A DESCRIPTION OF CULTURAL HUMILITY AS PERCEIVED BY NURSING FACULTY IN BACCALAUREATE NURSING EDUCATION

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Dedication

I would like to dedicate this dissertation to my late parents, Dorothy and Raymond Webster, who instilled their love of God, family, hard work, and the importance of education into all their children. Thank you for your love and guidance that continues to sustain me.

To my siblings – Raymond, James, Brenda, and Sidney. Thank you for your love, support, and encouragement throughout this endeavor. I am eternally grateful to each of you who reminded me how important it was to keep moving forward to complete this education milestone.

To my dear friends who kept me going throughout this journey. I share this achievement with each of you. Your cards and wishes lifted me; your prayers sustained me; your love surrounded me. Thank you from the bottom of my heart.

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Abstract

In diverse populations, health inequities can exist, thereby contributing to health disparities. A lack of knowledge regarding unfamiliar cultural patterns and practices by health care providers can contribute to miscommunication and mistrust. The willingness to adopt the practices of self-awareness and self-reflection with critique is cultural humility. This concept may help to reduce health inequities and suboptimal health outcomes when a mutual respect for culture and diversity is present.

A foundational, qualitative descriptive study was proposed to investigate cultural humility as perceived by nursing faculty. The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students. An atheoretical approach was adopted for this study. A snowball sampling technique was used to recruit nursing faculty who teach baccalaureate nursing students. Participants were recruited from different universities within Pennsylvania, New Jersey, and South Carolina. Online synchronous focus group sessions were conducted for data collection with participants using a web-based software technology program on a secure server. Cultural humility is a lifelong process that develops over time. Research findings identified the following themes: self-awareness of one's own culture; being self-reflective is an ongoing process; respecting other cultures; and being unbiased. Additional themes included: distinguishing between cultural humility and cultural competence; and threading cultural humility throughout the nursing curricula. Subthemes included being respectful and humble; self-discovery of one's own cultural influences; and walking in another's shoes.

Identified strategies for emulating cultural humility included: nursing snimulations; interpersonal communication skill; and role modeling. Additional research findings that offered supportive insight from faculty participants in their description of cultural humility in nursing education were self-critique; critical behavior; and re-direction of thought processes.

Research findings from this study affirmed that cultural humility is a process that requires a lifelong commitment to self-awareness with critical self-reflection with critique of already-held assumptions and beliefs which could be conscious or tacit in nature. Cultural plays a pivotal role in how one views the world. A continued delineation between the concepts of cultural humility and cultural competence is warranted.

There was a gap in nursing research and literature regarding cultural humility dialogue, its conceptualization, and instruction in nursing education. The recognition and demonstration of this concept by nursing faculty was warranted to model for student nurses in an effort to better meet the health care needs of a diverse society overall. As a result, health equity will be better achieved along with a fuller appreciation of nursing care through the lens of cultural humility.

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Chapter 1

Introduction

Health disparities continue to be a significant health concern for individuals from certain cultural, racial, and ethnic backgrounds. According to the Agency for Healthcare Research and Quality (AHRQ, 2014), "health care quality remains suboptimal for diverse populations in the United States because some individuals do not receive quality care or believe that their values are honored or respected" (AHRQ, 2014). The 2016 *National Healthcare Quality and Disparities Report* from AHRQ presented the progress and opportunities for improving health care quality and reducing health care disparities. As a key finding related to health disparities on the national level, "disparities persist, especially among people in poor and low-income households, uninsured people, Hispanics and Blacks" (AHRQ, 2016). As the demographics of the United States changes, the issue of disparity in health care becomes more apparent. An example of inequities that contribute to health disparities include socioeconomic status, educational opportunities, neighborhoods, stress, and access to quality health care according to Schaffer and Hargate (2015). Social concerns including health care coverage, access to health care, and the global migration of individuals with various backgrounds contribute to the increasing health inequities experienced by diverse individuals, groups, and communities. According to Yeager and Bauer-Wu (2013), the approach to dealing with the many factors that contribute to health disparities and social inequities requires an examination of the environment, context, and culture of those experiencing the disparities.

Defined by Tervalon and Murray-Garcia (1998), “cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redress the power imbalances in the physician-patient dynamic” (Tervalon & Murray-Garcia, 1998, p. 117). This concept requires health providers to be attuned to how conscious and tacit assumptions and beliefs about diverse individuals can affect the provider-client relationship. Yeager and Bauer-Wu (2013) offered a nursing definition of cultural humility (in part) as “a process of self-reflection, and self-critique whereby the individual not only learns about another’s culture, but one starts with an examination of his/her own beliefs and cultural identities” (Yeager & Bauer-Wu, 2013, p. 251).

Nursing faculty are challenged in preparing students to practice in diverse health care environments where health inequities exist. Instruction on how health as well as non-health challenges, such as the social determinants of health (SDH) affects the health status of diverse communities is necessary. SDH are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (healthypeople2020.gov). Structural determinants include socioeconomic status, education, the physical environment, employment, social support networks, and access to health care. *Healthy People 2020* is a national health program that provides science-based, 10-year national objectives for improving the health of all Americans. It is the result of a multi-year process reflecting input from diverse groups of individuals and organizations. According to *Healthy People 2020,*

> health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (healthlypeople2020.gov).

The U. S. Department of Health and Human Services (HHS, 2016) published the thirteenth annual report entitled, *Addressing the Social Determinants of Health: The Role of Health Professions Education.* This report stated that while progress has been made to eliminate health disparities on many levels, health providers report inadequate educational training to address the social determinants of health (SDH) that have an impact especially on vulnerable populations. According to this report, by providing health care services that address the cultural practices and preferences of individuals, groups, and communities, health professionals can facilitate communication, reduce health disparities, and improve health outcomes.

The instruction, practice, and demonstration of cultural humility to students serves to better prepare nurses working within a diverse society. The recognition of cultural humility by nursing faculty requires a lifelong commitment to self-awareness and self-reflection with critique of one's own preconceived assumptions, beliefs, and biases. The willingness to examine conscious or tacit prejudices, beliefs and biases, coupled with an appreciation of the cultural practices of diverse individuals regarding health allows for

more authentic communication to better meet the health care needs of diverse individuals collaboratively.

There is a need for dialogue and instruction within baccalaureate nursing education on cultural humility to prepare future nurses to meet the health care needs of a diverse population. Nursing research was warranted to investigate cultural humility as a tool by which nursing faculty can use to increase the quality of interaction between the educator and student through modeling of the process for students to employ when working with diverse populations.

Background

Culture plays a dynamic role when providing health care to diverse populations. It is defined as "attitudes and behaviors that are characteristic of a group or community" (HRSA.gov, 2016). Culture influences the beliefs and practices related to how and when health care is sought by an individual, group, or community.

In 1985, Dr. Margaret Heckler, then Secretary of the U. S. Department of Health and Human Services (HHS), presented Congress the seminal *Report of the Secretary's Task Force on Black and Minority Health*, also known as the *Heckler Report.* This report presented the paradox of phenomenal scientific achievements, and the steady improvement in the overall health status of many Americans, while at the same time minority Americans were experiencing health inequities and health decline. "This report documented health disparities in the United States that impact the health of racial and ethnic minority populations, and was one of the first to identify a link between social determinants of health (SDH) and health disparities" (HRSA, 2016, p. 12). Health

disparities are defined as “differences in health outcomes that are closely linked with social, economic, and environmental disadvantage” (HRSA, 2016, p. 8). These disparities in health created an excess burden of disease within diverse populations. The *Heckler Report* elevated public awareness of health inequities among Black and minority groups to a national level. It is currently over 30 years since the release of this landmark report – and health care disparities among diverse populations still exist.

Over twenty years ago, the concept of cultural humility was coined by Tervalon and Murray-Garcia (1998) in their seminal work in medicine that made a distinction between cultural humility and cultural competence. Cultural humility is a “lifelong commitment to self-evaluation and critique to redressing the power imbalances in the patient-physician dynamic” (Tervalon & Murray-Garcia, 1998, p. 117). According to these physicians, that power imbalance can be reflected in various sociocultural “mismatches” between clients and providers. There exists a lack of knowledge by the provider regarding the client’s health beliefs and life experiences. Also, the provider may be dealing with unintentional or intentional processes of racism, classism, homophobia, and sexism. The researchers in their examination of medical education found that developing cultural humility would better prepare medical students for future practice when interacting with individuals from diverse cultures and backgrounds.

There are variations in the definition of cultural humility by different disciplines stemming from Tervalon and Murray-Garcia (1998). To further explain the concept, Isaacson (2014) went on to say cultural humility requires one to take responsibility for their interactions with others. Actively listening to those from differing backgrounds,

while at the same time being attuned to what one is thinking and feeling about other cultures is critical.

The U. S. Department of Health and Human Services, Health Resources and Services Administration (HRSA, 2016) recognized the definition of cultural humility put forth by Tervalon and Murray-Garcia (1998). By providing health care services that respect "the cultural practices and preferences of the individuals and communities they serve, health professionals can facilitate communication, reduce health disparities, and improve health outcomes" (HRSA.gov, 2016, p. 15).

A lack of cultural awareness and sensitivity can pre-exist with some nursing faculty; this may be conscious or tacit in nature. Tervalon and Murray-Garcia (1998) discussed when a health care provider does not take time to understand the uniqueness of culture, an imbalance in care exists. This imbalance can contribute to mistrust and hostility when diverse individuals interact with members of the health care community. Attitudes of ethnocentricity can come forth, thereby contributing to a power imbalance between the individual and the health care provider.

The concept of cultural competence is frequently referred to when addressing the cultural needs of diverse populations. Yeager and Bauer-Wu (2013) offered that cultural competence was a concept related to cultural humility, but is not the same in meaning or approach. Cultural competence assists one to recognize nuances of a particular culture. It may be considered an "endpoint" that has been achieved from learning the cultural components of a diverse population group, but it is a process. While there is no one definition for the concept, for the purpose of this study, the definition of cultural

competence was adopted from HRSA (2016) that stated "cultural competence in health care refers to providing appropriate services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients" (HRSA.gov, 2016, p. 15).

Both Purnell (2002) and Campinha-Bacote (2002) have conducted extensive research in the area of cultural competence. According to Purnell (2002), "cultural competence is the adaptation of care in a manner that is consistent with the culture of the client" (Purnell, 2002, p. 193). Campinha-Bacote (2002) stated cultural competence as an ongoing process that "involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire" (Campina-Bacote, 2002, p. 181).

Research specific to how nursing faculty demonstrate cultural humility, and model it to students was noted especially in transcultural and international cultural immersion nursing experiences. Ferranto (2015) reported how an international experience among nursing students in Tanzania led to the development of cultural humility. The need for cultural humility education in nursing was identified by Brennan et al. (2011) in an article which spoke to lesbian, gay, bisexual, transgender, or intersexed (LGBTI) content within nursing curricula. These authors identified that in order to move nursing toward the goals of health equity and cultural humility in practice, nursing education, research, and the nursing curricula itself must integrate core lay, gay, bisexual, transgender, or intersexed (LGBTI) concepts, experiences, and needs within the education of nursing students as it relates to health and illness.

Statement of the Problem

Baccalaureate nursing education emphasizes culturally appropriate and competent care provision as a value asset. *The Essentials of Baccalaureate Education for Professional Nursing Practice* by the American Association of Colleges of Nursing (AACN, 2008) addresses nursing preparation and practice in response to a multicultural and multifaceted society. According to the AACN (2008), the professional nurse practices in a multicultural environment and must possess the skills to provide culturally appropriate care. As nursing curricula outlined by the AACN (2008) provides instruction on culturally appropriate care, there was limited emphasis on the concept of cultural humility which requires self-awareness and self-reflection with critique of one's own preconceived assumptions, beliefs, and biases. Nursing faculty's self-awareness and demonstration of cultural humility in the classroom and clinical settings would serve as a model for students to emulate when addressing the health care needs of a diverse population in society.

Contributing factors to health disparities for diverse populations include social factors that impact achieving health equity. HRSA (2016) identified the social determinants of health (SDH) as non-medical circumstances related to how people live, grow, and work (such as housing, education, income) that impacts on health outcomes. These health determinants contribute to an individual's ability to achieve and maintain health. "SDH contextualizes the system and structural challenges that patients may face in addressing their health goals" (HRSA, 2016, p. 13). A willingness to acknowledge that diverse individuals may be coping with social factors that can affect their health can

produce a change in one's self-awareness and sensitivity to others. Students need to be taught to think critically about social and cultural issues that impact on a client's health, or lack thereof. Cultural humility can serve as the link to understanding "others" by practicing self-awareness and self-reflection with critique of one's own personal views, beliefs, biases, and assumptions that may be in contrast to clients receiving health care.

Within health care delivery, social justice is grounded in the belief that every individual is entitled to fair and equal opportunities in health care as stated by AACN (2008). Self-awareness of cultural biases, fears, and prejudices must first be recognized by nursing faculty before demonstrating cultural humility to students. Both nursing faculty and students need to address preconceived misconceptions, assumptions, and beliefs that are influenced by one's own culture. The components of self-awareness, self-reflection with critique of one's own preconceived beliefs, biases, and assumptions may not be consistently modeled by nursing faculty in the educational context.

Nursing research on the recognition and practice of cultural humility by nursing faculty was warranted to prepare nursing students to meet the health care needs of a diverse population. Nursing faculty instruct from a curricula that includes topics of cultural competence, diversity, and cultural awareness as it relates to working with diverse populations. However, there was a gap in baccalaureate nursing education that existed in acknowledging that cultural humility is not always presented in the curriculum, nor demonstrated to students in the classroom and clinical setting. According to the National League for Nursing (NLN, 2016) document entitled, *Achieving Diversity and Meaningful Inclusion in Nursing Education,* the inclusion of cultural humility within

nursing curricula was recommended. Nursing faculty "provide curricula that includes culturally appropriate health care of diverse populations with attention to health disparities" (NLN.org, 2016, p. 10). When working with diverse populations, an awareness of one's own culture and how it affects the ability to provide care is paramount in respecting all belief patterns, groups, or communities which would add to the body of nursing knowledge.

Purpose of This Study

The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students.

Research Questions

The following were the research questions for this study:

1. What are nursing faculty perceptions of cultural humility in baccalaureate education?
2. What are the characteristics of cultural humility as perceived by nursing faculty?
3. How do nursing faculty perceive that they demonstrate cultural humility in the educational context?

Definition of Terms

The following terms were defined to provide clarity of these concepts for this study. The terms included the following: *culture; cultural competence; cultural humility; diversity; health disparities; health outcomes; nursing faculty;* and *social determinants of health.*

Culture was “attitudes and behaviors that are characteristic of a group or community” (HRSA.gov, 2016).

Cultural competence was “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations” (HRSA.gov, 2016).

Cultural humility was “a process of reflection and lifelong inquiry that involves self-awareness of personal and cultural biases, as well as awareness and sensitivity to significant cultural issues of others” (Yeager & Bauer-Wu, 2013, p. 256).

Diversity was “the multiplicity of human differences among groups of people or individuals, including gender, sexual orientation, race, ethnicity, nationality, religion, age, cultural background, socio-economic status, disabilities, and language” (NACNEP.gov, 2013, p. 6).

Health disparities are “differences in health outcomes that are closely linked with social, economic, and environmental disadvantage” (HRSA.gov, 2016, p. 8).

Health outcomes are “changes in health that result from measures or specific health care investments or interventions” (CDC.gov, 2014).

Nursing faculty are educators academically prepared as nurses for the areas in which they teach. Academic preparation of faculty includes degree specialization, specialty coursework, or other preparation sufficient to address the major concepts included in courses they teach. Faculty teaching in the nursing program have a graduate degree. Faculty who are nurses hold current RN licensure. Faculty teaching in clinical/practicum courses are experienced in the clinical area of the course and maintain

clinical expertise. Clinical expertise may be maintained through clinical practice or other avenues. (aacnnursing.org, 2013, p. 11)

Social determinants of health (SDH) are "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (healthypeople2020.gov).

Methodology

This study used a qualitative descriptive design to explore nursing faculty's perception of cultural humility in nursing education. This research approach allowed nursing faculty to describe in everyday language their perspective on a concept that requires a lifelong commitment to self-assessment and self-reflection with critique of one's own preconceived assumptions, beliefs, and biases.

This nurse researcher took an atheoretical approach of inquiry in this study. Sandelowski (2000) stated that qualitative descriptive studies are arguably the least "theoretical" in the spectrum of qualitative approaches. The inquiry to cultural humility was conducted without a specific theoretical framework that specifically addressed the concept in philosophic or theorectical terms. An atheoretical approach allowed more freedom for participants to describe their understanding of the concept that may be modeled for students.

A naturalistic paradigm, or worldview as provided by Lincoln and Guba (1985) helped to provide the framework of inquiry for this study. Willis et al. (2016) stated qualitative description as a research approach based in the philosophical tenets of naturalistic inquiry. The nature of shared experiences in human interactions can be

described using this design. Naturalistic inquiry in qualitative research allowed for observation and collection of content-rich data collected in a natural setting. The researcher was the human instrument for data collection. Multiple realities were noted using a naturalistic inquiry paradigm in qualitative research. In naturalistic inquiry, there is no manipulation of the environment from where data are collected.

Worldview

This researcher's worldview, or personal philosophy was shaped by my culture, life experiences, family and religious influences, and my commitment to nursing education for myself, while providing service to others. My worldview on health disparities among diverse populations reflects my overall perspective from which I view and interpret the world.

As a professional nurse, I have had the privilege to care for individuals from various cultural backgrounds and belief systems. Having worked in various community health settings, I frequently observed that members of diverse ethnic groups were adversely affected by higher rates of illness and disease compared to the general population. Many of my clients had been diagnosed with heart disease, diabetes, or cancer. The majority of clients were African Americans with very limited financial resources. Nutritional concerns related to diet and health management were primarily based around the ability to purchase food that often was not in congruence with recommended nutritional guidelines for healthy eating habits. Transportation to one's health provider, or even within the community was a challenge for many. A persistent question that I was seeking an explanation for was: "Why is this happening to these

diverse individuals at a higher rate of incidence?" My inquiry led me to yet another question: "What are the health disparities in diverse populations?" Contributing health, social, environmental, financial, and cultural factors can be associated with the state of health (or lack thereof) of individuals living in communities where health resources may be plentiful, but not necessarily accessible to all.

The epistemology of knowing how my own culture responded to health and illness was reflected in recognizing traditional cultural belief patterns that are shared, and sometimes not questioned. There is a strong faith belief system that can support individuals facing an adverse health state. Seeking health care from modern medicine may be an option of last resort for some individuals; while for others, it may be the initial response to identifying and treating an adverse health state.

My ontology, or nature of my reality of the world, was based on my perceived reality. I use deductive reasoning from information gathered through research, my senses, and personal faith beliefs. I strive to gather information first before responding to a health situation that is present. My perception of reality may be different from others within my culture. My conclusions are validated from using critical thinking skills to make rational decisions based on information as perceived – not from assumptions that may be inaccurate.

It is my belief that cultural humility transcends the issue of diversity. As a professional nurse, my care must be congruent with the cultural beliefs of my clients. In planning nursing care, I must be aware of the cultural practices of my clients – I cannot "assume" that I know everything there is to know about someone's culture based on prior

knowledge of interacting with diverse clients. I have to engage in a mutual conversation with clients to learn what is important to them before planning to address their health care needs.

Assumptions and Biases

Assumptions

This researcher's assumptions for this study include that the nursing profession acknowledges the need to prepare nurses with the knowledge, skills, and self-awareness to provide culturally congruent nursing care. Cultural awareness and diversity training are essential for nurses to recognize and provide culturally appropriate care.

Within the discipline of nursing, all nurses and students are expected to provide culturally appropriate care to individuals, groups, and communities. Knowledge of cultural variations was presented within the educational preparation for the nursing profession. Cultural diversity is a challenge within a multifaceted environment that must be recognized and respected for the richness in value it brings to society as a whole.

Biases

Biases of this nurse researcher are nursing faculty are not consistently culturally humble when interacting with individuals from diverse populations in the classroom and/or the clinical setting. Some nursing faculty may be uncomfortable with individuals from diverse backgrounds due to conscious or tacit biases within themselves. This can create a barrier to understanding cultural differences that may be translated within the classroom and/or clinical setting. Nursing education and its clinical practice needs to

reflect the value of diversity within the context of culture. The academic environment must be inclusive of diverse students and faculty educators.

Significance of this Study

The potential significance of this study is that cultural humility may be used to foster communication between the health provider and the client to help reduce health disparities among diverse populations. Concept attributes of self-awareness with self-reflection and critique of one's own preconceived assumptions, beliefs, and biases can produce consequences of respect and understanding. With the practice of cultural humility, it can serve as a link to reducing health disparities according to HRSA (2016) by providers tailoring services to meet the cultural practices and preferences of individuals, communities, and populations. Nursing education would include instruction not only on awareness of differences in relation to health outcomes, but also present learning experiences that demonstrate how race, ethnicity, and inequality are connected. Health equity among culturally diverse individuals is possible when the practice of cultural humility is incorporated when providing health care.

The reduction, or elimination of health disparities remains a challenge in today's society. According to HRSA (2016), the quality of health care and the management of health conditions can be deficient among diverse populations when compared to the general population. Evidence-based practice (EBP) which uses the integration of best research evidence along with clinical expertise and client values; however, was not necessarily helping to close the "gap" in health care for diverse populations according to Lee, Fitzpatrick, and Baik (2013). These authors acknowledged when client values and

preferences are not included or respected in care decisions, health inequities will persist. The use of cultural humility, according to Lee et al. (2013), is the provider's acknowledgement of their own limitations to the cultural perspectives of the client. Patient-centered evidence-based care and nursing practice can be achieved through mutual respect, and self-awareness with self-critique and reflection.

Nursing Science and Research

Nursing science can increase through expanding evidence-based nursing and teaching strategies to reduce health inequities among diverse populations. There was limited research on nursing faculty's perception of cultural humility, and how to demonstrate this concept to students during the educational process. Additional nursing research on cultural humility as a practice that can help reduce health disparities with the potential to improve health outcomes is warranted.

Deficits in health care within diverse populations warrant nursing investigation of how to better meet this need in a multicultural society. Health equity for diverse populations would be supported when self-awareness and self-reflection with critique of one's own preconceived assumptions, beliefs, and biases is used during client interactions. In addressing health disparities, Villarruel, Bigelow, and Alvarez (2014) stated it was necessary for all providers to be aware of and understand the impact of the social determinants on health.

The reduction of health disparities requires a host of social, political, community, environmental, and educational interventions to improve health outcomes. "The current lack of diversity in the nurse workforce, student population, and faculty impedes the

ability of nursing to achieve excellent care to all" (NLN, 2016, p. 2). This study allowed nursing faculty to reflect on their experience or reality of how today's nursing student population and nursing workforce does not fully reflect the diversity of a multicultural society. This study acknowledges the need to increase the diversity of nursing faculty in baccalauareate education to reflect workforce development efforts targeted to address the nursing education of an increasingly diverse student body population, as well as practicing nurses. Cultural humility serves as a communication process that can be integrated into continuing education courses of practicing professional nurses for exposure and education to this concept.

Nursing Education

This study would benefit nursing education through identifying evidence-based teaching strategies that promote self-awareness and self-reflection with crititque of one's own preconceived assumptions, beliefs, and biases. "The concept of cultural humility should be interpreted in the broadest sense incorporating pillars of diversity as well as extending to include interprofessional hierarchies and the patient-provider relationship" (Foronda & MacWilliams, 2015, p. 290).

As nursing students learn to provide care in culturally appropriate ways, this can change how individuals relate to each other in terms of social justice and equity. As stated by the NLN (2016), nursing students need to be prepared to provide health care in a culturally responsive manner. Nursing faculty can model the practice of cultural humility in the classroom and clinical settings for students to emulate. In turn, this

practice model of behavior facilitates student learning and interactions with diverse populations.

Nursing education at the baccalaureate level on the concept and practice of cultural humility would prepare nurses for challenges in health care within a multicultural society. Clark et al. (2011) identified cultural humility as a process that should be introduced at the graduate level of nursing education as a required competency at the advanced practice nursing level. However, this researcher advocates for nursing education on this concept be presented within the baccalaureate education process to provide culturally appropriate care as a student and as a professional nurse after graduation. Foronda and MacWilliams (2015) asked the question if cultural humility is a missing standard in nursing simulation education. "To increase opportunities to learn cultural humility, interprofessional simulations should be prevalent throughout the curriculum" (Foronda & MacWilliams, 2015, p. 289). International cultural immersion experiences in nursing education offers students the opportunity to increase cultural awareness and diversity exposure to better understand, and perhaps experience cultural humility when interacting with diverse clients. Beard (2014) noted that faculty who are aware of culturally responsive practices are better positioned to implement teaching-learning strategies that meet the educational needs of culturally diverse learners.

Nursing faculty are challenged in modeling self-awareness with self-reflection with critique in educating students. The concept of cultural humility is not always presented in nursing education when discussing cultural awareness and diversity. Cultural competence, however, was consistently presented within nursing curricula.

Faculty demonstrating respectful, humble interactions with diverse individuals serves as an example for students to emulate both in the classroom and clinical settings.

The increasing diversity within society is also reflected in the nursing student body. "As society grows in diversity, nursing classrooms are likely to become more ethnically and racially mixed which could result in a cultural chasm" (Beard, 2014, p. 60). This chasm, or difference especially in culture between nursing faculty and students, may be modeled by nursing faculty by not effectively addressing the learning needs of diverse students.

Nursing Practice

Preparing baccalaureate nurses to provide client-centered care that respects cultural differences, values, and preferences is crucial throughout the educational process according to AACN (2008). Nursing faculty help facilitate the process of knowledge transfer into practice. However, nursing literature is deplete to how cultural humility is demonstrated in nursing practice by nursing faculty. Health disparities and health care inequities are influenced by social factors that can adversely impact the well being of diverse populations as stated by HRSA (2016).

Cultural humility as a concept in nursing can serve as a method for reflecting on the impact of institutional policies in nursing education regarding the social justice commitment to serve individuals fairly and without discrimination as noted by AACN (2008). The Office of Minority Health (OMH, 2015) included cultural humility as a method to address the cultural practices and preferences of individuals, groups, and

communities that can help decrease the incidents of health disparities and improve health outcomes.

Evidence-based nursing practice supports implementing safe, cultural practices that includes the client's perspective for care. The U. S. Department of Health and Human Services Office of Minority Health (OMH, 2015) published the updated *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).* The enhanced *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health disparities. This, in turn, provides a "blueprint" for individuals and health care organizations to implement culturally and linguistically appropriate services that are respectful of and responsive to the health beliefs, practices, and needs of diverse individuals. Providing quality health care in nursing must include strategies to appropriately address the increasing diversity within society.

Nursing workforce development was another area where cultural humility can have a positive impact within the nursing profession. Educating student nurses as well as experienced nurses on cultural humility can provide a change needed when addressing the health disparities within vulnerable and diverse populations in society. The AACN (2008), the National Advisory Council on Nurse Education and Practice (NACNEP, 2013), HRSA (2016), and the NLN (2016) all address the importance of a diversified nursing workforce that is needed to help reduce health inequities among diverse populations. A more diversified nursing workforce would strengthen the nursing

profession as it strives to meet the challenges of a more diverse society according to the NLN (2016).

Chapter Summary

The concept of cultural humility was introduced with its definition and components, and how the application of this practice can be used to reduce health disparities and poor health outcomes among culturally diverse populations. Nursing faculty are key in the demonstration of the concept of cultural humility in the educational process of students. In order for this to occur, nursing faculty must first be aware of their knowledge of cultural humility, and be willing to reflect on their own preconceived assumptions, biases, and prejudices that may be present. This will help sensitize nursing faculty to some of the challenges diverse populations face in health care delivery. In turn, nursing faculty can model the process of cultural humility in the classroom and clinical settings for students to pattern their behaviors and responses when interacting with individuals from diverse cultures.

The significance of this study is that it highlights the gap in nursing education and research on this concept. Distinguishing cultural humility from cultural competence is not always clear within the literature. Health disparities within a multicultural society have multiple contributing factors – the lack of cultural humility could be considered one. Baccalaureate nursing education would be further enhanced with the inclusion of this concept in addressing the holistic needs of all clients served by the nursing profession. An atheorectical qualitative descriptive approach to describe cultural humility as perceived by nursing faculty in baccalaureate education was employed for this study.

Chapter 2

Literature Review

In this chapter, a literature review on cultural humility was presented. The literature reflected discipline specific areas where the concept has been demonstrated when interacting with individuals from diverse populations. Research studies where cultural humility was identified, perceived, or developed in individuals was noted in this literature review, along with a level of evidence that cultural humility was present as noted in the Evidence Table (Appendix A). The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students.

Cultural humility is "a lifelong process of self-awareness and self-reflection with critique" (Yeager & Bauer-Wu, 2013, p. 256). The concept has been noted in various disciplines of study, including nursing, nursing education, medicine, kinesiology, psychology, social work, and transcultural immersion experiences. With the increasing diversity of race, culture, and ethnicity in society, the value of understanding the different lifeways of diverse individuals was warranted. This chapter was organized to highlight cultural humility within the above stated disciplines of study.

Search Strategy

With the use of a computerized electronic database approach, a total of eight databases were accessed in the literature search. They included: Cochrane Library; Cumulative Index of Nursing and Allied Health Literature (CINAHL®); ERIC; Health Source: Nursing/Academic Edition; MEDLINE; ProQuest Central; PsycARTICLES; and

Science Direct. The search was limited to peer-reviewed scholarly journals between the years 2003 to 2017.

Keywords used to identify possible articles included: *cultural competence; cultural humility; cultural sensitivity; diversity;* and *health disparity*. ProQuest Central produced the most abundance of literature using the search term *cultural humility* alone; 12,049 hits for peer-reviewed scholarly journals between the years 2003 to 2017 were listed. The timeframe was narrowed between the years 2010 to 2017; 6,535 hits were listed. Again, the timeframe was narrowed between the years 2013 to 2017; a total of 3,930 hits were listed. A review of 100 article abstracts with the keyword *cultural humility* were read for content. A total of 75 peer-reviewed articles from the earlier listed databases were read for relevance to the topic of cultural humility; and a total of 56 articles from various disciplines of study were selected for analysis. Excluded items included book reviews and newspaper articles. The conceptual meaning of cultural humility was not addressed when the term was separated into two separate keywords when searching within the electronic databases. Articles that focused solely on *culture* or *humility* were excluded. Articles that only mentioned cultural humility once in the body of the article were also excluded.

The CINAHL® database was searched for relevant articles. Using *cultural humility* as the search term between the years 2003 to 2017, a total of 51 articles were listed. Combining the terms *cultural humility* and *nursing*, 23 articles were noted from the years 2005 to 2010. The first search produced the most articles for review, so all 51 article abstracts were reviewed for relevance. Four articles that were originally reviewed

in the ProQuest Central database were also in the CINAHL® database. When searching the terms *cultural competence* with *cultural humility* between the years 2013 to 2017, a total of 9 articles were listed. All these article abstracts were reviewed for relevance; and a total of 7 articles were selected for further analysis.

Nursing and Cultural Humility

Nursing as a profession acknowledged the responsibility to provide care that is culturally appropriate, sensitive, and congruent to an individual's cultural preferences according to AACN (2008). The increasing diversity of the U. S. population requires nurses who are professionally and culturally adept to address the health care needs of the population.

In discussing areas of nursing where the concept of cultural humility can facilitate the appreciation of diverse cultural practices, this review began with maternal nursing. The impact of culture during labor and delivery was explored by Fahey et al. (2013) in Northern Guatemala, an area where maternal and neonatal mortality was high. An initiative developed to decrease maternal and perinatal mortality known as *PRONTO* was implemented in Northern Guatemala to provide local health providers with obstetric and neonatal emergency training. Included in the educational framework was the concept of cultural humility. A qualitative study was conducted; however, the specific design was not stated in the literature. Two focus groups and 65 individual interviews were conducted within a local Guatemalan community along with health providers to better understand reasons women do, and do not seek birth care at the community health clinics. Four principle barriers to seeking maternal health care from community health clinics

were identified from this qualitative study. The barriers included "language; a lack of warmth (warm beverages and blankets); a lack of inclusion of support people; and the lack of respectful interactions" (Fahey et al., 2013, p. 38). The *PRONTO* curricular program used to implement maternal care to diverse populations needed to adapt patient-provider interactions to where the cultural influences surrounding birth were recognized and respected by foreign health providers. An understanding of providing culturally appropriate care was critical in maternal health care. The provider-patient encounter was influenced by both the patient's and the provider's cultural perspectives according to Fahey et al. (2013). An adult learning theoretical framework of constructivism along with the practice of cultural humility generated discussions on culture, ethnicity, and culturally informed care during the birthing process in an international setting. This framework enhanced nursing sensitivity and understanding of the clients served within the context of culture.

In evaluation of this qualitative study, the health providers responsible to help implement the *PRONTO* program, a maternal health initiative were foreigners who needed to understand and respect the cultural differences and beliefs in Northern Guatemala. Adaptations to health care provision was necessary to promote maternal health through cultural awareness and understanding, self-reflection, and cultural humility during patient interactions. This study has been replicated even though a specific qualitative design was not provided. The study was well done in addressing cultural awareness of self and others with objectivity of researcher neutrality being established. The curriculum used to instruct local health providers to the PRONTO

method was adapted based on the culture where the program was being implemented. This study has been replicated in other foreign countries to help reduce maternal death and complications. An audit trail and transferability of this teaching strategy was established when the same teaching curriculum was presented in other countries, using the same teaching strategy of low-fidelity simulators, conducting focus groups and individual interviews to implement the PRONTO method to health providers in a specified area of the world. A limitation to promoting facility-based care during birth was the need to increase the cultural fluency among foreign health providers. The cultural beliefs, patterns, and practices surrounding birth must be understood and kept in context by the health providers in practicing cultural humility.

Yeager and Bauer-Wu (2013) presented an article that recognized in order to conduct culturally competent nursing research, an understanding of the historic and cultural influences on individuals was needed. The article recognized cultural humility as a process that has an important role in research to better understand the perspectives and context of the researcher and the participants. The practice of cultural humility in relating to research subjects was presented. According to these researchers, when conducting nursing research, the researcher needs to "pause" to take a reflective inventory of one's personal self, the nursing profession, and research values guided by ethical principles. Stereotypical thinking must first be recognized and acknowledged by the researcher – so not to have this influence the integrity of the research process or the research findings.

While recognizing Tervalon and Murray-Garcia's (1998) definition of cultural humility, Yeager and Bauer-Wu (2013) provided the most encompassing nursing definition of the concept for this study. These nurse researchers addressed that cultural humility is not cultural competence, a related concept that does not incorporate self-awareness, or a lifelong commitment to practicing the concept. According to Yeager and Bauer-Wu (2013), cultural competence is about the provider being confident and comfortable when interacting with "others". They go on to say the cultivation of cultural humility in research requires reflection of personal beliefs in order to be more aware of potential judgments that can happen during data collection and analysis when conducting research. "Cultural humility is a process of reflection to gain a deeper understanding of cultural differences in order to improve the way vulnerable groups are treated and researched" (Yeager & Bauer-Wu, 2013, p. 252).

Yeager and Bauer-Wu (2013) addressed cultural humility as a required tenet for nurse researchers dealing with human subjects. There was recognition how historical factors can influence the participant response in research. This article acknowledged that researcher biases can adversely affect the integrity of the research process itself that can cause the trustworthiness of the data presented to be questionable. The article was well written in addressing how researcher reflection of oneself was needed to address and acknowledge personal biases and prejudices that can influence research findings. Stereotyping of research participants needs to be recognized and avoided.

Having self-awareness of one's own biases and prejudices, and an understanding that one's own culture shapes interactions with others is crucial when working with

individuals or families facing palliative and end-of-life care decisions. Fahlberg et al. (2016) addressed in their article how nurses have a process that can assist them, and their patients and families facing difficult care decisions. Adopting the concept of cultural humility can help nurses to identify their own biases and prejudices, while respecting that the patient or family's decision may not be in agreement with their own judgment. One needs to be self-aware, and self -reflective of one's own biases and judgments to a stressful event while being a facilitator, or advocate for the patient or family. Using cultural humility allowed for a better understanding of how "an attitude of openness and a willingness to listen, to learn, to collaborate, and to negotiate" (Fahlberg et al., 2016, p. 14) facilitated mutual respect and understanding within the context of culture. With the process of cultural humility, the nurses gradually became self-aware of their judgments being placed upon the family, which was producing conflict between the health provider and the family. Using self-reflection, the nurses recognized the need to "ask" the family to share their cultural beliefs and preferences surrounding health – instead of placing judgment on the family decision to prolong life. A partnership developed from being open and being aware of others. The evaluation of this article was that recognition of different belief systems can be difficult in nursing, especially when health care decisions are not congruent with the health care community.

In an effort to gain an increased understanding of cultural humility, its definition and meaning, Foronda, Baptiste, Reinholdt, and Ousman (2016) conducted a concept analysis using the Rodgers and Knafl (2000) method. Using multiple databases, a total of 62 articles were included in the analysis. Concept attributes, antecedents, consequences,

and a proposed definition were identified. Concept attributes included the terms openness; self-awareness; egoless; supportive interactions, and self-reflection and critique (one term). With regards to self-reflection and critique, "this attribute is defined as a critical process of reflecting on one's thoughts, feelings, and actions" (Foronda et al., 2016, p. 211). It was described as a journey or endless process of continual reflection and refinement, according to Foronda et al. (2016).

Antecedents included the terms diversity and power imbalance. Diversity, or multiculturalism, was referred to the existence of many cultures in this concept analysis. Diversity was expressed in relation to values, belief systems, social power, health disparities, and linguistic differences. Power imbalances were reflected in different areas of social injustice. Some terms that relate power imbalance in the context of cultural humility included inequality; systematic oppression; and inequity as identified by Foronda et al. (2016). Concept consequences, or what occurs as a result of achieving cultural humility included mutual empowerment; optimal care, and lifelong learning.

The proposed definition from this concept analysis was "cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals" (Foronda et al., 2016, p. 213). As an unexpected finding, the authors identified another understanding of the term cultural humility by viewing what it was not. Discussion of antonym terms such as prejudice, oppression, and intolerance were identified to be opposite in meaning to cultural humility.

In evaluation of the concept analysis, it provided a derived definition that corresponds with Tervalon and Murray-Garcia (1998). The concept analysis revealed the antecedents of diversity and power imbalance may contribute to health disparities according to the authors. Interactions within a multicultural society can be enhanced by the practice of cultural humility.

As part of this literature review, it was necessary to distinguish between cultural humilty and cultural competence. Cultural humility is "a process of reflection and lifelong inquiry that involves self-awareness and sensitivity to significant cultural issues of others" (Yeager & Bauer-Wu, 2013, p. 256). Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations" (HRSA.gov, 2016). The distinction between cultural humility and cultural competence lies within the definition and intent behind both concepts. Cultural humility is a lifelong process that requires self-acknowledgement of preconceived assumptions, biases, and prejudices. With this in mind, an individual takes into account their own cultural influences that can affect their interactions with "others" from diverse populations. Cultural competence, on the other hand, does not require a lifelong commitment to self-awareness and self-reflection with critique of one's own preconceived assumptions, biases, and prejudices related to "others". The ability to identify cultural differences and influences may be thought of as "mastery" of the concept itself.

Cultural competence oftentimes may be considered an "endpoint" to having achieved a set of skills and knowledge about a diverse group, behavior, or custom.

Cultural competence was more often recognized and cited in the literature as a concept that deals with culture and diversity. It continues to be a process that can facilitate improved communication with diverse populations within the cultural context of those individuals, groups, or communities.

Campinha-Bacote (2002) viewed cultural competence as "an ongoing process where the health care provider continually strives to achieve the ability to effectively work within the cultural context of the client" (Campinha-Bacote, 2002, p. 181). Her extensive research on cultural competence led to a model of care for the delivery of health care services that are culturally responsive to the individual. *The Process of Cultural Competence in the Delivery of Healthcare Services* model by Campinha-Bacote (2002) consisted of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Campinha-Bacote (2002) stated that the moment when the five constructs that have an interdependent relationship with each other "intersect" with one another – that was when cultural competence was present within the health provider. According to Campinha-Bacote (2002), health providers need to see themselves as "becoming" culturally competent instead of "being" culturally competent. In evaluation, the author recognized the impact culture has when providing culturally responsive health care services to diverse populations. Clear definitions of each model construct was noted. The cultural desire construct involves a willingness to provide culturally responsive care. Being willing to learn from others was recognized as a lifelong process with reference to cultural humility by Campinha-Bacote (2002).

In the formation of a clinical assessment tool for student nurses to collect data regarding an individual's cultural preferences, Purnell (2002) defined cultural competence as "the adaptation of care in a manner that is consistent with the culture of the client" (Purnell, 2002, p. 193). He developed the *Purnell Model for Cultural Competence* originally designed as an organizing framework for student nurses to use as a clinical assessment tool. The model was intended to be used by multiple disciplines of study in addressing the cultural components of care provision to diverse populations.

Extensive work in cultural competence was noted in the nursing literature by Purnell (2002). More recently, Purnell (2016) stated "one of the major goals of culturally competent nursing and health care is to decrease health disparities" (Purnell, 2016, p. 124). Knowledge of diverse cultures was helpful when assessing the health care needs of diverse clients. Becoming culturally competent as a health provider was a "prerequisite" in a multicultural society, according to Purnell (2016). This article raised the awareness that researchers need to be able to measure cultural competence at the clinical level interprofessionally with validated instruments.

Dudas (2012) conducted an evolutionary concept analysis on cultural competence using Rodgers' (2000) method. "Upon review of the literature, cultural competence is best described as a process that can be categorized into three dimensions: awareness, attitudes, and behaviors" (Dudas, 2012, p. 318). The perceived level of competence "acquired" can give a false sense of security on the provider's part that one "knows" how to interact effectively with individuals from diverse backgrounds. Dudas (2012) stated cultural competence was a key component in preparing nurses to meet the needs of a

changing society. This evolutionary concept analysis recognized nursing and nursing education as being compliant with cultural competence training to nurses, while recognizing, however, that the nurse workforce was not culturally representative of the growing diversity in the U. S.. Cultural competence remains one component to meeting the health care needs of a diverse society.

Douglas et al. (2014) presented adaptable guidelines for the practice of culturally competent nursing care to diverse populations as a resource tool for nurses in various roles, such as clinicians, administrators, researchers, and educators. According to Douglas et al. (2014), these guidelines were collectively formulated from nursing organizations around the world in response to the global migration of populations that present nursing challenges in providing culturally ompetent nursing care. With increasing population diversity, "there is growing evidence of increasing inequities in access to health care and health outcomes among populations in local, national, and global contexts" (Douglas et al., 2014, p. 109). The purpose of this document was to present universally applicable guidelines for implementing culturally competent care. These guidelines are adaptable to the different cultures according to varying cultural norms. Ten guidelines were presented for the provision of culturally competent nursing care. Two specific guidelines were relevant to cultural humility as a concept – cultural knowledge and critical reflection.

Guideline 1: Knowledge of Cultures addresses how nursing as a profession must provide care that is culturally congruent to individuals, groups, or communities. Douglas et al. (2014) recognized evidence-based care as essential in the planning and delivery of

culturally congruent care. *Guideline 3: Critical Reflection* addresses how the provision of culturally congruent care requires critical reflection by the nurse. This guideline addressed the understanding of one's own culture as well as the individual, group, or community as necessary in nursing. Douglas et al. (2014) stated how self-awareness was an initial step to understanding the cultural values and beliefs of oneself and others. Through critical reflection, one can identify potential conflicts in values and beliefs that can hinder interactions with diverse groups.

In evaluating the article by Douglas et al. (2014), the guidelines supports how culturally competent nursing care contributes to reducing health disparities through the recognition of culture which is complex. Culturally competent nursing care was required when working with diverse populations.

Nursing Education and Cultural Humility

The concept of cultural humility has been identified in nursing education literature. A discussion on various evidence-based educational trainings and innovative teaching strategies that have been implemented in nursing education was presented in this literature review.

In the article by Brennan et al. (2012), the authors identified a gap in nursing education related to the health concerns of lesbian, gay, bisexual, transgendered, or intersexed (LGBTI) individuals, and the need for instruction on cultural humility when interacting with this population in nursing education. As per Brennan et al. (2012), there was a need to incorporate content related to LGBTI health care needs across the nursing curricula to help eliminate health care deficiencies and move toward the goal of health

equity and cultural humility in practice, education, and research. The authors addressed the attitudes, knowledge, and skills in nursing education and practice. The attitudes of nursing students should be open to diversity to provide respectful care to all clients. An understanding of how personal biases can affect interactions with others was identified. Students require knowledge related to the strengths and challenges faced by the LGBTI community within nursing curricula. The skills to provide quality nursing care to this community include physical assessment skills; communication skills, and sensitivity during assessments. According to Brennan et al. (2012), nursing curricula need to include education regarding the health care needs of this segment of society to provide safe, competent, and sensitive care.

This article addressed the need for nursing curricula to include content related to the health care needs of the LGBTI population. The achievement of health equity and cultural humility in nursing practice, education, and research required a willingness to be self-aware and self-reflective of preconceived assumptions, biases, and prejudices that can negatively impact on quality health care to a diverse population. Nursing curricula would be enhanced in preparing students to practice cultural humility as a process towards health equity for all clients.

Schuessler, Wilder, and Byrd (2012) reported in a qualitative descriptive study how reflective journaling can lead to the development of cultural humility in nursing students within their community health experience. The study was based in naturalistic inquiry of 50 students' written reflections. The research question for the study was, "What does reflective journaling reveal about the experience on cultural humility in

nursing students participating in the community partnership clinical?" (Schuessler et al., 2012, p. 96). Semi-structured interview questions were asked of the students throughout four semesters. After reading 200 student journal entries, three broad themes emerged: the practice of psychomotor skills; a beginning understanding of culture in the lives of clients; and the learning awareness and value of community nursing. The study revealed that reflection on experiences over time led to the development of cultural humility in the nursing students. With faculty guidance, students were instructed to reflect on the importance of encouragement, support, and being non-judgmental when interacting with clients from different socioeconomic status and cultures. Sensitivity to their clients' challenges was noted in the reflective journal entries by students. The beginning awareness of health disparities within a diverse community was brought forth through clinical interactions, reflective journaling, and self-analysis by student nurses over four semesters. The self-awareness of preconceived assumptions, biases, and stereotypical thinking was a beginning development of cultural humility. Through reflective journaling, students progressively developed critical thinking and self-reflective skills that are part of the process of cultural humility. Within the community setting, students saw firsthand how poverty contributed to health care disparities. "The imbalance in power in the patient-health care provider relationship brought about by lack of resources" (Schuessler et al., 2012, p. 99) was the second recognition of the process of cultural humility development by the students.

In evaluating this study, it offered insight that student reflection on their clinical experiences over a two-year period led to cultural humility development. Eleven

qualitative themes emerged from data saturation that revealed evidence of student learning over a two-year period. Only three broad themes were mentioned in the study: practicing psychomotor skills; a beginning understanding of the importance of culture to clients; and student understanding of community nursing and its value. Three nursing faculty went through the 200 student journal entries to identify themes. Student biases and prejudices were noted in some of the journal entries. By the fourth semester, journal entries reflected changed thinking on part of students, with increased self-awareness, and self-reflection with critique of their own preconceived assumptions, biases, and prejudices. This qualitative study was well designed. There was recognition that cultural humility cannot be learned solely in a classroom setting; and that the students were developing cultural humility which is a lifelong process of self-awareness and self-reflection with critique of preconceived assumptions, biases, and prejudices. Limitations to this study include the tenets of naturalistic inquiry were not specifically addressed. Secondly, research rigour was not identified in relation to the method used in data analysis of the student journal entries reviewed.

Distinguishing between cultural humility and cultural competence was not always clearly delineated in the literature, and can contribute to a "blending" of concept definitions.

> Cultural humility illustrates the importance of including the patient's views in the interpretation of culture, while cultural competence implies that the health care professional has an a priori understanding of the person's culture before engaging with the patient. (Isaacson, 2014, p. 252)

Isaacson (2014) conducted a mixed method study to identify if differences in perceptions of cultural competence were present in senior nursing students ($N = 11$) before and after cultural immersion experiences on an American Indian reservation. The sample was further broken into two groups (Group 1: $n = 8$; and Group 2: $n = 3$). Qualitatively, the study approach used "hermeneutic phenomenology to interpret narrative data from the students' reflective journals, while descriptive and inferential statistics were used to analyze the Likert-response item questionnaires" (Isaacson, 2014, p. 252).

The quantitative portion of the study produced findings that measured the impact of the cultural immersion experience using the *Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals – Student Version* (IAPCC-SV) measurement tool by Campinha-Bacote (2002). The IAPCC-SV was a 20-item instrument that measured four categories of cultural competence (proficient, competent, aware, and incompetent), and five constructs of cultural competence (desire, awareness, knowledge, skill, and encounters). The instrument used Likert-type questions; with a 4-point scale ranging from 1 (strongly disagaree) to 4 (strongly agree). Face validity of the instrument was reviewed by transcultural experts, and had a Cronbach's alpha of .78. Scores can range from 20 to 80 (higher scores indicating a greater degree of cultural competence). Students answered questionnaires just before and immediately after the immersion experience.

For the qualitative portion of the study, responses to critical reflection journals before and after the immersion experience were analyzed. Three themes emerged:

seeing with closed eyes; seeing through a fused horizon; and disruption to reshaping. The first theme – seeing through closed eyes, related to initial narratives that reflected students' preconceived notions revealing judgments, misconceptions, and prejudices regarding the American Indian population. The second theme – seeing through a fused horizon, reflected the initial narratives that revealed the students' narrow personal horizon regarding American Indian culture. The third theme – disruption to reshaping, noted how "reshaping" referred to a shift in the power structure that disrupted the ways students interpreted their world. Students initially reported they were culturally competent before the immersion experience; however, their narratives regarding preconceived notions demonstrated stereotyping and racial biases.

Quantitatively, to identify levels of cultural competence, student scores of pre-post experiences were analyzed separately using descriptive statistics calculated using SPSS, Version 19. Independent samples *t*-tests were conducted to compare differences in pre-post levels of cultural competence scores between Group 1 and Group 2. "Pre-immersion *t*-tests revealed a significant difference in scores between Group 1 (M = 64.88, SD = 5.38) and Group 2 (M = 59.33, SD = 2.08, $p = .037$)" (Isaacson, 2014, p. 254). "Post-immersion *t*-tests reflect a shift in the students' reported levels of compentency and again, identified a significant difference between Group 1 (M = 57.63, SD = 3.74), and Group 2 (M = 71.33, SD = 2.52, $p = .000$)" (p. 254).

In evaluating the Isaacson (2014) study, this mixed method research approach revealed a gap in nursing education with respect to cultural humility instruction. Cultural immersion experiences can help to reshape previously held beliefs of diverse populations.

Stereotypical thinking and racial biases were noted by faculty among the students while immersed in a diverse culture. This may be due to a lack of exposure to culturally diverse individuals in school, and in their own cultural experiences. A limitation of this study was the lack of ethnic diversity in the sample size. Research rigor and trustworthiness was maintained guided by Lincoln and Guba (1985). In terms of credibility, a safe environment for students to confide their preconceived thoughts and fears during the immersion experience was maintained. Dependability was present through the use of participants' verbatim examples cited during data analysis. Transferability was present through providing thorough descriptions of the immersion setting and the participants. Confirmability was maintained by the researcher sharing the original transcripts and interpretations with expert collegues for member checking.

A second mixed method study was conducted by Kamau-Small et al. (2014) who investigated different perceptions of cultural competence among 149 senior-level nursing students before and after clinical experiences in a community/public health nursing course. There was no formal research design identified for this study.

Kamau-Small et al. (2014) used a teaching-learning 6-hour workshop educational theater teaching strategy to instruct on cultural humility and care equity. Senior-level nursing students were required in their nursing course to complete a quiz, and submit weekly clinical application reports (CARs). Post-workshop online surveys were completed at two and eight-week intervals after the theory course began. The survey data provided information on barriers to transfer knowledge from theory to the clinical setting. After reviewing student journal entries, the researchers using a project team approach

identified student biases, misconceptions, and prejudices to the "*other"* (the culturally diverse client). The students' reflective journals were the source of qualitative data findings along with workshop evaluations, and coded data from the weekly CARs. The CARs were structured to ask students to apply knowledge from the theory portion of the course to their assigned clinical practicum experiences. The project team discussed any discrepancies to get a consensus to validate stages of change as identified from evaluations and weekly CARs. An audit tool was developed by the project team to review the CARs. Each document was reviewed and assigned a stage of change by a member of the project team. Key phrases or statements were identified and reviewed; quotes were transferred onto an audit tool.

Validation of data results occurred using a team approach to code identified themes using the Stages of Change framework by Prochaska and DiClemente (2005), a theoretical model for behavior change. The model "assessed for an individual's readiness to act on a new healthier behavior. The Stages of Change were defined as precontemplation; contemplation; determination; action; maintenance; and relapse" (Kamau-Small et al., 2014, p. 170). The behavior change sought was that of cultural humility among senior nursing students. Student narrative responses were assigned a stage of change. Pre-contemplation narratives identified student exposure to different community groups. Student-identified discrepancies between expected and actual student behavior were noted. Contemplation narratives provided insight to students' plan to change an existisng practice or behavior. Determination narratives addressed plans to

include or implement improvements in patient care. Action narratives identified active changes or improvements in patient care during the clinical practicum.

Qualitatively, the study results reflected barriers to change among the provider-student group. Nursing faculty recognized the need to instruct students on strategies that help identify and manage barriers to change that occurred in the care provision to clients as identified by the researchers. The quantitative data collected was based on raw scores for course quiz grades, and a diversity quiz grade. Both student groups were able to apply course content, and recognize the concepts presented during the educational theater learning workshop, achieving 100 percent on the course quiz (which was open-book in nature), and achieving the maximum points (12) on the diversity quiz.

In evaluation of the research by Kamau-Small et al. (2014), changing student behavior with respect to culture and health disparities is possible by applying the tenets of cultural humility - self-awareness and self-reflection with critique of preconceived assumptions, biases, and prejudices. Student nurses needed to be instructed on the concept of cultural humility in order to assess for a change in behavior that was being measured. Trustworthiness was maintained by validating qualitative themes using a team approach method. The quantitative data collected did not fully reflect the impact of care equity as the qualitative data revealed. Limitations to this study include the lack of a formal research design. Secondly, interpretation of the study results were limited. Also, the different perceptions of cultural competence the researchers set out to investigate were not stated; data results from the stages of change were reported. Barriers to change

as noted in the qualitative portion of the study could be facilitated by the practice of cultural humility.

The diversity of populations receiving health care reflects differences in cultures, ethnicity, and gender identification. Nursing education, research, and literature has identified a gap in addressing the health care needs of the lesbian, gay, bisexual, and transgender (LGBT) population through the lens of cultural humility. Intersexed culture was not addressed by Carabez et al. (2015) who explored in a community/public health nursing course using guided assignments issues in health care delivery to LGBT patients, families, and the experience of LGBT nurses in the workforce. "Nursing education programs may want to include information on LGBT issues but have questions about placement and priorities within their rigidly organized curricula" (Carabez et al., 2015, p. 50). In addition, as societal attitudes shift towards this population, Carabez et al. (2015) have noted there was a corresponding need to guide the nursing workforce towards culturally sensitive practices. With this in mind, diverse teaching modalities such as readings, a two-hour presentation on LGBT health issues, and a scripted interview were conducted to assess student awareness of the health care needs of this population. Students participated in taking a pre-interview survey, an interview, and a post-interview survey. "The first step to engaging cultural humility is to establish what is not known, then to provide avenues to acquire knowledge" (Carabez et al., 2015, p. 51). The pre-interview survey allowed students to explore the limits of their own knowledge on sexual identity and orientation. The interviews conducted provided data on student knowledge (or lack thereof) regarding LGBT health issues. The post-interview survey

and summaries demonstrated self-reflection, which is a key component of cultural humility pedagogy. Diverse teaching strategies enhanced student awareness, attitudes, and skills related to LGBT health care needs. The exploration of the experience of LGBT nurses in the workforce by Carabez et al. (2015) highlighted LGBT nurses reporting instances of being treated unfairly or differently compared to heterosexual nurses in nursing practice. Issues of discrimination in the workforce have been reported by LGBT nurses.

As an evaluation of Carabez et al. (2015), the article highlighted a gap in nursing education regarding the health care needs of individuals whose gender identity was other than heterosexual. Personal biases and prejudices regarding gender identity may contribute to this gap in nursing education regarding LGBT health disparities. Social justice in caring for all individuals regardless of sexual orientation is a professional nursing responsibility. This article was well written in identifying an area for further nursing research in exploring the health disparities related to sexual orientation and gender identity. The framing for further research within the context of cultural humility may benefit student learning through self-awareness and self-reflection.

Foronda and MacWilliams (2015) addressed cultural humility inclusion within nursing simulation. They raised the question if teaching cultural humility in simulation was in fact a missing simulation standard in nursing education. Simulation instruction on cultural competence included the need to provide nursing care through awareness, knowledge, and skills sensitive and congruent to diverse populations. Simulation, according to Foronda and MacWilliams (2015) challenged students to see beyond their

own values, cultural ideas, and lived experiences. The debriefing after simulation encourages students to reflect on their own values, and recognize the values of others. By providing a simulated learning space for students to explore inclusive therapeutic practices, this supported the development of self-awareness and self-reflection in students who can apply their training and education to practice cultural humility when working with diverse individudals, groups, or communities. Diversity of the student body allowed for inclusion in the learning process of future nurses according to these authors.

In evaluating Foronda and MacWilliams (2015) in their identification of simulation as a method to teach cultural humility in a safe, structured learning environment, this was a start to including cultural humility as a simulation standard consistently in nursing education. Clinical instruction on diversity, inclusion, and sensitivity are concepts that can support student learning in preparation for future roles as health providers prepared to work with diverse populations. The recognition to include diverse simulation and team members, and diverse faculty supported learning the process of cultural humility and emulating this for students to experience and follow in their nursing practice.

The use of photovoice to enhance clinical experiential learning by Gallagher and Stevens (2015) was an evidence-based teaching strategy that can lead to the practice of cultural humility through self-awareness and self-reflection with critique of one's own preconceived assumptions, biases, and prejudices. The photographs taken by students in a community health course was the medium used while conducting a window survey in the community. Student narratives were added to the photographs providing contextual

insight of the community through the eyes of students. Self-awareness can begin with "stepping back" and appreciating what are actual experiences of community members themselves in relation to health care. Faculty provided students with disposable cameras to prevent the use of personal cellphones and video recordings that could compromise the confidentiality of community members. Verbal permission was first granted by the community member who agreed to be photographed. The students placed the photographs on a tri-fold presentation board, and "voiced" the significance of the photographs.

This teaching strategy in evaluation of the article by Gallagher and Stevens (2015) was that photovoice allowed students to "see" and respect a diverse community with a new vision of awareness and sensitivity. The photovoice strategy allowed students to develop a sense of importance when assisting in prioritizing community interventions together with community members. The students integrated the "voice" of the community in working to developing community-based interventions together for sustainable solutions.

McInally, Metcalfe, and Garner (2015) presented the benefit of global nursing between the U. S. and Scotland while providing service learning opportunities for undergraduate nursing students from both countries. An international cultural immersion experience was the teaching strategy. Using a collaborative cultural learning model, four primary themes were identified: educational, cultural, collaborative, and clinical learning experiences. The U. S. and Scotland nursing programs provided students enrolled in the international student experience the clinical exposure to pediatrics, adult nursing care,

and intensive care through one-week and two-week immersion experiences in both countries. An appreciation for cultural differences was noted among the students from both countries.

Student evaluation information was collected from reflective journal assignments. Open-ended questions related to personal gains as perceived by the students from the global experience were asked. Themes of professional and personal growth in student journal entries was noted. Faculty also noted that some of the U. S. students had a "preconception that their way of providing care was somewhat more advanced than nursing care in other countries" (McInally et al., 2015, p. 164). Through collaboration with students, faculty witnessed a reduction in this bias as students from both countries had the opportunity to work together and experience universalities of the nursing profession more so than the differences that might exist. "Embedded in the idea of commonality is the acceptance of cultural humility" (p. 164).

In evaluation of this article on global nursing, the awareness of cultural differences and similarities in health care provision was achieved by the cultural immersion teaching strategy. The process of being self-aware, self-reflective with critique in a foreign country was the process of cultural humility that was experienced and practiced by nurses from both countries. Mutual respect among health providers from both countries supported a strong workforce in a global community. Cultural awareness through international learning experiences supports the practice of cultural humility. The commitment to continue practicing cultural humility as a lifelong process contributed to the successful global nursing model for student learning.

Schaeffer and Hargate (2015) identified evidence-based learning experiences in community engagement in nursing education that supported the commitment to social responsibility and service, and to prepare nurses to work effectively with diverse populations. With community engagement in mind, these researchers explored nursing student development of cultural humility using reflective journaling to help students link poverty to health disparities for a better understanding of how a lack of resources contributes to power imbalances within diverse populations. Some learning experiences included nursing students listening to the life experiences of individuals and families surrounding their health, and access to health care services within their community. The contextual framework of reconciliation, social justice, and community engagement was designed to promote student learning, development of student leadership, and social awareness and community collaboration according to Schaeffer and Hargate (2015).

In evaluation, Schaeffer and Hargate (2015) presented the educational value of exposing students to community members using community engagement as a method of instruction in nursing education. Experiential learning was the teaching strategy used within a community setting that allowed students to "witness" the effects of health inequities that contribute to health disparities among diverse individuals, groups, and communities. This article provided an example of how the practice of cultural humility in community engagement could help to reduce health disparities and improve in health outcomes within diverse populations through self-awareness and self-reflection. Evidence-based nursing practice was presented in the experiential learning process of these nursing students.

In an effort to address the health care needs of the changing demographics in the U. S., nursing education included within the curricula nursing care to diverse populations as a topic. Bahreman and Swoboda (2016) addressed honoring diversity through cultural competence communication skills using clinical simulation in the laboratory setting. These authors explored best practices in nursing education that addressed the inclusion of cultural humility and diversity in existing nursing programs. The use of standardized patients, and high fidelity simulators as teaching strategies provided a sense of "realism" to learning how to communicate and interact with diverse populations. The authors argued that the use of self-reflection also provided students with an awareness of their own biases, assumptions, and blindspots through the inclusion of cultural humility and diversity in simulation pedagogy. Cultural differences and communication during simulation were presented to help identify that awareness of self and others is crucial in diversity education. The authors also noted that cultural knowledge was gained by exposure to caring for diverse individuals.

As an evaluation, Bahreman and Swoboda (2016) recognized diversity education as being necessary to prepare nurses with culturally competent communication skills through the use of simulation. The inclusion of diversity within the simulation experiences of students offered some dynamics of culture that impacts on health care provision within diverse populations. While cultural humility instruction was addressed in working with diverse populations, this article focused on teaching diversity through simulation within nursing education. There was recognition of challenges in teaching cultural competence, including biases, stereotypes, and using standard instructional

techniques (lectures and assignments). The possible lack of faculty awareness of how to teach cultural diversity itself was addressed by the authors. The article addressed key elememts in presenting cultural care in nursing curricula. The practice of cultural humility can support communication skills in diversity education.

An integrative review on interprofessional communication was conducted by Foronda, MacWilliams, and McArthur (2016) who stated miscommunication and poor client outcomes are present in health care. In conducting an integrative review, Foronda et al. (2016) reviewed a total of 18 research studies, six short papers, three literature reviews, and one theoretical framework paper to identify the communication style between nurses and physicians. The review revealed differences in communication styles between both professions that involved ego, a concept antecedent (by physicians), and feelings of inferiority, another concept antecedent (by nurses) that limited feelings of mutual respect. Education on cultural humility and valuing diversity were identified for both professions to benefit client safety and improved interprofessional communication.

In evaluation, Foronda et al. (2016) identified the power imbalance between nurses and physicians. The concept of cultural humility acknowledged that a power imbalance was present, namely between the provider and the client. A lack of communication between health providers can adversely affect patient care and safety. Simulation training in effective interprofessional communication through workshops, online modules, and training programs on cultural humility was recommended. This integrative review provided insight to the impact of poor communication skills between health providers that can contribute to poor health outcomes among diverse populations.

Simulation pedagogy to build interprofessional communication skills between nurses and physicians can create a mutual understanding and respect beween the professions through teamwork and collaboration.

This integrative review documented the differences in communication training, styles, and expectations between nurses and physicians. An awareness to different communication styles can enhance communication to diverse populations. The review presented a balanced need to improve communication between nursing and medical professions to promote improved outcomes for diverse populations.

To summarize the nursing education literature, there remains a gap in nursing education and literature of how to care for individuals belonging to the lesbian, gay, bisexual, transgender, or intersexed (LGBTI) and the LGBT populations that are diverse in gender identity. An awareness of one's own biases, assumptions, and blindspots is necessary to interact authentically with diverse populations overall. There was an identified need for nursing education programs to include curricular content that addresses sexual orientation and gender identity issues that would better prepare students for future nursing careers in a multifaceted society. Health equity for diverse populations is a goal in health care. A lack of self-awareness and self-reflection with crititque of preconceived assumptions, biases, and prejudices may be present in nursing education by faculty. Meeting the health care needs of a diversity society requires nurses who are able to offer sensitive, culturally congruent care to help reduce health disparities. Evidence-based practice methods can enhance the nursing profession in meeting the health care needs of a diverse population.

Research studies have been conducted using quantitative, qualitative, and mixed method approachs to identify the practice of cultural humility and cultural competence. Innovative teaching strategies such as photovoice, service learning, clinical simulation with standardized patients, as well as high fidelity simulators provided creative approaches to teaching and learning self-awareness and self-reflection in a safe, structured learning environment to move towards the practice of cultural humility. Interprofessional communication between nurses and physicians remains critical to meeting the health care needs of diverse indiviuals, groups, and communities.

Medicine and Cultural Humility

Over twenty years ago, Tervalon and Murray-Garcia (1998) recognized a gap in health care provision by physicians that can contribute to health disparities within a multicultural society. A willingness to address and relinquish one's preconceived assumptions, along with acknowledging that a power imbalance exists – ultimately serves to promote a physician-client relationship that is authentic and respectful. "The increasing cultural, racial, and ethnic diversity of the United States compels medical educators to train physicians who will skillfully and respectfully negotiate the implications of this diversity in the clinical practice (Tervalon &Murray-Garcia, 1998, p. 117).

In this seminal article, Tervalon and Murray-Garcia (1998) addressed a critical gap in medical training, and perhaps in health care in relation to cultural humility. Sensitive topics including institutional racism, and a lack of respect for understanding diverse client viewpoints during health care encounters was brought forth by these

physicians. With respect to this concept as per these physicians, "it is a process that requires humility as individuals continually engage in self-reflection, and self-critique as lifelong learners and reflective practitioners" (Tervalon & Murray-Garcia, 1998, p. 118). When practicing cultural humility, the health provider "brings into check" the power imbalance that is present between the physician-client dynamic. The physician becomes flexible and humble enough to assess the cultural dimensions of each client experience, while also being humble enough to say *they do not know when they truly do not know*. The search for and access of resources will hopefully enhance client care and future clinical practice of physicians. The role of "expert" is relinquished to the client according to Tervalon and Murray-Garcia (1998).

In evaluation of this seminal article, the authors explored institutional and personal ways of thought related to diverse populations that can adversely affect patient care. Assumptions, biases, and preconceived notions of "others" are challenged by applying the practice of cultural humility within the physician-client relationship. Physician training outcomes could produce future physicians who are sensitive and attuned to their clients' cultural identities. The notion of "knowing" the cultural influences of clients because of having learned discrete information from training in cultural competence does not embrace lifelong self-awareness, self-reflection with critique, or self-appraisal of one's own assumptions, biases, and prejudices.

Cultural competence and humility training in medical schools was recognized as an essential strategy to address health care disparities. Butler et al. (2011) conducted a MEDLINE review of published literature in medical education from 2000 to 2009 on

cultural competence training, along with interviewing five faculty members dedicated to advancing cultural competence training in medical education by implementing this essential training in their own school's curriculum. According to Butler et al. (2011), competence implied that a health provider can attain a certain level of knowledge on different cultural traits that will prepare them to interact with diverse patients. The integration and training on cultural competence and cultural humility for medical students was noted in the initial two years of the medical curriculum through coursework, seminars, or case-based cultural competence and cultural humility lectures. The intended outcome of this instruction was to improve student knowledge, attitudes, and perceptions regarding the health care of diverse populations. But as students moved into their third and fourth year of training, specific courses addressing cultural competence and cultural humility was not a primary focus of instruction for medical students.

> The third and fourth years of training is the time when medical students learn to put theory into practice. The absence of cultural competency and humility training during this time could result potentially in the provision of culturally insensitive care by these future physicians after graduation. (Butler et al., 2011, p. 224)

Five medical school faculty members were interviewed, and addressed the importance of exposing medical students to diverse client populations while in training. There was a consensus among the five members that not all medical schools present cultural competence or cultural humility training when addressing health care disparities among diverse populations.

To evaluate this article, it was identified that a commitment from medical schools to provide instruction on cultural competence as well as cultural humility was paramount. Medical leadership to ensure that medical school curricula includes instruction on cultural humility throughout the training of future physicians was not present. Institutional barriers to change may be present, thereby limiting how future physicians will effectively interact with diverse client populations. This article addressed key points of cultural humility and health disparities among diverse populations.

Controversy in medicine arose when Chang, Simon, and Dong (2012) presented the *QIAN* model and identified themselves as the first researchers to use the term of cultural humility. *QIAN* is an acronym for Questioning, Immersion, Active-listening, and Negotiation between the physician and client as a model to meet their diverse cultural needs. "The goal of the *QIAN* model is the transformation of culturally sensitive health care in a globalized world" (Chang et al., 2012, p. 276). Tervalon and Murray-Garcia (1998) presented these same tenets in 1998, and responded with a letter to the publishing editor of *Health Affairs* requesting a public correction to the claim made by Chang et al. (2012) of being first to use the term cultural humility. Chang and Dong (2012) responded back to Tervalon and Murray-Garcia (1998) with a letter to the same editor stating their use of cultural humility was from the Chinese tenet of *qian*, which means humbleness, and that they stand by their claim as presented.

The Chang et al. (2012) article was philosophical in nature when addressing the concept of cultural humility in medical education. Integration of the *QIAN* model was adaptable to providing health care to diverse populations. Culture shapes the lifestyles

and beliefs of individuals in how they respond to health conditions that may affect them. The *QIAN* model was adaptable to all cultural and ethnic groups; it can enhance cross-cultural communication skills of health care providers. The *QIAN* model does allow for the transformation of culturally sensitive health care in a global society through cultural humility.

Kutob et al. (2013) conducted a quantitative study on cultural competence education through a skills-based online course with culturally competent diabetic care provided by 90 medical school students working with a diverse patient population. The study design was a controlled, posttest-only design. A pretest was not done in an effort to mitigate pretest sensitization effects which occurred on a previous study conducted by these researchers using the same research design. "The study's primary hypothesis was that physicians who had taken the online course would have higher *Cultural Competence Assessment Tool* (CCAT) scores than a control group of physicians who had not taken the course" (Kutob et al., 2013, p. 169). There were 41 physicians in the control group; and 49 physicians in the intervention group. The intervention group had one month to complete an introductory online case module. The control group did not receive training on the introductory online module. The results of this study revealed data scores collected from the CCAT (self-reported) self-awareness scores were lower in the intervention group compared to the control group. The internal reliability of the modified CCAT instrument had a Cronbach's alpha of 0.94. "There was no significant difference between the two groups on total CCAT scores (2.12 ± 26.7 for the control group versus 217.2 ± 28.6 for the intervention group, $p = .444$), or mean CCAT scores (2.70 ± 0.29 for

control, versus 2.79 ± 0.30 for intervention, $p = .154$)" (p. 170). Total CCAT scores were obtained by the summation of individual Likert scale items ranging from 1 to 4.

A plausible explanation was the skills-based course contributed to an increased appreciation of the cultural influences among diverse patients. This study offered quantitative data that measured cultural competence education for practicing physicians. A skills-based approach to patient care can be affected by the practice of self-awareness, and non-judgmental behaviors during patient encounters, leading to improved health care according to these researchers.

The evaluation of the Kutob et al. (2013) study is physician training includes instruction on cultural competence to improve the health care needs of clients. While cultural humility was not specifically addressed in this study, components of the concept (self-awareness and self-reflection on judgmental behaviors) was present. Further instruction on the human interaction between the physician and client would be enhanced if simulation instruction provided training on cultural awareness and sensitivity, which would support the concept of cultural humility. The quantitative design included validated instruments that provided empirical data that physician learning occurred from an online course. Study limitations include the small sample size of subjects that limited the power to detect differences between subgroups. Another study limitation was the posttest-only design was used to avoid pretest sensitization effects. Baseline differences could not be accouted for; there was similarity in scores for both groups.

Cultural awareness training in medical schools was addressed by Llerena-Quinn (2013) as a Latina care provider. The integration of multicultural courses into the

medical curricula was presented by a group of diverse medical faculty, including Llerena-Quinn, for medical students to explore and reflect on their own cultural identities, and to learn about the inherent dynamics that can come forth when cultural differences interact. According to Llerena-Quinn (2013), the instructional approach to encouraging self-awareness aligned with the concept of cultural humility. The pedagogy for teaching about cultural differences needs to occur where students and faculty feel "safe" to express issues that surround culture and diversity.

The Llerena-Quinn (2013) article addressed cultural awareness training in medicine that needs a safe environment to explore preconceived ideas and beliefs that are not "spoken" out loud due to fear, or ignorance. Cultural awareness along with self-awareness training supported the important dialogue of providing culturally appropriate and congruent care to diverse individuals, groups, or communities. "The pedagogy of 'self-awareness' focuses on the self and does not seek to become an 'expert' about the other" (Llerena-Quinn, 2013, p. 342).

For this article evaluation, it presented a pedagogy for instruction on sensitive topics such as bias recognition and self-awareness that needed to be addressed in a safe teaching environment. The article supports moving beyond stereotypes regarding "others" - to work collaboratively to "speak above the silences" in a safe environment. A principle of cultural humility was presented in supporting cultural awareness of oneself and others.

Loue, Wilson-Delfosse, and Limbach (2015) identified cultural competence/sensitivity gaps in the formation of first and second-year medical students

attending Case Western Reserve University School of Medicine in Cleveland, Ohio through an online survey and focus group addressing the issue of diversity. A mixed method study was designed to assess how first and second-year medical school students perceived their curriculum for addressing diversity; and to what extent do issues related to a patient's culture are considered important to patient care. Anonymous web-based surveys were delivered to a total of 167 first-year, and a total of 166 second-year medical students; along with two focus group sessions (N = 14) conducted on campus. Topics of discussion with the focus groups included: cultural humility; distinguishing between cultural competence and cultural humility; knowing diverse cultural patterns and diseases; and addressing a lifelong commitment to self-reflection, self-awareness, and lack of knowledge of others' cultural background. A problem-based learning group activity session (the Case Inquiry Group) was also presented to medical students (N = 6) for critical analysis, concept integration, and reflection on issues of culture and patient care.

For the quantitative portion of the study, first-year students (N = 94) and second-year students (N = 45) responded to the anonymous web-based survey that used a 6-point scale to record responses to survey questions rated as "not important" to "greatest importance". Self-reflection was rated most important for first-year students. Second-year students responded that patient interviewing skills were most important. According to Loue et al. (2015), a large portion of the first and second-year medical students do not believe that self-reflection regarding one's cultural biases is important to one's

performance as a physician. This belief can contribute to a power imbalance between the physician and client that can lead to health disparities in care provision.

For the qualitative portion of the study, themes identified from the two focus groups included student discomfort with cultural issues in patient care; a desire to improve communication skills; and a fear of speaking inappropriately due to not knowing. The Case Inquiry Group (focus group session) was facilitated by one investigator, while the second investigator recorded questions, curiosities, amd learning objectives generated by student participants. A coding scheme book using a grounded theory approach was established. General categories and sub-categories of topics were agreed upon by the two investigators.

The quantitative survey results were as follows: A total of 94 first-year medical school students, and a total of 45 second-year medical school students responded to the anonymous web-based survey. Self-reflection of one's own values and beliefs had the largest survey response from first and second-year students. There was no statistical difference in the responses of first and second-year medical school students to the survey taken.

The evaluation of this study was that medical school education on cultural awareness and sensitivity remains a challenge. The perception by medical students that self-reflection was not important to their performance as a physician could contribute to the power imbalance that may already be present in the physician-client dynamic, particularly with diverse populations. The findings from this study may be limited to this one medical school where the study was conducted, and the results may not be

generalized. Instruction on cultural humility within the medical school curricula would help to sensitize future physicians to be self-aware and self-reflective of one's own cultural assumptions and biases.

In addressing assumptions and stereotypes about "different" cultures, Kim (2016) discussed the topic of cultural humility in health care from his own personal self-reflective narrative on cultural humility. The author stated that health providers need to inquire about culturally shaped health values, beliefs, and behavior of their clients instead of making assumptions about individuals, groups, or communities. The connection between inquiring information and insight from the individual without assuming or generalizing is respectful when working with diverse populations.

Kim (2016) identified that multiple disparities exists within society. Health, socioeconomic, educational, and political power disparities can contribute to how individuals may be pre-judged and treated by society in general. "It is critical that providers inquire about culturally shaped health values, beliefs, and behavior instead of making assumptions" (Kim, 2016, p. 814). The author provided his own personal experience of cultural humility that has transferred into his medical practice as a physician. Self-awareness, self-reflection with critique of his own cultural beliefs and assumptions led the author to more authentic communication and understanding of members of his own culture, and the diverse cultures of his patients.

In summary, medical training of physicians at some schools includes instruction on cultural humility. Training in cultural competence and cultural humility was noted in medical education during the first and second year of training, but not in subsequent third

and fourth years of training. The potential for insensitive physician providers after graduation exists – attributing this to the lack of training in being self-aware, and self-reflective when working with diverse populations. Quantitative and mixed method research designs were conducted that addressed cultural competence education and sensitivity in medical school training. Self-awareness and self-reflection with critique of preconceived beliefs remains a necessary component to provide culturally appropriate health care.

Kinesiology and Cultural Humility

Physical and occupational therapy education includes instruction on cultural competence, and in more recent years, cultural humility. The ability to provide appropriate and congruent care to various cultures requires an awareness of oneself, and how interactions with diverse populations may be impacted by preconceived beliefs and practices.

The recognition of how culture can impact the client-therapist relationship was presented by Hammell (2013) who addressed the power imbalance between occupational therapists and culturally diverse clients. The constructs of culture, race, class, gender, sexuality, and ability can impact the therapist-client relationship. Hammell (2013) wanted to provoke critical thinking concerning occupational therapy's theories and practices in understanding clients whose cultures differ from dominant Canadian norms. The practice of cultural humility was presented as an opportunity for occupational therapists to self-reflect on their own cultural values and assumptions regarding the

physical abilities of the clients they serve, by becoming critically self-aware of their own assumptions, beliefs, values, and biases.

Hammell (2013) identified how a Eurocentric mindset can be challenged when occupational therapists practice cultural humility when working with diverse populations. A willingness to be self-aware, and to self-reflect with critique on preconceived beliefs and assumptions can challenge already-held beliefs on privilege, power, societal class, and status.

Physical therapy in a global environment requires an understanding of cultural differences, and the need to reflect on one's interactions with culturally diverse individuals. Cleaver, Carvajal, and Sheppard (2016) stated how self-reflection as part of cultural humility required the consideration of power imbalances that may exist. According to the authors, self-awareness and self-reflection with critique through the lens of cultural humility would support inclusive care that is culturally safe and congruent. Global practice within the discipline of physiotherapy required a broader understanding of culture. A reflective practice by Canadian physiotherapists in global health incorporated the practice of cultural humility in an environment with exceptional diversity and areas of tremendous inequality according to Cleaver et al. (2016).

This article by Cleaver et al. (2016) on global health care by physical therapists required not only self-reflection, but also reflection on the power imbalance that may exist between the physical therapist and their clients from diverse populations. Belief systems and cultural practices can be better understood when explored from the process of cultural humility. In evaluating this article, the authors supported a reflective practice

based on the concept of cultural humility with the goal of providing culturally congruent care to clients served by this discipline.

Paparella-Pitzel, Eubanks, and Kaplan (2016) presented results of a two-year prospective longitudinal quantitative pilot study on the competence level of a convenience sample of 48 second-year physical therapy students comparing teaching strategies for cultural competence and cultural humility. The teaching strategies included a two-hour lecture on cultural competence with small group discussions. An additional two-hour lecture was held where students were "sensitized" to conditions that ascribe power, and were provided with language that allowed for greater participation in the interview process. Thirdly, culturally diverse patient scenarios were conducted using role play as a teaching strategy for students to experience the role of the client, the physical therapist, the consultant, and a general observer. The study outcome demonstrated physical therapy students shifted in their initial level of being "culturally incompetent" and/or "culturally aware", to being "culturally competent" – measured by the 25-item Likert scale instrument *Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised* (IAPCC-R). This instrument was "designed to measure cultural competence across various healthcare clinicians, educators, and students, and is the preferred tool for assessing curricular outcomes" (Paparella-Pitzel et al., 2016, p. 141). However, the reliability and validity of this instrument was not stated in the study.

This study compared the levels of cultural competence in second-year physiotherapist students enrolled in a Doctor of Physiotherapy program at three time

points; and compared the effects of three strategies for teaching cultural humility and cultural competence. A two-hour interactive class on cultural competence was presented to all 48 students approximately four weeks after the semester started by an experienced facilitator. Cultural safety was established by faculty – ground rules for appropriate behavior were presented before and during the two-hour interactive class. Self-reflection was addressed surrounding one's own culture, social identities, cultural differences, and personal biases.

"Prior to the focused coursework, the majority of students (n = 25, 71%) rated their cultural competence as 'good but could be improved', 6 (17%) rated themselves as culturally competent, and 4 (11%) was minimally competent" (Paparella-Pitzel et al., 2016, p. 143). Student scores on the IAPCC-R instrument before and after educational instruction reflected the students' ratings of their cultural competence at pretest and two posttest ratings. "Students were able to shift levels from scoring as 'culturally incompetent' and 'culturally aware' to scoring as 'culturally aware' and 'culturally competent' and maintained that for 1.5 years" (p. 144).

This pilot study by Paparella-Pitzel et al. (2016) demonstrated the long-term benefit of a two-hour lecture on cultural competence to physical therapy students. A lasting change in students becoming more culturally aware after 16 months post-instruction by a skilled facilitator comfortable with cultural topics was noted. This well-designed prospective longitudinal quantitative pilot study provided empirical data gathered from an instrument designed to measure cultural competence among health care professionals, along with focused coursework. A limitation of this study was the

IAPPC-R instrument only measured cultural competence and not cultural humility. Secondly, the actual value for instrument credibility and validity was not provided to support instrument value.

In summary, both occupational and physical therapists provided culturally appropriate care when consideration was given to already-held beliefs on culture and biases. Cultural humility as a process may not be present between occupational and physical therapists if a power imbalance was present and went unrecognized between the therapist and the individual receiving care. Having a reflective position as a therapist can help mitigate a power imbalance that may be present between the therapist and their client.

Psychology and Cultural Humility

The field of counseling psychology involves working with clients from multiple cultural backgrounds. Psychologists recognize the importance of having multicultural competencies (MCCs) consisting of knowledge, skills, and awareness of culture which are needed when working with diverse clients as endorsed by the American Psychological Association (APA). The working relationship between the therapist and the client forms a working alliance that can have a positive or adverse effect on counseling sessions.

Hook et al. (2013) recognized the concept of cultural humility as beneficial in maintaining an openness to the "other" in counseling therapy. The researchers conducted one pilot study and three quantitative studies, and reported the findings within one report that measured cultural humility as a client-related measure for the therapist. A cross-

sectional correlational design was used in all the studies. A pilot study was first conducted to gather initial evidence that individuals perceive cultural humility as an important aspect of a therapist. The *Cross-Cultural Counseling Inventory – Revised* (CCCI-R) (LaFromboise, Coleman, & Fernandez, 1991) instrument was used to measure multicultural competencies (MCCs) from the client's perspective. The internal consistency estimate was above .70 according to the researchers. This same instrument was used in the remaining three studies. The main hypothesis was, "Participants would report cultural humility as important to them when seeking a prospective therapist, and that cultural humility would be more important than other therapist characteristics typically associated with multicultural competencies" (Hook et al., 2013, p. 355). The sample for the pilot study was (N = 117) college students from a large university in the Southwestern region of the U. S.. Participants responded to an online questionnaire completed using SurveyMonkey® where they identified aspects of their cultural background most important to them. Therapist characteristics were rated in relation to MCCs – namely similarity, experience, knowledge, and skills. A therapy scenario was presented asking participants to describe qualities of their therapist as perceived by them. After statistical analysis of data was conducted by analyses of covariance (ANOVAs), the hypothesis for the pilot study was found to be supported.

The purpose of Study 1 was to develop a client-rated measure on the cultural humility of a therapist. Participants were college students (N = 472) from a large university in the southwest region of the U. S. who attended therapy at some previous point in their lives. Participants rated the severity of their presenting problem for which

they attended therapy from 0 (absent) to 4 (severe). The hypothesis was, "Client perceptions of their therapist's cultural humility would be positively associated with a strong working alliance" (Hook et al., 2013, p. 356). A working alliance refers to the therapeutic relationship between a therapist and client. Participants completed the short form of the *Working Alliance Inventory* (WAI – SF) (Tracey & Kokotovic, 1989). This instrument measured three aspects of a strong working alliance with the therapist. The Cronbach's alpha coefficient was .96 (95% CI [.95, .96]).

For cultural humility, participants were asked to identify three aspects of their cultural background that was important to them. A list of 32 item statements that corresponded to the concept of cultural humility was presented to the participants. Twelve experts in the field of MCCs provided feedback before presenting the items to participants who rated them from 1 (strongly disagree) to 5 (strongly agree). The *Cultural Humility Scale* (CHS) (Hook et al., 2013) had a Cronbach's alpha of .93. "This study resulted in the development of a brief measure of the client's pereption of a therapist's cultural humility" (p. 358). Initial evidence was also provided that clients who viewed their therapist as more culturally humble tended to report stronger working alliances.

The purpose of Study 2 was to replicate and expand on Study 1 to show that client perceptions of a therapist's cultural humility would predict therapy outcomes. The researchers "conducted a confirmatory factor analysis (CFA) to see whether the factor structure found in Study 1 would replicate on an independent sample" (Hook et al., 2013, p. 358). This study provided further evidence that client perceptions of a therapist's

cultural humility are positively related to higher quality attributes with the therapist. The sample size was (N = 134) adults currently in therapy. The hypothesis for Study 2 was, "Client perceptions of their therapist's cultural humility would predict developing a strong working alliance while controlling for the effects of client perceptions of their therapists' MCCs" (Hook et al, 2013, p. 358). In evaluation of Study 2, the practice of cultural humility by the therapist did affect the working alliance between the therapist and client. Clients responded favorably to therapists who honor the cultural differences that may be present with respect and sensitivity. The study hypothesis was supported.

The main purpose of Study 3 was to replicate and expand the findings from Study 1 and Study 2 using a reliable and valid measure of therapy improvement, and using a sample of adult participants (N = 120) who self-identified as being Black and currently in therapy. Cultural humility and a working alliance between the diverse client and the therapist was associated with positive therapy outcomes. The hypothesis for Study 3 was, "Client perceptions of a therapist's cultural humility would be positively associated with their perceived improvement to date in therapy, and this relationship would be mediated by working alliance" (Hook et al., 2013, p. 360).

To measure improvement in psychotherapy, participants completed the *Patient's Estimate of Improvement* (PEI) (Hatcher & Barends, 1996) instrument of 16 items that assessed improvement during therapy. The Cronbach's alpha coefficient for this sample was .95 (95% CI [.94, .96]). The working alliance instrument for this sample had a Cronbach's alpha coefficient of .92 (95% CI [.89, .94]). The *Cultural Humility Scale*

(CHS) (Hook et al., 2013) for this sample had a Cronbach's alpha coefficient of .86 (95% CI [.82, .89] for the full scale. The hypothesis for Study 3 was supported.

In evaluation of Hook et al. (2013), research was presented in a quantitative pilot study on cultural humility recognition, along with three studies to replicate findings regarding multicultural competencies (MCCs) within one report. The research results revealed that a client's perception of a therapist's cultural humility was positively associated with the working alliance with the therapist, and a perceived improvement in therapy by the client. It may be important for therapists to practice cultural humility when engaging clients about their cultural backgrounds. A notable limitation of this set of studies was that two samples of clients were mostly Caucasian. Multiple instruments and statistical methods were employed to demonstrate relationships between identified variables. A notable limitation to these studies was the same cross-sectional, correlational design was used in all four studies. No causal relationships could be inferred.

In follow-up, the Hook (2014) article reported when interacting with clients, that engagement with cultural humility is often the "glue" that holds the alliance with a culturally different client together. Therapists aim to engage clients without making assumptions, or having all the knowledge on cultural patterns that can be considered being an "expert" in cultural nuances and mores. In evaluation of this article, the ability to engage clients with cultural humility allowed for seeing oneself through another's eyes. Being aware of one's own worldview is important, especially when faced with a

client's worldview that may be different altogether. Diversity of beliefs and practices can be appreciated when cultural humility is practiced.

Owen et al. (2014) conducted a quantitative, cross-sectional study to examine if a client's religious/spiritual commitment has an effect on one's perception of a therapist's cultural humility and therapy outcomes. The two study hypotheses were: "Perceived cultural humility would be positively associated with therapy outcomes" (p. 92); and, "The association between perceived cultural humility and therapy outcomes should be greater for clients whose religious/spiritual commitment is more salient as compared to clients whose religious/spiritual commitment is not as salient" (p. 93). The sample size was (N = 45) participants who were recruited from a large, urban university in Southeastern United States. Participants were currently in treatment (n = 18), or treatment had ended (n = 27). Instruments used in this study included the *Patient's Estimate of Improvement* (PEI) (Hatcher & Barends, 1996). This was a 16-item questionnaire that assessed improvement during psychotherapy. The Cronbach's alpha was .96. The *Cultural Humility Scale* (CHS) (Hook et al., 2013) was used; the participants identified the aspect of their cultural background considered most important to them. For this study, the Cronbach's alpha was .92. The *Religious Commitment Inventory* (RCI-10) (Worthington et al., 2013) was used to measure religious/spiritual commitment of participants from multiple faith backgrounds. The Cronbach's alpha was .93.

Study findings revealed all participants identified their religious/spirituality as the most salient aspect of their cultural identity. Study results demonstrated that perceptions

of cultural humility were positively associated with therapy outcomes. In evaluation, the sample size (N = 45) was small for a cross-sectional study. Also, the therapy outcomes rated by clients may reflect "recall biases". Thirdly, therapists may need to create opportunities for clients to discuss their cultural identity – with the therapist taking an "other-oriented" stance. The two study hypotheses were supported in the religious/spiritual commitment being a key determinant of how a client's view of their therapist's cultural humility affects treatment outcomes. In evaluation, this study was well designed using validated instruments that measured specific variables identififed by the researchers.

Hook and Watkins (2015) asked the question if cultural humility was the cornerstone of positive contact with culturally diverse individuals or groups. With the increasing diversity in society, interacting with individuals will undoubtedly include those who are culturally considered to be "other". This article offered the possibility that cultural humility might be the "missing link" in authentic multicultural interactions. A willingness to learn about "others" starts with learning about oneself. The practice of cultural humility includes self-awareness and self-reflection with critique of preconceived assumptions, biases, and prejudices. In evaluating this article, having positive contact or interactions with diverse individuals or groups, the authors state openness to and respect for others and their perspectives as a point to start to practicing cultural humility.

Owen et al. (2015) reported on the results of a quantitative, retrospective study that demonstrated clients who rated their therapist as being more culturally humble also reported better therapy outcomes. In this study, clients who perceived their therapist

missed cultural opportunities reported poor therapy outcomes. According to Owen et al. (2015), a missed cultural opportunity was when the client brings up during a session some aspect of their culture, and the therapist does not engage the client to explain their perspective of their cultural identity. In counseling therapy, cultural humility allowed for an "other-oriented stance" that demonstrated openness, a lack of arrogance, and a genuine desire to understand the client's cultural identity.

This quantitative, retrospective study examined clients' ratings of their therapists' cultural humility, and the degree that clients perceive that their therapist missed opportunities to discuss cultural issues during therapy. The sample size was (N = 247) participants who identified as African-Amerian; Asian-American; Latino(a)/Hispanic; White/Euro-American; or Multiethnic from a large university counseling center. The participants had recently ended therapy, and were treated by one of 50 therapists. Owen et al. (2015) stated three hypotheses. The first hypothesis was, "Clients who reported better therapy outcomes reported their therapist did not miss opportunities to discuss their cultural heritage." The second hypothesis was, "Cultural humility would be positively related to client improvement." The third hypothesis was, "Cultural humility would moderate the relationships between missed cultural opportunities and client improvement" (Owen et al., 2015, p. 3). Using an online survey for study recruitment, selected participants were asked to identify an aspect(s) of their cultural background that was most important to them. The responses were rated by importance to the client using a 5-point Likert scale ranging from 1 (not at all) to 5 (very important). Four validated

instruments were used for data collection. All three hypotheses were supported when analyzing data findings.

Results from this study revealed correlations suggesting that "client's ratings of cultural humility, missed opportunities and therapy outcomes are interrelated and likely mutually influence one another" (Owen et al., 2015, p. 5). In evaluation of this study, a client's perception of their therapist can influence their therapy outcome. The practice of cultural humility by therapists supports an openness to learning from the client in an non-judgmental manner. This study supported the therapeutic relationship between the client and therapist influenced by respect and understanding of the "other", or diverse client. The relationship between therapists attending to what the client identified as important regarding their identity was noted. The client's perception of their therapist's cultural humility was another important finding. This retrospective study controlled for reducing client bias by using an instrument that measured psychological well being. A limitation of this study was the inability to assess how specific client-reported cultural identities were associated with perceptions of cultural humility, or the therapist's response to discussions on important identities.

Davis et al. (2016) addressed how the relationship between the therapist and client is built on trust and respect. Counseling outcomes in fact can be affected by racial microaggressions, defined as

> brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and

> insults that potentially have a harmful or unpleasant psychological impact on the target person or group. (Sue et al., 2007, p. 273)

The therapeutic working alliance was adversely affected when this type of offense was present, and can contribute to poor counseling outcomes. A quantitative, cross-sectional correlational study was conducted to assess how a client's perception of their counselor's cultural humility mediates the relationship between microaggressions and counseling outcomes. Microaggressions were distinguished by the researchers as the client's attribute of how an offense to an aspect of their identity affected them. The study sample was (N = 128) racial/ ethnic minority undergraduate students enrolled in psychology at a large, southwestern university. The ethnic background of the students included: African American; Asian/Pacific Islanders; Latino(a); and individuals who identified as Other. All participants had attended counseling at some point in the past year of the study. The purpose of the study was to explore how microaggressions affect counseling outcomes for clients. Microaggressions can cause a client to view their therapist as being less culturally humble. Four hypotheses were stated – the first being, "Clients with a severe offense would rate the offense as more severe than those in the microaggression condition." The second hypothesis was, "Participants who experience microaggressions would more likely attribute the offense to either gender or race/ethnicity compared to participants in the first hypothesis." The third hypothesis was, "Attributes of race/ethnicity or gender would be associated with poorer outcomes in counseling." The fourth hypothesis was, "Perceived cultural humility would mediate the relationship

between negative emotions due to rupture and counseling outcomes." (Davis et al., 2016, p. 485)

Participants completed an online survey, and after being prompted by a statement addressing microaggressions and severe offense in relation to counseling, participants wrote a brief description of their perceived offense. Five measures were used to collect data. A series of independent group *t*-tests were conducted to examine group differences between severe offense and microaggression conditions.

One measure used a single-word item Likert-type scale to assess the context of an offense ranging from 1 (not at all hurtful) to 5 (extremely hurtful). Negative emotion due to rupture was assessed with a 10-item negative emotion subscale of the *Positive and Negative Affect Scale* (PANAS) (Watson, Clark, & Tellegen, 1988). A 5-point Likert-type scale ranged from 1 (very slightly or not at all) to 5 (extremely). The Cronbach's alpha coefficient value was .96. To assess working alliance, a 12-item *Working Alliance Inventory* (WAI) (Tracey & Kokotovi, 1989) was used. A 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree). The Cronbach's alpha coefficient was .94. The participant's perceived improvement in counseling was assessed using the *Patient's Estimate of Improvement* (PEI) (Hatcher and Barends, 1996). A 16-item 9-point Likert-type scale was used. Response options varied by question. The Cronbach's alpha coefficient was .97. Perceived cultural humility was measured using the 12-item *Cultural Humility Scale* (CHS) (Hook et al., 2013). Responses were rated on a 5-point Likert-type scale from 1 (strongly disagree) to 5 (strongly agree). The Cronbach's alpha coefficient was .94.

Davis et al. (2016) reported that the statistical analysis of the collected data revealed the first hypothesis was supported because the severity of the offense was greater in the severe offense condition than in the microaggression condition. The second hypothesis was not supported – race/ethnicity and gender evoked microaggression to a similar degree in both participant groups. In testing the third hypothesis, the race/ethnicity attribute did not correlate with any outcome variable in analysis. Gender, however, was associated with negative emotion due to rupture, perceived cultural humility, working alliance, and perceived improvement in counseling. The fourth hypothesis was supported – negative emotions due to rupture and perceived improvement in counseling was mediated by perceived cultural humility.

This quantitative, cross-sectional correlational study provided statistically measureable data including an online survey as well as validated scales to rate offense severity, negative emotions due to rupture, working alliance, and a cultural humility scale. Independent group *t*-tests were conducted to examine group difference. Mediation analyses were conducted using the variables of working alliance and perceived improvement in counseling. Perceptions of cultural humility in counseling can be adversely affected by microaggressions and rupture between clients and their therapists. Davis et al. (2016) conducted a well designed study related to microaggressions in therapy. Limitations to this study were that the researchers were not able to evaluate the counselor relationship implied. Secondly, data source was gathered from clients only; therapist effects were not assessed.

Hook et al. (2016) addressed cultural humility and racial microaggressions (as defined by Sue, 2007) in therapy focusing on a large sample size of clients (N = 2,212) and the frequency of clients perceiving to have experienced microaggressions in counseling sessions. A cross-sectional quantitative study examined five hypotheses using one-way and two-way ANOVAs (analysis of variances) to determine the presence of racial microaggressions and the clients' perceived cultural humility of their therapist. Variable groupings were stated in testing the five hypotheses. The first variable group was diversity and the frequency of racial microaggressions that occurred during counseling sessions. The second group of variables dealt with client race and racial microaggressions. The third variable group looked at counselor race and racial microaggressions. The fourth variable grouping was racial match and racial microaggressions between the client and therapist. The fifth variable set associated perceived cultural humility and racial microaggressions. Causal relationships could not be made by the researchers in this study.

Participants were recruited via an online survey method and received $1.00 compensation for their involvement. The sample consisted of adults (mean age = 29.6). All participants had attended counseling at some point in their lives; a third of the participants were in couseling during the study. Validated instruments to measure racial microaggressions, cultural humility, multicultural competencies, and general competence were used to collect data. The instruments had a Cronbach's alpha coefficient score of .91 or .97, with the exception of the racial microaggressions tool which had a Cronbach's

alpha coefficient of .85. Likert-type scoring was used with all instruments, using a 5-point, 6-point, or 7-point rating scale.

Five research questions were stated. "Explore the prevalence of racial microaggressions in counseling and describe what kinds of microaggressions were more common in counseling." (Hook et al., 2016, p. 272). The second research question was, "Explore the differences in the frequency and importance of racial microaggression's impact." The third research question was, "Explore differences in the frequency and impact of racial microaggressions based on the race of counselors." The fourth research question was, "Explore the difference in frequency and impact of racial microaggressions based on counselor dyads matched and non-matched on race" (p. 273). The fifth research question was, "Explore the associations between the perceived cultural humility of the counselor and racial microaggressions" (p. 274).

For the first research question, 81.7% of participants reported experiencing at least one racial microaggression during their counseling experience. "The most common racial microaggression reported by the *Cultural Humility Scale* in our sample focus on a) denial of stereotypes or bias about cultural issues, and b) avoidance of discussion of cultural issues" (Hook et al., 2016, p. 274). With respect to the second and third research questions, the researchers report there was no significant difference in racial microaggression among various racial minority groups – namely Black, Hispanic, and Asian. Regarding the fourth research question, there was no difference between clients who were matched with a therapist of the same race regarding frequency and impact of racial microaggressions. With respect to the fifth research question, "perceptions of

cultural humility were associated with, a) lower racial microagaressions frequency in counseling, and b) lower negative impact of those racial microaggressions" (Hook et al., 2016, p. 275).

In evaluation of this study, race contributed to microaggressions by therapists, and the perception of cultural humility by clients affected the counseling relationship. The most common racial microaggression reported by clients was a denial of stereotypes or bias about cultural issues, and the avoidance of discussion on cultural issues by the therapist. Multiple variables were evaluated in this study. The large sample size had sufficient power to explore differences between clients in relation to microaggressions in therapy. A study limitation was the cross-sectional design – causal relationships could not be made with regards to perceived cultural humility, and racial microaggressions. More research is needed in this area.

Therapists who display openness, respect, and client interactions from a culturally humble posture would be representative of displaying the attributes of cultural humility, according to Shaw (2017). This author reported how embracing the client's view of culturally responsive counseling using multicultural counseling competencies (MCCs) as a model in counseling supports the opportunity for improved counseling sessions with clients. Counselor knowledge, skills, and awareness of diverse cultures, the use of culturally appropriate counseling approaches with diverse clients, and an awareness of one's own cultural heritage is inmportant to acknowledging how personal attitudes and beliefs can affect counseling diverse clients. Microaggressions as defined by Sue (2007) in this article can affect the working relationship between the therapist and client. The

overall evaluation of this study is that multicultural competence may need to include strategies of how to provide culturally responsive counseling to diverse clients. Microaggressions which can be committed unintentionally by the therapist also contributed to the negative perception a client may have about their counselor being culturally humble.

To summarize this section, psychologists working with diverse individuals recognized the need for self-awareness and self-reflection with critique. It is not enough to practice multicultural counseling competencies (MCCs) of knowledge, skills, and awareness of culture when working with diverse populations in therapy sessions. The establishment of a working relationship, or alliance between the therapist and individual can have a positive effect on therapy outcomes. Studies have been conducted that support clients rating their therapist on being culturally humble, and the outcome of improved couseling sessions contributed to the process of cultural humility.

Social Work and Cultural Humility

In social work, the education of students from the United States going abroad has occurred for years. The learning experiences in other countries by American students have provided exposure to the richness of diversity in cultures with opportunities for appreciating cultural differences as well as similarities.

Sheridan, Bennett, and Blome (2013) documented how a social work education program being established in the Phillipines required an understanding of cultural diversity, and an understanding of the socio-political, religious, and cultural influences. The Social Work Education Project (SWEP) was designed to increase social work

leadership in the conflict-affected areas of Minadando in the Phillipines. These areas are ethnically, socially, and religiously diverse in their makeup. Economic and political influences impact the ability to establish an educational exchange program in social work. Social workers are vital to the delivery of humanitarian assistance in response to the effects of political conflict in this area of the Phillipines. The SWEP program incorporated cultural humility as a framework to appreciate the need for self-awareness of cultural differences of a diverse population with sensitivity and respect. Social work faculty from the U. S. and the Phillipines developed a master's level curriculum for SWEP along with several organizations with international reputations of assisting in maintaining peace in conflict-affected regions of the world.

Three central concepts regarding teaching international social work were noted: contextuality, power, and responsibility. "Contextuality refers to the need to develop a broad and in-depth understanding of the socio-cultural, political, and environmental context of the country where the teaching will occur" (Sheridan et al., 2013, p. 819). International education in social work required an awareness of the socio-cultural, political, and environmental structure of foreign countries where disparities in power exist surrounding class, gender, ethnicity, clan, sexual orientation, and other topics. Also, awareness of possible Western influence surrounding contextuality, power, and responsibility in the Phillipines was important to acknowledge when educating in an international setting. "Specifically, this involves recognizing the active role (historically and/or currently) that the U. S. has played in creating negative or exploitive conditions in the host country" (p. 819). Faculty engaged in education within a different country need

to have a working knowledge of both the history and status of power relations between the visiting and host country.

A mixed method program evaluation was conducted to determine if the SWEP program met short and long-term goals. Both quantitative and qualitative assessment tools were used to assess student learning. A quantitative assessment was administered immediately before and after completion of the ten courses in the social work SWEP curriculum. Student self-ratings of increased knowledge and skill in five areas specific to each course was completed; using a 5-point Likert type response format. There was "statistically significant increases in post-test scores ranging from 8.19 to 13.42 points across a 20-point range" (Sheridan et al., 2013, p. 826).

The qualitative portion of the formative evaluation was administered, along with a standard course evaluation routinely completed after each SWEP course. All qualitative responses were from student surveys that were entered into *Atlas.ti.v.5* to facilitate content analysis. No specific qualitative design was stated in the article. Three themes emerged through content analysis: students stressed they learned "new" theories, models, strategies and knowledge; students developed knowledge and strategies specific to conflict resolution and peacebuilding; and students experienced personal transformation in SWEP, in part from exposure to cultural differences in the course content, and friendships that developed during the program.

Limitations to the study findings included there was no stated member-checking of the qualitative data collected. The validation of the qualitative findings could not be determined. Cohorts of students have participated in the SWEP program from 2008 to

2012. However, no specific sample size was stated for this study. More than 100 social work students have completed the program overall. The specific quantitative assessment tools used were not stated; nor the content validity of the instruments used for this study.

In evaluation of this article, an understanding of the power structure within an international setting assists in the need for cultural sensitivity and understanding of the socio-political, educational, and historical influences on the education process, and how it is instructed abroad. Social work students and faculty reported transformative learning experiences from participating in the SWEP program.

Social work as a discipline has experienced a shift in focus from stressing cultural competence, to an alternative framework of cultural humility when addressing the needs of clients with diverse cultural influences. Fisher-Borne, Cain, and Martin (2015) addressed how cultural humility includes the need for accountability on the individual and institutional level. An analysis of power (social and political), its imbalance, and privilege are required in understanding the concept of cultural humility. Fisher-Borne et al. (2015) acknowledged that cultural humility as a concept takes into account the dynamic nature of culture that challenges individuals and institutions to address the inequities that are present in society. "Acknowledgement of how institutional accountability and the mitigation of systemic power imbalances factor into the core model of cultural humility are missing from the literature" (Fisher-Borne et al., 2015, p. 173). Accountability is a commitment to self-reflection that is on a deeper level. During self-reflection, both individuals and institutions search for a deeper understanding

of the clients and communities they support. Structural forces that come into play when addressing client issues may help identify power imbalances that are in effect.

Fisher-Borne et al. (2015) highlighted not only the change in approach to interactions that represent cultural humility, but also how institutional accountability for the power imbalance is missing in social work literature. In evaluating this article, the recognition of a power imbalance dynamic is challenging but necessary when working from the concept of cultural humility.

To summarize the literature in social work, there is a shift in focus from stressing cultural competence, to the framework of cultural humility with diverse clients. Curricular changes that include cultural humility training in social work education would support the relevance in addressing the social needs of individuals, groups, and communities. Current pedagogy methods include classroom and foreign exchange experiences that can enhance self-awareness and self-reflection with critique when dealing with the effects of institutional biases that can affect the power balance between the health provider and client.

Transcultural Immersion Experiences and Cultural Humility

Transcultural immersion experiences were noted in nursing, medicine, social work, and other disciplines. These learning experiences may ultimately shape future practices as health professionals render care that is culturally appropriate, evidence-based, and culturally congruent.

International learning experiences afford students and faculty an opportunity to be immersed in a culture different from their own. Holmes, Zayas, and Koyfman (2012)

addressed how cultural humility in medical education can assist in promoting critical thinking skills and competencies needed to better understand how culture itself impacts on the health care delivered and received. Included in the learning experience of medical students, the development of medical knowledge and skills in an international context was achieved, along with health status awareness, cultural health care influences, and self-reflection that lead to personal and professional growth.

The ability to respond appropriately to cultural differences within a transcultural immersion learning experience required sensitivity and an awareness that cultural differences needs to be acknowledged and respected. The clinical experience gained from international exchange programs can help students to develop trusting cross-cultural interactions with diverse clients by learning how to be cognizant of one's clinical approach to diverse populations.

Morton (2012) documented The Transcultural Immersion in Healthcare (TIH) program partnership between the University of New England (UNE) in Maine and the Ghana Health Partnership (GHP) in West Africa involving students and faculty across health professions throughout the university. "The TIH curriculum focuses on cultural humility as foundational to establishing trusting relationships with those from another culture" (Morton, 2012, p. 304). The TIH model exposed students and faculty to international global health experiences that promoted a sense of humility, and lifelong service. The *Model for Interprofessional Immersion in Cultural Settings* (MIICS) was the guiding framework for the development of the TIH. The MIICS included social, clinical, and behavorial components joined with the constructs of personal desire, cultural

humility, and value sets that emphasized respect and reverence for culturally diverse perceptions of health. Through student learning, influences on patient health and positive interprofessional and community-based collaboration can lead to optimal service delivery in multicultural health settings. This article presented the practice of cultural humility as a requirement for successful transcultural learning experiences.

Hipolito-Delgado et al. (2013) conducted a grounded theory study to document the lived experience of cultural immersion of three graduate-level counseling students at an urban university in the Rocky Mountain region of the United States. A reflective journal was maintained by the students during the cultural immersion experience which lasted one semester. Data analyses of the student journal entries were systematic in approach using a constant comparative method. The researchers read line-by-line each student narrartive identifying 425 codes. Categories within each narrative were compared, followed by each narrative being compared by categories. This comparative method resulted in 45 codes identified between the three narratives. The researchers then performed selective coding to identify the core criteria that explained the lived experience of the students engaged in the cultural immersion experience. As a result of this constant comparative method of analysis, three phases (goal setting, interaction, and evaluation) were identified. Four recurrent themes were identified (bias, gender, barriers, and self-awareness) in explaining the lived experience of cultural immersion for the three students. Results from the cultural experience were “increased self-awareness and improved understanding of diverse communities, evidenced in the themes of bias and self-awareness” (Hipolito-Delgado et al., 2013, p. 204). Communication with members

of the immersed community facilitated student learning. The results of this study reflected the benefit of immersion experiences as "holistic and humanistic" in understanding oneself and diverse communities. The components of cultural humility were experienced by the researchers. Gaining insight to the lives of community members requires self-awareness and self-reflection with critique of personal values and unresolved issues on the part of the researhers. Self-reflection on preconceived biases was achieved through this cultural immersion experience.

In evaluating this study, the researchers gained insight to the culture they were immersed in during the study. The grounded theory approach allowed the researchers to gain knowledge from the participants by not imposing an already defined theory to explain their lived experiences. Cultural immersion experiences offered a way to gain insight to members of diverse populations. Member checking was used to verify trustworthiness during data analyses. The research team included an outside qualitative expert who provided alternate interpretations of the data, and agreed the conclusions drawn by this study as tenable. Limitations to this study would include the small sample size of three students. Also, the researchers were the actual participants in the study. No pseudonyms were used to maintain participant confidentiality. Trustworthiness of the data collected and analyzed was conducted with rigor being maintained.

A qualitative interpretive study was conducted by Ferranto (2015) regarding how nursing students created meaning from an eight-day (short-term) international cultural experience in Tanzania, Africa. Ferranto (2015) noted a gap in nursing literature that reported on the efficacy of international immersion programs less than one month in

duration. "Cultural humility serves as the basis for good moral education toward optimal health care and culturally competent and effective nursing care" (Ferranto, 2015, p. 94). The concept of cultural humility "developed" as a result of this international cultural experience. Eight nursing students were culturally immersed into an environment very different from their everyday experiences. Students maintained daily reflective journals, and were debriefed daily by nursing faculty. Two focus group discussions, personal interviews, and reflective journals served as the data collection sources. Students developed a keener sense of self-awareness and self-reflection with critique – they experienced "culture shock", along with an appreciation for cultural differences while interacting with a diverse population with different cultural beliefs and practices. Cultural immersion experiences can offer a greater student appreciation for cultural differences that can lead to the development of cultural humility. A greater sense of "self" occurred, along with an understanding of how power imbalances, social injustices, prejudice, and biases affect health care delivery.

In evaluating this study, nursing faculty clarified themes and codes through an ongoing review of pertinent literature. Students member-checked their journal entries and transcripts for accuracy. Transcripts from personal interviews and focus group discussions were peer-reviewed by faculty. Qualitative data collection occurred over a six-month period after the immersion experience. Faculty identified six major themes from the data analysis of student reflective journals, two focus groups discussions, and personal interviews. The themes were: feelings of disequilibrium and culture shock; greater self-awareness and a new understanding of prejudice and bias; a deeper

understanding of similarities and differences; an enhanced awareness of "others" and the development of cultural empathy; a sense of loss ensued after returning home; and descriptions of the international experience as life-changing – with the development of cultural humility. The participants began to understand the shortcomings of an "ethnocentric" belief system. "The immediate benefits of intercultural learning can be seen through the acquisition of cultural skills and the development of cultural humility when interacting with a different culture" (Ferranto, 2015, p. 99). An interpretation of the themes was provided in this study theoretically framed by Langer's theory of mindfulness (1999), and Campinha-Bacote's (1999) concepts of awareness and skills.

Limitations to this study included some students were not able to overcome already-held biases; the immersion experience may have reinforced them rather than reduce preconceived biases. Secondly, the long-term lasting effects of this experience was not stated.

Culturally humble and sensitive care is required especially when providing health care to marginalized populations. Kools, Chimwaza, and Macha (2015) documented that

> marginalization devalues a person based on some social characteristic, condition, or experience. Populations who are marginalized by others are at risk of disrespectful treatment, poor access to care, and overall health disparities, and thus are in great need of culturally competent care. (Kools et al., 2015, p. 54)

Kools et at. (2015) identified a learning model for integrating cultural humility within the clinical supervision and training of health fellows interacting with diverse, marginalized clients in Malawi and Zambia in southern Africa. The HEALS model (Halt, Engage,

Allow, Learn, and Synthesize) promotes self-awareness and self-reflection through respectful and effective classroom and clinical discussions. The HEALS model supports the need to reflect on when the health provider displayed insensitive, disrespectful behavior towards a diverse client. Self-awareness was heightened through self-recognition of preconceived beliefs, prejudices, and biases.

The HEALS model was conducted in group sessions by fellows to support the modeling of diversity and cultural humility in the clinical setting. Respectful communication, as well as modeling culturally sensitive and empathetic care was the focus. "Cultural humility allowed fellows to broaden their definitions of potentially marginalized populations to include people with poor social status based on income, education, or orphanhood, and socially unacceptable behavior such as premarital sex, adolescent pregnancy, and transactional sex" (Kools et al., 2015, p. 57). The article by Kools et al. (2015) identified cultural humility as a key competency for all health care providers providing culturally responsive care, especially to marginalized populations. The article identified a model of care for interacting with diverse, marginalized populations that can be utilized domestically and globally.

To summarize, transcultural immersion experiences for students affords an opportunity to learn and study abroad in a culture different from their own. The experience can be impactful and life-changing for some who have experienced this type of learning. Working with diverse populations requires being respectful to the cultural and social influences that one might observe in practice. Transcultural immersion experiences promotes learning about diverse cultures and lifeways. The practice of self-

awareness with self-critique promotes cultural humility and an appreciation for diverse cultural interactions.

Synthesis of the Literature

Cultural humility has been identified as a practice that requires a lifelong commitment to self-awareness and self-reflection with critique of preconceived assumptions, biases, and prejudices. Variations in the definition have been noted in the literature reviewed. It is a way of being that can be practiced by health professionals to help provide culturally congruent and respectful care to diverse populations.

Literature on cultural humility as a concept is at times "blended" to have the same meaning as cultural competence, a related, but separate concept. The distinguishing features of cultural humility from cultural competence is the lifelong commitment to self-awareness and self-reflection with critique of one's own preconceived assumptions, biases, and prejudices in relation to cultural humility. Cultural competence, on the other hand, oftentimes is viewed as having achieved a finite body of cultural knowledge that has been "mastered" by an individual. Both concepts are processes that can be learned. From the literature reviewed, the concept of cultural humility is not as readily referred to by health care providers, nor is it consistently instructed in nursing education by faculty. It is a concept that focuses on the health care provider being more attuned to their own self-awareness and self-reflection of the power imbalance that may be present between the health care provider and the client that impacts on the provider-client dynamic in health care. While this concept can complement the framework of cultural competence, it is a process that can be developed over time with a lifelong commitment to practice it,

and recognize that through self-awareness and self-reflection, a willingness to learn from "others" can help mitigate the power imbalance that may be present between the health care provider and the diverse individual, group, or community. Institutional accountability in acknowledging and recognizing this power imbalance would support discussions and strategies to reduce inequities in health care.

There was an identified gap in the literature on how to consistently include cultural humility education in the curricula of multiple disciplines of learning. The level of evidence of faculty consistently presenting and educating nursing students on cultural humility is limited in the literature reviewed. The reviewed literature had several studies that addressed cultural humility as a concept that can be used especially when working with diverse populations. There was a lack of empirical data in nursing research on cultural humility. With the changing demographics in society, students from multiple disciplines are faced with how to effectively address the complexities of diverse clients with sensitivity and respect.

The educational preparation of nursing students includes instruction on patient values, diversity, and nursing care provision in a culturally appropriate and congruent manner. Nursing faculty are challenged in presenting students with issues surrounding the increasing diversity of clients within health care. Instruction on cultural competence is a standard and value asset in nursing education. Instruction on cultural humility, however, is not consistently presented in baccalaureate nursing education.

A body of research literature on cultural humility exists within several discipline areas. At present, the need for validated instruments to quantitatively measure cultural

humility is needed. One validated instrument to specifically measure cultural humility from the client's perspective was identified in the literature from the field of psychology. Nursing science would advance in the development of a nursing tool that empirically measures some aspect(s) of cultural humility from a nursing perspective that could be used in research. Qualitative research studies have provided insight to a client's response to health care provided by health professionals practicing the concept. Research instruments used to assess aspects of cultural competence do not explain the concept of cultural humility.

Some strategies to address the use of cultural humility with diverse populations includes cultural immersion, service learning experiences, and reflective journaling that can help sensitize health care professionals and students to the effects of health inequities in society. Nursing simulation instruction and exercises on cultural humility can be designed to promote student awareness and student learning on aspects of social justice, and student empowerment to address health equity within society. A willingness to be self-aware, and self-reflective with critique to identify already-held beliefs and biases can offer a heightened awareness of the power imbalance that may be adversely affecting health care provision due to conscious or tacit reasons. With faculty instruction and guidance, students can use reflective journaling to safely express one's thoughts, concerns, beliefs, and self-awareness. Cultural immersion and service learning offers a richness in learning that cannot be obtained solely in a classroom. The practice of cultural humility can be exemplified during these experiences.

Chapter Summary

A literature review on cultural humility revealed a concept that was not as familiar in definition or approach. An exploration of the concept definition, and a review of discipline specific areas where the concept has been identified was performed. The disciplines of nursing, nursing education, medicine, kinesiology, psychology, social work, and transcultural immersion experiences were each presented with reference to research studies and discussion papers on cultural humility in each disicipline area.

Literature on cultural humility can be overshadowed, and sometimes embedded with cultural competence. Discipline specific areas were presented in addressing cultural humility. Research studies and discussion papers on the topic were presented to understand how the concept was demonstrated within different areas of learning. A synthesis of the literature was presented to identify areas where the concept of cultural humility was recognized, as well as gaps in learning about the concept. Nursing faculty may be challenged to instruct on cultural humility based on their knowledge of the concept itself. While instruction in nursing education generally included content on cultural competence, the same may not be true regarding cultural humility.

The literature review presented in this chapter has identified an area for nursing investigation – a description of cultural humility as perceived by nursing faculty. There is a gap in nursing research and literature regarding nursing faculty's perception of cultural humility, and how nursing faculty perceive that they demonstrate cultural humility in the educational context.

Chapter 3

Methodology

The methodology of this qualitative descriptive study is presented in this chapter. Data collection was performed using an online focus group methodology. The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students. In the seminal work on qualitative research methods, Sandelowski (2000) stated "qualitative descriptive study is a method of choice when straight descriptions of phenomena are desired" (p. 334). The researcher remains "close to the data" being observed and described.

The research questions for this study were:

1. What are nursing faculty perceptions of cultural humility in baccalaureate education?
2. What are the characteristics of cultural humility as perceived by nursing faculty?
3. How do nursing faculty perceive that they demonstrate cultural humility in the educational context?

Research Design

In this study, a qualitative descriptive design using a naturalistic inquiry paradigm was used to gain insight from nursing faculty on their perception of cultural humility. Naturalistic inquiry was proposed as an independent paradigm of inquiry by Lincoln and Guba (1985). This type of inquiry allowed for describing the nature of reality from multiple perspectives. This nature of reality can neither by proven or unproven.

The naturalistic paradigm by Lincoln and Guba (1985) has five tenets, or axioms that are identified in qualitative research. The first tenet relates to the nature of reality (ontology) which is multiple in number. These realities are constructed and holistic. Researcher inquiry into these multiple realities will be different, and more questions will be generated by the inquiry. There is an unlikely outcome to make predictions or to control the realities as they unfold. The researcher gains some understanding from their inquiry. The second tenet of naturalistic inquiry speaks to the relationship between the knower and the known. This tenet deals with the epistemology between the researcher and the subject. According to Lincoln and Guba (1985), the source of knowledge and the researcher are inseparable.

The possibility of generalization is the third tenet of naturalistic inquiry. Naturalistic inquiry acknowledges that phenomena explored are bound by time and context. Causal linkages are the fourth tenet in naturalistic inquiry. It is not possible to distinguish cause from effect at this level of inquiry. All entities are being shaped at the same time, so no causal linkages can be identified. The fifth tenet of naturalistic inquiry states that inquiries are influenced by the values of the researcher, such as choosing a particular phenomenon of interest to be explored. Inquiry is also influenced by the researcher's choice of paradigm to guide the research process. The choice of a substantiative theory guides data collection, analysis, and interpretation of the findings. Researcher inquiry will be influenced by the values inherent in the context of the phenomena of interest. In order to produce meaningful results, the inquiry process must

be congruent with the problem statement, paradigm, theory, choice, and context (Lincoln & Guba, 1985).

The strength of qualitative descriptive research is that it permits inquiry into a phenomenon in its natural state. "The researcher studies something in its natural state and does not attempt to manipulate or interfere with the ordinary unfolding of events" (Colarafi & Evans, 2016, p. 18). According to Sandelowski (2000), qualitative research allows for an interpretive description of the data. This interpretation can offer insight to the concept of cultural humility from the faculty's perspective through self-awareness and self-reflection with critique. Baccalaureate nursing faculty's perception of cultural humility was sought; and faculty reflective comments were used to document preconceived beliefs; assumptions; biases; and prejudices that may exist regarding diverse populations influenced by one's own culture.

Setting

Online synchronous focus group interview sessions were conducted at pre-determined dates and times. This researcher moderated the sessions from a locked, private office within the home. All focus group sessions were digitally recorded. The teleconferencing platform Zoom® was used as a method of data capture. According to Tuttas (2015), web technology can provide the immediacy of participant responses, along with moderator involvement. Also, the observance of group interactions and group dynamics was possible. Participants remained at their own locations which eliminated the need to travel in order to participate in the focus group sessions. Participants were

required to have access to a computer with a front-facing camera, a microphone, speakers, and an Internet® connection.

Sample

Full-time and part-time nursing faculty from local colleges and universities who taught at accredited baccalaureate nursing programs were invited to participate in the study. Nursing faculty taught in a variety and number of courses within the baccalaureate nursing curriculum. Faculty taught in a variety of settings, including classroom, patient care areas with students, as well as a combination of both settings.

Inclusion Criteria

Nursing faculty with at least two years teaching experience in a baccalaureate nursing program who self-identified as practicing cultural humility were recruited to participate in this study. Faculty self-identification was defined by the researcher as having prior knowledge of cultural humility, and by participants already instructing and displaying the concept from their perspective among nursing students in the classroom and/or clinical settings. Faculty who taught in RN-to-BSN and Accelerated BSN programs were included in recruitment. Didactic and recent clinical teaching experience within the past academic year was required. The minimum level of educational preparation was a Master's degree. All nursing faculty had to be able to read and write English; and have the ability to provide written, informed consent to participate in the study.

Exclusion Criteria

Nursing faculty teaching in non-baccalaureate nursing programs were excluded from the sample. Accredited nursing programs for this study had been established by this researcher. Any nursing faculty without a Master's level of education were excluded. Faculty with less than two years teaching experience at the baccalaureate level were excluded.

Description of the nursing faculty sample. The purposive sample of nursing faculty (N = 20) consisted of all females; predominantly White; ranging in age between 30 years to 66 years; the median age was 53. Racial diversity within the sample included Black (n = 5) and Hispanic or Latino (n = 1) nursing faculty. The majority of faculty participants were Master's prepared nurses (70%), followed by doctorally prepared nurses – DNP (5%); EdD (5%); and PhD (20%). There was a total of 12 different clinical areas of specialty taught by the participants; along with a wide variety of teaching specialty areas. Most faculty participants provided instruction in multiple specialty areas with baccalauareate students both in the classroom and clinical areas. Descriptive statistics were used to display the demographic data collected, and are presented in Tables 1 and 2.

Table 1

Descriptive Statistics of Categorical Demographic Data (*N* = 20)

Variable	**Category**	***n***	**%**
Race	Black	5	25.0
	White	14	70.0
	Other	1	5.0
Ethnicity	Hispanic or Latino	1	5.0
	Non-Hispanic or Latino	19	95.0
Highest Level of Education	Master's	14	70.0
	DNP	1	5.0
	PhD	4	20.0
	EdD	1	5.0
Clinical Area(s) of Specialty*	Cardiac/Pulmonary	1	5.0
	Care Management	1	5.0
	Community/Public/Urban Health	6	30.0
	Critical Care	9	45.0
	Emergency Room	1	5.0
	Leadership	2	10.0
	Maternal Health	2	10.0
	Medical-Surgical	2	10.0
	Oncology	1	5.0
	Pediatrics	3	15.0
	Psychiatric Nursing	2	10.0
	Telemetry	1	5.0
Teaching Area(s) of Specialty*	Community/Public/Urban Health	6	30.0
	Critical Care	6	30.0
	Epidemiology	1	5.0
	Evidence-Based Practice	1	5.0
	Fundamentals	1	5.0
	Genetics and Genomics	1	5.0
	Global Health	1	5.0
	Health Policy	1	5.0
	Informatics	1	5.0
	Leadership	3	15.0
	Maternal Health	2	10.0
	Medical-Surgical	6	30.0
	Pediatrics	4	20.0
	Pharmacology	1	5.0
	Psychiatric/Mental Health	2	10.0
	Simulation	2	10.0
	Telelmetry	1	5.0
	Trauma	1	5.0

Note: *Participants were experienced in more than one clinical and/or teaching specialty area.

Table 2

Descriptive Statistics of Continuous Demographic Data (*N* = 20)

Variable	Mean	Median	Mode	Range
Age in Years	52.7	53.0	53, 65	30 - 66
Years Teaching Nursing	10.7	7.5	3, 4, 6, 15	2.5 - 38
Years of Nursing Experience	29.5	31	18, 23	6 - 45

Recruitment

Following Institutional Review Board (IRB) approval for solicitation of participants, a target sample size of 20 participants was sought. A minimum of four focus group sessions had to be conducted in order to obtain sufficient qualitative data to reach saturation. A snowball sampling technique was used to recruit study participants. This technique allowed for enlisting potential participants who self-identified with the concept of cultural humility to participate in this research study. Recruitment techniques included professional networking among nursing faculty from various baccalaureate nursing programs to reach potential participants. This researcher over-recruited by two additional participants to allow for the possibility that a participant might need to cancel for unforeseen circumstances. All recruited participants were able to partake in their scheduled focus group session as agreed. The number of participants for each online focus group session ranged from two to four participants. The small number of participants for each focus group session allowed the researcher/moderator to manage the online discussion between participants. Participants made their selection for one

scheduled focus group date from pre-determined dates and times as provided by the researcher.

A recruitment e-mail (Appendix B) was sent to potential participants with an attachment that was the Information Flyer (Appendix C) stating the purpose of the study, along with the basic criteria to participate. Recruiting a sufficient number of participants was key to ensuring that enough participants contributed to the in-depth discussion that afforded a full range of respondent experiences (Forrestal et al., 2015).

Potential participants who responded to the Information Flyer (Appendix C) were contacted by the researcher via a dedicated e-mail address specific for this study. The researcher then screened potential participants by telephone contact within three days after receiving an interest to participate in this study. A Screening Tool (Appendix D) was used by the researcher to facilitate recruitment. If deemed appropriate, participant contact information (name, e-mail address, and contact phone number) was confirmed. Two potential participants were screened ineligible to participate in this study. One nursing faculty had been instructing nursing students in the classroom setting less than two years as required in the inclusion criteria. The second nursing faculty was instructing nursing students at the associate's level.

Next, participants received an e-mail message (Appendix E) containing the pre-determined online focus group dates and times, as well as two attachments that contained the Consent Form (Appendix F) and Demographic Data Form (Appendix G) for review and signature. Participants were required to return to the researcher within seven days both the Consent Form (Appendix F) signed, and the Demographic Data Form

(Appendix G) via e-mail to participate in this study. These documents were required prior to participation in the study. Once received, the researcher sent an e-mail confirming receipt of the signed Consent Form (Appendix F), the completed Demographic Data Form (Appendix G), and preferred date and time for the online focus group session.

Efforts were made by the researcher to keep the number of participants in each focus group at a manageable number. From the dates and times provided, each focus group consisted of two to four participants per session. A total of seven focus group interview sessions were conducted at pre-determined dates and times. Two additional dates and times for focus group interviews were offered to accommodate participants who were not able to confirm on a pre-determined date and time. All focus groups were conducted by the researcher using the Focus Group Interview Guide (Appendix H). The focus group interview sessions occurred over a two-month period. Study recruitment was continued until the targeted sample size was achieved.

Instrumentation

Researcher as Instrument

This researcher was an instrument for data collection in this qualitative descriptive study. This allowed the researcher to stay close to the data as it was being collected. There was no manipulation or interference with how the information was collected. This researcher was the moderator for all focus group sessions.

This researcher conducted a qualitative descriptive study with a background training of graduate level courses each in qualitative and quantitative research. Prior to

actual data collection, this researcher conducted a "simulated" online focus group session with several nurse educators who were not study participants to test the ability to connect remotely into the teleconferencing platform Zoom®. Clarity in statements and interview questions was sought before the actual focus group sessions.

Demographic Data Form

A demographic form (Appendix G) was used to collect information regarding the diversity among nursing faculty within the focus group sessions conducted. First names, or pseudonyms were used by participants in completing and returning this form to the researcher.

Interview Guide

This researcher used an Interview Guide for Focus Group Sessions (Appendix H) to start each interview session which was digitally recorded. After a brief welcome to all participants, an overview of the purpose of the interview for this study was presented. In the spirit of staying focused to gather data, the researcher presented general guidelines for conduct during the online focus group sessions as outlined in Appendix H.

Interview Questions

Semi-structured, open-ended interview questions (Appendix I) were asked. The interview questions were guided by the research questions for this study. Interview questions were developed to allow participants to reflect on their perception and demonstration of cultural humility in the educational process.

Data Collection Procedure

The researcher collected via e-mail a signed Consent Form (Appendix F) to voluntarily participate in this research study and a completed Demographic Data Form (Appendix G). Two follow-up e-mail contacts were made by the researcher to maintain participant interest in the research study, and to help minimize the possibility of not being present during the scheduled online focus group session that was selected. Communication regarding the use of Zoom® technology to connect into the web-based meeting environment was provided before the scheduled focus group sessions in the e-mail follow-up communication sent by the researcher to maintain study interest. Instructions to click on the Zoom® meeting link sent by the researcher to connect into the web-based meeting environment was provided. Participants were invited to test their ability to connect with the online platform prior to their actual online session by having them connect to the virtual meeting space 10 to 15 minutes before their scheduled focus group session. Four participants experienced difficulty connecting to Zoom® via their Internet® connection. Each participant had to either try again to connect to the meeting using the provided link, or use their cellphone or landline to dial in directly to the meeting. Once connected, the moderator brought all participants into the interview session to allow everyone to participate in the discussion generated by the interview questions.

Online Focus Groups

The online synchronous focus group sessions were conducted using a web-based software technology program called Zoom®. This software technology was chosen in

light of the ease of coordinating online interviews via a computer link, along with audio and visual capabilities. If a participant chose not to be on video during the online focus group, they had that option. Four participants from different focus groups were not visual to the group or moderator, but were active during their assigned session. The visual interaction between these four participants, their interview group members, and the moderator was not possible. However, the verbal responses with their focus group and the moderator was engaging and insightful. The audio-video portion of all interviews were digitally recorded and stored on a secure server. The Zoom® software package had the capability to "save the audio-video recording to the cloud necessitating an immediate download of the file after completion of the focus group to a secure server" (Forrestal et al., 2015, p. 7). As a safety back-up for technical difficulties while using Zoom®, the researcher recorded all focus group sessions with a portable audio recorder that had the capacity to pick up sound from the computer speakers attached to either a desktop or laptop computer. The researcher was located in a private, locked office during all focus group sessions.

Data Analysis

At the conclusion of each focus group session, the digital recording of the session was downloaded from Zoom® to an audio file. Each audio file was forwarded via a secure Internet® encrypted computer to an independent transcription service for a verbatim transcription record of all focus group sessions. By one week after submission, a typed transcribed record was forwarded to the researcher for each focus group session.

The researcher read through the transcribed document line-for-line, along with reviewing the digitally recorded focus group session for accuracy of the transcription.

Content and Thematic Analyses

Data analysis consisted of content and thematic analyses using the Morgan and Krueger (1998) approach. A systematic approach to data analysis was used to ensure qualitative validity of data collection and analysis. The purpose of content analysis was to describe the characteristics of the document's content by examining who says what, to whom, and with what effect. Data were coded and categorized to analyze each focus group session. Data collected from the transcripts were read word-for-word, and then coded for accuracy in the transcription to gain an understanding from the participants' perceptions and reflective comments offered during the focus group sessions.

Content analysis provided for analysis of words and phrases in the transcribed documents. "The expected outcome of qualitative descriptive studies is a straight descriptive summary of the informational contents of data organized in a way that best fits the data" (Sandelowski, 2000, p. 338). A detailed descriptive summary of the qualitative findings for this study were organized, coded, transcribed, and grouped according to identified themes, subthemes, and strategies.

This researcher worked from the transcribed interviews to determine how the data would be coded in a systematic process for consistency in data analysis. According to Morgan and Krueger (1998), systematic analysis is a prescribed, sequential process to ensure study results will be as authentic as possible. During the review of each transcript,

when an idea or phenomenon was noted, a label was attached to it, and given a code in the margins of the transcript document. Common codes were then clustered together.

Thematic analysis was used to identify and report patterns (themes) of the data. According to Vaismoradi et al. (2013), thematic analysis provides a qualitative, detailed account of data. Themes were generated by coding same or similar data findings from the transcribed data. Specific themes were labeled to see how the data "fit" the description of the grouped data. This researcher identified common threads from the collected data as faculty shared their perceptions of cultural humility demonstrated in the educational process of students.

The researcher identified themes, subthemes, and strategies from the recorded interviews to capture the data. Theme codes were established for the grouping of data in the overall analysis of findings. Triangulation, as a research method, uses multiple approaches to generate meaningful data. In this study, data generated from the online focus group sessions, faculty reflective comments during group interviews, and researcher notes helped to establish triangulation and validity of research findings. Reflective comments from participants were shared during the interview process itself; no participant used the chat area within Zoom® to communicate any individual comments to the researcher. Saturation of research data was achieved when recurrent themes were generated capturing the participants' perceptions. No new information at this level was identified in the data analysis.

Research Trustworthiness/Rigour

The trustworthiness, or validity of the collected data was established to minimize possible researcher bias. Research rigour in qualitative research allowed for accurately representing the participants' experiences. Qualitative rigour was maintained in this study by establishing researcher objectivity, dependability, credibility, transferability, and application (Colorafi & Evans, 2016). Peer debriefing allowed for the validation of collected data with the assistance of three experienced qualitative researchers in the process.

Objectivity

"Objectivity (confirmability) is conceptualized as relative neutrality and reasonable freedom from researcher bias" (Colorafi & Evans, 2016, p. 23). An audit trail sample of analysis (Appendix K) was created by the researcher describing explicitly study methods and procedures, how data were collected, analyzed, and presented. This researcher remained neutral throughout the research process to establish and maintain authenticity of the captured data. A reflective journal was maintained by this researcher throughout the research study to record observed data and participant group dynamics as they occurred during the interview for each focus group.

Dependability

Research dependability, or the reliability or auditability of the data collected, was obtained by demonstrating consistency in procedures (Colorafi & Evans, 2016). The same interview questions were used in all focus groups to generate discussion within

each group. The same interview guideline was used for all focus groups during the interview process by the moderator.

Credibility

Credibility (or internal validity) refers to the truth value of the data. The findings of this study must make sense to be deemed credible. Participants made thoughtful and insightful comments when responding to the interview questions. Content-rich descriptions were reviewed by the dissertation committee during peer debriefing of data analysis and research findings.

Transferability

Transferability, or the "fitting" of the research findings, refers to whether the findings possibly have a larger impact and application in other settings or studies. Colorafi and Evans (2016) stated that the generalizability of data gathered will permit areas for further nursing research. Data collected demonstrated how the concept of cultural humility can be recognized and put into nursing practice by nursing faculty, students, and professional nurses in the workforce.

Application

Possible changes in nursing faculty perception of cultural humility may be facilitated by this research. Secondly, instruction on cultural humility in nursing education consistently in baccalaureate nursing programs could be considered. Also, the opportunity for nursing faculty to demonstrate cultural humility from their perception could allow for the concept to be modeled by students to improve provider-client

relations. The differentiation between cultural humility and cultural competence, a related, but different concept, was noted with the information generated by this study.

Ethical Considerations

Protection of Human Subjects

Institutional Review Board (IRB) approval through Widener University was first obtained to ensure human subject research protection and privacy. Permission to participate in this study required the participant's signed informed consent (Appendix F) that one was doing so on their own free will and without coercion.

Confidentiality. Participant confidentiality was maintained throughout the study. Pseudonyms, or use of participants' first name only was established for privacy. No specific university was identified by name, and no specific geographical location of any institution was stated. The researcher conveyed to participants they were participating in a research study, and were given the purpose of the study (stated in the Information Flyer - Appendix C) to provide disclosure.

Risks. Describing one's perception of cultural humility may generate a minor, untoward psychological response from and between participants that may cause a participant to feel uncomfortable. A participant may recognize a focus group individual from the screen view of the web-based meeting environment in Zoom®. This occurred during two focus group sessions; the researcher/moderator verbally reminded the group of the purpose for the online session was to collect research data, and not to personalize the group dynamic process. Participants could leave the focus group session at their discretion, as well as not respond to an interview question if this helped to mitigate their

feelings. As the researcher, boundaries on limiting an untoward emotional response was established by maintaining participant privacy and establishing self-disclosure limits.

The need to re-focus the group discussion to the concept at hand was done by the researcher during two interview sessions. Sensitive issues regarding culture, diversity, ethnicity, and race were raised in discussing cultural humility when one participant began a lengthy discourse on the need to justify their race to a nursing student while in the clinical setting. Another participant spoke at length about the perceived lack of respect displayed by nursing students towards diverse clients in the clinical area. The concept of discussion was reiterated by the moderator in both instances, and the interviews moved to completion. These two incidents did not negatively impact the tone or spirit of the discussions in the group process. The Interview Guide for Focus Group Sessions (Appendix H) assisted in keeping the discussion on course. Participants from all focus group sessions responded to all questions asked from the Interview Questions as stated in Appendix I.

After receiving the Interview Guide (Appendix H) from the researcher, participants were provided information of where to seek outside professional help and support if needed for possible emotional psychological discomfort revealed during data collection from the focus group interview (Appendix J). Each participant was free to withdraw from the study at any time with no penalty of reprisal. Participants were able to contact the researcher with questions about the study through a dedicated e-mail address that was provided. None of the participants withdrew from the study.

Data storage. Collected data were secured, stored, and maintained by the researcher, and accessible only to the researcher. Collected data were stored in a locked, fire-proof file cabinet. The computer used to access and retrieve study data was password-protected, and accessible only to the researcher who was the sole user. It was kept in a private, locked office within the researcher's home. No full names or identifying information was used during data collection. Reflective comments made during the group session interviews from participants were coded and secured for data analysis.

The selected transcription service provided a written statement that as a business, audiotaped recordings are protected from unauthorized access, as well as protected from alteration of data submitted. A Confidentiality/Non-Disclosure Agreement between the researcher and the independent transcription service was signed by both parties prior to the transfer of any digitally recorded data collected from focus group interview sessions. This researcher maintained security for the external back-up digital recordings for each focus group session. The portable recorder which contained an audio record of each focus group session was kept locked inside a fireproof filing cabinet in the researcher's home when not in use. All external audio recordings were permanently deleted after receiving the typed, transcription record of all sessions from the selected transcription service.

Informed Consent

The purpose of this research study was clearly stated in the Consent Form (Appendix F) that was sent electronically to all potential participants. After reading the

information provided, interested nursing faculty who desired to participate in this study did so under their own free will, and free from coercion.

Compensation and Costs

Participants in the study received a $50.00 VISA® gift card electronically after the conclusion and participation in the scheduled focus group interview session. The interview time limit of 120 minutes needed to be compensated for time spent in a focus group session. There were no additional participant costs.

Chapter Summary

The methodology for conducting a qualitative descriptive study regarding cultural humility as perceived by nursing faculty was presented. This particular qualitative method was selected to gain a fuller understanding of faculty's perception of the concept, and how it is demonstrated by faculty in the education of nursing students in baccalaureate programs.

Institutional Review Board (IRB) approval was granted before recruitment of any participant. Research trustworthiness/rigour was maintained with peer debriefing, and data analysis performed in a systematic manner. Participants were compensated for their time, and received the agreed value of a $50.00 VISA® gift card electronically after the focus group.

Recruitment for this study used the snowball sampling technique; the targeted sample size of 20 participants was achieved. A total of seven, synchronous online focus group interview sessions were conducted using the teleconferencing platform Zoom®. This researcher was the moderator for all sessions for consistency in data collection.

Specific interview questions were presented to generate discussion among group participants.

Content and thematic analyses assisted in the systematic coding and categorization of the data. Three experienced qualitative researchers assisted this researcher in the analysis.

Chapter 4

Findings

This chapter includes a presentation of the findings from the focus group interviews, and the themes, subthemes, and strategies that were generated from data analysis. The themes, subthemes, and strategies have no order of priority as presented in this chapter. This chapter is organized by the study research questions. Quotes from participant responses are provided to support each theme, subtheme, and strategy.

The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate nursing students. Twenty nursing faculty participated in this study (*N* = 20*)* from eight universities in Pennsylvania, New Jersey, and South Carolina. Participants provided full-time or part-time instruction in the classroom, the clinical areas, or a combination of both. A total of seven synchronous online focus group interview sessions were conducted using the teleconferencing platform Zoom®, with group discussions ranging between two to four participants in each focus group session.

The recognition of culture – be it one's own culture, someone else's culture, or the professional culture of nursing was present in all focus group interviews. For this study, culture was defined as shared attitudes and behaviors, values, beliefs, customs, rituals, and practices of a group or community. Additional findings from participant responses are also presented in this chapter although these data did not reach saturation. Participant insights and comments that had bearing on the discussion are also noted.

Themes

Participants were asked to respond to questions targeted to provide a description of cultural humility as perceived by nursing faculty in baccalaureate education. Three research questions guided this study. Qualitative data were collected from focus group interviews that generated the themes and subthemes presented in Table 3.

Table 3

Themes and Subthemes Related to A Description of Cultural Humility

Themes for Perceptions of Cultural Humility	**Subthemes**
Having self-awareness of one's own culture	*Being respectful and humble to others*
Being self-reflective is an ongoing process	*Self-discovery of one's own cultural influences*
	Walking in another's shoes
Themes for Characteristics of Cultural Humility	
Respecting other cultures	
Being unbiased	
Themes for Cultural Humility in Educational Context	
Distinguishing between cultural humility and cultural competence	
Threading cultural humility throughout the nursing curricula	

Cultural Humility in Baccalaureate Education

Having Self-Awareness of One's Own Culture

"What are nursing faculty perceptions of cultural humility in baccalaureate education?" Faculty participants were interviewed to get their perspectives of cultural humility in baccalaureate education. From the data analysis, self-awareness was identified as being necessary to have in the practice of cultural humility. The first research question guiding this study generated two themes and three subthemes from participants responding to their perceptions of cultural humility. The first theme *having self-awareness of one's own culture* had the subtheme *being respectful and humble to others.* The second theme generated *being reflective is an ongoing process*, had two subthemes *self-discovery of one's own cultural influences*, and *walking in another's shoes.*

The first theme generated was *having self-awareness of one's own culture.* This *self-awareness* was described by the participants as having knowledge of one's own culture and background necessary to understand another person's culture. Participants in all seven focus groups stated *having self-awareness of one's own culture* as necessary to having cultural humility. Monica described cultural humility as "being aware of one's own culture as well as others; its an awareness that you have your own culture, but also others have their own culture as well." Shari offered this statement on her perception of cultural humility in baccalaureate education, "It has to start with you recognizing your own culture and that it is a product of your upbringing." Another description provided by

Tasha stated, “It allows you to be able to understand and be receptive to other people’s cultural aspects.”

The understanding of one’s own cultural background can provide insight to exploring, understanding, and appreciating the differences in others. Roberta shared her thoughts on *having self-awareness of one’s own culture*:

> It’s an ongoing process throughout life. Self-awareness, I mean, you really have to do that self-introspection as uncomfortable as it may be to identify things that truly aren’t aligned with our stated values.

In describing this theme, an understanding of one’s own beliefs and prejudices was stated by Tasha, “I think cultural humility is understanding what your beliefs and prejudices are towards whatever population, or your understanding of what a certain population’s beliefs are.”

Being respectful and humble to others. A subtheme was identified from the data, *being respectful and humble to others.* In striving to better understand an individual’s position and viewpoint, an interpersonal stance of being open to others is warranted when practicing cultural humility. The ability to demonstrate meekness and sensitivity as feelings associated with being humble when trying to understand another individual was expressed by several participants who stated how *being respectful and humble to others* was paramount in establishing a meaningful dialogue between the health care provider and the individual. When practicing cultural humility, assumptions, biases, prejudices, and misconceptions can be brought forth through self-awareness and a critical self-reflection with critique of preconceptions already held. Lori expressed in her

description of how *being respectful and humble to others* as, “Immersing myself in a different environment than I’m used to, and trying to see how other people live.” The intent to earnestly “hear and understand” the other person was present in participant responses. Being humble to others is taking a compassionate, empathetic stance towards another person to critically listen to better understand that person’s perspective.

Sofia provided additional elements of cultural humility with the following comments, “Being respectful; understanding of differences; being unbiased; and being egoless.” Nichole described having empathy when practicing cultural humility as, “Understanding what people are going through; I always go back to sometimes you have to humble yourself.” Cecilia expressed the following comment on this subtheme, “I think it’s being personally sensitive and considerate of someone who is different than I am.”

Being respectful and humble to others requires one to “step back” to self-reflect and relinquish their position of “expert” in seeking to understand the perspective of others. When the value system from other cultures are recognized and acknowledged, a sense of humility and respect for others is present. Loraine offered the comment:

> It means I need to be humble enough to understand that there’s multiple cultures in our world that all influence each of us in a different way. I think it could be a lifelong journey for all of us.

Being Self-Reflective is an Ongoing Process

The second theme generated from the data analysis of the first research question was *being self-reflective is an ongoing process,* with the subthemes *self-discovery of one’s own cultural influences,* and *walking in another’s shoes*. This second theme is an

ongoing process that requires people to self-examine their own personal culture, as well as being willing to learn about someone else's culture with an openness and appreciation for the differences that may be identified. Overall, each focus group described this theme in relation to continuingly looking inward, taking into account patient care, cultural preferences, and an understanding of the nursing students being taught. A key component expressed in *being self-reflective* was that it required a continual introspective as well as a retrospective examination of oneself that was ongoing. Roberta expressed that cultural humility as a lifelong journey of self-reflection with the following comment:

> When I think about cultural humility I do think of critical self-reflection. It doesn't happen; it's not a one-time thing. It's an ongoing process throughout life. This is the lens that you use to look at patient care, patient services, how you communicate, how you partner. You want to be self-reflective but you need to bring in those things such as power, privilege, discrimination, biases be they conscious or unconscious. Being self-reflective hones in on being able to see yourself in this 'space' – be you like it or not like it – and how you want to move and go about things differently based on that reflective component.

Being self-reflective requires an ongoing critical inner examination of one's own attitudes, beliefs, and values. It can provide insight to one's own pattern of behavior originating back to one's own cultural experiences and background. Diane offered a comment in reference to culture and being *self-reflective*:

> I think culture is more than an ethnic situation. It's everything we bring to whatever situation we are in, to our homes and family backgrounds, our social groups. And it's definitely a lot of self-reflection because sometimes you don't. It's a whole different approach to looking at patient care, or at your students. Your cultural understanding is probably rooted in all of your history.

Shari offered her comment on *being self-reflective*:

> It has to start with you recognizing your own culture, and that you are a product of your upbringing, and how you were raised, and the various influences on your whole life. In recognizing that everyone has their own cultural background and influences, this opens the door to interact with others from different backgrounds more effectively.

Participants from the various focus groups expressed that culture itself was an essential component to be cognizant of when *being self-reflective.* Participant SBD shared when instructing students on the subject of cultural humility, the subtheme of *being self-reflective as an ongoing process* is present:

> So without using the words (self-reflection), teaching about cultural humility, and having them examine themselves as to their own culture, and how they got to where they are with their culture, and then looking at others, students have to think about what they know about their own culture, then take into consideration what they know about someone else's culture.

Self-discovery of one's own cultural influences. This subtheme was identified as participants shared how *being self-reflective* required a critical examination of one's

own culture and belief system. Participants expressed that their own conscious awareness of their beliefs was necessary. In "stepping back", participants shared that they had a heightened self-awareness of their preconceived assumptions, beliefs, misconceptions, and prejudices about other cultures. Through self-examination, this leads to an openness to learn about and from others from a culture different from their own. Meg shared the following:

> Cultural humility has to do with yourself, like myself as an individual. And it's kind of about looking retrospectively. Once you're realizing your own misconceptions as well as how you view each person, you're able to kind of understand other people and students.

For one participant, *self-discovery of one's own cultural influences* included a self-awareness regarding her own acknowledgement of her own culture. Tasha shared:

> Cultural humility is discovering for myself that knowing my own culture and being comfortable with it, and being able to identify with my own community. That allows me to be able to understand and be receptive to other people's cultural aspects. You have to remove yourself and take out all of the personal biases about the situation.

Culture impacts how individuals communicate with each other. Using *self-reflection* to help bring one's beliefs to the forefront, the subtheme of *self-discovery* can offer an acknowledgement of how one's own culture impacts on interactions with people from different cultures. Sofia shared the following comment:

> A step-back approach, rather than going into some relationship knowing that you're having preconceived notions of what that will be like. It allows me to be understanding of different cultures and unbiased towards others.

Self-discovery from the perspective of the interviewed nursing faculty allowed one to look back and reflect on their own beliefs, misconceptions, and preconceived ideas related to others, with an acknowledgement of these views. In practicing cultural humility, the participants shared an individual is willing to understand and learn viewpoints and beliefs that may be different from their own belief system. An openness to learn and better understand the "other" is present. The client is allowed to express their concern(s) without interruption or interjection of an opinion or statement by the listener. Authentic, or critically listening to the individual speaking at that moment was required of nursing faculty. The intent of authentically listening was to better understand the perspective of the "other" person. Respectful engagement when interacting with clients was noted by nursing faculty. Shari provided her reflection on *self-discovery*, adding:

> It has to start with you recognizing your own culture and that it is the product of your upbringing. And then recognizing that it is unique to you, and is not better or worse than any other belief system or culture.

This subtheme offered insight to participants' reflecting on how their own culture can influence interactions with others. Culture is transmitted through learned and shared patterns of behavior, traits, and customs.

Walking in another's shoes. A second subtheme was generated from data analysis *walking in another's shoes.* This subtheme was identified as participants were probed to gain a deeper understanding of what occurred from their own self-introspection. A self-recognition of preconceived assumptions and beliefs were acknowledged by participants. Participants noted that a non-judgmental position is brought into the interaction with others from different cultures and belief systems. Critical listening skills helped to foster an understanding of another's viewpoint or life experiences in their own words. Participants stated feelings of empathy and compassion for individuals they were interacting with, and in sharing that other person's experience, the subtheme of *walking in another's shoes* was noted in the data analysis.

All focus group participants shared some experience either in the classroom and/or clinical setting where cultural sensitivity and empathy were expressed by "stepping back" to better appreciate some aspect of another's situation. Loraine shared the following comment:

> Cultural humility is being respectful. Cultural humility is being kind; other-centered, versus always about egocentric 'me'. And it's not believing that I'm better than anybody else. I don't have that superiority going on.

Participants critically self-reflected on their perception of cultural humility. Several participants offered similar responses that fell under this subtheme that requires self-introspection when practicing cultural humility. Claire provided a self-reflection with students as, "What I say to the students is we never learn anything about anyone else unless we understand other people's culture." Monika expressed:

> Lifelong learning and critical self-reflection, recognition and challenge of power imbalances, and then institutional accountability. Its basically like walking in someone's shoes. I use cultural humility teaching international health and public health, so I think a lot of it as walking in someone else's shoes and perspective. I talk a lot about perspective. I use that as an example to the class, just like saying you always have to challenge yourself in terms of perspective. How do others see you?

Taking a "step back", and "not looking down on a person" were comments shared by participants when asked to describe characteristics of cultural humility perceived by nursing faculty. Loraine shared the following comment, "It's meeting that person where they are. Leaving the bias outside. An appreciation of culture." Claire further commented, "But you have that preconceived thing, so you have to be open to differences, how people live their lives and who they're connected with and so forth, and what's their experience."

This subtheme allowed participants to share how *walking in another's shoes* displays respect for others through sensitivity and showing empathy. Participants critically reflected how already-held belief patterns and assumptions are put aside to better appreciate others in the present moment.

Characteristics of Cultural Humility

"What are the characteristics of cultural humility as perceived by nursing faculty?" A description of characteristics of cultural humility was asked of faculty participants for a response. Discussions from the focus group interviews offered

characteristics that were repeatedly expressed by the participants as a whole. The second research question guiding this study generated descriptions of characteristics of cultural humility as perceived by participants. From the focus group interviews, two themes were generated from data analysis: *respecting other cultures,* and *being unbiased.*

Respecting Other Cultures

The recognition of culture as a perceived characteristic of cultural humility was expressed by all focus groups. Participants were asked to describe *respecting other* cultures in relation to cultural humility. As a whole, group members described *respecting other cultures* as acknowledging another person and the culture they ascribe to. There was a recognition that differences in belief systems may exist. One's ego is not being called upon when recognizing differences in thoughts, behaviors, beliefs, customs, or practices. There is a call to openness to another person's viewpoint and perspective. Loraine offered this response:

> To have that respect for attitudes with patients, and understanding; respect that we should be giving to all patients. It means I need to be humble enough to understand that there are multiple cultures in our world that all influence each of us in a different way.

Diane responded how *respecting other cultures* influences nursing practice in sharing the following:

> I think being open to other people's cultures and recognizing that it does have a big impact in the way we practice, the way our students practice, and being respectful of other people's cultures.

Ruth offered her perception of faculty respecting students as a characteristic in describing cultural humility, “It all starts with respect. The good news, you realize you have to respect the students and the students respect you. That’s the basis for cultural humility.”

One participant shared a comment in *respecting other cultures*, stating that cultural humility offers a wider view to multiple aspects of interactions with different cultures. Monika shared this statement:

> I think we need to understand that one of the roles of cultural humility is to help go beyond the task and to understand where the patient is coming from, where their family is coming from, what is life outside of the hospital, and then just progress out even to the organizational level.

Culture impacts interactions with individuals. Having the ability and willingness to examine oneself in order to better understand others allows for a more open channel of communication between individuals. Shari shared when educating students on how to relate to patients, a cultural awareness of others was necessary:

> We have a whole section we teach referred to as cultural awareness. So without using the words, teaching about it and then having them examine themselves as to what their culture is, how they got to where they are with their culture, and then looking at others. And actually a big project they have for the semester is they have to in small groups pick a culture that they say they know nothing about. And then do a project on it of general terms, but then also how that culture feels about many different levels of medicine and nursing care.

Cultural awareness as expressed by participants is intertwined in *respecting other cultures*. Individual cultural differences are recognized, while honoring those differences in cultures without being egocentric or ethnocentric. Cathy shared that faculty awareness of different cultures was needed among students and their patients, "Nursing faculty have to be aware of the different cultures in their classroom or in their, you now, whether it be the clinical area or the classroom arena."

In demonstrating *respecting other cultures,* Tasha shared how one needs to be receptive to how nursing faculty carry out their behaviors and tasks in the midst of teaching students:

> You have to be respectful of people's cultural beliefs, and be humble enough to know how that this is not you. You have to remove yourself and take out all personal biases about the situation.

Diane expressed what she perceived *respecting other cultures* would entail:

> Someone who's very open minded, somebody who's respectful of other cultures. You know, understanding everything that we – your cultural understanding is Probably rooted in all of your history your – you know, it's a lifelong learning process.

Being Unbiased

A second theme came forth from the data analysis, *being unbiased,* related to the second research question in describing characteristics of cultural humility as perceived by nursing faculty. Participants in all focus groups defined *being unbiased* as having non-judgmental feelings towards another race, culture, or belief system in describing this

characteristic of cultural humility. Participants agreed that one is practicing self-awareness when their own biases are acknowledged, and set aside to facilitate communication between self and others. Biases, whether conscious or tacit in nature, need to be recognized by faculty as a way to better understand and challenge harmful assumptions and ideas when instructing nursing students. Participants provided comments that offered a more in depth meaning to working with individuals from a culture different from oneself. Sofia commented:

> Being understanding of different cultures and unbiased. A step-back approach, rather than going into some relationship knowing that you're having your preconceived notions of what that will be like.

Tasha shared that, "We have to be mindful of our own biases, and not automatically be defensive or whatever right off the bat." Claire also provided insight to this topic, "People with a different value system, may not have the same value system you do. And, you know, just be unbiased and non-judgmental and things like that." Cecilia provided emphasis on having students recognize their own biases in relation to patients by commenting:

> Really talk to students about how they have to address their biases and understand why they are there, and to give the care to patients who are different from them. We have the same things that they want.

Claire provided insight to recognizing one's own biases to support students when interacting with patients from different cultures:

> So I generally start my courses with them sharing with one another who they are, what has been some of their experiences, and to recognize that yeah, we are all biased in some way. So that's sort of how I see it, in that everybody's biased. But unless you understand the other person, you won't understand your own bias.

Respecting other cultures, the differences that exist within them, and *being unbiased* were identified by participants as characteristics of cultural humility as perceived by nursing faculty. No subthemes were identified in the data analysis for this research question.

Cultural Humility in the Educational Context

"How do nursing faculty perceive cultural humility in the educational context?" The third research question guiding this study provided participants an opportunity to discuss their perceptions of cultural humility. Discussions within the focus groups provided descriptions of how this concept impacts on nursing practice, as well as the educational formation of baccalaureate nursing students. Two themes came forth during the discussions, *distinguishing between cultural humility and cultural competence,* and *threading cultural humility throughout the nursing curricula.* Three strategies were noted during the discussions to facilitate educating students on cultural humility – *nursing simulations, interpersonal communication skill,* and *role modeling*.

Distinguishing Between Cultural Humility and Cultural Competence

One theme that came forth from data analysis of the third research question was *distinguishing between cultural humility and cultural competence.* As a whole, the participants shared an unclear delineation between cultural humility and cultural

competence in nursing literature, and in some cases, the delineation between the two concepts is not clearly articulated in the nursing curricula where they teach. Several focus group members responded by acknowledging nursing faculty do not always possess an awareness of cultural humility itself. Fran offered the following comment:

> Cultural competence and cultural humility; I don't think that we have a clear distinction between them. There is a distinction. I just think that we're still a little bit muddy with really being very, very clear about the distinction between the cultural competence notion versus humility. But I don't see them as the same thing.

Diane added, "I don't hear the words 'cultural humility', but I think I am seeing more of an awareness with staff and with students and faculty." Mary Ellen provided insight stating, "I think you have to have, like, an awareness; some faculty may not have that." Patty added, "But I think a lot of people just don't have a concept of getting your own self-awareness – as to what's going on with their practice."

It was shared by the focus groups overall that the concept of cultural humility is being introduced to students within nursing education along with cultural competence. A general feeling among the focus group members was that cultural humility as a concept has been observed more often in clinical settings, compared to the classroom. One focus group member noted how the concept of cultural humility itself "lacks vocabulary" in nursing education. Participant SBD went on to explain her comment: "But cultural humility hasn't been articulated with the words. People do try very hard and reach within. But it's the vocabulary, it has not really filtered into nursing education." Roberta

offered a recognition that cultural humility has been "embedded" in cultural competence work, which contributes to the confusion about what cultural humility is as its own conceptual entity.

Threading Cultural Humility Throughout The Nursing Curricula

All the focus groups responded that the concept of cultural humility impacts nursing practice, and stated the concept should be included within the baccalaureate nursing curricula. However, it was noted that the inclusion of cultural humility as a concept did not map across the nursing curricula from the institutions where the participants taught. Patty commented how cultural humility is now being discussed in nursing education where she teaches:

> Well, I'm glad to see its at least being discussed now, where – you know, it had not before. It wasn't discussed in curriculum. It gives you entry to bigger conversations about patient care and being more focused on the patient and the family, and not yourself.

Monica shared the following comment:

> Because I think that's what I live and I breathe every day, I make sure it's infused in the classroom. And then I also make sure that it goes into the clinical, because I look at the clinical log and I try to ask those questions for the students to think about. I don't think that goes across the curriculum.

Roberta shared the following thoughts on *threading cultural humility throughout the nursing curricula*:

> It has to be valued, and recognized as important. It needs to be how we look at things, how we do our day-to-day work, how we practice and how we live and do our work really. So I mean it has to be weaved throughout because if they see this is a critical or core aspect of how they think and the work that they're doing, they will understand it if they see that it's important and relevant. But they're not getting it because they're not being taught.

Other participants shared how cultural humility was threaded in their institutions of higher learning – the concept was included both didactically and clinically, and at what class level chosen by their respective institution. Some participants stated the concept was introduced at the freshman through senior level; other participants shared it was introduced at the junior/senior level of instruction of nursing students. One participant shared that cultural humility was part of their institution's accreditation process. Lori shared the following comment on this theme:

> That's something that's really depending on what standards your school goes by. I think that has to guide your curriculum. And maybe they haven't recognized the term 'cultural humility', so therefore, how you can really thread that into the curriculum.

Monica noted in nursing education the following comment:

> I think we have to make a decision, as nursing, you know, we have competencies for everything, it seems, and standards for everything, but I can't say that there's a 'standard' for cultural humility. I almost would like to see it as part of the mission and the vision for the institution, because I think that's the only way

you're really gonna see it, you know, in everything that we do.

Strategies for Emulating Cultural Humility in Baccalaureate Nursing Education

In discussing characteristics of cultural humility as perceived by nursing faculty, data analysis revealed the following strategies for emulating cultural humility in baccalaureate nursing education: *nursing simulations*, *interpersonal communication skill*, and *role modeling*. These strategies listed in Table 4 were identified as participants were discussing ways nursing faculty can demonstrate cultural humility to students. Participants provided their insights to how cultural humility can be incorporated into baccalaureate nursing education. Participants agreed that faculty can display their demonstration of cultural humility to students starting with these three strategies in the educational context for baccalaureate nursing students.

Participants were asked to share how they demonstrate cultural humility to their students. Participants stated these strategies were tools utilized to support student learning of nursing concepts with the opportunity for nursing faculty to demonstrate via observation by nursing students, then to have the application of the strategies in the clinical settings by the students with faculty oversight and input when needed.

Table 4

Strategies for Emulating Cultural Humility in Baccalaureate Nursing Education

Strategies
Nursing simulations
Interpersonal communication skill
Role modeling

Nursing simulations. *Nursing simulations* on cultural humility can provide a learning environment to safely role play in therapeutic scenarios that support self-awareness, partnerships with clients, and can promote lifelong learning. Faculty can support student learning by mentoring students within the learning process. *Nursing simulations* within the educational context for baccalaureate nursing students was noted by focus group participants as a method of demonstrating cultural humility to students. Several participants noted that students need more opportunities for exposure to interact with individuals from different cultures to increase their understanding of cultural humility. One participant offered that nurses serve as "cultural advocates" for patients. In presenting cultural humility in *nursing simulations*, having a culturally diverse group is important. One participant commented that they found the simulation experience much richer with the inclusion of individuals from various cultures and backgrounds. Participants offered two different *nursing simulations* incorporated into student learning at their respective institutions to present the concept of cultural humility to students. Monika shared the following:

> I do a poverty simulation for the students in their first semester of their community semester, and a lot of that is based on cultural humility and putting yourself in another's person's shoes.

Debriefing was done after the simulation exercise with the students which offered the opportunity to reflect on the simulation experience as a group and individually, along with a written journal assignment to critically reflect on feelings generated from the simulation exercise. Claire offered the following simulation experience with students at her institution:

> We do a similar simulation. There is a poverty simulation, and there is also the simulation, 'In Her Shoes' that makes the students 'think' before they judge someone facing life challenges. The students said afterwards that they really felt the need to be more self-aware of their own biases and judgments once they were pointed out to them by faculty. A learning experience occurred for the students during simulations.

Interpersonal communication skill. Nursing practice is affected by the ability to relate to patients from different cultures. *Interpersonal communication skill* was generated during data analysis as a strategy to promote communication with others. This strategy translates into nursing practice for students, nursing faculty, and nurses already in the profession. Terri shared the following comment on this strategy:

> We have to, like you said, self-examine and then understand somebody else's world so that we can in a respectful way communicate with them and assist them with their needs.

Referring to cultural humility as an *interpersonal communication skill*, Terri went on to say:

> I think it should be introduced on the undergraduate level. Only because I think students need to understand right from the get-go how to communicate. This is a communication technique or mannerism.

Participant SBD offered insight to this strategy in nursing education, sharing:

> It's a communication skill. But teaching about cultural humility is a fundamental communication skill in my opinion and it needs to be incorporated into 21st century nursing curricula already.

SBD made reference to learning to communicate in the profession of nursing as a skill that builds with nursing experience. Teaching cultural humility, according to SBD, should start at the nursing fundamental level of nursing education and increase throughout the nursing educational curricula. Monika shared this comment regarding communication by nursing students within the practice of nursing as, "So I think the communication is – they may not recognize it as being so critical, but it is really I think number one in nursing."

The communication of recognizing differences in gender preferences was noted by one participant. Her comment was, "And people are more open about their gender and preferences and so forth, I think that has changed from what we understood back in the day."

The translation of cultural humility instruction within institutions of higher learning into nursing practice may be challenging. There was a general consensus from

the focus groups that currently practicing nurses may not be familiar with the concept of cultural humility itself. Fran commented that:

> I think if we bring more cultural humility into the baccalaureate programs, I think the challenge is going to be when they get out into the working world – how do they bring that into the workplace when it's not there, when there are a lot of biases among the other staff? I think that's a big challenge.

The recognition that cultural humility can represent a different communication process may be new for students, nursing faculty, and practicing nurses. Patty shared her insight on this process stating, "Re-directing the thought process to be what does the patient want, what does the patient need; it's about the patient."

Role modeling. Another strategy in response to displaying cultural humility characteristics was *role modeling.* From the focus group members, they commented that nursing faculty serve as mentors to students in teaching students the profession of nursing. *Role modeling* the concept of cultural humility to students can demonstrate self-awareness, the use of self-reflection with critique, and lifelong learning in relation to practicing cultural humility. Participants noted the value of *role modeling*. Terri commented that:

> There is a lot of positive and there are nurses that go out of their way. There are instructors that go out of their way to teach these students everything they know and what they think they should be. So they're modeling the profession. I guess as far as role modeling cultural humility, you have to be with the student.

Monika shared her comment on *role modeling:*

> Yeah, I think that role modeling is key. The other area where I think we can really model cultural humility is also when we are advising students. So I think that the way that we interact with each other in committees and hear the students out, that validates the role modeling component; it validates the cultural humility role in organizational structure.

For *role modeling* the concept of cultural humility to students, Roberta offered the following statement, "We're the ones that are modeling, educating, and setting the expectations; exactly the structure of what's supposed to be produced."

Additional Findings

During the focus group discussions on cultural humility as perceived by nursing faculty in baccalaureate education, several additional findings were noted after themes, subthemes, and strategies were identified from data analysis. Nursing faculty interviewed provided instruction to nursing students either in the classroom, the clinical areas, or a combination of both settings.

Self-Critique

Self-critique was expressed in participant responses when commenting on having an openness and willingness to learn about and learn from cultural differences. Participants offered examples of when they were able to *self-critique* on a cultural situation in the academic setting. An example was provided by Meg in relation to a misinterpretation of a patient response in the clinical area that was thought to be due to a language difference between the patient, the nursing staff, and nursing student. Monika

shared how assumptions about culturally different patients does not show respect for individuals, and how those assumptions may, in fact be inaccurate. Nichole shared that while educating her students, an assessment of the patient, the family dynamics, and the community where the client lives was important and necessary to provide the best nursing care possible. Self-critique as a component of cultural humility supports one's self-assessment of how an interaction with someone from another culture can be supported or hindered due to a lack of self-introspection.

Cultural humility also includes an examination of power imbalances, privilege, discrimination, and institutional accountability in society. Some participants specifically offered their description of cultural humility with a discussion how this concept also requires self-reflection with self-critique of how society in their assessment normalizes issues of race, power, privilege, discrimination, and lack of institutional accountability.

Critical Behavior

The need to engage effectively with patients and families was referred to as a *critical behavior* in practicing cultural humility. The need to be "authentic" in faculty dealings with students, clients, and families was discussed during the focus groups when sharing how faculty demonstrate cultural humility in the education of baccalaureate students.

One participant shared that, "To truly embrace cultural humility to me will get us to that pinnacle of really delivering holistic care." This comment was provided during the focus group discussions when all participants were asked to share how cultural humility translates into nursing practice. An additional comment related to cultural

humility translation into nursing practice was that different participants agreed that "one may see moments of it in practice, but not seeing anyone establishing an entire nursing practice based on cultural humility."

Nursing simulations incorporate aspects of culture and diversity for students to be able to work effectively in nursing practice with individuals from different cultures and backgrounds from the nursing provider. Some nursing faculty shared that perhaps a cultural humility competency is needed in baccalaureate education to teach the concept to nursing students.

Re-direction of Thought Processes

The *re-direction of thought processes* by nursing students was shared by focus group participants when asked to provide characteristics of cultural humility as perceived by nursing faculty. Several participants commented that students need to be less task-oriented in providing care – while learning to ask the patient what it is that they want to receive in their care from nurses. Having cultural humility allows for nursing faculty to teach "beyond the tasks" – while modeling this behavior to nursing students to emulate.

Chapter Summary

This chapter included a presentation of findings from this qualitative descriptive study on a description of cultural humility as perceived by nursing faculty in baccalaureate nursing education. Three research questions guided this study. A total of seven synchronous focus group interviews were conducted with nursing faculty who provided qualitative data in answering interview questions. Themes, subthemes, and strategies were generated during the data analysis.

Table 3 represents the themes and subthemes as generated from the research questions guiding this study. Table 4 represents the strategies identified for emulating cultural humility in baccalaureate nursing education. Additional findings were presented in this chapter which captured ideas not directly asked from the research questions themselves, but offered supportive insight to participant viewpoints.

Chapter 5

Discussion of the Findings

This chapter presents the findings of a qualitative study on cultural humility in nursing education. Seven synchronous focus group interviews were conducted using a web-based teleconferencing platform that generated data. Data were reviewed and analyzed along with three expert qualitative researchers for validation of the findings. Themes, subthemes, and strategies for emulating cultural humility in nursing education are presented for discussion. Additional findings were also identified during data analysis that presented topics not necessarily captured in the themes, subthemes, or strategies themselves, but offered insight to nursing faculty's demonstration of cultural humility in nursing education.

The purpose of this study was to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students. Three research questions guided this study. The questions were:

1. What are nursing faculty perceptions of cultural humility in baccalaureate education?
2. What are the characteristics of cultural humility as perceived by nursing faculty?
3. How do nursing faculty perceive that they demonstrate cultural humility in the educational context?

A sample of twenty (N = 20) nursing faculty in baccalaureate nursing were recruited to participate in one, synchronous online focus group interview session that was digitally

recorded using a teleconferencing platform. A total of seven focus group sessions were conducted on pre-determined dates and times. This researcher was the moderator for all interview sessions that lasted no longer than 120 minutes each.

Participant Characteristics

Twenty (N = 20) nursing faculty from various baccalaureate programs within the United States provided informed written consent to participate in one, online focus group interview session. All participants were female and predominantly White (14 / 70.0%). The ethnic diversity of nursing faculty consisted of five Black (20.0%) participants, and one Hispanic/Latino participant (5.0%). The median age of participants was 53 years; with ages ranging from 30 to 66 years. Participants had a wide range for years of instruction in baccalaureate nursing – ranging from 2.5 years to 38 years. While all faculty actively teach in baccalaureate nursing, three faculty participants also provided instruction to nurses at the Master's and/or doctoral levels of education. The majority of participants had Master's degree preparation in nursing (14 / 70.0%), with the remaining participants being doctorally prepared. For this study, most of the classroom instruction on cultural humility was presented by full-time doctorally prepared faculty; some full-time faculty had some clinical overlap for instruction. Clinical instruction of nursing students was done primarily by the Master's prepared faculty whose job status was part-time. The *NLN Faculty Census Survey, 2016 to 2017* documented multiple demographic aspects for full-time and part-time nurse educators nationally. This *Census Survey* provided data specific to this study's faculty demographics reported earlier.

As reported by the NLN (2017), full-time nurse educators between 46 to 60 years made up 49.7% of the nurse educator population; with 93.2% being White females. Part-time nurse educators between 46 to 60 years made up 39.0% of the nurse educator population; with 86.7% being White females. Participants' age range and race were similar to the *Census Survey* data.

The participants were experienced in a variety of clinical and teaching specialty areas. Most participants provided instruction in Critical Care and Community/Public/ Urban Health. Participants provided nursing instruction either in the classroom, clinical areas, or a combination of both.

The NLN (2017) *Faculty Census Survey* for 2016 to 2017 documented a breakdown of full-time and part-time nurse educator demographics by race and ethnicity. From the national sample size of nurse educators (*N* = 13,700), the *Faculty Census Survey* reported the following breakdown: "Multiracial – 0.6%; White Non-Hispanic – 80.8%; Hispanic – 3.2%; African American – 8.8%; Asian – 2.7%; and American Indian – 0.4%" (NLN, 2017). For this study, the sample size for nurse educator demographics reflected a dominant number of White faculty, followed by African American, then Hispanic educators. While this study's sample size does not compare to the NLN's sample size, the total sample numbers in both groups reflect there are more White female nursing faculty compared to other races and ethnicities in nursing education. This study had participants who worked full-time and part-time in nursing education. All participants were female for this study; and the majority of the nursing faculty for this study worked full-time. According the Beard (2014), "the continued

underrepresentation of African American, Hispanic/Latino and American Indian nurses threathens initiatives to end racial and ethnic health disparities" (Beard, 2014, p. 59).

Research Questions with Themes, Subthemes, and Strategies

There were three research questions guiding this study that generated themes, subthemes, and strategies from data analysis. The first research question was: *"What are nursing faculty perceptions of cultural humility in baccalaureate education?"* The themes from the first research question were *having self-awareness of one's own culture,* and *being self-reflective is an ongoing process.* The subthemes identified were *being respectful and humble to others, self-discovery of one's own cultural influences,* and *walking in another's shoes.* The second research question was: "*What are the characteristics of cultural humility as perceived by nursing faculty?"* Two themes were identified – *respecting other cultures,* and *being unbiased.* The third research question was: *"How do nursing faculty perceive that they demonstrate cultural humility in the educational context?"* Two themes were identified – *distinguishing between cultural humility and cultural competence,* and *threading cultural humility throughout the nursing curricula.* Three strategies for emulating cultural humility in baccalaureate nursing education were identified during data analysis. The strategies were *nursing simulations, interpersonal communication skill,* and *role modeling.*

An explanation relating the first research question to the generated themes and subthemes starts with the study participants self-identifying with the concept of cultural humility. Participants were already familiar with the concept by definition itself, and their perceived demonstration of the concept within their own nursing practices. Also,

the recognition of self-awareness and self-reflection with critique of already-held assumptions, beliefs, biases, preconceptions, and prejudices were acknowledged by participants as essential qualities to address before presenting the concept to students.

Cultural Humility in Baccalaureate Education

"What are nursing faculty perceptions of cultural humility in baccalaureate education?" The first research question provided insight to nursing faculty perceptions of cultural humility in baccalaureate education. There was a consensus from group members that one's culture consists of shared beliefs and patterns of behavior already practiced by an individual. "Culture describes the knowledge, beliefs, values, assumptions, perspectives, attitudes, norms, and customs that people acquire through membership in a particular society or group" (Hammell, 2013, p. 225). Culture plays an integral role in how an individual makes sense of the world. Participants expressed how they perceived culture's influence on one's behavior based on learned traits and customs.

Having Self-Awareness of One's Own Culture

Nursing faculty perceptions of cultural humility included a self-awareness of one's own assumptions, beliefs, misconceptions, and prejudices that were conscious or tacit in nature. This self-awareness was extended to having an "awareness" of the cultural differences among nursing students being taught by faculty participants. Comments were made by faculty participants that resonated with how nursing faculty do not always allow students to recognize and respect their own particular cultural background. The value of recognizing cultural differences was brought forth in data

analysis when individual cultural practices are acknowledged and respected by nursing faculty, with a desire to learn from that individual with respect and humility. Yeager and Bauer-Wu (2013) emphasized the overall purpose of cultural humility is to be aware of one's own values and beliefs that result from a combination of cultures that assist in increasing one's understanding of others.

Nursing research has addressed self-awareness in relation to understanding oneself and others in the context of culture. The self-awareness component of cultural humility was noted by the following researchers in terms of the ongoing process of looking at oneself as well as others regarding already-held beliefs.

Campinha-Bacote's (2002) model of cultural competence defined cultural awareness, one of five constructs in her model, as self-examination and exploration of one's own culture and professional background. An individual self-examines their own biases, prejudices, and assumptions about others who are different from oneself. This cultural awareness supports the components of cultural humility. Purnell (2002) has presented cultural competence as a process that can heighten one's own self-awareness of culture as being integral to understanding others.

Eckroth-Bucher (2000) provided a derived definition of self-awareness in her concept analysis stating:

> Self-awareness is a multidisciplinary introspective process used to understand one's thoughts, feelings, convictions and values with the use of this understanding to guide behavior. (Eckroth-Bucher, 2000, p. 5)

Eckroth-Bucher (2014) researched the process of self-awareness development in female BSN students in nursing education. The ongoing process of having self-awareness for cultural humility is supported by this derived definition that contributes to components inherent when practicing cultural humility. Culture is integral to how individuals perceive and interact with others.

Being respectful and humble to others. All faculty participants agreed the subtheme of *being respectful and humble to others* requires critical self-reflection of already-held preconceptions and beliefs. This critical self-reflection is ongoing, not just a brief thought that does not produce an intentional, introspective and retrospective reflection of oneself. This subtheme was demonstrated with clients and students alike through faculty-student interactions that displayed sensitivity and empathy. Faculty stated these interactions were how they demonstrated cultural humility to students and clients.

Carroll (2012) conducted a concept analysis on respect. Her research addressed student and faculty perceptions of respect and a respectful learning environment. The derived definition of respect supports the value of this behavior in recognizing this subtheme. According to Carroll (2012):

> Respect is courteous communication, authentic listening and an active interest in the relationship that a person directs towards an individual, which acknowledges, appreciates, honors, and values one's person for being. (Carroll, 2012, p. 10)

Respect was discussed by Foronda and MacWilliams (2015) in discussing the importance of interprofessional communication in health care. In training medical students at a

major medical center in California, respect was defined as "the process of honoring someone by exhibiting care, concern, or consideration for their needs or feelings" (Masters et al., 2018, p. 628). Clinicians are challenged to address their own implicit biases in an effort to reflect and choose more mindful responses during client interactions by using a clinical tool known as *The 5Rs* (*Reflection, Respect, Regard, Relevance*, and *Resiliency*) during medical training to help reduce implicit biases by the health provider when interacting with clients from various cultural backgrounds.

This study finds that the recognition of respect for oneself and others is supported in nursing and other disciplines. Identifying *being respectful and humble to others* as a subtheme is integral to practicing cultural humility. Masters et al. (2018) noted that "being humble can be conceptualized as doubt and self-depreciation. However, evidence supports that humility is perceived as a strength of character" (p. 628). Interactions with others is influenced by one's own culture. All participants agreed *being respectful and humble to others* is continuous. Communication between the health care provider and client can be facilitated in mitigating the power imbalance dynamic that can be present in didactic and clinical areas of instruction through respectful interactions with others.

Being Self-Reflective is an Ongoing Process

The theme *being self-reflective as an ongoing process* was voiced by all participants during the focus group interviews. Participants acknowledged how *being self-reflective* required a lifelong process of critical self-examination of one's own belief systems, assumptions, biases, and prejudices that may have not been self-recognized before, and could be conscious or tacit in nature. Participants acknowledged their self-

reflection was not always critical in nature, so they did not demonstrate cultural humility as intended in the classroom or clinical setting. According to the participants, some nursing faculty were not aware of their own assumptions and biases because they were not aware these assumptions and biases even existed for them; they did not have the self-awareness to critically self-reflect on their own state of awareness. The effectiveness of engaging with clients and students in a genuine, caring manner is enhanced when done so with intention and authenticity according to Tervalon and Murray-Garcia (1998).

Nursing research specific to cultural humility has been conducted. Schuessler, Wilder, and Byrd (2012) conducted a qualitative research study addressing how reflective journaling assisted nursing students in developing cultural humility. Global nursing through an exchange program between the United States and Scotland used a cultural learning model documented by McNally, Metcalfe, and Garner (2015). Reflective nursing practice and student immersion experiences between the two countries identified cultural humility as being needed to support the experiential learning process. Cultural differences and similarities were experienced by the nursing students and faculty.

Findings from this study were consistent with the belief that supports *being self-reflective* is a necessary component to the process of cultural humility. Participants agreed that critical self-reflection is required to address assumptions, biases, misconceptions, and prejudices. This process is continual and lifelong as the definition of cultural humility states.

Reflection is a multifaceted process, and a necessary skill in nursing practice. According to Garneau (2016), reflective practice encourages health care providers to

"step back" and critically think before making judgments on complex situations within nursing practice. Jacobs (2016) stated "reflective practice is a process of obtaining new insights through self-awareness and critically reflecting upon present and prior experiences" (Jacobs, 2016, p. 62). Being self-reflective as a theme in cultural humility is supported in the literature reviewed for this study. Participants identified self-reflection as an ongoing process that contributes to an introspective assessment of oneself. This study's findings related to self-reflection is supported in the literature reviewed.

Self-discovery of one's own cultural influences. This subtheme was described by the participants in the data analysis as requiring an introspective view of already-held beliefs, assumptions, misconceptions, preconceived ideas, and prejudices that requires critical self-reflection. The self-acknowledgement of already-held beliefs and assumptions is a critical self-reflective stance when practicing cultural humility as stated by Tervalon and Murray-Garcia (1998). Participants recognized the value of understanding and respecting the various cultures in both the classroom and clinical settings. Faculty self-awareness was needed to address both students and clients where a cultural difference may be present. This *self-discovery* subtheme was acknowledged by faculty in understanding how culture influences one's response in the educational or health care setting.

The findings from this study in relation to *self-discovery of one's own cultural influences* was supported in the literature reviewed. As an example, Yeager and Bauer-Wu (2013) noted "in the process of cultural humility, personal values, beliefs, and biases

that are derived from your own culture must be examined" (Yeager & Bauer-Wu, 2013, p. 253). Awareness of one's own culture is critical in appreciating the influence it has in how one views the world. According to Fahlblerg, Foronda, and Baptiste (2016), cultural factors influence the way people view and experience health. *Self-discovery* is an introspective review of oneself; culture may influence one's belief patterns. Participants shared how the recognition of honoring one's culture as well as the culture of others provided the opportunity to reflect on already-held belief patterns, assumptions, and biases; and the opportunity to learn more about others and their cultures.

Walking in another's shoes. This subtheme resonated from *being self-reflective is an ongoing process*. The majority of participants agreed that as nursing faculty, in order to demonstrate the concept of cultural humility, it was necessary to "step back" and be willing to examine one's own belief system, while being willing to understand another person's perspective. There was a general consensus in all focus groups that there needs to be institutional accountability related to the power imbalance that may exist between the health care provider and individuals from diverse cultures. In redressing institutional accountability, client advocacy that reflects a mutually beneficial and non-paternalistic relationship between the client and health care provider, and communities being served is suggested by Tervalon and Murray-Garcia (1998). These researchers identified that the "culture" of institutions may in fact contribute to biases and the imbalance of understanding between the health care provider and the client. An appreciation for "differences" in race, culture, belief systems, and sexual orientation in practicing cultural humility requires one to recognize that *walking in another's shoes* also includes faculty

being sensitive and aware to the students and clients that faculty are interacting with in the classroom or clinical setting. Several participants expressed the need for faculty to be "aware" of others to appreciate the experiences of students and individuals alike.

Participant comments in describing what it means to be *"walking in another's shoes"* expressed the multiple ontologic realities as captured through a naturalistic inquiry approach (Lincoln & Guba, 1998). Participants expressed from their perspective what it meant to *"walk in another's shoes"* including professional and personal experiences in teaching nursing students. A general consensus was noted during data analysis that nursing faculty may not always be sensitive or empathetic to their students' cultural status. This, in turn, can affect a student's ability to provide quality nursing care to individuals that is both culturally and linguistically appropriate.

The ability to understand and share the feelings of another person represents empathy. McKinnon (2018) defined empathy as "the ability to grasp the frame of reference of another" (p. 3882). Having empathy resonated with *walking in another's shoes*. McKinnon (2018) offered empathy in nursing practice as "requiring self-awareness and emotion in interpersonal understanding" (p. 3882). Similar terms such as sensitivity and compassion were noted in the literature to describe what it means to *walk in another's shoes*. The demonstration of how these qualities are conveyed to the client are variable. Bramley and Matiti (2014) researched patients' perceptions of compassion in nursing care received by them, along with addressing how to develop compassionate nurses. These researchers recommended "introducing vignettes of real-life situations

from the lens of the patient to engage practitioners in collaborative learning in the context of compassionate nursing" (Bramley & Matiti, 2014, p. 2790).

The findings from this study identifies empathy as a quality associated to the subtheme *walking in another's shoes* is supported by Mennenga, Bassett, and Pasquariello (2016) who noted empathy development was a process – not something that could be read about and then acquired. Empathy is a quality that can allow one to better understand the perspective of others. Participants who shared this subtheme offered a deeper insight to the clients and students they were interacting with. According to Mennenga, Bassett, and Pasquariello (2016), being able to empathize is a genuine human experience.

Characteristics of Cultural Humility

"What are the characteristics of cultural humility as perceived by nursing faculty?" The second research question for this study was presented to the participants to better understand how nursing faculty would describe their perception of characteristics of cultural humility in baccalaureate nursing education. Two themes were generated from the data analysis of the second research question, *respecting other cultures*, and *being unbiased*. All participants conveyed that *respecting other cultures* was required as a characteristic of cultural humility. Respect was identified by the participants as "meeting and interacting with an individual on their terms" – not the health care provider's terms. With critical self-reflection according to the participants, nursing faculty can be more sensitive and responsive to others (referring to individuals receiving health care and students alike) from different cultural backgrounds and experiences.

There was a recognition and acknowledgement by the focus groups that some nursing faculty members (in their perception) may not have that self-awareness and critical self-reflection needed in cultural humility when working with individuals or students from diverse backgrounds. An awareness of one's own biases was strongly verbalized by many participants in responding to this research question. The awareness of different cultures was perceived as vitally important for nursing faculty to practice culture humility. This awareness, according to the participants, needs to be present both in the classroom and the clinical areas when instructing students from the spirit of cultural humility. Participants shared their reality within their focus groups in calling for an "openness" on the part of faculty to understanding another person's view.

Respecting Other Cultures

The theme *respecting other cultures* included the awareness of someone else's cultural practices as a component associated with this theme. An understanding of one's own culture, as well as the culture of others was expressed by focus group participants. In the data analysis, nursing faculty were perceived as needing to have an awareness of student cultures as well as client cultures when interacting with both groups to practice and demonstrate cultural humility.

Observing cultural differences may be a point of self-awareness to consider when educating students. Some focus group participants commented on their awareness of the diversity of their students in the classroom and the clinical areas was limited, sometimes due to a lack of diversity within their student body composition, or the location of their institution or clinical sites. This comment prompted further exploration of faculty.

Participants felt they had no way to mitigate this deficit. Again, the exposure to a more diverse population may be limited to the demographics where one's institution is located, or the location of clinical sites to train student nurses. Additionally, faculty and student personal experiences within their own culture may contribute to limited interactions with diverse populations.

This study identified faculty awareness of their own culture, as well as acknowledging the culture of their students and the clients in the clinical areas as being necessary to provide optimal care in nursing. The findings in this study regarding *respecting other cultures* is supported in the reviewed literature including articles from Tervalon and Murray-Garcia (1998), Campinha-Bacote (2002), Purnell (2002, 2016) and other authors. Report documents from the *Agency for Healthcare Research and Quality (AHRQ)* (2014, 2016), and the Department of Health and Human Services' (2015) *National CLAS Standards* speak to the value of respecting the culture of others when interacting with individuals to help reduce health disparities and health inequities in society. This theme is vital to practicing cultural humility.

Being Unbiased

This theme, *being unbiased* addressed a characteristic of cultural humility. Focus group participants conveyed their biases as needing to be self-recognized, then put aside in working with diverse populations and students. Participants felt that self-awareness with critical self-reflection of assumptions, biases, prejudices, and misconceptions is necessary in order for nursing faculty to demonstrate cultural humility. Faculty

awareness of how their own biases can hinder communication with diverse populations may not always be present.

Biases can be conscious or tacit in nature. Yeager and Bauer-Wu (2013) stated in the process of cultural humility, one must examine their personal values, beliefs, and biases derived from one's own culture. Data generated from this theme supports how *being unbiased* is a critical component of cultural humility. Bellack (2015) addressed how unconscious biases adversely affects care that is supposed to be culturally responsive to individuals, stating "unconscious biases are more often than not the root contributors to unintentional, insensitive attitudes and behaviors that reflect prejudice or biases (p. 563).

A discussion of race came about in the focus groups with the participants speaking about biases, diversity, and at times the lack of diversity among the students and nursing faculty they interact with. Racial microaggressions may be discovered when addressing faculty biases.

> Racial microaggressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group (Sue et al., 2007, p. 273).

While Sue (2007) noted racial microaggressions can exist within the therapist-client relationship, this behavior can also exist between nursing faculty-student relationships; as well as faculty-faculty interactions, and student-student interactions. Bellack (2015) addressed racial microaggressions in her article on unconscious biases that are obstacles to culturally appropriate care. She offered a definition of microaggressions as "hurtful,

demeaning, and dismissive words and actions committed by one individual or group against another whose characteristics and backgrounds are different" (Bellack, 2015, p. 563). Bellack (2015) offered that racial microagressions are often the result of unconscious biases that contributes to discrimination against or the degradation of individuals who are viewed as "marginalized" in society.

Within the NLN (2016) document, *Achieving Diversity and Meaningful Inclusion in Nursing Education,* microaggressions are recognized as "micro-inequities" that may be present within nursing education. These "micro-inequities" can be subtle in nature, unconscious, or unintentional messages received by students that can contribute to biased behavior by nursing faculty within nursing education.

In this study, participants shared moments when they unconsciously displayed a lack of cultural awareness and sensitivity to diverse students in the classroom, and clients in the clinical areas by making biased comments in the educational setting. Clients may have been labeled "difficult", or students may have been considered "disinterested" in learning by nursing faculty. These comments could be considered a display of microaggression. Participants were able to critically self-reflect on these moments with an acknowledgement that cultural humility was not being practiced. The literature reviewed by Bellack (2015), Sue (2007), and other authors support study findings that *being unbiased* requires self-awareness, and critical self-reflection of one's already-held beliefs, assumptions, misconceptions, and prejudices.

Microaggressions of any type can adversely impact faculty instruction to students and clients, as well as the patient safety environment within clinical settings, or the

workplace environment of health care providers. Self-awareness with critical self-reflection on the power imbalances related to institutional racism was a discussion point during the focus group sessions. There was an acknowledgement by participants that institutional biases and racism exists in society, and contributes to health disparities. Faculty support through education on cultural humility can serve to address racial microaggressions when observed or practiced. This can provide an opportunity to move towards cultural humility as a practice when interacting with diverse individuals. Also, employing de-escalation strategies to diffuse potentially hostile situations can foster safety for the clients, nursing students and faculty, and health care providers.

Cultural Humility in the Educational Context

"How do nursing faculty perceive that they demonstrate cultural humility in the educational context?" From the participant responses answering this research question, two themes were generated, *distinguishing between cultural humility and cultural competence,* and *threading cultural humility throughout the nursing curricula.* Participants felt they demonstrated cultural humility by showing respect to their students' diversity by allowing them to voluntarily share how health care is provided in their diverse cultures, and comparing that to the care they are providing in the clinical settings. The distinction between cultural humility and cultural competence, however, remains unclear in the articulation of both concepts as noted by the participants.

Distinguishing Between Cultural Humility and Cultural Competence

From the focus groups, it was noted that not all nursing faculty in baccalaureate education or practicing nurses had knowledge of cultural humility as a concept. Without

knowledge of the concept, nursing faculty cannot effectively demonstrate it to their students in the classroom or clinical setting. Some participants did state at their particular institution of learning how cultural humility as a concept is not always present within their baccalaureate nursing curricula. Other participants shared examples of how cultural humility was included within their nursing curricula. The level of introduction of the concept to nursing students varied among nursing programs. An opportunity to provide education that distinguishes between both concepts along with nursing practice that includes the demonstration of cultural humility can help close the gap of educating about this concept.

All participants agreed there is a need to clearly distinguish between cultural humility and cultural competence in nursing education. While both concepts have their own definitions, not all nursing faculty can distinguish between the two concepts, thereby contributing to cultural humility not being demonstrated in the educational context of baccalaureate nursing students. There are variations to the definition of cultural humility as first stated by Tervalon and Murray-Garcia (1998). These researchers documented how a critical distinction between cultural humility and cultural competence was necessary in the training of physicians to provide health care within a multicultural society. According to these researchers, cultural humility "is a process that requires humility in how physicians bring back into check the power imbalances that exist in the dynamics of physician-patient communication" (p. 118). They identified in medical education the importance of not defining cultural competence as "an easily demonstrable mastery of a finite body of knowledge, an endpoint" (p. 118). A commitment and active

engagement in a lifelong process with reflective health care providers is the premise for cultural humility.

Isaacson (2014) conducted a mixed method study to clarify the concepts cultural humility and cultural competence in nursing education. However, the perceptions of cultural competence by nursing students was the primary focus of the research, not so much cultural humility. The researcher was not clearly able to delineate between the two concepts. The result of this study supports the need for distinguishing between cultural humility and cultural competence in nursing literature, and nursing practice. Isaacson (2014) stated that "cultural humility illustrates the importance of including the patient's views in the interpretation of culture. Cultural competence implies the mastery or successful completion of a skill set" (p. 252).

This study identified there remains a need to differentiate cultural humility from cultural competence. The literature reviewed for this study included articles that specifically set out to distinguish between the two concepts (Tervalon & Murray-Garcia, 1998; Isaacson, 2014; and Foronda & MacWilliams, 2015). Literature in nursing as well as other disciplines continue to use both concepts interchangeably, but each entity has its own definition, meaning, and translation of how it is practiced. Findings from this study supports the continual need for clarity between the two concepts as expressed by the participants.

All participants agreed that nursing education literature does not clearly delineate between the two concepts. Secondly, there was the recognition by participants that cultural humility is thought to have the same meaning as cultural competence. As a point

of clarity, the nature of being self-aware in cultural humility is not defined in cultural competence where individuals learn the nuances of a particular culture, and are able to recognize those nuances when interacting with diverse individuals. This researcher conducted a concept analysis using the Chinn and Kramer (2011) method to reach a derived definition of cultural humility in relation to its critical attributes, or "essence". The derived definition was "a lifelong commitment to self-awareness, self-reflection with critique to redress power imbalance and privilege with an authentic, humble willingness to be other-focused" (Webster, 2015, p. 28).

Some participants had a clear understanding of cultural humility, and how it differed from cultural competence in definition and context. A few participants, however, needed clarification and re-direction by the researcher on both concepts. Examples of faculty demonstrating cultural humility in the classroom and clinical settings were provided during the focus groups by participants. The recognition that cultural humility as a lifelong process of self-awareness along with critical self-reflection was shared by all participants. Participants agreed that more faculty instruction on cultural humility was needed, and how demonstrating cultural humility may enhance nursing practice as identified in this study's findings.

Threading Cultural Humility Throughout the Nursing Curricula

The second theme to the third research question was *threading cultural humility throughout the nursing curricula.* Some participants shared that cultural humility as a concept was already being included in their school's curricula, and was threaded throughout their particular nursing curricula in baccalaureate nursing education. Other

participants shared that while the concept is currently being included in the education of nursing students in theory and practice in the clinical settings, it is not necessarily threaded throughout their institution's nursing curricula. Cultural humility is a process that is learned over time through the practice of lifelong self-awareness and self-reflection; it is not "acquired" right after didactic or clinical instruction of the concept by nursing faculty.

Baccalaureate nursing programs offer curricular content that provides the educational framework for entry-level professional nursing practice. This program of study is guided by *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008). The nine *Essentials* within this document are "the curricular elements that provide the framework for baccalaureate nursing education" (AACN, 2008, p. 10). Nursing program outcomes delineate the knowledge, skills, and attitudes expected from graduates of baccalaureate nursing programs. Nursing faculty are guided in obtaining and measuring their nursing program and course objectives. Included in the Glossary within the *Essentials* document is cultural humility. The concept definition is referenced to Tervalon and Murray-Garcia (1998). The *Essentials* provides the following statement, "Cultural humility is proposed as a more suitable goal than cultural competence in healthcare education" (AACN, 2008, p. 36). This concept, however, has not consistently been included within the baccalaureate nursing curricula. The theme of *threading cultural humility throughout the nursing curricula* first requires the placement of the concept within the nursing curricula of institutions of higher learning to support being a valued asset within baccalaureate education.

The value of having cultural humility as a part of the nursing curricula was strongly voiced throughout all the focus groups. There was faculty recognition this concept would need to be part of an institution's mission and values statement. In doing so, this concept would be considered a value asset to warrant it as important enough to be included and instructed throughout the nursing curricula. Participants, however, did not articulate how to thread cultural humility throughout the nursing curricula. This may be due, in part, that the majority of study participants had limited, or no experience in curricular development in baccalaureate nursing education. The scaffolding, or building of knowledge and nursing experience in practicing cultural humility is warranted. At this time, the concept of cultural humility is not necessarily included in the "language" or nomenclature of all institutions that recognize the value of ensuring this concept is presented consistently in nursing education. Contributing to this concept not being included in the "language" of perhaps accrediting bodies for education – is that the concept of cultural humility is not clearly stated in nursing literature, and at times, is "embedded" into the concept of cultural competence.

Participants identified that curricular development of *threading cultural humility throughout the nursing curricula* in nursing baccalaureate education would add to the richness of the educational experience for students. This theme supports the value of instructing this concept to increase awareness and familiarity with the concept which would be presented throughout all levels of nursing baccaulareate education. This study supports the incorporation of this concept within the educational process as essential as noted by AACN (2008).

An inclusive curricula that integrates the benefits of cultural diversity of both faculty and students is recommended. Bahreman and Swoda (2016) stated that "understanding the unique manifestations of different cultures and how they impact an individual's health related practices is meaningless if this cannot be applied to practice" (p. 105). Findings from this study include how participant faculty were aware that their student body is ethnically and culturally diverse. Being culturally aware of self and others was the general consensus from the participants.

Strategies for Emulating Cultural Humility in Baccalaureate Nursing Education

Three strategies were identified in the data analysis for emulating cultural humility in baccalaureate nursing education - *nursing simulations, interpersonal communication skill,* and *role modeling.* These strategies, or categories were noted through the data analysis in response to identifying characteristics of cultural humility from the second research question guiding this study.

Some participants stated that they have noticed an "awareness", or recognition by nursing faculty in relation to addressing cultural differences within the classroom and clinical settings, which can affect the interactions with and between students and diverse individuals. This "awareness" can stem from the changing demographics within the United States itself. Secondly, the increase in diversity within the nursing student body and nursing workforce may have contributed to faculty recognition of cultural differences within the context of the baccalaureate nursing student body.

Nursing Simulations

Nursing simulations as a strategy to identifying characteristics of cultural humility as perceived by nursing faculty has been noted to provide learning opportunities for nursing students to learn and practice interacting with diverse individuals. Participants overwhelmingly agreed that *nursing simulations* using scenarios in cultural humility are needed to help guide nursing students in how to appropriately and effectively interact with diverse populations. *Nursing simulations* offers the students and faculty the learning opportunity to recognize from their own self-awareness and self-reflection with critique those preconceived assumptions, biases, misconceptions, and prejudices exists for them. Also, the distinction between cultural humility and cultural competence can be presented during *nursing simulations* to help clarify the difference between both concepts. Foronda and MacWilliams (2015) posed the question if cultural humility in nursing education was in fact a "missing standard" in simulation education to nursing students. Their research in nursing simulation identified that the concept of cultural humility is not present in nursing simulations while educating students to working with diverse populations.

Additional strategies that faculty can use for emulating cultural humility would include case studies, role play, vingettes, and service learning experiences. These additional strategies along with simulations can serve to enrich the learning experience of students through exposure to culturally different individuals with mutual respect and understanding. In this research study, participants primarily instructed students in the clinical areas. Some participants had limited didactic teaching experiences. From the

data analysis, this study identified *nursing simulations* as a strategy for teaching cultural humility. It is important to note that this concept is a lifelong process of self-awareness and critical self-reflection with critique. From instruction and structured learning through *nursing simulations*, students can begin to internalize the development of cultural humility. Findings from this study supports this teaching strategy method for learning.

Interpersonal Communication Skill

Communication is a core element of patient-centered care. Participants from all focus groups considered the practice of cultural humility as an *interpersonal communication skill* in nursing. Participants voiced how having self-awareness and self-reflection with critique can promote respectful interactions with diverse populations. The ability to effectively communicate with those who are "different" from oneself requires sensitivity, empathy, and a willingness to learn and share with diverse individuals. All participants agreed the practice of cultural humility is a vital *interpersonal communication skill* that can be incorporated throughout the baccalaureate nursing program from the freshman level through to the senior level of learning.

According to Day and Beard (2019), "the nursing workforce will not only have to look diverse, but also speak with multiple voices in order to communicate and support diverse perspectives and experiences" (Day & Beard, 2019, p. 1). Bahreman and Swoboda (2016) noted how miscommunication resulting from language differences as well as a lack of awareness of cultural nuances can adversely impact on client needs being met appropriately. This study is supported in the identified importance of fostering

interpersonal communication skill to foster effective dialogue between faculty, nursing students, client interactions, and cultural humility practice.

Role Modeling

Role modeling was generated as a third strategy for emulating cultural humility in baccalaureate nursing education. Participants acknowledged that nursing faculty are role models for the profession of nursing. The demonstration of cultural humility by nursing faculty was described as being humble and self-aware of one's own preconceived assumptions, biases, misconceptions, and prejudices with acknowledging they exist within oneself. The willingness to "step back" and acknowledge an authentic willingness to learn from diverse populations was demonstrated by faculty both in the classroom and clinical settings. Participants admit students did not always observe a demonstration of cultural humility in the classroom and/or clinical settings, especially if faculty had no knowledge of cultural humility as a concept. Being transformative as a faculty member teaching and practicing the concept of cultural humility to baccalaureate nursing students can serve as an example of *role modeling* this concept to nursing students.

This study is supported in efforts to address and increase the diversity within nursing faculty to serve as role models for future nurses. Reports from the NLN (2016), and the AACN (2008) both identified the need for a more diverse nursing workforce, along with more diversity within nursing education. As society becomes more diverse in ethnicities and cultures, the nursing workforce is challenged to keep pace with the changing environment for safe and appropriate health care practice. A more diverse nursing faculty presence in the classroom and clinical areas would serve to display the

value of diversity within the profession for future and currently practicing nurses to emulate. In having a framework of cultural humility in health care provision, client needs would be better met which contributes to improved client satisfaction for health care received.

Additional Findings

During data analysis, the focus group discussions provided additional insights from the participants that expressed content that influenced how faculty identify with the concept of cultural humility. Participants discussed *self-critique, critical behavior,* and *re-direction of thought processes.*

Self-Critique

The ability to critically self-reflect when practicing cultural humility is a requirement of cultural humility. The critical self-reflection is a self-analysis of one's own behavior and assessment of interactions with diverse populations. Participants offered examples in the classroom and clinical settings when their own self-critique of the situation at a particular time was necessary when interacting with students and clients alike. Self-awareness of one's own assumptions, biases, and misconceptions was required in order for faculty to assist students in working with diverse populations to recognize their own assumptions, biases, and misconceptions in the classroom or clinical setting.

For this study, se*lf-critique* was a supported finding in cultural humility. A critical conscious awareness of one's own cultural perspectives that goes beyond self-awareness is present. Participants frequently used the term "being mindful" when

emulating their own cultural beliefs. According to Yeager and Bauer-Wu (2013), mindfulness "involves a mental trait and practice when one pays attention to present-minded experiences with an attitude of receptivity and acceptance" (Yeager & Bauer-Wu, 2013, p. 254). Additional findings related to *self-critique* was also noted by Yancu and Farmer (2017) who recognized cultural humility as "a dynamic process which includes personal, or self-critique of one's own cultural background" (p. e2).

Critical Behavior

Participants expressed that client interactions by faculty and nursing students should be purposeful and respectful. A genuine desire to better understand the perspective of others was considered a critical behavior by the participants. Participants used the term "authentic" to describe how interactions between faculty, students, clients, and families should be conducted with respect, sensitivity, and empathy. Understanding how one interacts with others who are diverse can affect the quality of care given to diverse clients. Assumptions, biases, and stereotypical thinking when interacting with diverse populations requires one to self-assess and critically self-reflect on one's interactions with diverse individuals.

The literature reviewed supports this study's finding that authentic engagement of clients and communities is a *critical behavior* that can produce a heightened awareness and demonstration of respect to clients from vulnerable populations. Woolf et al. (2016) documented the promotion of patient-centered care by implementing authentic, or genuine respectful interactions between the researchers and the residents in a community health screening effort. Webster (2015) noted how cultural humility can produce more

authentic interactions between nursing faculty and students as a nursing implication to practicing cultural humility.

Re-directing Thought Processes

Faculty as well as students could benefit from a re-direction of thought processes when practicing cultural humility. Being task-oriented as a nursing student was acknowledged by all participants. However, with faculty demonstrating to students how to see the "bigger picture" while providing client care is a learning process in practicing nursing and cultural humility. The capacity to recognize client needs, as well as student needs is enhanced when practicing cultural humility. Faculty self-awareness and critical self-reflection with critique can support student learning, along with the demonstration of cultural humility by faculty to nursing students.

This study recognized the finding that not all nursing faculty possess the knowledge or skills to practice cultural humility. The continual need to be cognizant of self and others is documented in the nursing literature. As nursing faculty, "the primary responsibililty of an educator should be to assure that every student feels a sense of belonging and security within the classroom" (Iheduru-Anderson, 2015, p. 23). This author suggested teaching strategies that are inclusive of students from culturally diverse backgrounds.

A study finding regarding *re-directing thought processes* was that it can offer meaningful discourse between nursing faculty and students supporting cultural humility instruction in nursing education. Day and Beard (2019) suggest offering alternative perspectives in classroom discussions that would encourage students to frame concepts

based on their life experiences. These researchers suggest culturally responsive teaching that "strengthens the learner's ability to recognize and respond in an inclusive way to diverse perspectives and voices" (Day & Beard, 2019, p. 3). Nursing instruction that supports critical thinking and reflection can support the process of cultural humility.

Implications for Nursing

The results of this qualitative study add to the body of nursing knowledge surrounding a description of cultural humility as perceived by nursing faculty in baccalaureate nursing education. The findings capture how nursing faculty perceive the concept, with participants describing what they believe cultural humility is as a concept. Characteristics of cultural humility are provided as perceived by these nursing faculty. This study strengthens the nursing literature related to the need to provide a distinction between cultural humility and cultural competence in nursing education. The concept of cultural humility offers a plausible approach to addressing how nursing as a profession can incorporate self-awareness with critical self-reflection when interacting with diverse clients in health care. The areas of nursing science and research, nursing education, and nursing practice can be enhanced with nursing faculty instructing and demonstrating cultural humility in both the classroom and clinical settings.

Additional implications for nursing education includes the integration of cultural humility instruction and practice throughout the baccalaureate curricula; along with the consistent inclusion of cultural humility within nursing simulation instruction with the opportunity for reflective journaling and feedback with faculty debriefing. Nursing faculty would benefit from additional education on cultural humility as a nursing practice

model. The recognition and support for diversity among nursing faculty as well as the nursing student body has been noted. Transformative changes in nursing education can support nursing practice in a globalized world. The support and development of community partnerships can offer collaborative learning experiences within diverse populations that would foster community trust, and student interaction with diverse communities. Lastly, there is a need to address institutional accountability to remove barriers that prevent the inclusion of all populations from receiving culturally appropriate nursing care.

The significance of this study supports the findings that culture plays a dynamic role in health care. Cultural humility fosters communication between the health care provider and client through culturally appropriate interactions. The recognition that culture is integral to one's own assumptions, beliefs, misconceptions, preconceived notions, and prejudices was noted.

The "gap" in health care for diverse populations remains present. This is partly due, perhaps, to health care providers not having the cultural awareness and sensitivity that is practiced through cultural humility. According to the AHRQ (2016), Healthy People 2020, HHS (2016), and HRSA (2016), health disparities are still present in the populations most vulnerable in society.

Nursing faculty are vitally important to instructing students on the concept of cultural humility. However, not all nursing faculty are familiar with this concept, or how to effectively interact with diverse students and clients receiving care. There remains a

need for a clear delineation between cultural humility and cultural competence in the nursing literature.

Nursing Science and Research

The results of this study identify a need for continued nursing research on the concept of cultural humility. Cultural humility has been considered to have a similar definition and meaning as cultural competence. A central recognition of this concept surrounds that it is a lifelong process of self-awareness, and critical self-reflection with critique of already-held assumptions, biases, misconceptions, and prejudices when interacting with diverse populations.

A clear differentiation between cultural humility and cultural competence in the nursing literature is warranted. Culture is the pivotal component to both concepts, but the definitions of each concept are not the same, nor is the process for practicing both concepts. Findings from this study identified the two concepts are still referred to interchangeably in nursing literature and other disciplines which contributes to the unclear differentiation between cultural humility and cultural competence.

For this study, culturally appropriate health care is congruent with the client's cultural pathways for them as represented in the Principal C*LAS Standard*. This study identified respectful interactions as a quality of cultural humility that is supported by these enhanced national standards of care. Health equity for diverse populations is possible with the process of cultural humility, and the delivery of health care that respects the diversity of individuals receiving care. Health care delivery practices in line with the

CLAS Standards would provide assistance to clients in need of support via language assistance appropriate to the client's needs.

The concept analysis conducted by this researcher supports the research findings that a clear distinction between the two concepts is warranted. The concept antecedents noted in the research for this study included: disparities, diversity, and power imbalance. Concept attributes expressed by participants were also identified within the concept analysis: being egoless; self-awareness; and self-reflection. Consequences from the concept analysis included: equity; inclusiveness; lifelong learning; and respect. A possible conceptual meaning from the concept analysis stated: "Cultural humility may be considered the 'missing link' to understanding how culture is an inherit element of one's makeup. Cultural humility is a process that develops with the intentional desire to identify the power imbalance that contribute to health disparities" (Webster, 2015, p. 25).

The foundations to understanding how cultural humility is different from cultural competence is the self-awareness and self-reflection with critique as defined by Tervalon and Murray-Garcia (1998). Secondly, there is the lifelong commitment to critically self-reflect and critique already-held assumptions, biases, and prejudices when interacting with diverse populations in an effort reduce the power imbalance that may exist between the health care provider and the client. This research finding is in tandem with the recognition that cultural humility is a lifelong commitment that develops over time. One does not become "culturally humble" by observing nursing faculty demonstrate it in the classroom and/or clinical areas. The processs of cultural humility is "internalized" by the individual who practices the concept by displaying an earnest, humble regard towards

others. The imbalance in power within the client-provider relationship is minimized, because there is a genuine desire to learn from the client what their health care needs are from the client's perspective – not the health care provider's perspective.

Nursing science related to cultural humility would benefit from including this concept as an approach to nursing care that includes the lifelong commitment to being self-aware, along with critical self-reflection with critique of one's own cultural influences related to interacting with diverse populations. Additional research is warranted to test the concept of cultural humility using a validated instrument(s) in nursing developed by nurses.

Currently, there are no identified nursing theories in the literature related to cultural humility as a concept. Nurse researchers have utilized non-nursing theories to provide a richer nursing insight to cultural humility. As examples, Kamau-Small et al. (2014) implemented the experiential learning theory (Kolb, 1984) as a foundation to the development of cultural humility and the impact of care equity among community/public health nursing students. This same learning theory was used by Gallagher and Stevens (2015) who used photovoice as a teaching strategy in a baccalaureate community health nursing course that emphasized self-reflection, a component of cultural humility.

The Transformational Learning Theory by Mezirow (1998) may help explain the research findings from this study. This adult learning theory "maintains that human communication requires critical reflection of assumptions" (Mezirow, 1998, p. 188). Becoming critically reflective of one's assumptions is the key to transforming one's

frame of reference which are assumptions through which one understands their experiences. Transformative learning is the essence of adult education.

The philosophical foundation of Mezirow's (1998) transformative learning is by Siegal's (1988) concept of reason rationality. "Reasons imply an assumption of some supporting principle" (Mezirow, 1998, p. 186). Frames of references (assumptions) can change, or transform through critical reflection of assumptions, beliefs, points of view, and habits to move towards autonomous thinking. Critical reflection is principled thinking that is impartial, consistent, and non-arbitrary. Transformative learning is facilitated when adults become aware of, and are critical of their own assumptions and those of other's according to Mezirow (1998). This theory of Transformative Learning "fits" the need for critical self-reflection when practicing cultural humility. The application of this learning theory would require one to look at their own frame of reference through critical reflection, to recognize when already-held beliefs, assumptions, biases, misconceptions and prejudices are present which may be adversely affecting interactions with diverse populations.

In conducting additional nursing research, this researcher has not yet to date identified a validated nursing instrument(s) developed to measure some aspect(s) of cultural humility. However, a large volume of nursing research on cultural competence is available with validated research instruments that specifically measure some aspect(s) of this concept. With additional nursing inquiry, a research instrument specific to measuring cultural humility from different aspects could be developed and tested for its validity as a starting framework for a possible research intervention.

Some of the challenges this researcher experienced conducting this research study included how the literature may refer to the concept of cultural humility, but the focus was essentially on cultural competence. Secondly, the nursing profession is currently increasing research on this topic. There is a larger body of research conducted on this topic in other disciplines such as medicine, psychology, and social work. This may be, in part, due to the vast amount of research and funding related to cultural competence. The longitudinal effects of this research study hopefully will serve as a catalyst for developing a nursing competency and standard on cultural humility.

Nursing Education

The results of this study identified that student nurses and nursing faculty could benefit from learning cultural humility either in nursing academics, or professional education/staff development inservices. The instruction of cultural humility in nursing education and practice can serve to increase effective communication with clients, improve client safety in the clinical areas, and forge a mutual learning opportunity between nursing faculty, students, and practicing nurses. Participants for this study responded that cultural humility should be threaded throughout the nursing curricula of baccalaureate nursing education to demonstrate the value and importance of this concept from a mission and value stance within nursing education.

Nursing academics. The baccalaureate nursing curriculum provides a liberal education for entry into nursing practice (AACN, 2008). Newly graduated baccalaureate nurses are entering a diverse, complex environment in which to practice. Nursing care

needs to be culturally and linguistically appropriate to meet the needs of a diverse population according to the Office of Minority Health (OMH, 2015).

Efforts to reduce health disparities especially within vulnerable, diverse populations are addressed on the national level. The *National Standards for Culturally and Linguistically Appropriate Services* (CLAS) helps to bridge the health gap due to cultural and linguistic differences within a diverse society. These *Standards* are intended to advance health equity, improve quality, and help reduce health disparities. Health care delivery to diverse clients must be culturally and linguistically appropriate. With culturally responsive care provided within the framework of cultural humility, health care needs are better met, which contributes to improved patient satisfaction in the health care received by diverse clients.

In developing a curriculum that includes cultural humility as a topic to be presented within baccalaureate nursing education, it would require curricular scaffolding to build upon earlier presented information to support student learning. Participants suggested the presentation of this concept in all nursing courses. This researcher suggests repeated instruction and exposure to this concept throughout one's educational preparation for all baccalauareate students in higher education. Educational instruction on this topic would build over a four-year process.

From this study, cultural humility has been identified as a concept that warrants instruction to nursing students in the baccalaureate curriculum. *Nursing simulation* was identified as a strategy for teaching, learning, and applying this concept in a structured learning environment. In addition, the use of vignettes during freshmen seminars could

offer an entry opportunity to start the introduction of cultural humility in nursing education, along with nursing simulation exercises. Student journaling could start in supporting reflective writing in guiding students to think critically. As the student's level of progression continues within the baccalaureate program, the topic is not totally "foreign" to nursing students. Earlier knowledge of the concept builds to where the development of cultural humility has started. Nursing students have the opportunity to apply didactic principles of this concept to support clinical learning and application into nursing practice with a focus on patient-centered care. Evidence-based teaching strategies supports the learning needs of students. Reflective journaling as a teaching strategy would promote student learning, while addressing possible "blindspots" in student assimilation to culturally appropriate care.

Schuessler, Wilder, and Byrd (2012) offered that as a teaching strategy in nursing, reflective journaling involves writing to learn. In their study, nursing students for one semester were instructed to critically reflect and journal about their interactions with clients using self-awareness and evaluation (self-crititque) of their own cultural make-up, and the client's cultural perspectives. By the end of the semester, nursing faculty noted the beginning development of critical self-analysis, along with an increased student awareness of their environment and of others. The starting process of cultural humility was noted by nursing faculty by the end of the semester.

The placement of cultural humility as a subject presented within the baccalaureate curricula varies. Discussions by participants within this study noted that the presentation of this concept is present in all nursing courses at some institutions of learning. Other

institutions present cultural humility at the junior or senior level of nursing education during community health/public health instruction. It was noted during data analysis that not all institutions of higher learning include cultural humility as a topic of instruction to nursing students. As a result, these nursing students do not have the strengthened foundation of self-awareness that can impact the quality of client care that cultural humility can help support. This study supports the instruction of cultural humility throughout the baccalaureate nursing curriculum from freshman through senior level. Cultural humility education would start with identifying what the concept is by definition; while defining self-awareness and self-reflection with critique; and presenting what are some implications in nursing education and practice applying this concept to nursing care and practice. Consideration to develop nursing curricula standards would support the instruction of cultural humility throughout baccalaureate nursing education for students throughout the educational process.

Professional education/staff development. This study supports additional professional education of nursing faculty on cultural humility in baccalaureate nursing education. Participants in this study shared that not all nursing faculty who teach in nursing education are aware of the concept itself. The translation and demonstration of cultural humility by nursing faculty, therefore, is not always presented in baccalaureate nursing either in the classroom or clinical settings.

The professional education/staff development of nursing educators and practicing nurses is crucial in meeting the diverse health care needs of this multicultural society. According to Day and Beard (2019), “the nursing workforce will not only have to look

diverse, but also speak with multiple voices in order to communicate and support diverse perspectives and experiences" (Day & Beard, 2019, p. 1). These researchers offer that a method "to move nursing education toward valuing diversity and cultural humility is through culturally relevant teaching" (p. 2) in the classroom and clinical settings.

In an effort to support professional education/staff development on cultural humility, it is important to address how already-held biases, misconceptions, beliefs, and prejudices need to be acknowledged, then "put aside" to allow for an authentic exchange between the health care provider and the client. Masters et al. (2018) addressed provider biases which can be implicit or explicit, and cultural humility in health care using a coaching tool as a framework for addressing provider bias. These researchers offer using *The 5Rs of Cultural Humility* (*Reflection; Respect; Regard; Relevance,* and *Resiliency*) tool. The intent of using this coaching tool is to remind providers to be mindful and compassionate during client interactions. The use of this tool according to Masters et al. (2018) can increase awareness into clinical encouters aimed at decreasing health disparities and improving the client-health care provider relationship. The practice of cultural humility, according to Masters et al. (2018) "helps to mitigate implicit bias, promote empathy, and aids the provider in acknowledging and respecting patients' individuality" (p. 628).

The results of this study also supports nursing faculty development on cultural humility that is continual. Venues for instruction can include professional workshops, seminars, and conferences, including online module instruction, continuing education specific to cultural humility, and evidence-based practice methods in nursing that

includes cultural humility as the focus for learning. These instructional venues are opportunities that support nursing faculty to increase their learning on cultural humility as it relates to interactions with persons from a culture different from their own culture.

Nursing Practice

Nurses are educated to be culturally responsive in practice. The results of this study identified that nursing faculty may not know about the concept of cultural humility itself. Also, nursing faculty and practicing nurses may not have the institutional recognition to incorporate this concept into their nursing practice. "Understanding the unique manifestations of different cultures and how they impact an individual's health-related practices is meaningless if this cannot be applied in practice" (Bahreman & Swoboda, 2015, p. 105). A collaborative effort that can support nursing practice where cultural humility can be applied is in de-escalation training for health care staff when working towards conflict resolution that minimizes and reduces harm and distress in the workplace.

An ongoing emphasis in workforce development on diversity in nursing is necessary. The NLN (2016) stated, "The current lack of diversity in the nurse workforce, student population, and faculty impedes the ability of nursing to achieve excellent care for all" (NLN, 2016, p. 2). The results of this study supports the NLN position of this statement, along with the need for knowledge and training on cultural humility to better address the health care needs of a diverse population. Nursing workforce development strategies aimed at increasing the diversity in nursing would benefit by including the

concept of cultural humility as part of the educational requirements for workforce development.

The results of this study support nursing mentorship in cultural humility both in nursing education and nursing practice. Nursing faculty can demonstrate the practice of cultural humility for students to emulate. Practicing nurses need to be introduced to the concept of cultural humility through self-learning online modules as part of continuing education requirements at work, as well as attending workshops and seminars that present the topic. Professional development opportunities for practicing nurses can be made available for meeting personal growth and nursing practice elevation. Secondly, when nursing students are in the clinical areas, the practice of cultural humility by faculty and students better serves the clients receiving care. Practicing self-awareness and critical self-reflection with critique may create a behavior change both in didactic and clinical practice that can lead to exemplifying the benefit of practicing cultural humility by both nursing faculty and students.

Institutional accountability for addressing barriers to achieving cultural humility is a key component in redressing the power imbalance that exists in health care between the health care provider and the diverse client. A recognition by higher learning institutions of nursing would benefit from the acknowledgment that cultural humility may not even be known to exist by nursing faculty, administrators, and staff alike. With this in mind, institutions of higher learning can work collaboratively with educators, administrators, and staff to address how this concept can be integrated into the curriculum of nursing education as a required topic of instruction.

Recommendations

The following are recommendations for future research of this topic for consideration:

- Develop a research instrument with validation of the instrument.
- Conduct a predictive study over time to measure cultural humility.
- Develop an intervention for testing longitudinally.
- Test the intervention on cultural humility longitudinally.

Chapter Summary

This chapter included a discussion of the findings of a nursing research study that was conducted to describe the concept of cultural humility as perceived by nursing faculty in the educational process of baccalaureate students. Three research questions guided this study. Twenty participants who self-identified with cultural humility were interviewed during several focus group sessions using an online teleconferencing platform. Themes, subthemes, and strategies were identified from the data analysis that documented, discussed, and linked to current literature and theory related to cultural humility as perceived by nursing faculty. Additional findings were also documented to provide additional insights that influenced how nursing faculty identify with the concept of cultural humility.

Research implications from the results of this study provided information how this study impacts on nursing science and research, nursing education, and nursing practice. Recommendations for future research were identified in several topics for further nursing research on cultural humility to strengthen the literature on this concept.

The conclusions from this research study identified that not all nursing faculty are knowledgeable on cultural humility as a concept. Nursing faculty and practicing nurses need to be educated on this concept. The inclusion of cultural humility throughout the nursing curricula to introduce and instruct nursing students to this topic is imperative in preparing them to practice in a global society that is diverse in thought, belief systems, and cultural practices.

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Appendices

Appendix A

Evidence Table

Appendix A

Evidence Table

Citation	Design Method	Theoretical Framework	Sample Size	Level of Evidence	Outcomes
Owen et al. (2015)	Quantitative Retrospective	Multicultural Orientation (MCO)	*N* = 247	3	Cultural humility, missed opportunities, & therapy outcomes influence one another
Owen et al. (2014)	Quantitative Cross-Sectional	Multicultural Competencies (MCCs)	*N* = 45	3	Client perceptions of therapist's cultural humility can affect therapy outcomes
Hook et al. (2013)	Quantitative Cross-Sectional (4 studies)	Strong working alliances between client & therapist predict therapy outcomes	(Pilot) *N* = 117 (Study 1) *N* = 472 (Study 2) *N* = 134 (Study 3) *N* = 120	3	Client's perception of their therapist's cultural humility was associated with improved therapy outcomes
Schuessler et al. (2012)	Qualitative Descriptive	Naturalistic Inquiry	*N* = 50	3	Cultural humility can be developed by nursing students
Ferranto (2015)	Qualitative Interpretive	Theory of Mindfulness (Langer) Process of Cult. Competence (Campinha-Bacote)	No sample size stated in the literature	2	Awareness of "others" with the development of cultural empathy can occur
Fahey et al. (2013)	Qualitative	Constructivism	N = 65	2	Achieving cultural humility was associated with cultural awareness
Hipolioto-Delgado et al. (2013)	Qualitative Grounded Theory	Cultural Immersion	*N* = 3	2	An increase in self-awareness occurred with an improved understanding of diverse communities

Level of Evidence Scale: 1 = Weak Evidence 2 = Medium Evidence 3 = Strong Evidence

Citation	Design Method	Theoretical Framework	Sample Size	Level of Evidence	Outcomes
Davis et al. (2016)	Quantitative Cross-Sectional Correlational	Microaggress. in Counseling	*N* = 128	1	No causal relationships could be determined between variables
Hook et al. (2016)	Quantitative Cross-Sectional	Racial Micro-aggressions in Counseling	*N* = 2212	1	No causal relationships could be determined between variables
Paparella-Pitzel et al. (2016)	Quantitative Longitud. Pilot Study	2-hour teaching strategy on cult. compet. & cult. humility	*N* = 48	1	Long-term benefit was noted in learning self-awareness during physical therapy care to diverse populations
Loue et al. (2015)	Mixed Method Quantitative (Survey) Qualitative (Focus Grps; Problem-based learning module)	Cross-cultural Education	(1st yr) *N* = 94 (2nd yr) *N* = 45 *N* = 14 *N* = 6	1	Cultural awareness & self-reflection were not perceived as important by medical students in their training
Isaacson (2014)	Mixed Method Descriptive & Inferent. Statist. Hermeneutic Phenomenology	Cultural Compet. (Campinha-Bacote)	*N* = 11	1	Stereotypical thinking & racial biases noted after cultural immersion experience by senior nursing students
Kamau-Small et al. (2014)	Mixed Method	Stages of Change (in behavior)	*N* = 149	1	Barriers to change were noted in student behavior regarding cultural awareness
Kutob et al. (2013)	Quantitative Controlled Posttest-Only	Skills-based online course on cultural competence	*N* = 90	1	Physician learning occurred & measured after cultural competence training from an online skills-based course

Level of Evidence Scale: 1 = Weak Evidence 2 = Medium Evidence 3 = Strong Evidence

Appendix B

Recruitment E-Mail

Appendix B

Recruitment E-Mail

From: Linda Webster
culturalhumility01@gmail.com

To: E-Mail Address of Potential Participant

Subject: Invitation to Participate in a Nursing Research Study on Cultural Humility

Attachment: Information Flyer

My name is Linda Webster, RN, PhD (candidate) from Widener University in Chester, Pennsylvania. I have received Institutional Review Board (IRB) approval to solicit participants for a qualitative nursing research study on cultural humility, a process of self-awareness and self-reflection with critique where one not only learns about another's culture, but one starts with an examination of his/her own beliefs and cultural identities. Nursing faculty who self-identify with this concept are being recruited to share their perspective of cultural humility in nursing education.

Purpose: The purpose of this study is to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students.

Eligibility:
- RN nursing faculty teaching in an accredited baccalaureate nursing program
- Teach on a full-time, or part-time basis in the classroom and/or clinical setting
- Two years teaching experience with recent instruction to students in the past academic year
- Master's degree or doctoral degree

Your participation which is voluntary consists of participating in one, online focus group interview session along with 5 to 8 other participants. The session will be digitally recorded using the teleconferencing software called Zoom®. The maximum duration of the focus group interview is two hours.

Your time will be compensated after completion of your focus group interview. A $50.00 VISA® gift card will be sent electronically to your designated e-mail address. Your privacy during data collection will be maintained. No institution of higher learning will be identified in the study.

Contact me, the principal investigator through this e-mail address designated for this study. Feel free to pass this e-mail and Information Flyer along to other colleagues in nursing education.

Best regards,

Linda Webster, RN, PhD (candidate)
culturalhumility01@gmail.com

Faculty Advisor: Dr. Esther Brown
Widener University, School of Nursing

Appendix C

Information Flyer

Appendix C

Widener University

Information Flyer

Participants Needed for A Nursing Research Study on Cultural Humility

Cultural humility is a lifelong process of self-awareness and self-critique and reflection whereby the individual not only learns about another's culture, but starts with an examination of his/her own beliefs and cultural identities.

Purpose: The purpose of this study is to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students.

Eligibility: You are an RN nursing faculty who self-identifies with cultural humility. You teach in baccalaureate nursing education full-time or part-time in the classroom and/or clinical setting; with at least two years of teaching experience, educating students in the past academic year. You have a Master's degree, or a doctoral degree.

You will participate in one, online focus group interview session along with 5 to 8 other participants

using the teleconferencing software called Zoom®. The focus group will be digitally recorded.

The maximum length of time for the focus group interview session is 120 minutes.

To acknowledge your time and effort to participate in this study, you will receive a $50.00 VISA® gift card delivered electronically after completing your scheduled focus group interview.

To learn more ~

Contact the Principal Investigator:
Linda Webster, RN (PhD candidate), Widener University at:
culturalhumility01@gmail.com

Faculty Advisor: Dr. Esther Brown, Widener University, School of Nursing
Widener University Institutional Review Board has approved recruitment of participants
IRB Protocol Number 124-18

Appendix D

Screening Tool

Appendix D

Screening Tool

1. Are you able to read English? Yes___ No___
2. Do you self-identify as practicing cultural humility? Yes___ No___
3. Do you teach in an accredited baccalaureate nursing program? Yes___ No___
4. Do you have at least two years of teaching experience in baccalaureate nursing education? Yes___ No___
5. Have you taught nursing (or other courses within the nursing curriculum), and/or taught in the clinical area within the past academic year? Yes___ No___
6. Do you hold a Master's of Science in Nursing degree? Yes___ No___
7. Do you hold a doctoral degree? Yes___ No___
8. What is your nursing clinical area(s) of specialty? _____

_____

Appendix E

Online Focus Group Schedule E-Mail

Appendix E

Online Focus Group Schedule E-Mail

From: Linda Webster
culturalhumility01@gmail.com

To: E-Mail Address of Potential Participant

Subject: Online Focus Group Dates and Times

Attachments: Consent Form; Demographic Data Form

You have been screened to voluntarily participate in a nursing research study on nursing faculty's perception of cultural humility in baccalaureate education. Before sharing your valuable insights, you are required to provide written consent.

Attached to this e-mail is the Consent Form, and Demographic Data Form. After reviewing both documents, please sign and date the Consent Form. Provide your responses to the Demographic Data Form. Both documents need to be returned via e-mail to the researcher within (7) days of receiving this communication. Completion of these documents are required before your participation in the study.

The schedule for the online focus group interview sessions is listed below. Review the dates and times, and select ONE interview session date and time that best meets your availability. You can reply with this e-mail your selected date and time. You will be contacted via e-mail when your Consent Form, Demographic Form, and selection of the focus group session have been received by the researcher.

Focus Group Session 1:
Date and Time:_____

Focus Group Session 2:
Date and Time:_____

Focus Group Session 3:
Date and Time: _____

Focus Group Session 4:
Date and Time:_____

If you have questions or concerns regarding this process, contact me via e-mail at: culturalhumility01@gmail.com. Thank you for your cooperation.

Appendix F

Consent Form

Appendix F

CONSENT FORM

Widener University IRB Protocol Number 124-18

INVESTIGATOR NAME: Linda Webster, RN (PhD candidate) Student
Widener University, School of Nursing

STUDY TITLE: A DESCRIPTION OF CULTURAL HUMILITY AS PERCEIVED BY NURSING FACULTY IN BACCALAUREATE NURSING EDUCATION

PURPOSE OF THE STUDY
The purpose of this research study is to describe the concept of cultural humility from the perspective of nursing faculty in the educational process of baccalaureate students.

Cultural humility is a lifelong process of self-awareness and self-critique and reflection whereby the individual not only learns about another's culture, but one starts with an examination of his/her own beliefs and cultural identities.

I am being asked to be a participant in the study because a description of nursing faculty perception of cultural humility in baccalaureate nursing education is being investigated. I am nursing faculty with at least two years teaching experience in a baccalaureate nursing program who self-identifies as practicing cultural humility. I have teaching and/or recent clinical instruction experience within the past academic year. My level of education as nursing faculty is at the Master's level or doctoral level. I am able to read and write English, and have the ability to provide written, informed consent to voluntarily participate in this study.

DESCRIPTION OF THE STUDY
As a participant in the study, I will be required to participate in one, online a digitally recorded focus group interview session along with approximately five to eight other participants. The teleconferencing software that will digitally record the focus group is called Zoom®. I may choose not to use my front-facing computer camera during the focus group interview session to maintain my privacy. I will be asked semi-structured, open-ended interview questions on cultural humility in the academic setting to facilitate discussion. I have the right not to answer an interview question asked by the researcher who is the moderator for the focus group interview.

The amount of time required to participate in the study is 120 minutes.

There will be no cost to me related to study participation.

RISKS AND DISCOMFORTS
As a participant in this study, I may experience some feelings of psychological discomfort such as anger, uneasiness, or defensiveness while listening, and responding to participant viewpoints that may be different from my own. The risk that I might experience psychological discomfort will be minimized by the established guidelines to all participants to adhere to before the online focus group interview questions are presented.

As a participant, I may recognize a focus group participant from the teleconferencing software Zoom®. To maintain my privacy, I may choose not to use my front-facing computer camera during the focus group interview session. I have the option to leave the focus group interview at my discretion if I become too uncomfortable during the interview process.

If I experience any of the risks identified, I should request to skip the question(s), or choose not to participate in the online focus group interview session that is taking place, and sign off from the online meeting room. I can contact the resources identified for psychological discomfort.

BENEFITS
There may be no direct benefits of participating in this study; however, the knowledge received may be of value to increasing nursing science and knowledge in nursing education.

ALTERNATIVE PROCEDURES
The alternative procedure is not to participate in this study.

CONFIDENTIALITY
All documents and information pertaining to this research study will be kept confidential in accordance with all applicable federal, state, and local laws and regulations. I understand that data generated by the study may be reviewed by Widener University's Institutional Review Board, which is the committee responsible for ensuring my welfare and rights as a research participant, to assure proper conduct of the study and compliance with university regulations. If any presentations or publication result from this research, I will not be identified by name.

The information collected during my participation in this study will be kept until the final data collection and analysis is completed by the researcher. All paper-based data collected during this study will be stored in a secure, fireproof filing cabinet in the researcher’s home, and my privacy and confidentiality will be protected by a password-protected, encrypted laptop computer located in the researcher’s home office that no one other than the researcher has access to. All paper-based data, and electronic data collected will be shredded or permanently erased one year after completion of this study.

I will use only my first name or pseudonym during the focus group interview session. There will be no reference to the specific institution of higher learning where I work during the focus group interview.

TERMINATION OF PARTICIPATION

I may choose to withdraw from this study at any time and for any reason without penalty or reprisal. If I choose to drop out of the study, I will contact the investigator and my Online Focus Group Schedule E-mail; signed Consent Form; Demographic Data Form; e-mail address and contact phone number will be shredded by the researcher.

The researcher may terminate my participation in the study if a display of behavior during the online focus group interview is deemed inappropriate, non-professional, or deleterious to the group dynamic that is required for the focus group interview.

COMPENSATION

As a study participant, I will receive the following compensation for being in this study. A VISA® electronic gift card in the amount of $50.00. To receive the compensation, I must complete participation in the one-time scheduled online focus group session. Compensation will be provided after participation in the focus group session, and will be distributed electronically after completion of the scheduled focus group session.

INJURY COMPENSATION

Neither Widener University nor any government or other agency funding this research project will provide special services, free care, or compensation for any injuries resulting from this research. I understand that treatment for such injuries will be at my expense and/or paid through my medical plan.

QUESTIONS

All of my questions have been answered to my satisfaction and if I have further questions about this study, I may contact Linda Webster, RN (PhD candidate) at: culturalhumility01@gmail.com. If I have any questions about the rights of research participants, I may call the Vice-Chairperson of the Widener University's Institutional Review Board at 610-499-4110.

VOLUNTARY PARTICIPATION

I understand that my participation in this study is entirely voluntary, and that refusal to participate will involve no penalty or loss of benefits to me. I am free to withdraw or refuse consent, or to discontinue my participation in this study at any time without penalty or consequence.

I voluntarily give my consent to participate in this research study. I understand that I will be given a copy of this consent form.

Signatures:

_____
Participant's Name (Print)

_____ _____
Participant's Signature Date

I, the undersigned, certify that to the best of my knowledge, the subject signing this consent form has had the study fully and carefully explained by me and have been given an opportunity to ask any questions regarding the nature, risks, and benefits of participation in this research study.

Linda Webster
Investigator's Name (Print)

_____ _____
Investigator's Signature Date

Widener University's IRB has approved the solicitation of participants for the study until August 14, 2019.

Appendix G

Demographic Data Form

Appendix G

Demographic Data Form

Directions: Indicate your response(s) to the following items.

First Name or Pseudonym: _____

Age:_____

_____Prefer not to Answer

Gender: Indicate which gender you most closely identify

_____

_____Prefer not to Answer

Race:

- Alaskan Native _____
- American Indian _____
- Asian _____
- Black/African American _____
- Caucasian/White _____
- Middle Eastern North African _____
- Native Hawaiian _____
- Other Pacific Islander _____
- Prefer not to Answer _____

Ethnicity:

- Hispanic or Latino _____
- Not Hispanic or Latino _____
- Specify:_____
- Prefer not to Answer _____

Years Teaching Baccalaureate Nursing:

_____

Years of Nursing Experience:

_____

Highest Level of Education Obtained:

- Master's _____
- DNP _____
- PhD
  - Nursing _____
  - Non-Nursing _____
- EdD _____
- DNS _____
- DNSc _____
- Other _____ Specify: _____

Clinical Area(s) of Specialty:

_____

_____

Teaching Specialty Area(s):

_____

_____

What Curricular Level Do You Primarily Teach?

- Freshmen _____
- Sophomore _____
- Junior _____
- Senior_____

Appendix H

Interview Guide for Focus Group Sessions

Appendix H

Interview Guide for Focus Group Sessions

Welcome participants to the focus group session. Session is being digitally recorded.

Give an overview of the topic of discussion for the focus groups.

Give the purpose of the focus group interviews.

Start with introductions of researcher/moderator and participants (First name or pseudonym) only.

Provide Guidelines for Focus Group Sessions:

1. Mute/turn off all other electronic devices (cellphones; beepers; televisions, etc.) to reduce distraction during the focus group session.

2. One person speaks at a time (no cross-talking).

3. Be respectful of all participant responses (one does not have to agree with the responses gsiven).

4. Moderator will ask the questions during the focus group to generate Discussion. Moderator will re-direct discussion, when necessary, to stay focused on the topic.

5. All participants are expected to contribute to the discussion.

6. If for any reason a participant feels uncomfortable and needs to be excused from the interview, let the Moderator know by sending a chat message within Zoom® that is viewable only to the Moderator; and remove oneself from the discussion.

Appendix I

Interview Questions

Appendix I

Interview Questions

Cultural humility is a concept termed by Tervalon and Murray-Garcia (1998) defined as a practice that requires "a lifelong commitment to self-awareness and self-reflection with critique to redressing the power imbalance in the patient-provider dynamic". There are variations of this definition in the literature. Yeager and Bauer-Wu (2013) offered a nursing definition of cultural humility as: "a process of self-reflection and self-critique where the individual not only learns about another's culture, but one starts with an examination of his/her own beliefs and cultural identities" (Yeager & Bauer-Wu, 2013, p. 251).

1. Describe what you believe cultural humility is?
2. What are the characteristics of cultural humility you perceive as nursing faculty?
3. Talk about a time when you observed cultural humility in the academic setting.
4. How do you perceive cultural humility in baccalaureate nursing education?
5. How do you perceive cultural humility translation into nursing practice?

Appendix J

Where Participants Can Seek Professional Psychological Support

Appendix J

Where Participants Can Seek Professional Psychological Support

Participants seeking psychological support in response to discomfort caused by questions and responses voiced in the data collection portion of this research study can go to their own primary care physician for a referral to a specific mental health professional equipped to address the specific concern(s) that caused discomfort during the online focus group session conducted. Participants may also seek the support of the Employee Assistance Program (EAP) from their place of employment. The following phone number is from the American Psychological Association (APA) Practice Organization as a resource for further psychological assistance in a participant's local area: (800) 374-2723.

Appendix K

Audit Trail

Appendix K

Audit Trail

Faculty Descriptions	Open Coding	Themes and Subthemes
RQ #1: What are nursing faculty perceptions of cultural humility in baccalaureate education?		
Fran: I think clearly there is a self-awareness piece to cultural humility that is to be aware of how would you describe yourself culturally, you know, that is important to think about. Patty: You need to be self-aware. Loraine: You need self-awareness about another's culture. Cathy: Being open to other cultures; having a self-awareness being non-judgmental of others; being respectful to others. Nichole: You can't look down on a person. Claire: I think it has to be, you know, intentional and just to kind of really respect their viewpoint and their beliefs and their values, even though it may be totally different than mine.	Self-awareness	Having self-awareness of one's own culture *Being respectful and humble to others*
Roberta: For me, honestly, cultural humility is a lifelong journey of self-reflection. Its not a one-time thing; its an ongoing process throughout life. Diane: It's a whole different approach to looking at patient care; or at your students. It requires self-reflection.		Being self-reflective is an ongoing process
Tasha: Knowing your own culture and being comfortable with it. Meg: Cultural humility has to do with yourself, like myself as an individual. Shari: Recognizing how you were raised and the various influences on you for your whole life.		*Self-discovery of one's own cultural influences*
Monika: You have to challenge yourself in terms of perspective; how do others see you.		*Walking in another's shoes*

Faculty Descriptions	Open Coding	Themes and Subthemes
Claire: I kind of see that as what I call an openness, to that you're always open to that other person's view. Monika: Recognizing how people got to where they are. You have to listen to people. Lori: Immersing myself in a different environment than what I'm used to, and trying to see how other people live. Nichole: Cultural humility transcends; it doesn't necessarily mean its this culture or that culture. When it comes to cultural humility, you have to take a look and see what other people are going through, and you may never have lived it, so you don't understand the struggle.		
RQ #2: What are the characteristics of cultural humility as perceived by nursing faculty?		
Mary Ellen: I also think its more like being respectful of other people; their cultural choices, and knowing what they want done for their care. Diane: I think being open to other people's culture, and recognizing that it does have a large impact on the way we practice, the way our students practice, and being respectful of other people's cultures. Lori: Being respectful of the culture – the practices. It was really good to see different cultures within the center. Loraine: I think its meeting that person where they are. Leaving the bias outside, and being able to get through to the heart of the patient. Sofia: Being "egoless". Being aware of relationships and understanding of differences. Claire: You have to be open to differences, how people live their lives, and who they're connected with, and what's their experience and that's	Respecting cultures Unbiased traits	Respecting other cultures Being unbiased

Faculty Descriptions	Open Coding	Themes and Subthemes
something I think our biases prevent us from being open.		
RQ #3: How do nursing faculty perceive that they demonstrate cultural humility in the educational context?		
Monika: I think role modeling is key. Patty: This is like almost being a cultural advocate. Tasha: You have to be willing to be receptive to others. Sofia: Being respectful of others.		
Claire: Respecting different viewpoints and beliefs even when totally different than mine.		
Fran: Cultural competence with cultural humility – I don't think that we have a clear distinction between them. There is a distinction. Sofia: Whereas cultural humility is borne of this is the way to obtain these skills; cultural competence is more of – its sounds like more of something you're checking off a list. Roberta: They'll talk about cultural humility, but they have it embedded in the cultural competence work.	Cultural humility or cultural competence	Distinguishing between cultural humility and cultural competence
Monika: Its threaded throughout where I teach as well. I try to incorporate it as much as possible because I feel its important. Sofia: I've been with two different institutions; cultural humility was threaded throughout their curricula. Roberta: It has to be weaved throughout because if they see it as a critical or core aspect, they will understand its important and relevant.		Threading cultural humility throughout the nursing curricula

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