MOS SF-36, Ware, Kosinski, and Keller (1994) recommended that researchers do not overlook this normative standardization step, otherwise the reliability and validity of the MOS SF-36 scales could be compromised. For the MOS SF-36, the Cronbach’s alpha for the present study was .94.

Subjective Well-Being

Subjective well-being was measured with the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). The SWLS is a 5-item scale that measures one’s evaluative satisfaction with life as a whole. Participants rate each item using a 7-point rating scale ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores indicate greater satisfaction with life. The SWLS does not assess different life domains (e.g., health, finances), but allows each participant to integrate and weight various domains in their life as they choose. The SWLS has been normed on diverse samples (e.g., college students, older adults, prisoners, abused women, psychotherapy clients) and has been shown to be a compliment to scales that assess psychopathology or emotional well-being (Pavot, & Diener, 1993). The SWLS has demonstrated sensitivity to detecting change in life satisfaction during clinical interventions, and the SWLS has shown strong internal reliability and moderate temporal stability. For example, Diener et al. (1985) reported a coefficient alpha of .87 for the scale and a 2-month test-retest stability coefficient of .82. For the SWLS, the Cronbach’s alpha for the present study was .91.
Depression

Depression was measured by the Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977). The CES-D consists of 20-items that assess the frequency of depressive symptoms that represent the major symptoms of the clinical syndrome of depression. Total scores can range from 0 to 60, with scores of 16 and higher indicating the need for adults to seek clinical evaluation for major depression. The CES-D has four subscales, including positive affect (range 0 to 12), negative affect (range 0 to 21), somatic symptoms and retarded activity (range 0 to 21), and interpersonal difficulties (range 0 to 6). The CES-D has well-established concurrent and construct validity, and has demonstrated high reliability across various populations (Devins et al., 1988). For the CES-D, the Cronbach’s alpha for the present study was .93.

Anxiety

Anxiety was measured by the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). The STAI is a 40-item self-report measure that is used to examine symptoms of anxiety as a state (e.g., “I feel at ease”; “I feel upset”), and trait (e.g., “I am a steady person”; “I lack self confidence”). Participants rate each item on a 4-point rating scale, ranging from 1 (not at all) to 4 (very much so) for the state anxiety and 1 (almost never) to 4 (almost always) for trait anxiety. Higher scores indicate greater state and trait anxiety. The STAI has appeared in over 3,000 studies and has been translated into over 30 languages (Spielberger, 1989). The measure has demonstrated excellent internal consistency (e.g., average αs > .89), test-retest reliability at multiple intervals (e.g., average r = .88), and has evidence for good convergent and discriminant validity with other measures of state and trait anxiety (Grös,
Antony, Simms, & McCabe, 2007). For the STAI, the Cronbach’s alpha for the present study was .95.

Transgression Recall and Severity

Participants were asked to think about and describe a personal transgression that was committed by a religious individual. Participants rated the degree of severity on a 7-point rating scale ranging from 0 (not at all severe) to 6 (extremely severe). Additionally, participants estimated the time since the offense.

Cultural Humility—Individual

Cultural humility of the religious individual who committed a transgression toward the participant was measured by the Cultural Humility Scale (CHS; Hook et al., 2013). This CHS is a 12-item measure designed to assess perceptions of another person’s humility towards one’s cultural background. Seven items reflect positive aspects of cultural humility, and five items reflect negative aspects of cultural humility. The CHS was modified to assess perceptions of the cultural humility of the religious individual who committed a transgression toward the participant’s sexual orientation. Specifically, the instructions were: “Please think the religious individual who committed the personal transgression described above. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about that individual. Regarding my sexual orientation, he/she…” Example items include “is respectful,” “acts superior (reverse coded),” and “is genuinely interested in learning more.” Participants rate each item on a 5-point Likert scale, from 1 (strongly disagree) to 5 (strongly agree). Scores on the CHS have evidence for internal consistency and construct validity. Scores on the CHS have
been significantly associated with other measures of multicultural competency and therapy outcomes (Hook et al., 2013). For the CHS, the Cronbach’s alpha for the present study was .91.

Forgiveness

Forgiveness was measured by the Transgression-Related Interpersonal Motivations Inventory (TRIM; McCullough & Hoyt, 2002; McCullough et al., 1998). The TRIM is an 18-item measure of a victim’s motivations toward an offender. Participants indicate their agreement with each item on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicated higher motivations. The TRIM consists of three subscales: avoidance (e.g., “I am trying to keep as much distance between us as possible”), revenge (e.g., “I’ll make him/her pay”), and benevolence (e.g., “Even though his/her actions hurt me, I have goodwill for him/her”). The TRIM has strong estimated internal consistency, with Cronbach’s alphas ranging from .84 to .93 for the avoidance and revenge subscales (McCullough et al., 1998) and .86 to .96 for the benevolence subscale (McCullough & Hoyt, 2002). Estimated test-retest reliability for the avoidance and revenge subscales was adequate in a sample of people who have difficulty forgiving, with scores ranging from .64-.86 (McCullough et al., 1998). The scale shows evidence of construct validity, and was positively correlated with other measures of forgiveness, relationship satisfaction, and commitment (McCullough et al., 1998). In the present study, I will reverse code the avoidance and revenge items, and average these items with the benevolence items for a total scale score. For the TRIM, the Cronbach’s alpha for the present study was .92.

Internalized Homophobia

Internalized homophobia was measured by the Internalized Homophobia Scale (IHP;
Martin & Dean, 1992). The IHP consists of 9 items that assess the extent of participants’ rejection of their sexual orientation, uneasiness about same-sex desires, and avoidance of same-sex attractions and sexual feelings. The IHP was designed to assess the construct of internalized homophobia in the context of the minority stress model—distinct from mental health outcomes and isolated from concerns with community connectedness and outness. Participants complete each item on a 4-point rating scale ranging from 1 (often) to 4 (never). An example item is, “I often feel it best to avoid personal or social involvement with other gay men.” Items are worded so that the subject of the question matched the participant’s self-reported sexual identity label so that “gay” in the example above was replaced with “lesbian” or “bisexual”, as relevant to the participant. Scores were recoded so that higher scores indicated more internalized homophobia. Previous studies have found the IHP to demonstrate convergent validity for gay men and lesbians (Herek et al., 1998), and the IHP was found to significantly correlate with other widely used measures of internalized homophobia (as cited by Shildo, 1994). Previous studies have demonstrated that scores on this scale have internal consistency reliability of .79 (Meyer, 1995; Meyer & Dean, 1998) to .83 (Lewis, Derlega, Griffin, & Krowinski, 2003). For the IHS, the Cronbach’s alpha for the present study was .89.

Procedure

Participants were recruited from (a) an online research marketplace (i.e., Amazon’s Mechanical Turk) and (b) undergraduate courses. First, participants read an informed consent form that discusses the procedures of the study and their rights as participants. Once enlisted for the study, they were directed to fill out measures online via Survey Monkey. After participants completed the questionnaires, they were compensated for their participation. Participants
recruited via Mechanical Turk were given a small monetary compensation for their participation, and participants recruited through undergraduate courses were given a small amount of course credit or extra credit for their participation.

Hypotheses and Planned Analyses

Hypothesis 1

Statement

Religiousness will be positively correlated with physical, mental, and emotional health for LGB individuals.

Justification

There is a large body of research supporting the positive link between religion and physical, mental, and emotional health (Koenig, 2012). Because religion and spirituality have been demonstrated to facilitate coping and imbue negative events with meaning and purpose, one way religion and spirituality can lead to better health outcomes is through this psychological pathway of adding meaning and purpose to life (Koenig, 2012). Also, religion and spirituality has been associated with greater social support, as well as promoting virtues such as forgiveness, gratitude, altruism, and humility, which further enhance social relationships (Koenig, 2012). Behaviors that increase physical health and longevity of life (e.g., less alcohol and drug use, less cigarette smoking, safer sexual practices) are also correlated with religion and spirituality, and these behavioral pathways may positively impact physical health (Koenig, 2012). In sum, religious beliefs and practices can lead to healthier thoughts, feelings, and behaviors that are correlated with better health outcomes (Koenig, 2012).
Planned Analysis

The Pearson product moment correlation coefficient will be calculated between (a) religious commitment and (b) physical health, depression, anxiety, and satisfaction with life.

Hypothesis 2

Statement

The relationship between religion and health will be moderated by perceptions of cultural humility of the religious community. Specifically, for participants who perceive their religious community to be high in cultural humility, the relationship between religion and health will be positive. However, for participants who perceive their religious community to be low in cultural humility, the relationship between religion and health will be negative.

Justification

Although a large body of research has found a positive relationship between religion and health, little research has explored the effects of religion on health in communities that may experience conflict between certain religious viewpoints and important aspects of their cultural identity. Specifically, one cultural group that might experience conflict in religious environments due to their cultural identity is individuals who identify as LGB. One factor that may influence whether religion has a positive or negative impact on the health of LGB individuals is the cultural humility of the religious community toward sexual orientation. Specifically, LGB individuals may experience the health benefits of religion only in religious environments that have a high degree of cultural humility toward sexual orientation. One variable that may
confound this relationship is the viewpoint or political belief a religious community has towards LGBT issues, so I aimed to control for this in the current analysis.

**Planned Analysis**

This hypothesis will be tested using the steps for moderation outlined by Baron and Kenny (1986). I will conduct four analyses, with physical health, depression, anxiety, and satisfaction with life as dependent variables. For each analysis, I will first center the continuous predictor (i.e., religious commitment) and moderator (i.e., cultural humility) variables to reduce multicollinearity. Second, I will create a product term by multiplying the predictor and moderator variable. Third, I will conduct a hierarchical regression analysis with the predictor variable (religious commitment) and moderator variable (cultural humility) entered into the first step, followed by the interaction term (religious commitment X cultural humility) in the second step. If the interaction is significant, I will graph the interaction and conduct a simple slopes analysis (Aiken & West, 1991) to interpret the interaction. I will use one standard deviation above and below the mean to create the high and low levels of the variables.

Hypothesis 3

**Statement**

The relationship between religion and minority stress (i.e., internalized homophobia) in LGBT populations will be moderated by perceptions of cultural humility of the religious community. Specifically, for participants who perceive their religious community to be high in cultural humility, the relationship between religious commitment and minority stress will be
negative. However, for participants who perceive their religious community to be low in cultural humility, the relationship between religious commitment and minority stress will be positive.

Justification

Another reason to explore religious participation and commitment in LGB populations is to see how religion might be related to the experience of minority stress. There have been several research articles exploring the negative effects of stress caused by minority status among LGB populations. Religious communities could be one source of minority stress, due to the negative attitudes of some religious communities toward LGB individuals. On the other hand, religious communities could be a source of support for LGB individuals when dealing with minority stress. The effect of one’s religious community on level of minority stress could depend on characteristics of the religious community, such as cultural humility. A national polling firm surveyed over 1,200 LGBT individuals and found one third had a conflict between their religion and minority status, but LGBT individuals who were religious were less likely to see religious institutions as unfriendly towards their sexual orientation (Pew Research Center, 2013). It was suggested that stronger religious commitment in LGBT individuals could be related to less stress and conflict about their sexual minority status. However, this relationship could be moderated by the perceived cultural humility of the religious community towards one’s sexual orientation. Specifically, being involved in culturally humble religious communities might reduce internalized homophobia and minority stress, whereas being involved in less culturally humble religious communities might actually exacerbate internalized homophobia and minority stress.
**Planned Analysis**

This hypothesis will be tested using the steps for moderation outlined by Baron and Kenny (1986). First, I will center the continuous predictor (i.e., religious commitment) and moderator (i.e., cultural humility) variables to reduce multicollinearity. Second, I will create a product term by multiplying the predictor and moderator variable. Third, I will conduct a hierarchical regression analysis with the predictor variable (religious commitment) and moderator variable (cultural humility) entered into the first step, followed by the interaction term (religious commitment X cultural humility) in the second step. If the interaction is significant, I will graph the interaction and conduct a simple slopes analysis (Aiken & West, 1991) to interpret the interaction. For the simple slopes analysis, I will test the effect of the predictor variable on the dependent variable at one standard deviation above and below the mean of the moderator variable. I will control for the religious community’s views on LGB issues in this analysis.

**Hypothesis 4**

**Statement**

Perceived cultural humility of an offender will predict higher levels of forgiveness motivations towards a religious individual with whom participants have had an interpersonal conflict.

**Justification**

Conflict about views on sexual orientation between a religious individual and an LGB individual could lead to negative relational outcomes, but the cultural humility of the offender could predict higher levels of forgiveness and relationship repair. Since conflict often occurs in
relationships, it is important to explore how a cultural conflict between religious individuals and LGBT individuals could lead to unforgiveness, resentment, or anger. Given that one third of LGBT individuals felt there was a major conflict between their sexual orientation and religion (Pew Research Center, 2013), conflict might occur at the interpersonal level that could lead to negative relationships with religious individuals. Perceptions of cultural humility could predict forgiveness toward a religious offender. In past research, perceptions of humility have been linked with higher levels of forgiveness in couples (e.g., Farrell et al., 2015) and individuals experiencing a religious conflict (Zhang et al., 2015). Similarly, higher levels of cultural humility could predict forgiveness and preserve positive views of a relationship even if two parties argue or disagree about a cultural value or belief, and lower levels of cultural humility could predict unforgiveness and lead to increased negative views of a relationship.

Planned Analysis

This hypothesis will be tested using a hierarchical regression analysis with forgiveness as the dependent variable and cultural humility of the offender as the predictor variable. I will also control for the severity of the offense in this analysis.
CHAPTER 5
RESULTS

Preliminary Analyses

Before conducting the primary analyses, I checked for missing data, outliers, and normality. The data set had minimal amounts of missing data from the various items that formed the scales used in the analyses (less than 1.0%). There were a small number of outliers on 5 of the scales used in the primary analyses, which were all less than .01% per variable. Outliers were recoded to 3 standard deviations above or below the mean. I checked normality of the data by investigating skewness and kurtosis for each variable (see Table 3). The data did not display evidence of non-normality, so no data transformations were required. Means, standard deviations, and intercorrelations between all variables are in Table 4.

I conducted a series of preliminary analyses. First, I compared individuals who were involved in a religious community with those who were not (see Table 5). Individuals who were involved in a religious community reported significantly higher satisfaction with life as well as higher internalized homophobia than individuals not currently involved in a religious community. Also, I compared the intercorrelations between individuals currently religiously involved versus individuals not currently religiously involved (see Table 6). Also, I compared the sample collected online through Amazon’s Mechanical Turk (MTURK) and the online sample of undergraduates (see Tables 6). In the comparison of samples, the undergraduate sample reported higher internalized homophobia than the sample collected online using MTURK. Using a Chi-square to compare the demographics in the two samples collected, there were two significant differences between samples in sexual orientation (see Table 8) and religious affiliation (see Table 10). Also, an independent samples t-test revealed significant
differences in age between the two samples (see Table 9). To see how the sample’s demographics might impact the outcome variables, I used a t-test to examine the impact of gender on outcome variables (see Table 11) and included age in the intercorrelations matrix between all variables in Table 4. Age was significantly negatively correlated with depression, anxiety, internalized homophobia, and motivations to forgive, but positively correlated with positive perceptions of humility in religious communities. For gender, males reported higher internalized homophobia than females, and males also reported more positive perceptions of an offender’s cultural humility than females.

Hypothesis 1

Hypothesis 1 was that religious commitment would be positively correlated with physical, mental, and emotional health for LGB individuals. This hypothesis was assessed using the Pearson product moment correlation coefficient between (a) religious commitment and (b) depression, anxiety, satisfaction with life, and physical health.

This hypothesis was mostly unsupported. Supporting my hypothesis, religious commitment was significantly positively correlated with satisfaction with life ($r = .14$, $p = .001$). Contrary to my hypothesis, religious commitment was negatively correlated with overall physical health ($r = -.10$, $p = .023$). Regarding the physical health subscales, religious commitment was negatively associated with physical functioning ($r = -.25$), lack of role limitations due to physical health ($r = -.20$), and lack of pain ($r = -.11$). Religious commitment was not significantly correlated with depression or anxiety.
Hypothesis 2

Hypothesis 2 was that the relationship between religious commitment and health would be moderated by perceptions of cultural humility of the religious community. This hypothesis was assessed using the steps for moderation outlined by Baron and Kenny (1986) in a series of analyses, with satisfaction with life, depression, anxiety, and physical health as dependent variables. Of the 555 participants collected in the sample, 159 reported being involved in a religious community (Group 1) and 396 reported not being currently involved in a religious community (Group 2). Group 1 was asked to rate the cultural humility of their religious community, and Group 2 was asked to rate the cultural humility of Christians in the United States.

Group 1

For participants involved in a religious community, the hypothesis was not supported. First, I explored perceptions of cultural humility of the participant’s religious community as a moderator of the relationship between religion and satisfaction with life (see Table 12). There was a significant, positive main effect for religious commitment ($\beta = .26, p = .001$), but there was not a significant main effect for cultural humility ($\beta = .19, p = .108$). However, these main effects were qualified by a significant interaction between religious commitment and cultural humility ($\beta = -.25, p = .033$). The moderator effects are illustrated in Figure 1. I conducted a simple slopes analysis at one standard deviation above and below the mean on the moderator variable (i.e., perceptions of cultural humility). Simple slopes analyses revealed that for participants who perceived their religious community to have low levels of cultural humility, the relationship between religious commitment and satisfaction with life was actually stronger ($\beta =$
than for participants who perceived their religious community to have high levels of cultural humility ($\beta = .23, p = .016$). Thus, high satisfaction with life was observed when participants had high levels of religious commitment (irrespective of their perceptions of cultural humility), with the lowest satisfaction with life observed when both religious commitment and cultural humility were low.

Second, I explored perceptions of cultural humility of the participant’s religious community as a moderator of the relationship between religion and depression (see Table 13). There were no significant main effect for religious commitment ($\beta = .02, p = .783$) or cultural humility ($\beta = -.10, p = .403$). The interaction between religious commitment and cultural humility was also non-significant ($\beta = -.14, p = .231$).

Third, I explored perceptions of cultural humility of the participant’s religious community as a moderator of the relationship between religion and anxiety (see Table 14). There were no significant main effects for religious commitment ($\beta = -.07, p = .374$) or cultural humility ($\beta = -.11, p = .345$). The interaction between religious commitment and cultural humility was also non-significant ($\beta = -.15, p = .212$).

Fourth, I explored perceptions of cultural humility of the participant’s religious community as a moderator of the relationship between religion and physical health (see Table 15). There was a significant, negative main effect for religious commitment ($\beta = -.18, p = .028$). The main effect for cultural humility was non-significant ($\beta = -.04, p = .747$). The interaction between religious commitment and cultural humility was also non-significant ($\beta = .19, p = .115$).

Group 2

For participants not currently involved in a religious community, the hypothesis was not
supported. First, I explored perceptions of cultural humility of Christians in the United States as a moderator of the relationship between religion and satisfaction with life (see Table 16). There was not a significant main effect for religious commitment ($\beta = .03, p = .593$), but there was a significant, positive main effect for perceptions of cultural humility ($\beta = .12, p = .029$). The interaction between religious commitment and perceptions of cultural humility was non-significant ($\beta = .01, p = .856$).

Second, I explored perceptions of cultural humility of Christians in the United States as a moderator of the relationship between religion and depression (see Table 17). There was not a significant main effect for religious commitment ($\beta = .09, p = .094$), but there was a significant, negative main effect for perceptions of cultural humility ($\beta = -.13, p = .011$). The interaction between religious commitment and cultural humility was non-significant ($\beta = -.04, p = .464$).

Third, I explored perceptions of cultural humility of Christians in the United States as a moderator of the relationship between religion and anxiety (see Table 18). There was not a significant main effect for religious commitment ($\beta = -.01, p = .834$) or perceptions of cultural humility ($\beta = -.10, p = .063$). The interaction between religious commitment and cultural humility was non-significant ($\beta = -.01, p = .857$).

Fourth, I explored perceptions of cultural humility of Christians in the United States as a moderator of the relationship between religion and physical health (see Table 19). There was a significant, negative main effect of religious commitment for physical health ($\beta = -.19, p < .001$), and there was a significant, positive main effect for cultural humility ($\beta = .12, p = .020$). The interaction between religious commitment and cultural humility was non-significant ($\beta = .01, p = .826$).
Hypothesis 3

Hypothesis three was that the relationship between religion and minority stress (i.e., internalized homophobia) in LGB populations will be moderated by perceptions of cultural humility of their religious community. This hypothesis was assessed using the steps for moderation outlined by Baron and Kenny (1986), with internalized homophobia for lesbian/bisexual individuals and another for those who identified as gay/bisexual. Of the 555 participants collected in the sample, 159 reported being involved in a religious community (group 1) and 396 reported not being currently involved in a religious community (group 2). Group 1 was asked to rate the cultural humility of their religious community, and Group 2 was asked to rate the cultural humility of Christians in the United States.

Group 1

For Group 1, the hypothesis was not supported. I explored perceptions of cultural humility of the participant’s religious community as a moderator of the relationship between religious commitment and internalized homophobia (see Table 20). There was not a significant main effect of religious commitment ($\beta = .06, p = .449$) or cultural humility ($\beta = -.12, p = .331$). The interaction between religious commitment and cultural humility was also non-significant ($\beta = -.05, p = .660$).

Group 2

For Group 2 the hypothesis was not supported. I explored cultural humility of Christians in the United States as a moderator of the relationship between religious commitment and internalized homophobia (see Table 21). There was a significant positive main effect of religious
commitment (β = .17, p = .001) and cultural humility (β = .16, p = .002). The interaction between religious commitment and cultural humility was non-significant (β = .07, p = .209).

Hypothesis 4

Hypothesis 4 was that the perceived cultural humility of an offender would predict higher levels of forgiveness motivations towards a religious individual with whom participants have had an interpersonal conflict, even after controlling for the severity of the offense. This hypothesis was assessed using a hierarchical regression analysis with forgiveness as the dependent variable, the severity of the offense entered into step one of the hierarchical regression as a control variable, and perceptions of cultural humility of the offender entered into the second step as the predictor variable.

This hypothesis was supported. The hierarchical multiple regression revealed that at step one, severity of the offense contributed significantly to the regression model, F (1,544) = 20.91, p < .001, and accounted for 3.5% of the variation in motivations to forgive. Introducing cultural humility of the offender in step two explained an additional 15% of variance in motivations to forgive and this change in R² was significant, ΔF (1,543) = 100.31, p < .001. When both variables were included in the regression model, the severity of the offense was not a significant predictor of the participant’s motivations to forgive (β = -.05, p = .242), but the cultural humility of the offender was a positive predictor of the participant’s motivations to forgive (β = .41, p < .001).
CHAPTER 6
DISCUSSION

The present study examined the relationship between religion, health, and cultural humility in the LGB population. I tested hypotheses related to (a) the relationship between religious commitment and physical, mental, and emotional health outcomes, (b) cultural humility as a moderator of the religion–health relationship, (c) cultural humility as a moderator of the religion—internalized homophobia relationship, and (d) the relationship between cultural humility and motivations to forgive.

Overall Relationship between Religion and Health

The present study demonstrated evidence that religious commitment is associated with positive and negative health outcomes for the LGB population. Religious commitment as measured by the Religious Commitment Inventory (RCI) was positively correlated with higher satisfaction in life, but was negatively correlated with physical health. Religious commitment was not correlated with mental health outcomes of depression or anxiety. While it was not a specific hypothesis, it is interesting to note that religious commitment was positively correlated with internalized homophobia. It should be noted that the effect sizes for the effect of religious commitment on health were in the small to medium range.

The results show that the general associations between religion and health found in previous research findings (Koenig et al., 2012) may be more complicated and nuanced for the LGB population, suggesting there are possible struggles or barriers that exist between religion and sexual orientation that might interfere with the religion–health link. For the LGB population, barriers could exist at the cultural or societal level (e.g., sexual stigma).
At the community level, LGB individuals may feel isolated and disconnected from religious groups (Lease, Horne, & Noffsinger-Frazier, 2005), and at the interpersonal level there could be strains and conflicts in a relationship that disrupt social bonds. Also, LGB individuals may experience intrapersonal conflict between the intersection of their religious/spiritual and sexual orientation identities (Page et al., 2013). These are examples of possible barriers at multiple levels that could impact the religion – health link and help explain the mixed results found in this study.

Another aspect of the mixed results was how religious commitment was positively correlated with minority stress (e.g., internalized homophobia). This was especially true for participants not involved in a religious community (i.e., Group 2). Some researchers have theorized religious communities to be a possible source of minority stress due to negative attitudes or biases of some religious communities toward LGB individuals, but others have theorized how religion/spirituality could be an asset for LGB individuals when dealing with minority stress. This study’s findings of a small, positive correlation between religious commitment and internalized homophobia align with other research demonstrating that a large percentage of LGBT individuals have encountered conflicts between their religious and sexual identities (Pew Research Center, 2013). While this study’s research design does not allow for causal links to be made and generalizing these findings should be done with caution, it is possible that LGB individuals who are more committed to a religion will have a greater struggle or stress when navigating the intersection of their religious and sexual identities. Overall, this study’s findings suggest that religious commitment is associated with some positives (i.e., greater satisfaction with life) and some negatives (i.e., worse physical health, higher internalized homophobia) for the LGB population.
Cultural Humility

The present study sought to examine how cultural humility might influence the religion–health link in the LGB population through a series of moderation analyses with satisfaction with life, depression, anxiety, physical health, and internalized homophobia as dependent variables. To better understand how participants defined their religious community when asked about the cultural humility of the religious community, participants were separated into two groups. Group 1 was comprised of participants who were actively involved in a religious community and Group 2 was comprised of participants who were not currently involved in a religious community. Group 1 participants were asked to rate the cultural humility of the religious community they were involved with, but Group 2 participants were asked to rate the cultural humility of Christians in the United States. Since Christianity is the most dominant religion in the United States, it is important to consider how the cultural humility of this religious group might impact LGB individuals. Thus, both groups represent important information about how cultural humility might impact the religion-health link in LGB populations.

Group 1

For participants involved in a religious community, the results on cultural humility were mixed. Cultural humility did not moderate the relationships with physical health, depression, or anxiety. However, cultural humility did moderate the relationship between religious commitment and satisfaction with life, but the direction of the moderation effect was different than hypothesized. Also, it is important to note that cultural humility’s moderation of satisfaction with life had a small to medium effect size. High levels of religious commitment were associated with high levels of satisfaction in life, irrespective of whether participants perceived that their
religious community had high or low cultural humility. Low levels of religious commitment were associated with low levels of satisfaction with life. This was particularly true for participants who had low levels of religious commitment and perceived their religious community to have low cultural humility. In light of this, it appears that being involved in a religious community and being highly committed to one’s religion can bring satisfaction to an LGB individual’s life despite the presence of low cultural humility in one’s religious community. On the other hand, low levels of religious commitment were associated with lower satisfaction with life, especially when involved in religious communities that were not culturally humble.

It has been theorized that two possible mechanisms that contribute toward the religion–health link are how religion often provides social support and meaning in life (Hook, Worthington, Davis, & Wade, 2014). The present study’s findings suggest that religious commitment can be a large influence for an LGB individual’s satisfaction in life, and cultural humility might act as a buffer to conflict and make it easier for LGB individuals to develop a strong social support in religious communities and find greater meaning in life by being involved in a religious community.

Also, these findings suggest that simply being involved in a religious community is not enough to bring satisfaction to one’s life, but there needs to be an investment in one’s religion to see the benefits of higher satisfaction in life. There could be many barriers that weaken an LGB individual’s religious commitment (e.g., religious/spiritual struggle, sexual stigma, discrimination), and the cultural humility of the religious community could be especially important during the times in which an LGB individual’s religious commitment decreases. Religious communities that maintain a high cultural humility could allow for less religiously
committed LGB individuals to still experience high satisfaction in life, which could help strengthen their religious commitment over time.

Furthermore, Davis et al.’s (2012) social bond theory could provide some other reasons why cultural humility helps strengthen emotional health. They state that humility (a) increases one’s commitment to relationships, (b) buffers against the wears and tears of relational conflict, and (c) helps repair any strains in a relationship (Davis et al., 2012). Since people often experience positive emotions and high life satisfaction in flourishing relationships, cultural humility could be a conduit for strengthening the correlation of religious commitment and emotional health by promoting strong social bonds within a religious community. In other words, a religious community low in cultural humility may be wearisome to LGB individuals and lead to lower religious commitment, which could both contribute to decreased satisfaction in life. However, high cultural humility could act as buffer to conflict and strengthen an LGB individual’s commitment to religious individuals within their community, thus possibly strengthening their religious commitment and satisfaction in life.

Another interesting finding was that cultural humility was a negative, albeit small, predictor of internalized homophobia for Group 1 while religious commitment was a small positive predictor of internalized homophobia. While hypothesis 3 was not supported, the main effects still suggest that cultural humility might play an important role in helping religious LGB individuals reduce negative feelings about their sexual orientation. Cultural humility could permeate relational interactions between LGB individuals and people in their religious community so that LGB individuals feel more accepting of their sexual identity. Rather than receiving negative messages about their sexual orientation that then becomes internalized, LGB
individuals might experience more positive interactions with their religious community that is high in cultural humility.

Group 2

Group 2 consisted of individuals not currently involved in a religious community and were asked to rate the cultural humility of Christians in the United States. It is interesting to note that while all the individuals in Group 2 reported not being involved in a religious community, a little over half (54.6%) still identified as religious. Thus, while Group 2 was not currently involved in a religious community, most of the participants still identified as religious. One major difference between Group 1 and Group 2’s results was that religious commitment did not predict satisfaction in life for those not currently involved in a religious community (i.e., Group 2). This could indicate that being surrounded by a religious community is highly satisfying in life, but merely identifying as religious without participating in a religious community does not contribute toward satisfaction in life. Thus, Group 2 may not find higher satisfaction in life despite identifying as religious if they do not seek involvement in a religious community or feel unable to create strong social bonds with their religious community.

Another major difference between Group 1 and Group 2 is that Group 2’s religious commitment and perceptions of the cultural humility of Christians in the United States were significant, positive predictors of internalized homophobia. Whereas perceptions of cultural humility was a negative predictor for participants involved in a religious community, participants that were more removed and uninvolved in a religious community experienced higher internalized homophobia when they perceived Christians in the United States to be high in cultural humility. Also, the religious commitment of participants in Group 2 had a much stronger
positive association with internalized homophobia than Group 1. The positive correlation between cultural humility and internalized homophobia was small yet perplexing.

One reason for these findings could be that LGB individuals who are religious but not involved in a religious community could struggle to navigate the intersection between their religious and sexual identities. Thus, the struggle is an inner conflict and may act as a perceived barrier in seeking out religious support from their community, even if the community is perceived to be culturally humble. Also, many LGB individuals might feel as if they have to reject their sexual identity to embrace their religious identity or vice versa (Wagner, Serafini, Rabkin, Remien, & Williams, 1994). In this sense, the increased internalized homophobia could be a result of feelings of shame or intolerance for holding both religious and sexual identities, and Christians who display high cultural humility might exemplify the LGB individual’s ideal religious values or identity and increase negative feelings toward their sexual identity. Even if the religious community appears humble and respectful toward the LGB individual’s sexual orientation, they may not be able to accept their sexual identity themselves and thus be unable to accept the religious support of their religious community.

While Hypotheses 2 and 3 were not supported for Group 2, perceptions of the cultural humility of Christians in the United States was found to be a positive predictor of satisfaction in life and physical health, as well as a negative predictor of depression. For Group 2, religious commitment was not a big factor in their satisfaction in life, but perceptions of cultural humility could be an important factor in not just one’s satisfaction in life but for one’s physical health and depression as well. Thus, this group of LGB individuals that find themselves uninvolved in a religious community could benefit emotionally, mentally, and physically from their community demonstrating high cultural humility toward their sexual orientation. In this sense, perceptions of
cultural humility may be a more important factor for health than their religious commitment, which is in stark contrast to participants in Group 1, who primarily benefitted from staying active in a religious community and being highly committed to their religion.

However, it is important to note that high cultural humility of one’s community could also be associated with increased internalized homophobia, especially if LGB individuals feel isolated from a religious community or feel unable to navigate their religious and sexual identities. In this case, cultural humility may not be enough to help those LGB individuals not involved in a religious community, but they could benefit if they were able to start becoming more involved in a religious community and find more social support there. The key for highly religiously committed LGB individuals who are not involved in a religious community may be to find religious support and community that can help them cope with their internalized homophobia.

Cultural Humility and Forgiveness

The present study also explored the link between perceptions of cultural humility and forgiveness at the interpersonal level. Participants were asked to think of a time when a religious individual hurt them and then answered questions in regard to the severity of the offense, their motivation to forgive the offender, and the offender’s cultural humility. In this analysis, perceptions of the cultural humility of the offender accounted for an additional 15% of the variance in motivations to forgive, over and above the effect of the severity of the offense. This was a large effect size.

These results align with the social bonds theory and prior research that has found that humility can help repair strains on one’s relationship (Davis et al., 2013; Davis et al., 2016; Van
Tongeren et al., 2014). While the severity of the offense accounted for a small amount of variance, it was the cultural humility of the religious individual that hurt them that played the larger role in helping the participant to forgive. It appears cultural humility can lead to restoration in a relationship that has even suffered severe offenses. Religion and sexual orientation are two cultural identities in which people often strongly invest themselves, and it could be particular sources for conflict in interactions with religious individuals or communities. In light of this, cultural humility may be especially important for religious individuals in that it could help buffer against conflict, but even when mistakes happen or hurts occur cultural humility could permeate the relationship and allow for repairs to be made. Thus, cultural humility could help maintain or increase an LGB individual’s religious commitment through strong social bonds that are resistant to conflicts, but also allow for healing to take place when hurts occur.

Limitations

There are several limitations of the present study. First, the study used a cross-sectional rather than a longitudinal design. While little research exists on cultural humility, it could be that cultural humility is better studied as a change that occurs over time. For instance, the positive effects of being in a culturally humble environment might take time as relationships and trust can be built. Cultural humility may also fluctuate or be inconsistent since it is theorized to be difficult to stay humble in regard to culture (Hook et al., 2013; Worthington, Davis, & Hook, 2016). There are likely important differences in these experiences that are unable to be examined using a cross-sectional research design. The use of a cross-sectional research design also makes it impossible to make causal conclusions about the relationships found between variables.
Second, participants could be at different stages in their LGB identity development, which could act as an unseen variable influencing the results of the study. The sample’s characteristics may not be representative of the population’s experience in regard to religion and sexual orientation. Also, the study’s sample was almost two-thirds female with a higher percentage of bisexual and lesbian individuals than those identifying as gay. This disproportionate split between gender and sexual orientation might impact the findings since it has been shown that gay men tended to have higher internalized homophobia scores than lesbian women (Herek, Cogan, Gillis, & Glunt, 1998).

Third, the outcome health variables, minority stress, and motivations to forgive measures used in the study were self-report. Self-report data is useful and can be important because researchers are often interested in the individual’s subjective experience, but it can be confounded by social desirability and response bias (e.g., yes-saying), and difficulty with remembering the past (e.g., memory distortions). Participants may have also had difficulty remembering the religious individual’s offense accurately due to time since offense, or because recalling the incident would arouse negative feelings about the relationship.

Fourth, participants completed the self-report measures online rather than in a controlled laboratory setting. The participants’ responses may have been influenced by the environment in which they completed the study. For example, participants could have completed measures haphazardly, which could have affected the results of this study.

Areas for Future Research

There are several exciting areas of research on the topic of religion, health, and cultural humility. First, there is a need to explore the nuances of how religion affects health over time in
the LGB population. It may take time for a culturally humble religious community to positively connect with an LGB individual in a way that has positive effects on their health.

Second, future studies may examine how cultural humility develops so as to learn how to foster cultural humility among religious individuals and incorporate cultural humility development into the training of counselors and religious leaders. This could allow for individuals to foster positive relationships with others culturally different from them, buffer against conflicts that might occur from cross-cultural dialogues, and repair any strains in the relationship.

Third, the use of an experimental methodology or greater experimental control could provide a clearer understanding of the relationship between religion, health, and cultural humility. For example, although my hypotheses focused on religious commitment predicting better health, other designs could use different variables (e.g., spiritual well-being) or objective/behavioral measures for assessing health. More experimental designs could have randomly assigned participants to interact with a culturally humble person, a person with high cultural expertise, or a neutral person following a manipulated interpersonal transgression. Additionally, future studies could examine the coming out process and study the impact of cultural humility at the beginning stages of an individual’s LGB identity development.

Fourth, future studies may benefit from expanding to more diverse samples and looking at the intersection of religion with different cultural identities (e.g., race, ethnicity, gender). It may benefit future researchers to compare cultural humility across relationship context (e.g., parent-child relationship vs. religious leader-religious follower relationship), and control for relationship factors such as relationship closeness, longevity, and satisfaction. This would increase
 experimental control, and it would also expand the literature by illustrating the differences and similarities of cultural humility among different relationship contexts.

Fifth, further study is needed to examine possible moderators of the relationship between religion and health for the LGB population. While this study found partial evidence to support the moderation of religious commitment and satisfaction with life by cultural humility, more research could explore other possible moderators (e.g., social support, integration of religious/spiritual and sexual orientation identities).

Implications for Counseling

The findings of the present study have several implications for counseling. First, the cultural humility literature has remarked upon the uses of cultural humility for positively engaging with culturally diverse clients, and this study helps demonstrate some of these benefits. While some debate exists about whether to conceptualize cultural humility as a separate construct or extended evolution of cultural competency (see Chapter 2), it is clear that cultural humility could help clinicians and young trainees. For instance, the social bonds theory of humility lends support that cultural humility could help strengthen the therapeutic alliance and help the client feel safer with the clinician and more committed to the professional relationship (Davis et al., 2016). Also, the results of the study demonstrate that cultural humility may be helpful in order to repair any ruptures in the therapeutic alliance (Davis et al., 2016).

Second, the findings of this study provide evidence that religious counselors can positively engage with LGB-identifying clients when they strive to be culturally humble. This could help counselors focus on the client’s needs and values while navigating differences in cultural backgrounds or worldviews through an other-oriented approach that is respectful and humble.
The possible benefits could be that cultural humility acts as a buffer to harmful psychological symptoms, or cultural humility could create a safe space for clients to navigate their own conflicts between intersecting identities (e.g., religion, spirituality, sexual orientation).

Third, the present findings indicate the importance of fostering cultural humility in religious communities in order to promote better emotional health in the LGB population. Many LGB individuals may identify as religious/spiritual and seek support from a religious leader or religious community. Counselors could act as change agents that promote better relations among religious communities and LGB individuals by promoting and educating others about cultural humility.

Conclusion

A large amount of research has investigated the relationship between religion and health and found mostly positive correlations, but religion is complex and the religion – health link may be more nuanced than this. The current study investigated the religion – health link in the LGB population to better understand possible cultural barriers that might exist and to explore the role of cultural humility in breaking those barriers. In general, the religion – health link had mixed results with some positive (e.g., higher satisfaction with life) and negative (e.g., worse physical health) outcomes for the LGB population. Cultural humility of the participant’s religious community was found to moderate the relationship between religious commitment and satisfaction with life, with low religious commitment and low cultural humility conditions resulting in the lowest satisfaction with life. At the interpersonal level, cultural humility predicted significantly more of the variance than severity of the offense in motivations to forgive a religious individual that hurt the participant. Further research in this area of study will help us
better understand the nuances of religion and health for the LGB population as well as the importance of cultural humility in breaking cultural barriers.
### Table 1

**Cultural Humility: Conceptual/Theoretical Journal Articles**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alsharif (2012)</td>
<td>A panel discussion on cultural competency led to the insight that cultural humility is a tool that is a key for a successful framework for a culturally competent practice.</td>
</tr>
<tr>
<td>Borkan et al. (2008)</td>
<td>A framework using the acronym H.U.M.B.L.E. is presented for quality care that attends to culture. Tools and approaches for achieving cultural competency and humility are provided that may help improve the care of culturally diverse patients.</td>
</tr>
<tr>
<td>Butler et al. (2011)</td>
<td>A MEDLINE review of published literature regarding cultural competency &amp; humility training in medical education was performed. Results indicate academic medical institutions recognize the need for cultural competency &amp; humility training, but there is a deficit in training for 3rd &amp; 4th years of medical students’ education.</td>
</tr>
<tr>
<td>Chang et al. (2012)</td>
<td>A proposal is made to integrate cultural humility into competency trainings by complementing current models with the QIAN 谦 (Humbleness) curriculum.</td>
</tr>
<tr>
<td>Clark et al. (2011)</td>
<td>An expert nursing faculty group formulated core graduate cultural competencies and used cultural humility as the supporting framework.</td>
</tr>
<tr>
<td>Cruess et al. (2010)</td>
<td>Professionalism is directly influenced by the social contract, but how professionalism is expressed will differ between countries and cultures due to differences in their social contracts. When professionalism is taught, it should be related to the different cultures and social contracts, respecting local customs and values.</td>
</tr>
<tr>
<td>DeLemos et al. (2007)</td>
<td>Navajo participation with researchers helped to foster trust in research efforts during community interactions. Community engagement helps to sustain equitable partnerships and aids in culturally appropriate, relevant data collection.</td>
</tr>
<tr>
<td>Dong et al. (2011)</td>
<td>A review of the epidemiology of depression among Chinese older adults suggests that culturally appropriate approaches will improve the quality of life and care by leveraging cultural humility models in conjunction with existing cultural competency trainings.</td>
</tr>
<tr>
<td>Dong &amp; Chang (2014)</td>
<td>Authors reply to critiques about defining and citing the term cultural humility.</td>
</tr>
<tr>
<td>Fisher-Bourne et al. (2014)</td>
<td>Cultural competency has been challenged for its failure to account for the structural forces that shape individuals’ experiences and opportunities, but cultural humility takes into account the fluidity of culture and challenges both individuals and institutions to address inequalities.</td>
</tr>
<tr>
<td>Foronda et al. (in press)</td>
<td>A concept analysis was conducted to find a current definition for the term cultural humility. The attributes were openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. The antecedents were diversity and power imbalance. The consequences were mutual empowerment, partnerships, respect, optimal care, and lifelong learning. Cultural humility was described as a lifelong process. With a firm understanding of the term, individuals and communities will be better equipped to understand and accomplish an inclusive environment with mutual benefit and optimal care.</td>
</tr>
<tr>
<td>Foronda et al. (2015)</td>
<td>The International Nursing Association for Clinical Simulation (INACSL) recently published revised standards to guide educators and help standardize best practices in simulation (INACSL Board of Directors, 2013), but cultural humility appears to be missing and warrants consideration as a standard. The intentional creation of simulations steeped in cultural humility could provide a venue for nursing students to experience deeper social and professional ethical issues.</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (cont.).

<table>
<thead>
<tr>
<th>Citation</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster (2009)</td>
<td>A health professional interchange project has led to a dialogue on cultural humility, self-reflection, and empowerment among nursing colleagues across national boundaries, despite differences in assumptions.</td>
</tr>
<tr>
<td>Gallardo (2013)</td>
<td>Book that engages in thoughtful dialogue with psychologists that discusses both the challenges and rewards in their own journeys and how they continue to engage in the process of staying connected to their cultural identity and to being culturally responsive.</td>
</tr>
<tr>
<td>Graham-Dickerson (2011)</td>
<td>A variety of cultural humility strategies are presented for nursing professions to implement in courses that will increase the understanding and meaning of cultural humility within the health care arena.</td>
</tr>
<tr>
<td>Hammell (2013)</td>
<td>This paper highlights how a cultural humility approach can address power imbalances in client-therapist relationships by incorporating critical self-evaluation and recognizing that cultural differences lie not within clients but within client-therapist relationships. Cultural humility is an approach that can counter professional ethnocentrism and intellectual colonialism.</td>
</tr>
<tr>
<td>Hook (2014)</td>
<td>An account of personal experience in graduate school and the counseling field helps demonstrate the usefulness cultural humility has in professional development as well as engaging culturally diverse clients.</td>
</tr>
<tr>
<td>Hook &amp; Watkins (2015)</td>
<td>How psychologists engage with cultural diverse clients is an ongoing problem in effective psychological services despite being trained in the values of multiculturalism. This continuing problem could be answered by examining the foundational cornerstone of all cultural contact, which is cultural humility.</td>
</tr>
<tr>
<td>Kim (2015)</td>
<td>Culturally competent cancer care approaches are necessary to effectively engage cultural minorities. This reflection shares personal insights on this subject and advocates for practicing cultural humility.</td>
</tr>
<tr>
<td>Loue (2012)</td>
<td>A cultural competence approach in sandplay therapy often leads to stereotyping and an inability to view each individual as unique. In contrast, the concept of cultural humility is more congruent with sandplay therapy as it rests on the basic assumption that in each and every interaction, there is something that we do not know or understand. Interaction premised on cultural humility is characterized by active engagement, a commitment to reciprocity on the part of all individuals, and the exercise of humility in each and every encounter.</td>
</tr>
<tr>
<td>Mallon (2011)</td>
<td>An introduction stressing cultural humility is presented for six articles written by child welfare scholars on topics such as a community-based program's influence on parent-child relationships, training child welfare workers, and therapeutic mentoring's role in improving outcomes for foster care youth.</td>
</tr>
<tr>
<td>McNamara (2002)</td>
<td>A news article interviews Dr. Tervalon about the importance of cultural humility in healthcare and stresses the key aspects of cultural humility as an ongoing learning process with respect towards other’s culture.</td>
</tr>
<tr>
<td>Miller (2009)</td>
<td>Article recounts the evolution of culture sensitivity to cultural competence to cultural humility and explains that the newest evolvement (i.e., cultural humility) contains self-critique and addressing power imbalances.</td>
</tr>
<tr>
<td>Nambiar-Greenwood &amp; Timmins (2015)</td>
<td>Internationally, nursing is distancing itself from its religious heritage, and globally there are limited discussions and debate in contemporary nursing literature on the subject of religion and religiosity with an emphasis instead on spirituality and spiritual care delivery. At the same time clients' spiritual needs in many areas of the health care setting internationally are often unmet and while health care workers interventions are common they often lack the necessary training and knowledge.</td>
</tr>
<tr>
<td>Ortega &amp; Faller (2011)</td>
<td>Cultural competency models in child welfare may unintentionally over-emphasize group characteristics and undervalue individual differences. Cultural humility could compliment cultural competency to liberate social workers from expectations of cultural expertise about others. Skills and practice principles are discussed.</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Citation</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oswald &amp; Korsmo (2015)</td>
<td>Engaging in mentoring relationships &amp; practicing humility can lead to the beginning of an informal faculty-student mentorship developed to support each other’s quest to become increasingly competent global citizens.</td>
</tr>
<tr>
<td>Quigley (2016)</td>
<td>New paradigms of research include place-based community and cultural groups as partners or participants of environmental research interventions, and it is critical to train researchers in respecting “place” within human subjects protections applied to communities and cultural groups.</td>
</tr>
<tr>
<td>Rincon (2009)</td>
<td>Clinical health workers face diversity challenges in their jobs, and cultural training cannot make them an expert for every client. Thus, a cultural humility approach offers an invitation to practice humility and become a life-long learner.</td>
</tr>
<tr>
<td>Tervalon &amp; Murray-Garcia (1998)</td>
<td>The traditional method of training &amp; delivering health care is challenged by addressing shortcomings of cultural competency and suggesting a more appropriate goal is cultural humility. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial partnerships with communities.</td>
</tr>
<tr>
<td>Vogt (2011)</td>
<td>Humility is an overlooked virtue in physicians, and while medical knowledge and medical science are essential components of clinical competence, cultural humility can help physicians engage culturally diverse clients effectively.</td>
</tr>
<tr>
<td>Yeager &amp; Bauer-Wu (2013)</td>
<td>The Social Work Education Project (SWEP) was developed to train social workers and qualitative program evaluation findings reveal that students assessed their learning as culturally relevant and personally meaningful while also enhancing their capacities for effective social work practice.</td>
</tr>
</tbody>
</table>

*Note.* CHS = Cultural Humility Scale; CCAT = Cultural Competence Assessment Tool; IAPCC-SV = Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals–Student Version
<table>
<thead>
<tr>
<th>Citation</th>
<th>Study Design</th>
<th>Sample</th>
<th>CH Measure</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duntley-Matos (2014)</td>
<td>Qualitative</td>
<td>Not Reported</td>
<td>Home ethnography</td>
<td>Doctoral trajectories in social science and social service programs and the potential advancement of students can be predicted by the cultural humility of the mentee-mentor relationship.</td>
</tr>
<tr>
<td>Fahey et al. (2013)</td>
<td>Qualitative (Training Implementation)</td>
<td>65</td>
<td>Not Reported</td>
<td>A PRONTO curriculum was successfully adapted in Guatemala to train workers in both cultural humility and neonatal care.</td>
</tr>
<tr>
<td>Groll (2014)</td>
<td>Mixed Methods</td>
<td>392 (268 m, 124 f, 264 White, 127 Non-White, age M = 18.6)</td>
<td>M-GUDS-s &amp; IDI</td>
<td>The IDI revealed that first-year engineering students as a cohort largely overestimate their cultural sensitivity, and qualitative findings provide an understanding of how first year students culturally engage with others using polarizing and minimizing language. Collectively these studies establish a starting point from which engineering educators can begin a collaborative effort in creating evidence based practices to engage first-year students in cultural humility.</td>
</tr>
<tr>
<td>Har-Gil (2010)</td>
<td>Qualitative</td>
<td>1</td>
<td>Heuristic Approach</td>
<td>An art-based heuristic approach promoted engagement in cultural humility that increased the researcher’s awareness of previously unacknowledged aspects of her culture.</td>
</tr>
<tr>
<td>Hernandez-Wolfe et al. (2015)</td>
<td>Qualitative (Training Implementation)</td>
<td>20 (17 f, 3 m)</td>
<td>Observation &amp; Debriefing</td>
<td>The development of a transnational immersion was successfully implemented through a cultural humble and a dialogical framework.</td>
</tr>
<tr>
<td>Hilliard (2011)</td>
<td>Qualitative</td>
<td>8 (6 f, 2 m, 8 White, age M = 34.1)</td>
<td>Life History Approach</td>
<td>Eight physical therapists were interviewed about cultural humility in their work. Five themes emerged showing cultural humility to involve (1) being open-minded and listening attentively; (2) responding to emotions; (3) focusing on patient’s goals and needs; (4) teaching empowerment; and (5) evolving awareness needs and assets.</td>
</tr>
<tr>
<td>Hodgin (2015)</td>
<td>Mixed Methods</td>
<td>6 (6 f, 6 White)</td>
<td>Survey, Interview, Observation</td>
<td>Data from 6 White middle school and high school teachers indicated the importance of building mutually caring, respectful, and trusting relationships in a context where challenges (e.g., teacher turnover, distrust, high stakes demands) are difficult to surmount.</td>
</tr>
<tr>
<td>Hook et al. (2013)</td>
<td>Quantitative (Cross Sectional)</td>
<td>843 (307 m, 532 f, age M = 24.7, 408 White, 234 Black, 51 Asian, 94 Latino, 5 Native American, 51 Multiracial)</td>
<td>CHS</td>
<td>In 4 studies, evidence for the estimated reliability and construct validity of a client-rated measure of a therapist’s cultural humility was established. Cultural humility perceptions were positively associated with developing a strong working alliance and client improvement in therapy, with this relationship mediated by a strong working alliance.</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 2 (cont.).

<table>
<thead>
<tr>
<th>Citation</th>
<th>Study Design</th>
<th>Sample</th>
<th>CH Measure</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isaacson (2014)</td>
<td>Mixed Methods</td>
<td>11 (11 f, 11 White)</td>
<td>Hermeneutic Phenomenology &amp; IAPCC-SV</td>
<td>Two cultural immersion experiences (4 day &amp; 2 week) were implemented in a nursing program. For pre-immersion, cultural competency scores from the IAPCC-SV indicated nursing students reported high levels of cultural competence, but the qualitative reflective journals suggested lower levels of cultural competence. Post-immersion saw increased cultural competence for the 2-week immersion group, and higher cultural awareness coded in reflective journaling for both groups.</td>
</tr>
<tr>
<td>Juarez et al. (2006)</td>
<td>Mixed Methods (Training Implementation)</td>
<td>11</td>
<td>Self-assessment &amp; Observation</td>
<td>A cultural humility training was implemented for medical residents. As a result, residents increased patient involvement and were attentive to the patient’s perspective and social context. Resident self-ratings indicated high satisfaction with the learning activities, but no change in their perception of their ability to work with particular patients.</td>
</tr>
<tr>
<td>Kools et al. (2015)</td>
<td>Qualitative (Training Implementation)</td>
<td>Not Reported</td>
<td>Not Reported</td>
<td>A cultural diversity training program was delivered to Global Health Fellows and promoted culturally competent and humble care for marginalized populations.</td>
</tr>
<tr>
<td>Kutob et al. (2013)</td>
<td>Quantitative (Experimental/Pre-Test &amp; Post-Test)</td>
<td>90 (59 f, 31 m, age $M = 44$, 60 White, 6 Black, 15 Asian, 3 Latino, 3 Native American, 3 Other)</td>
<td>CCAT</td>
<td>A skills-based approach to training physicians (41 in control; 49 in intervention) was implemented, with results showing no significant scoring differences on total cultural competence or subscales measuring cultural knowledge. There were significant positive differences on the subscales measuring physicians’ nonjudgmental attitudes/behaviors and future likelihood of eliciting patients’ beliefs/preferences. There was a significant negative difference on the subscale measuring cultural self-awareness for control versus for intervention.</td>
</tr>
<tr>
<td>Liao et al. (2014)</td>
<td>Quantitative (Training Implementation; Pre-Test/Post-Test)</td>
<td>144 (114 f, 30 m, 144 Latino, age $M = 53$)</td>
<td>Self-report Survey</td>
<td>By means of a video-based education module, Latino caregivers were able to increase their self-awareness about caregiver stress and accept professional assistance while caring for their loved one.</td>
</tr>
<tr>
<td>Lund &amp; Lee (2015)</td>
<td>Qualitative</td>
<td>10 (10 f, 9 White)</td>
<td>Structured-Interviews</td>
<td>A community-initiated service-learning project guided by a social justice model in pre-service teachers found benefits of improved self-awareness, appreciation of the strengths of immigrant children and youth, and an increased sense of cultural humility in pre-service teachers.</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Citation</th>
<th>Study Design</th>
<th>Sample</th>
<th>CH Measure</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen et al. (2014)</td>
<td>Quantitative (Cross Sectional)</td>
<td>45 (27 f, 18 m, age M = 24, 21 Black, 11 White, 10 Asian, 3 Latino)</td>
<td>CHS</td>
<td>Perceptions of cultural humility were positively associated with therapy outcomes. Clients’ religious commitment moderated this relationship. The relationship between perceived cultural humility and outcomes was positive for clients with higher religious commitment, whereas it was not different from zero for clients with lower religious commitment.</td>
</tr>
<tr>
<td>Owen et al. (2016)</td>
<td>Quantitative (Cross Sectional)</td>
<td>247 (186 f, 57 male, 4 gender NR, age M = 23.2, 2 Black, 50 Asian, 35 Latino, 119 White, 34 Multiracial, 7 race/ethnicity NR)</td>
<td>CHS</td>
<td>Clients who rated their therapist as being more culturally humble also reported better therapy outcomes. Cultural humility moderated the association between missed cultural opportunities and therapy outcomes.</td>
</tr>
<tr>
<td>Reynoso-Vallejo (2009)</td>
<td>Qualitative (Intervention)</td>
<td>Not Reported</td>
<td>Not Reported</td>
<td>A culturally humble intervention was implemented to educate and support Latino caregivers of family members coping with Alzheimer’s disease, and caregivers reported the information useful.</td>
</tr>
<tr>
<td>Ross (2010)</td>
<td>Qualitative (Training Implementation)</td>
<td>5</td>
<td>Qualitative Coded Journals</td>
<td>A 2-course sequence successfully developed graduate students’ cultural humility by integrating community-based participatory research and ongoing reflection.</td>
</tr>
<tr>
<td>Schlusser et al. (2012)</td>
<td>Qualitative (Longitudinal/Training Implementation)</td>
<td>50</td>
<td>Qualitative coded journals</td>
<td>Reflective journaling as a teaching strategy helps students develop cultural humility skills. Naturalistic inquiry with person-centered written reflections found that cultural humility cannot be learned solely in the classroom with traditional methods. Reflection on experiences over time leads to the development of cultural humility.</td>
</tr>
<tr>
<td>Sheridan et al. (2013)</td>
<td>Mixed Methods (Longitudinal/Training Implementation)</td>
<td>100 (78 f, 22 m, age M = 31.6)</td>
<td>Self-report &amp; Interview</td>
<td>The Social Work Education Project (SWEP) was developed to train social workers and qualitative program evaluation findings reveal that students assessed their learning as culturally relevant and personally meaningful while also enhancing their capacities for effective social work practice.</td>
</tr>
<tr>
<td>Wouters (2012)</td>
<td>Qualitative (Training Implementation)</td>
<td>16</td>
<td>Not Reported</td>
<td>Experiential learning &amp; reflective activities involving narrative and collaborative therapy practices found students’ perspectives were transformed.</td>
</tr>
</tbody>
</table>

*Note.* CHS = Cultural Humility Scale; CCAT = Cultural Competence Assessment Tool; IAPCC-SV = Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals–Student Version; IDI = Intercultural Development Inventory; M-GUDS-s = Miville-Guzman Universality-Diversity Scale - Short
### Table 3

*Skewness, Kurtosis, and Range of Responses of Religious Commitment, Health, Minority Stress, Forgiveness, and Cultural Humility*

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Skewness (standard error)</th>
<th>Kurtosis (standard error)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Commitment</td>
<td>2.15</td>
<td>1.09</td>
<td>.72 (.10)</td>
<td>-.62 (.21)</td>
<td>4.00</td>
</tr>
<tr>
<td>Satisfaction with Life</td>
<td>4.07</td>
<td>1.51</td>
<td>-.19 (.10)</td>
<td>-.86 (.21)</td>
<td>6.00</td>
</tr>
<tr>
<td>Depression</td>
<td>1.06</td>
<td>.64</td>
<td>.36 (.10)</td>
<td>-.55 (.21)</td>
<td>2.97</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.23</td>
<td>.64</td>
<td>.05 (.10)</td>
<td>-.52 (.21)</td>
<td>2.98</td>
</tr>
<tr>
<td>Physical Health</td>
<td>63.73</td>
<td>19.42</td>
<td>-.44 (.10)</td>
<td>-.53 (.21)</td>
<td>94.53</td>
</tr>
<tr>
<td>Internalized Homophobia</td>
<td>1.80</td>
<td>.82</td>
<td>.88 (.11)</td>
<td>-.10 (.22)</td>
<td>3.30</td>
</tr>
<tr>
<td>Motivations to Forgive</td>
<td>3.13</td>
<td>.89</td>
<td>.36 (.10)</td>
<td>-.56 (.21)</td>
<td>4.00</td>
</tr>
<tr>
<td>Cultural Humility (religious community)</td>
<td>3.05</td>
<td>1.09</td>
<td>-.16 (.19)</td>
<td>-.76 (.38)</td>
<td>4.00</td>
</tr>
<tr>
<td>Cultural Humility (Christians in USA)</td>
<td>2.05</td>
<td>.65</td>
<td>.31 (.12)</td>
<td>-.38 (.25)</td>
<td>3.04</td>
</tr>
<tr>
<td>Cultural Humility (offender)</td>
<td>1.90</td>
<td>.83</td>
<td>.68 (.10)</td>
<td>-.52 (.21)</td>
<td>3.39</td>
</tr>
</tbody>
</table>
Table 4

*Intercorrelations of Religious Commitment, Health, Minority Stress, Forgiveness, and Cultural Humility*

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
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</thead>
<tbody>
<tr>
<td>1. Religious Commitment</td>
<td>2.15</td>
<td>1.09</td>
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<td>.14**</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Satisfaction with Life</td>
<td>4.07</td>
<td>1.51</td>
<td>.14**</td>
<td></td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Depression</td>
<td>1.06</td>
<td>.64</td>
<td>.02</td>
<td>-.53**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Anxiety</td>
<td>2.23</td>
<td>.64</td>
<td>-.08</td>
<td>-.64**</td>
<td>.83**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Physical Health</td>
<td>63.73</td>
<td>19.42</td>
<td>-.10*</td>
<td>.42**</td>
<td>-.73**</td>
<td>-.64**</td>
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</tr>
<tr>
<td>6. Internalized Homophobia</td>
<td>1.80</td>
<td>.82</td>
<td>.24**</td>
<td>-.08</td>
<td>.23**</td>
<td>.21**</td>
<td>-.12**</td>
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<tr>
<td>7. Motivations to Forgive</td>
<td>3.13</td>
<td>.89</td>
<td>.05</td>
<td>.16**</td>
<td>-.19**</td>
<td>-.17**</td>
<td>.17**</td>
<td>.02</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Cultural Humility (religious community)</td>
<td>3.05</td>
<td>1.09</td>
<td>.23*</td>
<td>.06</td>
<td>-.21**</td>
<td>-.24**</td>
<td>.14</td>
<td>-.16</td>
<td>-.05</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Cultural Humility (Christians in USA)</td>
<td>2.05</td>
<td>.65</td>
<td>.17**</td>
<td>.12*</td>
<td>-.11*</td>
<td>-.10*</td>
<td>.09</td>
<td>.17**</td>
<td>.21**</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Cultural Humility (offender)</td>
<td>1.90</td>
<td>.83</td>
<td>.19**</td>
<td>.06</td>
<td>.01</td>
<td>.01</td>
<td>.22**</td>
<td>.43**</td>
<td>.02</td>
<td>.38**</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Age</td>
<td>27.28</td>
<td>9.65</td>
<td>.04</td>
<td>.02</td>
<td>-.15**</td>
<td>-.19**</td>
<td>-.01</td>
<td>-.13**</td>
<td>-.09*</td>
<td>.19**</td>
<td>-.09</td>
<td>-.08</td>
<td>--</td>
</tr>
</tbody>
</table>

* * correlation significant at .05 level. **correlation significant at .01 level.*
Table 5

Comparison of Religiously Involved vs. Non-Involved Participants

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Religiously Involved M</th>
<th>Religiously Involved SD</th>
<th>Religiously Non-Involved M</th>
<th>Religiously Non-Involved SD</th>
<th>T-Test Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Satisfaction with Life</td>
<td>4.29</td>
<td>1.47</td>
<td>3.99</td>
<td>1.51</td>
<td>2.12*</td>
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<td>2. Depression</td>
<td>1.06</td>
<td>.65</td>
<td>1.07</td>
<td>.63</td>
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<td>.904</td>
</tr>
<tr>
<td>3. Anxiety</td>
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<td>.61</td>
<td>2.26</td>
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<td>4. Physical Health</td>
<td>64.78</td>
<td>18.63</td>
<td>63.31</td>
<td>19.74</td>
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<td>.420</td>
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<td>5. Internalized Homophobia</td>
<td>2.08</td>
<td>.89</td>
<td>1.70</td>
<td>.76</td>
<td>4.67**</td>
<td>&lt;.001</td>
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<tr>
<td>6. Motivations to Forgive</td>
<td>3.24</td>
<td>.87</td>
<td>3.08</td>
<td>.90</td>
<td>1.91</td>
<td>.057</td>
</tr>
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* significant at .05 level. ** significant at .01 level.

Table 6

Intercorrelations Based on Religiously Involved Versus Religiously Non-Involved

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>1. Religious Commitment</td>
<td>2.15</td>
<td>1.09</td>
<td>--</td>
<td>.05</td>
<td>.06</td>
<td>-.03</td>
<td>-.17**</td>
<td>.20**</td>
<td>.01</td>
<td>--</td>
<td>.17**</td>
<td>.15**</td>
</tr>
<tr>
<td>2. Satisfaction with Life</td>
<td>4.07</td>
<td>1.51</td>
<td>.26**</td>
<td>--</td>
<td>-.57**</td>
<td>-.65**</td>
<td>.46**</td>
<td>-.19**</td>
<td>.14**</td>
<td>--</td>
<td>.12**</td>
<td>.01</td>
</tr>
<tr>
<td>3. Depression</td>
<td>1.06</td>
<td>.64</td>
<td>-.03</td>
<td>-.45**</td>
<td>--</td>
<td>.83**</td>
<td>-.75**</td>
<td>.25**</td>
<td>-.17**</td>
<td>--</td>
<td>-.11**</td>
<td>.01</td>
</tr>
<tr>
<td>4. Anxiety</td>
<td>2.23</td>
<td>.64</td>
<td>-.12</td>
<td>-.60**</td>
<td>.85**</td>
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<td>-.64**</td>
<td>.24**</td>
<td>-.14**</td>
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<td>-.10*</td>
<td>.03</td>
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(table continues)
Table 6 (cont.).

<table>
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<tr>
<th>Variable</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>5. Physical Health</td>
<td>63.73</td>
<td>19.42</td>
<td>-.13</td>
<td>.33**</td>
<td>-.70**</td>
<td>-.64**</td>
<td>--</td>
<td>-.15**</td>
<td>.15**</td>
<td>--</td>
</tr>
<tr>
<td>6. Internalized Homophobia</td>
<td>1.80</td>
<td>.82</td>
<td>.03</td>
<td>.09</td>
<td>.21**</td>
<td>.20**</td>
<td>-.08</td>
<td>--</td>
<td>-.02</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Motivations to Forgive</td>
<td>3.13</td>
<td>.89</td>
<td>.05</td>
<td>.19**</td>
<td>-.25**</td>
<td>-.23**</td>
<td>.23**</td>
<td>.03</td>
<td>--</td>
<td>.21**</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Cultural Humility (religious community)</td>
<td>3.05</td>
<td>1.09</td>
<td>.23**</td>
<td>.06</td>
<td>-.21**</td>
<td>-.24**</td>
<td>.14</td>
<td>-.15</td>
<td>-.05</td>
<td>--</td>
</tr>
<tr>
<td>9. Cultural Humility (Christians in USA)</td>
<td>2.05</td>
<td>.65</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.39**</td>
</tr>
<tr>
<td>10. Cultural Humility (offender)</td>
<td>1.90</td>
<td>.83</td>
<td>.07</td>
<td>.12</td>
<td>.01</td>
<td>-.03</td>
<td>-.04</td>
<td>.23**</td>
<td>.25**</td>
<td>.02</td>
</tr>
</tbody>
</table>

Note. Currently Religiously Involved-bottom left, Currently Religiously Non-Involved – top right. * correlation significant at .05 level. **correlation significant at .01 level.

Table 7

Comparison of Outcome Variables In MTURK & Undergraduate (SONA) Samples

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>MTURK M</th>
<th>MTURK SD</th>
<th>Undergrad M</th>
<th>Undergrad SD</th>
<th>T-Test Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Satisfaction with Life</td>
<td>4.03</td>
<td>1.56</td>
<td>4.14</td>
<td>1.43</td>
<td>-.82</td>
<td>.415</td>
</tr>
<tr>
<td>2. Depression</td>
<td>1.03</td>
<td>.66</td>
<td>1.11</td>
<td>.59</td>
<td>-1.34</td>
<td>.182</td>
</tr>
<tr>
<td>3. Anxiety</td>
<td>2.21</td>
<td>.69</td>
<td>2.27</td>
<td>.56</td>
<td>-1.16</td>
<td>.248</td>
</tr>
<tr>
<td>4. Physical Health</td>
<td>63.15</td>
<td>20.53</td>
<td>64.58</td>
<td>17.69</td>
<td>-.88</td>
<td>.382</td>
</tr>
<tr>
<td>5. Internalized Homophobia</td>
<td>1.68</td>
<td>.78</td>
<td>1.97</td>
<td>.83</td>
<td>-4.11**</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>6. Motivations to Forgive</td>
<td>3.04</td>
<td>.86</td>
<td>3.25</td>
<td>.92</td>
<td>1.07</td>
<td>.287</td>
</tr>
</tbody>
</table>

* significant at .05 level. ** significant at .01 level.
### Table 8

**Comparison of Sexual Orientation in MTURK & Undergraduate (SONA) Samples**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Lesbian</th>
<th>Gay</th>
<th>Bisexual</th>
<th>Queer</th>
<th>Other</th>
<th>$\chi^2$</th>
<th>$\Phi$</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTURK</td>
<td>count</td>
<td>37</td>
<td>36</td>
<td>184</td>
<td>31</td>
<td>35</td>
<td>25.39**</td>
</tr>
<tr>
<td></td>
<td>(expected)</td>
<td>(30.8)</td>
<td>(39.7)</td>
<td>(204.5)</td>
<td>(22.5)</td>
<td>(27.9)</td>
<td></td>
</tr>
<tr>
<td>SONA</td>
<td>count</td>
<td>15</td>
<td>31</td>
<td>161</td>
<td>7</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(expected)</td>
<td>(21.2)</td>
<td>(27.3)</td>
<td>(140.5)</td>
<td>(15.5)</td>
<td>(19.1)</td>
<td></td>
</tr>
</tbody>
</table>

**significant at .01 level.

### Table 9

**Comparison of Age in MTURK & Undergraduate (SONA) Samples**

<table>
<thead>
<tr>
<th>Sample</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTURK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 328</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 31.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SD = 10.07)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SONA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 225</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 20.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SD = 2.95)</td>
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<td></td>
</tr>
</tbody>
</table>

**significant at .01 level.
Table 10

Comparison of Religious Affiliation in MTURK & Undergraduate (SONA) Samples

<table>
<thead>
<tr>
<th>Sample</th>
<th>Christian - Catholic</th>
<th>Christian – Evangelical Protestant</th>
<th>Christian – Mainline Protestant</th>
<th>Christian – Black Protestant</th>
<th>Latter-Day Saints</th>
<th>Muslim</th>
<th>Buddhist</th>
<th>Hindu</th>
<th>Jewish</th>
<th>Atheist</th>
<th>Agnostic</th>
<th>Other</th>
<th>$\chi^2$</th>
<th>$\Phi$</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTURK</td>
<td>count (expected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42 (47.4)</td>
<td>22 (24.9)</td>
<td>21 (17.8)</td>
<td>3 (10.1)</td>
<td>1 (1.2)</td>
<td>2 (4.1)</td>
<td>13 (11.3)</td>
<td>7 (4.1)</td>
<td>8 (5.9)</td>
<td>53 (42.1)</td>
<td>59 (66.4)</td>
<td>62 (54.5)</td>
<td>38.13**</td>
<td>.26**</td>
</tr>
<tr>
<td>SONA</td>
<td>count (expected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38 (32.6)</td>
<td>20 (17.1)</td>
<td>9 (12.2)</td>
<td>14 (6.9)</td>
<td>1 (0.8)</td>
<td>5 (2.9)</td>
<td>6 (7.7)</td>
<td>0 (2.9)</td>
<td>2 (4.1)</td>
<td>18 (28.9)</td>
<td>53 (45.6)</td>
<td>30 (37.5)</td>
<td></td>
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</tr>
</tbody>
</table>

**significant at .01 level.
Table 11

*Preliminary Analysis of Gender on Outcome Variables*

<table>
<thead>
<tr>
<th></th>
<th>Male (n = 138)</th>
<th>Female (n = 369)</th>
<th>t</th>
<th>df</th>
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<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment</td>
<td>2.31</td>
<td>1.16</td>
<td>1.77</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>2.12</td>
<td>1.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with life</td>
<td>4.11</td>
<td>1.46</td>
<td>-0.27</td>
<td>504</td>
</tr>
<tr>
<td></td>
<td>4.15</td>
<td>1.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1.00</td>
<td>0.62</td>
<td>-0.56</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>1.04</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.15</td>
<td>0.58</td>
<td>-1.17</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>2.22</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>67.49</td>
<td>18.03</td>
<td>1.99</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>63.71</td>
<td>19.51</td>
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<td></td>
</tr>
<tr>
<td>Internalized Homophobia</td>
<td>2.22</td>
<td>0.95</td>
<td>6.75**</td>
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<td>1.67</td>
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</tr>
<tr>
<td>Motivations to Forgive</td>
<td>3.19</td>
<td>0.93</td>
<td>0.46</td>
<td>505</td>
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<td></td>
<td>3.15</td>
<td>0.87</td>
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<td>3.12</td>
<td>0.97</td>
<td>0.44</td>
<td>149</td>
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<tr>
<td></td>
<td>3.03</td>
<td>1.12</td>
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</tr>
<tr>
<td>Cultural Humility (Christians in USA)</td>
<td>2.26</td>
<td>0.59</td>
<td>3.52</td>
<td>356</td>
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<tr>
<td></td>
<td>1.99</td>
<td>0.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Humility (offender)</td>
<td>2.10</td>
<td>0.89</td>
<td>2.88**</td>
<td>504</td>
</tr>
<tr>
<td></td>
<td>1.86</td>
<td>0.80</td>
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*Note. Participants who identified as other (n = 8) were not included. **significant at .01 level.*

Table 12

*Multiple Regression Analysis Predicting Satisfaction with Life in Group 1*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>ΔR²</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.07**</td>
<td>.26**</td>
<td>.06</td>
</tr>
<tr>
<td>Cultural Humility (CHS; religious community)</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.03*</td>
<td>.26**</td>
<td>.07</td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td>.19</td>
<td>.02</td>
</tr>
<tr>
<td>RCI x CHS</td>
<td></td>
<td>-.25*</td>
<td>.03</td>
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</table>

* *significant at .05 level. **significant at .01 level.*
Table 13

Multiple Regression Analysis Predicting Depression in Group 1

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.04*</td>
<td>.02</td>
<td>.00</td>
</tr>
<tr>
<td>Cultural Humility (CHS; religious community)</td>
<td>-.21**</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.01</td>
<td>.02</td>
<td>.00</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>-.10</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>RCI x CHS</td>
<td>-.14</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

* significant at .05 level. ** significant at .01 level.

Table 14

Multiple Regression Analysis Predicting Anxiety in Group 1

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.06**</td>
<td>-.07</td>
<td>.00</td>
</tr>
<tr>
<td>Cultural Humility (CHS; religious community)</td>
<td>-.23**</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.01</td>
<td>-.07</td>
<td>.00</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>-.11</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>RCI x CHS</td>
<td>-.15</td>
<td>.01</td>
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</tbody>
</table>

* significant at .05 level. ** significant at .01 level.

Table 15

Multiple Regression Analysis Predicting Physical Health in Group 1

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.05*</td>
<td>-.18*</td>
<td>.03</td>
</tr>
<tr>
<td>Cultural Humility (CHS; religious community)</td>
<td>.18*</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.02</td>
<td>-.18*</td>
<td>.03</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>.04</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>RCI x CHS</td>
<td>.19</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

* significant at .05 level. ** significant at .01 level.
Table 16

*Multiple Regression Analysis Predicting Satisfaction with Life in Group 2*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>ΔR²</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.02</td>
<td>.03</td>
<td>.00</td>
</tr>
<tr>
<td>Cultural Humility (CHS; Christians in USA)</td>
<td>.11*</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>.00</td>
<td>.03</td>
<td>.00</td>
</tr>
<tr>
<td>CHS</td>
<td>.12*</td>
<td>.01</td>
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</tr>
<tr>
<td>RCI x CHS</td>
<td>.01</td>
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</tbody>
</table>

* significant at .05 level. ** significant at .01 level.

Table 17

*Multiple Regression Analysis Predicting Depression in Group 2*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>ΔR²</th>
<th>β</th>
<th>sr²</th>
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<tbody>
<tr>
<td>Step 1</td>
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</tr>
<tr>
<td>Religious Commitment (RCI)</td>
<td>.02</td>
<td>.09</td>
<td>.00</td>
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<tr>
<td>Cultural Humility (CHS; Christians in USA)</td>
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<td>.01</td>
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<tr>
<td>Step 2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>RCI</td>
<td>.00</td>
<td>.09</td>
<td>.00</td>
</tr>
<tr>
<td>CHS</td>
<td>-.13**</td>
<td>.01</td>
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<tr>
<td>RCI x CHS</td>
<td>-.04</td>
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* significant at .05 level. ** significant at .01 level.

Table 18

*Multiple Regression Analysis Predicting Anxiety in Group 2*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>ΔR²</th>
<th>β</th>
<th>sr²</th>
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<tr>
<td>Step 1</td>
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</tr>
<tr>
<td>Religious Commitment (RCI)</td>
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<td>-.01</td>
<td>.00</td>
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<tr>
<td>Cultural Humility (CHS; Christians in USA)</td>
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<td>.00</td>
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<tr>
<td>Step 2</td>
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<td></td>
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<tr>
<td>RCI</td>
<td>.00</td>
<td>-.01</td>
<td>.00</td>
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<td>CHS</td>
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<tr>
<td>RCI x CHS</td>
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</table>

* significant at .05 level. ** significant at .01 level.
Table 19

**Multiple Regression Analysis Predicting Physical Health in Group 2**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\Delta R^2$</th>
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<td>.03</td>
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<tr>
<td>Cultural Humility (CHS; Christians in USA)</td>
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<tr>
<td>RCI</td>
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<td>-.19**</td>
<td>.03</td>
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<tr>
<td>Step 2</td>
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<td></td>
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</tr>
<tr>
<td>CHS</td>
<td>.12*</td>
<td>.01</td>
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<tr>
<td>RCI x CHS</td>
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</table>

* significant at .05 level. ** significant at .01 level.

Table 20

**Multiple Regression Analysis Predicting Internalized Homophobia in Group 1**

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</thead>
<tbody>
<tr>
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<td>.00</td>
</tr>
<tr>
<td>Cultural Humility (CHS; Christians in USA)</td>
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<td>.02</td>
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</tr>
<tr>
<td>RCI</td>
<td>.00</td>
<td>.06</td>
<td>.00</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>.12*</td>
<td>.00</td>
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</tbody>
</table>

* significant at .05 level. ** significant at .01 level.

Table 21

**Multiple Regression Analysis Predicting Internalized Homophobia in Group 2**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>$sr^2$</th>
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<tbody>
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<td>.03</td>
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<td>Cultural Humility (CHS; Christians in USA)</td>
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<td>RCI</td>
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<td>Step 2</td>
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<tr>
<td>CHS</td>
<td>.16**</td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

* significant at .05 level. ** significant at .01 level.
Figure 1. Moderator effect of cultural humility on the relationship between religious commitment and satisfaction with life.
APPENDIX

DEMOGRAPHIC QUESTIONNAIRE
1. What was your gender assigned to you at birth?
   a. Male
   b. Female

2. What is your current gender?
   a. Male
   b. Female
   c. Transgender Male
   d. Transgender Female
   e. Gender Queer
   f. Other __________

3. What is your age? __________

4. What is your current marital status?
   a. Single
   b. Married
   c. Separated
   d. Divorced
   e. Widowed
   f. Other __________

5. What is your ethnicity?
   a. Hispanic or Latino
   b. Not Hispanic or Latino

6. What is your race?
   a. White/Caucasian
   b. Black/African-American
   c. Asian/Pacific Islander
   d. Latino/Hispanic
   e. Native American
   f. Multiracial __________
   g. Other __________

7. What is your current sexual orientation?
   a. Heterosexual
   b. Gay
   c. Lesbian
   d. Bisexual
   e. Queer
   f. Other __________
8. What is your current religious affiliation?
   a. Christian – Catholic
   b. Christian – Evangelical Protestant
   c. Christian – Mainline Protestant
   d. Christian - Black Protestant
   e. Latter-day Saints
   f. Muslim
   g. Buddhist
   h. Hindu
   i. Jewish
   j. Atheist
   k. Agnostic
   l. None
   m. Other __________

9. Have you ever had a previous religious affiliation that is different from your current religious affiliation?
   a. Yes
   b. No

10. If yes, what was your previous religious affiliation?
    a. Christian – Catholic
    b. Christian – Evangelical Protestant
    c. Christian – Mainline Protestant
    d. Christian - Black Protestant
    e. Latter-day Saints
    f. Muslim
    g. Buddhist
    h. Hindu
    i. Jewish
    j. Atheist
    k. Agnostic
    l. None
    m. Other __________

11. What is your highest level of education?
    a. Less than HS diploma or GED
    b. HS diploma or GED
    c. Some college
    d. Associate’s degree
    e. Bachelor’s degree
    f. Master’s degree
    g. Professional degree
    h. Doctoral degree
12. What is your current occupation? (If none, type unemployed) __________

13. Please estimate your current family annual income? __________

14. Use one of the following numbers to indicate your political views in the accompanying categories.

<table>
<thead>
<tr>
<th></th>
<th>Very liberal (1)</th>
<th>Liberal (2)</th>
<th>Slightly liberal (3)</th>
<th>Middle of the road (4)</th>
<th>Slightly conservative (5)</th>
<th>Conservative (6)</th>
<th>Very conservative (7)</th>
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</thead>
<tbody>
<tr>
<td>1. Foreign policy issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. Economic issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. Social issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</tbody>
</table>
REFERENCES


