

Digital Commons
@ LMU and LLS

Loyola Marymount University and Loyola Law School
Digital Commons at Loyola Marymount
University and Loyola Law School

LMU/LLS Theses and Dissertations

Spring 2020

Cultural Humility Art-Based Training in the Helping Professions

Tara Al-Taan

Silvia Figueroa

Elizabeth Park

Beverly Pascua

Sachi Sosna

See next page for additional authors

Follow this and additional works at: <https://digitalcommons.lmu.edu/etd>



Part of the [Art Therapy Commons](#)

This Research Projects is brought to you for free and open access by Digital Commons @ Loyola Marymount University and Loyola Law School. It has been accepted for inclusion in LMU/LLS Theses and Dissertations by an authorized administrator of Digital Commons@Loyola Marymount University and Loyola Law School. For more information, please contact digitalcommons@lmu.edu.

Author

Tara Al-Ta'an, Silvia Figueroa, Elizabeth Park, Beverly Pascua, Sachi Sosna, Serap Spaltro, and Allison Sweeney

Cultural Humility Art-Based Training in the Helping Professions

by

Tara Al-Ta'an
Silvia Figueroa
Elizabeth Park
Beverly Pascua
Sachi Sosna
Serap Spaltro
Allison Sweeney

A research paper presented to the
Faculty of the Department of Marital and Family Therapy
Loyola Marymount University

In partial fulfillment of the requirements for the degree
Master of the Arts in Marital and Family Therapy

May 8, 2020

Signature Page

Authors' Signature

A stylized, cursive handwritten signature in black ink, consisting of a large initial 'T' followed by a series of loops and a long horizontal stroke.

Tara Al-Ta'an

A cursive handwritten signature in black ink, clearly legible as 'Silvia J. Figueroa'.

Silvia J. Figueroa

A cursive handwritten signature in black ink, clearly legible as 'Elizabeth Park'.

Elizabeth Park

A cursive handwritten signature in black ink, clearly legible as 'Beverly Pascua'.

Beverly Pascua

A cursive handwritten signature in black ink, clearly legible as 'Sachi Sosna'.

Sachi Sosna

A cursive handwritten signature in black ink, clearly legible as 'Serap Spaltro'.

Serap Spaltro

A handwritten signature in cursive script that reads "Allison Sweeney". The signature is fluid and elegant, with a large loop at the end of the last name.

Allison Sweeney

Research Advisor's Signature:

Anthony Bodlović, Ph.D., LMFT, ATR-BC

Louvenia Jackson, Ph.D., LMFT, ATR-BC

Abstract

There has been a lack of training and implementation of cultural humility in the helping professions. Clinician's awareness of their own biases, assumptions, and cultural identities is critical when working with individuals who each have their own array of cultural identities. The following research examined the efficacy of cultural humility art-based training courses through surveys and examining the art experiential activity that was provided. The purpose of this research was to determine whether cultural humility art-based training would effectively increase mental health practitioners' comfort, ability, and confidence in addressing culturally sensitive issues in their clinical work. The training focused on introducing the tenets of cultural humility with art directives to help participants reflect on their cultural identity. 47 Participants completed surveys that were analyzed in addition to their art in order to gain qualitative data. The data suggests that cultural humility art-based training effectively increased participant's comfort, ability, and confidence in practicing cultural humility in their work with clients/patients and colleagues. More training and research are needed to generalize findings and determine their longevity.

Keywords: Art Therapy, Art-Based Training, Cultural Humility, Counseling, Cultural competency, Cultural sensitivity, Mental Health

Disclaimer

This paper does not reflect the views of Loyola Marymount University nor the Department of Marital and Family Therapy.

Dedication

This research team has dedicated this project to the many people that have contributed to our journey of becoming lifelong learners and the pursuit of creating an inclusive learning space for all that seek it. To our family, friends, partners, and pets that continue to encourage us as we explored the clinicians, we wanted to become. We are thankful for your sacrifices and never-ending support. To our cohort that reminds us of the importance of having a community that accepts one another unconditionally. We appreciate the platform we were given to learn from you and with you. To our faculty advisors, Dr. Anthony Bodlović and Dr. Louvenia Jackson, who inspired us and provided us with the space to find our own voices. We are eternally grateful for your leadership and guidance through the completion of this project. To the facilities that opened their doors to us and our participants that were willing to engage in our training. We are impacted by their involvement and openness to the topic. Lastly, we want to dedicate this project to the Art Therapists that motivated us along our journeys and the Art Therapists who have yet to come.

Acknowledgments

We would like to acknowledge the Department of Marital and Family Therapy with Specialized Training in Art Therapy at Loyola Marymount University for providing a space where we were able to research a topic that we were passionate about and fostered our personal growth as clinicians. We want to acknowledge our faculty that led by example on how to be culturally humble as well as creating a platform where we could come together in a learning environment, without barriers, so we could challenge ourselves and grow as a community. We want to acknowledge all of our faculty that supported us through our time within the program and encouraged us to use the therapeutic space as another opportunity to learn, not only about the individuals that we serve, but who we want to be as Art Therapists.

Table of Contents

Title Page..... (not printed) i

Signature Page.....1

Abstract.....3

Disclaimer.....4

Dedication.....5

Acknowledgments.....6

Table of Contents.....7

List of Figures.....8

Introduction.....9

The Study Topic.....9

Significance of Study.....9

Background of Study Topic.....10

Literature Review.....11

Research Approach.....31

Methods.....32

Definition of Terms.....32

Design of Study.....33

Results.....37

Presentation of Data.....37

Analysis of Data.....48

Conclusion.....54

References.....60

List of Figures

Figure 1.	.....	36
Figure 2	.....	37
Figure 3	.....	39
Figure 4	.....	40
Figure 5	.....	42
Figure 6-7	.....	44
Figure 7	.....	45
Figure 8	.....	45
Figure 9	.....	46
Figure 10	.....	47
Figure 11	.....	48
Figure 12	.....	49
Figure 13 - 15	.....	50
Figure 16	.....	55
Figure 17	.....	56

Introduction

The Study Topic

The purpose of this research project was to explore if a cultural humility training would increase self-reported levels of comfort, ability, and confidence in implementing the tenets of cultural humility in their clinical work for professionals and staff in the mental health field.

Significance of Study

The significance of this study was to provide quantitative data through self-reported surveys and qualitative data exhibited through an art outlet illustrating the efficacy of art-based cultural humility training courses provided to professionals and staff in the mental health field. The art-based cultural humility training courses provided insight and awareness to increase understanding, competency, and humility in diverse cultural clinical settings.

Background of Study Topic

Through the study of the literature, it appeared that there was a shortage of information and research that has been conducted surrounding cultural humility. In 1998, Melanie Tevalon and Jann Murray-Garcia introduced the concept of cultural humility in the healthcare field. Since then, cultural humility has been explored in the field of art therapy, psychology, and other adjacent fields. In looking at different cultural models and art-based interventions, cultural humility may be used interchangeably with cultural competence. The focus of this research project was to explore the efficacy of an art-based cultural humility training course for professionals and staff in various fields through their self-reported levels of comfort, ability, and confidence.

Literature Review

Introduction

With the increasing cultural, racial, and ethnic diversity in the United States, there has become an urgent need for incorporating cultural competency training to those providing health care in diverse population groups. Although cultural competency has been incorporated in training courses within the health care and educational professions, there still appears to be a lack of consideration in these fields of those from different cultural, racial, and ethnic backgrounds. When cultural humility was first introduced to the healthcare profession in 1998 by Drs. Melanie Tevalon and Jann Murray-Garcia, it was to distinguish the idea of cultural competency from cultural humility. Both cultural competence and cultural humility share similar concepts. Cultural competency was viewed as an ability to understand and communicate with people across cultures; while cultural humility focused more on incorporating a commitment with oneself to self-reflect and emphasize attentive listening and openness to cultures other than your own. Tevalon and Murray-Garcia feel that cultural humility is a life-long learning process when working in a multicultural society. It appeared that the training courses conducted through the healthcare and educational professions were focused on helping individuals to become culturally aware of the diverse populations they were serving, yet they lacked the true understanding of the person's culture and how they would engage with them from a place of modesty. Cultural humility requires one to take responsibility for one's interactions with others and be humble to admit when they do not know something regarding another's background. The aim of this literature review was to examine previous research on cultural humility training courses that

have been used across various fields to understand what has been done, what has worked, and where there is a need for improvement.

Cultural Humility in Art Therapy

In Jackson's (2020) *Cultural Humility in Art Therapy: The Balance of Creativity, Introspection, and Advocacy*, she noted that "recognizing and shifting the power imbalance is a strong and activating principle of cultural humility. Power dynamics are at play at all times in and out of the therapeutic process; it is the art therapist's responsibility to not engage in the perpetuation of the power facilitation causing harm, derogation, or oppression within the art therapy practice" (Jackson, 2020, p. 72). Within the topic of art therapy and expressive arts, a review of the literature provided several articles that discussed cultural humility and other cultural models. This included the training of art therapists and the application or use of cultural models in interventions with client populations.

Cultural Humility

Awais and Keselman (2018) conducted a descriptive qualitative study on six practicing medical art therapists in the Northeast and Mid-Atlantic region of the United States in order to determine how cultural humility manifests within their profession. While all six participants had received multicultural training, it should be noted that none of them were specifically trained within the cultural humility model and the definition of cultural humility varied between participants. According to the article, however, "This study highlighted some of the current practices that are being employed in medical art therapy that might be useful to other clinicians: being cognizant of art therapists and client cross-cultural interactions, how a clinician introduces art therapy, the importance of collaborating with patients on treatment, and openness to learning from patients." (Awais & Keselman, 2018, p.84)

Other Cultural Models

Other cultural models have been used in art therapy education, including a cultural competency model. Linesch and Carnay (2005) conducted a study on ten art therapy graduate students who attended a Cultural and Ethnic Issues in Art Therapy course and assessed their experience taking a weeklong course in Multicultural Competencies during a study abroad program in Mexico using a 40-question Multicultural Competency Inventory (MCI). The course included discussion, art tasks, and homework. The authors found that art played an important role in increasing multicultural awareness and that, “In this experience, it was the art-making that provided the participants with the opportunities to look into unarticulated biases, fears, and resistances and it was the art-making that provided the participants the tools to experiment with change” (Linesch & Carnay, 2005, p. 393). Another article by Weinberg (2018) discussed the ways art therapists can gain cultural competency through alliances when working with Indigenous children in the Canadian foster care system, stating that “Art therapists who work with Indigenous people need to experience their culture in order to build trust and create safety. It also conveyed the importance of valuing Indigenous family and community life, while sensitively amalgamating these aspects into the therapy session, along with ongoing communication with the caregivers of children” (Weinberg, 2018, p. 20). An earlier arts-based heuristic study by Coseo (1997) documented her art therapy internship experience at a therapeutic day school in South-side Chicago by keeping a visual sketchbook and found that “Art making provided a way to uncover stereotypes I was not consciously aware of, and proved to be a valuable tool in exploring and revealing deeply held and denied feelings about African Americans” (Coseo, 1997, p. 156). The author found that working with clients of different racial

backgrounds as well as self-assessment of her experience helped her develop greater cultural awareness (Coseo, 1997, p. 156).

The literature review also produced an article describing the state of multicultural education within the art therapy profession. Calisch (2003) wrote that the American Art Therapy Association's (AATA) ethics document has recognized not only cultural diversity but also the impact of socioeconomic and political factors on the psychological development and sociocultural identifications of minority persons and their artmaking" (Calisch, 2003, p. 13). Although AATA has considered these elements within their ethics document, more can be done to build a more multicultural-oriented profession by addressing issues within art therapy educational curriculum and art therapists' professional development (Calisch, 2003). Other cultural models were found in two articles within the art therapy literature; one discussing cultural identity and its relation to the art therapist identity (Lumpkin, 2006), and the other serving as an introduction to cross-cultural psychotherapy (McNiff, 2009).

Cultural Models: Application and Interventions within Art Therapy

Jackson (2020) writes the following in *Cultural Humility in Art Therapy: The Balance of Creativity, Introspection, and Advocacy*: Creating directives that leave room for reflection can be assessed when offering artmaking to clients. Is the art therapist through the directive allowing the opportunity for the client to create based on their cultural lens or worldview? Or is the directive such that it guides the client to display the art therapist's biases? For example, asking the client to draw by asking, "Can you share what it is like for you?" could open more opportunities for the participant to approach the directive from their own experience. Unlike asking the participant, "Can you draw what frustration felt like," without the client disclosing that it was frustrating. (p.74). Jackson (2020) also emphasizes the importance of art therapists having their own art

practice to continue expanding their self-awareness and understanding their own identity in order to practice being culturally humble.

Additional articles within the literature discussed cultural considerations used by art therapists in their work and the application of culturally informed art-based interventions. Potash et al. (2017) identified several ethical considerations for art therapists providing services internationally using a cultural competence approach, including ethical decision making, preparation to work abroad, delivery of services, engagement in the work, and management of materials, product and studio, development of directives, interpretation of the artwork, and acquirement of consent and authorization. One article was published by researchers from the United States regarding interventions implemented internationally; Arrington and Yorgin (2001) describe how a multidisciplinary team consisting of medical, dental, and psychological (art therapist/psychologist) professionals went to Ukraine/Kiev to medically evaluate and assess homeless children that were either housed in shelters or still living on the streets. The art therapist/psychologist used art for both assessments and interventions. During the assessment phase, puppets were used as an effective form of cross-cultural communication. As the author noted, “Art is cross-culturally ubiquitous and not dependent on understanding a complex set of instructions” (Arrington & Yorgin, 2001, p.82).

Two articles, published in the Canadian Art Therapy Association Journal, examined art-based interventions with immigrant populations in Canada. In the first article, Epp (2013) described “The International Alliance Project,” a project conducted with the Tamil community (from Sri Lanka) in Scarborough, Ontario. This project used art-based activities integrated into a narrative therapy model that aimed to address intergenerational conflict in new immigrant communities. Following one of the art activities, which used a kite metaphor, the participants

discussed difficulties they faced within their communities and families, including cultural differences between generations (Epp, 2013). At the conclusion of the project, an evaluation of 18 participants reported that the group helped improve communication and connection between generations in their lives. From the project, the author also concluded that “a community model of therapy would be a better fit for the Tamil group in Scarborough, as newcomer families do not necessarily turn to professionals for help,” (Epp, 2013, p.22).

Similar to Epp (2013), the second article by Hanania (2018) discussed how designing culturally informed therapy groups may have a positive therapeutic impact on refugee and immigrant populations. The author examined the use of embroidery in art in various different settings and proposes that it can be used as a culturally appropriate art medium as a therapeutic tool for Syrian refugee women entering Canada (Hanania, 2018). The article concluded that “it is important for therapists to understand the cultural traditions, religious values, and language requirements of refugees, and how these factors might affect engagement with an art activity or even art or therapy in general, as there can be cultural stigmas around mental health concerns” (Hanania, 2018, p. 41).

Two articles highlight how culturally informed art-based interventions can aid in communication and self-expression during the therapeutic process. In the first, Lai (2011) described the Expressive Arts Therapy for Mother-Child Relationship (EAT-MCR) model and how it was adapted for Chinese culture for victims of domestic violence. The article provides a four-part guide to address the mother-child relationship that may be affected by the trauma of domestic violence and highlights the advantage of the non-verbal aspect of expressive arts” to circumvent any difficulties verbalizing internalized cultural perceptions and memories of a

traumatic event before therapists could guide clients to organize, explore, and find alternatives for a self-empowered future” (Lai, 2011, p.306).

Similarly, Lark (2005) discussed how art can aid in providing a “voice” to those who are not able to verbalize, particularly in a group setting. The article examined the creation and implementation of an arts-based group intervention called TREC: Talking Race, Engaging Creatively that can be used for interracial dialogues. The author noted, “Shifting between artmaking and verbalization creates shifts in power dynamics, requiring a reexamination of the group’s sociometry. This is particularly important for cross-cultural and interracial encounters” (Lark, 2005, p. 31).

Cultural Humility in Psychology

A review of the literature on cultural humility produced a number of articles within the field of clinical psychology and related fields. The articles to be discussed are divided into the following themes: cultural humility in supervision; cultural humility in therapy practice; and cultural humility in social work.

Cultural humility in supervision

Articles within the theme of cultural humility and in supervision discussed the supervisor-supervisee (trainee) relationship and presented a model with guidelines on how cultural humility can be applied within the training of graduate or doctoral students in the fields of psychology and psychotherapy. Hook et al. (2016) emphasized the importance of cultivating cultural humility in the psychotherapy supervisor-supervisee relationship and presented a model that details specific actions supervisors can implement in their interactions with supervisees, for example, “they make culture a welcome part of the supervisory conversation, initiating conversations about identity and cultural diversity regarding psychotherapy and supervision”

(Hook et al, 2016, p.154). Supervisors can also help supervisees develop cultural humility via outside experiences, activities, and self-assessment, which then can be implemented when supervisees work with clients (Hook et al, 2016, p.156). In an article published in the same year, Watkins and Hook (2016) discussed the role cultural humility plays in the realm of psychoanalytic supervision and proposed that this dynamic created a cultural third, a “space whereby dyadic cultural meanings and experiences are welcomed and can be explored, examined, and experienced anew” (Watkins & Hook, 2016, p.492). Similarly, a theory discussion published by Abbott, Pelc, and Mercier (2019) provided guidelines for utilizing cultural humility in psychology education.

Two articles focused on the supervisee perspective: Patallo (2019) explores the implications of the multicultural guidelines published by the American Psychological Association (APA), while Upshaw, Lewis, and Nelson (2019) describe how cultural humility can be applied in clinical supervision with trainees of color in particular and provided two case examples of the supervisory experiences of Black trainees.

One mixed methods study emerged from a review of the literature on cultural humility. Tormala, Patel, Soukop, and Clarke (2018) conducted a study utilizing cultural formulation (CF) as a tool to measure and improve cultural competence and cultural humility in doctoral students in professional psychology programs using course assignments. The authors report “measurable improvement on several dimensions of cultural competence and cultural humility” and concluded that the results of their study “support the idea that cultural competency and cultural humility do not necessarily spring from the natural ability or personal experience, but can be successfully cultivated in the classroom” (Tormala et al, 2018, p.59).

Cultural humility in therapy practice

Four articles were found to discuss the role of cultural humility in therapy practice, specifically the therapist-client dynamic, and the effects of cultural humility on client outcomes. Articles by Mosher et al (2017) and Hook (2014) go into a deeper discussion on the theory of cultural humility and how it applies to the clinical work of therapists and client interactions. An article published by Lewis, Hartwell, and Myhra (2018) provided guidelines for a 90-minute training program for mental health professionals working with indigenous clients based on a cultural humility framework. Although no study has been done to determine the effectiveness of this training program and its effects on client outcomes, the article discussed how the training program was developed with the objective of "...increase knowledge, awareness, and skills related to Indigenous mental health care" (Lewis et al., 2018, p.332).

The earliest article published in 2013 tests the reliability and validity of the Cultural Humility Scale (CHS) and used it to determine if therapists' cultural humility is important in clients' search of a prospective therapist (Hook, Davis, Owen, Worthington, & Utsey, 2013). The researchers found that "Client perceptions of a therapist's cultural humility were positively associated with both working alliances with the therapist and perceived improvement in therapy" (Hook et al, 2013, p. 361). Another study was done by Owen et al. (2014) using three questionnaires/scales: PEI (Patients Estimate of Improvement), CHS (Cultural Humility Scale), and RCI-10 (Religious Commitment Inventory). From the results, they found that "Clients' perceptions of therapist cultural humility were positively associated with therapy outcomes..." (Owen et al., 2014, p.94).

Cultural humility in social work

Three articles were found regarding the importance of cultural humility in social work.

An article published by Fisher-Borne, Cain, and Martin (2015) discussed a historical overview of cultural humility and how it can serve as an alternative to the cultural competency model for social work educators and practitioners. On a similar note, Rosen, McCall, and Goodkind (2017) provided an example of how cultural humility can be implemented into a social work graduate program and help students develop cultural competence and cultural humility through self-reflective assignments. Sloane, David, Davies, Stamper, and Woodward (2018) also looked at social work education and provide 4 case studies on how students can use the practice of looking at the past to begin demonstrating cultural humility by empathizing with past social workers, by acknowledging past mistakes, and by using past errors as a moment of professional reflection.

Cultural Humility in Adjacent Fields

When compiling articles on cultural humility, the researchers found the presence of training courses outside of the therapeutic space and felt it was impactful to explore further. The articles were examined for the purpose of understanding the different training courses and approaches of cultural humility conducted in the fields of nursing, medical, and education. However, as the articles were examined, it appeared that the training courses that were conducted in these fields compared the concepts of cultural competency and cultural humility and suggested the need for further research on cultural humility. For example, nurses are trained in cultural competency, indicating mastery or success in being capable of helping others from different cultures; however, they still carried personal biases and assumptions when helping a patient. This is different from what cultural humility represents, “Cultural humility illustrates the importance of including the patient’s view in the interpretation of culture, while cultural competence implies that the health care professional has a prior understanding of the person’s culture before engaging with the patient (Isaacson, 2014).”

Cultural Humility in Nursing

Two articles were examined from the field of nursing in order to explore cultural humility training courses that were conducted and demonstrated the need for additional research in regard to what is cultural humility.

In their article, Yeager and Bauer-Wu (2013) distinguish the difference between cultural competency and cultural humility. The writers stated that institutions in the healthcare profession require clinicians to participate in cultural competency training courses that focused on caring for racial and ethnic minority groups to include the traits and practices these groups have, which led to many care providers engaging in assumptions and stereotyping. In the discussion, Yeager and Bauer-Wu, dive into the practice of cultural humility and how cultural humility focuses on people's exposure to different cultures and being able to realize how much one knows or does not know about others.

The second article was a review of 16 studies, the aim of this review was to provide what is known about cultural competence and cultural humility in stimulated-based education. The authors of the review, Foronda et al. (2017) used Whittemore and Knafl's (2005) method of integrative review that involves five steps: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis, and (e) presentation. What was found after reviewing and synthesizing the data, were four themes that emerged from the review of articles: (a) cultural sensitivity and cultural competence, (b) insight and understanding, (c) communication, and (d) confidence and comfort. From the 16 studies, 14 were conducted in the United States, 1 in Australia, and the other one in Canada. The material viewed in the articles reviewed various topics in the number of diverse learners, patient populations, different cultural concepts, context, and methods of simulation. This integrative review provided a foundation of what is circulating

in regard to cultural diversity, cultural sensitivity, insight, and understanding. However, what it appeared to lack was proper teachings of cultural humility in stimulated-base education.

Cultural Humility in Medical Fields

Five articles were found and reviewed with the purpose of examining the different training conducted in the medical fields.

In their article Richard Harvey, Mei Lin, and Annette Booiman (2015) aimed to identify curricular considerations in Biofeedback practitioners and the training they received in multicultural and diversity training. In their report, Harvey, Lin, and Booiman (2015) discussed various models of cultural diversity that could be useful for education and clinical professionals who use biofeedback tools to either educate clients or students in institutional and clinical settings. The article emphasized the importance of identifying useful models and terminology when discussing multicultural diversity training; these three basic models for multicultural diversity awareness among mental and physical healthcare providers are cultural competence, cross-cultural efficacy, and cultural humility. Cultural competence was described as the level of the provider's knowledge, skills, and attitude in regard to cultural values and health-related beliefs. Cross-cultural efficacy is the way providers learn how their culture and behaviors have an impact on different cultures and understand how their patient's cultural behaviors may impact them, the provider. Cultural humility was described as an engagement the provider has within themselves, self-evaluating and self-critiquing; the goal of this model is a life-long practice, where the provider is able to develop a power-balance relationship between the provider and patients of different cultures. The monograph further suggested that multicultural training provides value in diversity, the conduct of self-assessment, cultural knowledge, etc. Harvey, Lin, and Booiman (2015) intended to reflect on training opportunities that address diverse

multicultural experiences in education, diagnostic, and treatment, as well as how multicultural diversity goes beyond race and ethnicity in the client and patient. Although training courses were conducted to teach cultural competency to biofeedback practitioners, the report concluded that multicultural diversity training from cultural competency and efficacy should move toward cultural humility in their practice. The second article examines the underpinning philosophies, assumptions, and effectiveness of cultural awareness training, as well as their limitations.

Stephane M. Shepherd (2018) discussed the disparities in public health in the United States and how cultural awareness training courses are often mandated in multiple sectors, and how this workshop has become an impactful component of the university curriculum. Shepherd referred to learning opportunities as workshops. The article examined the different workshops, and how they depend on underpinning philosophies including cultural awareness, cultural competence, cultural safety, cultural humility, and most recently cultural intelligence (used in business management). These five cross-cultural education philosophies encourage learning by incorporating their tenants into practice, understanding and processing one's own personal biases, and fostering tolerance and empathy. Shepherd (2018) noted that these workshops are rarely long enough to have any true significant meaning for people to implement into practice what was learned. Although this training was well-intentioned, Shepherd (2018) emphasized the need to improve cross-cultural engagement in health care settings.

Butler et al (2011) reviewed the published literature in Cultural Competency and Humility Training (CCH) and interviewed different clinical clerkships from prominent institutional medical education programs. They completed several expert interviews in which faculty members from prominent institutions demonstrated dedication and interest in advancing cultural competency in medical education. The schools whose faculty members were interviewed

included Stanford University of Medicine, University of California San Francisco, Ohio State University Medical Center, and University of San Francisco-East Bay. The results indicated that most CCH initiatives instituted by these medical schools focused on the first 2 years of training but lacked an integrated forum in practicing CCH, where lifelong professional habits are developed. The interviews revealed that students in their first 2 years take professionalism courses that are supposed to help instill awareness of professionalism, ethics, and patient-physician interactions. However, there seemed to be a lack in the third and fourth years of comprehension and exposure to CCH training, as medical students increased their interactions with patients. Although the CCH training continues to be conducted with multiple studies reinforcing how the training has enhanced the knowledge of healthcare providers and enriched the physician-patient relationship, the CCH training must be integrated into everyday aspects of medical training in order to be able to achieve the success they intended to achieve.

Mechanic et al (2017) focused on the well-known disparity in health care and health care access, and how this poses a threat to the well-being of particular populations. In particular, the article explored programs like “Health Care Quality Pathway 5” which focused on reducing disparities within their setting by encouraging residents, fellows, and faculty receiving training in cultural competency. Cultural competency as described in this study is a system that recognizes and incorporates the importance of culture, cross-cultural relations, and cultural adaptation to be able to meet unique outcomes; and how it is beneficial to teach cultural competency in residency. The purpose of the study was to assess residency and faculty exposed to cultural competency programs in Emergency Medicine and assess future needs for diverse education. Mechanic et al (2017) found that most of the EM residency programs included cultural competency education in their curriculum, however, it appeared that some of the programs incorporated limited English

proficiency, and there appeared to be a notable gap in gender identity and sexual orientation.

Although it was acknowledged that most of these EM programs provided cultural competency training to their EM residencies, there was still a notable gap.

The Qian (Humbleness) Model Curriculum, based on the Chinese philosophy of cultural values was explored in the Chang, Simon, and Dong (2010) article. Qian stands for Questioning, Immersion, Active-listening, and Negotiation. The article recognized that despite various programs designed to teach cultural competence curriculum, much of the literature discussed only the importance of cultural awareness, knowledge, attitudes, and skills; there appeared to be a lack of practice and real-world applications regarding cultural competency in the healthcare profession. The authors suggested that the Qian Model Curriculum is highly adaptable to other cultural and ethnic groups in multicultural societies. The Qian Model bears a similarity to the tenets of cultural humility, as they both include self-questioning, cultural immersion, practice active-listening, and accepting and learning the perspective of the expert, being the patient. However, the authors believed that Qian provides more cultural insights and sensitivity when approaching a community that they feel is lacking in other cultural models. Although the article discusses the Qian Model, a “Chinese philosophy, and it remains the Dao (way) to peaceful coexistence among diverse cultures” (Chang, Simon & Dong, 2010, p. 274), the review only focuses on a specific population within China, a demonstration of its wider implication was not presented. The review proposed the Qian Model Curriculum over Cultural Humility, as the authors believed that when trained in cultural humility, clinical professionals treat illnesses and encounter patients, however, patients are not well understood. Similar to Cultural Humility the Qian Model needs more literature to assess its effectiveness.

Cultural Humility in Educational Fields

Andrews, Kim, and Watanabe (2018) focused on a pilot workshop aimed at training volunteer tutors in Seattle, Washington from a program, Homework Help. The authors shared that the focus of the workshop was for volunteers to learn that competency is an ongoing process and for volunteers to take away strategies and tools they could use when providing support to students. Participants shared that the pre-workshop homework given beforehand was helpful in preparing them to converse with others during the workshop, gave them the tools to discuss challenging interactions with students, as well as creating ways their peers could manage students' behaviors and needs in a culturally humble way. From the literature, it would appear that there is a lack of training in cultural humility within the education field, although it also appears a different awareness and emphasis may be implied for this field.

Other Cultural Models in Psychology

In studying various cultural models historically used in psychology in our cultural humility research, it has been found that cultural humility and cultural competency have been used interchangeably. As previously mentioned, cultural competency was viewed as an ability to understand and communicate with people across cultures. In this section, cultural competency training will be further explored in regard to the field of Psychology.

In a mixed-methods research approach, De Jesus (2016) explored the “impact of structural racism on clients, providers, and the dynamics among them is a clear priority area that emerges from the data” (p. 314). Qualitative findings through interviews with a variety of participants in numerous studies exposed the possible challenges of being unable to encourage discussion of race, language, and culture when information and cultural awareness is lacking. Cultural competency had been measured through quantitative findings to gain a better understanding of the participants' awareness, knowledge, and skill through a pre and post-test.

Geerlings (2018) stated the importance of cultural competence training in a mental health clinical setting, especially for graduate students to apply what they have learned with culturally diverse communities they may be serving. It is important and vital for mental health clinicians to understand the cultural background and history of the populations being served. This awareness may lead one to reflect on their own cultural attunement to the society around them. Attunement may be described as the reactivity of one person's emotional state to another person's emotional needs. A clinician's ability to attune to a certain population may be determined by their ability to adapt and assimilate to the environment and community of the population. It will vary from location, cultural background, and life experiences. Elias-Jarez (2016) stated that "the experiences of positive socio-cultural attunement [...] represent each participant's commitment to a shared personal process that potentially transcends and transforms social divides" (Elias-Jarez, 2016, pg. 113). Through personal engagement, therapists learn to be culturally attuned through connection by listening and experiencing shared stories of participants. It is necessary to take into consideration the cultural background of clinicians, particularly those who have been educated in "westernized" training, and how it may reflect their approach when engaging with people of various ethnic backgrounds. Ultimately, "there is a great need to establish a more robust body of evidence as to which professional development strategies are more likely to contribute to the reduction of racial disproportionality in child welfare service" (De Jesus, 2016). Through further research, the efficacy of cultural humility training can enhance any clinician's attunement and competency in working with people of all backgrounds.

Art-Based Interventions

Art-based interventions implemented within art therapy and other fields that highlight self-reflective artmaking in order to facilitate insight and enhance understanding, awareness, and

competency have the potential to add to the current research on art-based cultural humility training. Furthermore, the use of art-making as part of cultural humility training may promote the efficacy of the training, enhance understanding of the concepts presented, and contribute to the application of these concepts in clinical settings by mental health professionals.

Two studies were found regarding the use of art-based interventions and their effect on the training of mental health and medical professionals. Burgin (2018) discussed the use of art-making within the context of supervision for counselors-in-training in order to promote self-awareness and allow them to interact with information in different ways. The Processing Wheel activity in her study was described as “an art-based intervention designed to increase insight about clinical issues. All of these interventions help the supervisees identify themes in their work and also leads to a sense of connection to their fellow classmates” (Burgin, 2018, p. 151). A literature review by Perry, Maffulli, Willson, and Morrissey (2011) examined the effectiveness of art-based interventions (such as mixed arts, literature, dance/performance art, and visual arts) in medical education. They found that although there was not much evidence of art-based interventions altering the attitudes of medical students, there appears to be stronger evidence that these types of interventions foster diagnostic skills. The article also called for more research to be done on art-based interventions and the effect on other clinical skills (Perry et al, 2011).

Three articles on the use of art-based interventions within medical art therapy in the hospital setting were found to focus on how art-making can contribute to the effectiveness of treatment and the promotion of trust and connection between clinicians and patients. In a study done by Monti et al. (2005), mindfulness-based art-therapy, including a body scan meditation and self-portrait assessment at the beginning and end of the study, was found to be an effective intervention during treatment for women diagnosed with a variety of cancer diagnoses in

improving quality of life and reducing symptoms of distress. Larsen (2018) used a hope collage as an art-based intervention for a group with chronic pain, which “intended to reduce anxiety about creating art and to foster an atmosphere of acceptance” (p. 728). Rubin (2019) emphasized how effective art-based interventions in the field of nursing were and found that “creating art side-by-side or working collaboratively can build trust between nurse and patient” (p. 96). In this instance, art-based interventions created an environment where art provided the therapeutic experience. The act of creating art provides an opportunity to “enrich the lives of individuals, families, and communities through the clinical, evidence-based application of art and creative processes,” thus contributing to the healing process (Rubin, 2019, p. 95).

Although we were not able to find any arts-based cultural humility training in our review of the literature we were able to find an article written by Dr. Louvenia Jackson and Dr. Anthony Bodlovic which covers the creation of an arts-based cultural humility class at Loyola Marymount University in Los Angeles CA. Prior to this class students in the Marriage and Family Art Therapy program took an arts-based cultural competency class based in the Multiple Dimensions of Cultural Competency (MDCC) theoretical model. In the MDCC model students were taught 3 components, “specific racial/cultural group perspectives, components of cultural competence and foci of cultural competence” (Bodlovic and Jackson, 2018, pg. 2). When making changes to this class the authors relied on student feedback namely that the MDCC approach to learning left students feeling as though “they did not obtain enough clinical skills or mastery, feeling the course relied too much on self-reflections, and students felt the course was more beneficial for white students in understanding their own privilege.” (Bodlovic and Jackson, 2018, pg. 2). In redesigning the class the co-authors sought to demonstrate how one can “sit in cultural humility within difference” (Bodlovic and Jackson, 2018, pg. 3) by co-facilitating the course together, the

co-facilitators were able to model cultural humility through a process of dialogue highlighting the differences in their cultural backgrounds and approaches to teaching. As the program is an art therapy program the co-facilitators utilized metaphors to conceptualize the tenants of cultural humility by dividing the course into three sections, mind, body, and soul. In using metaphors and various art reflective directives students were able to examine their own biases, assumptions, and beliefs in a deeper and more personal context. One art reflective piece the students were asked to engage in was to create a vessel that metaphorically held the “biases, assumptions, beliefs, and skills” students felt about the subjects the class explored. According to the authors this vessel art reflection “embodies the movement that happens when we are examining our biases and assumptions and making room for validation and change. The journey of cultural humility is fluid and alters with every validation and exchange.” (Bodlovic and Jackson, 2018, pg. 5). By creating an environment in which students felt welcome to thoughtfully and critically speak about challenging topics the co-facilitators were able to explore with the class any barriers to compassion the students may have. In their reflections of the class and the artwork made many students stated they “understood the course was only the beginning of their journey on being culturally humble art therapists,” and that they were “no longer seeking to feel competent but are instead beginning to self-reflect, and identify underlying structures of power and privilege in themselves, their communities and in the mental health field.” (Bodlovic and Jackson, 2018, pg. 8).

Conclusion

According to the literature review, the concept of cultural humility can be applied to various professional fields and is applicable within their populations. However, the literature showed there was a discrepancy within the pre-existing cultural humility training courses on

what it means to practice cultural humility. A majority of the studies that were found came from the United States, and the few that did not appear to lack information on how to define cultural humility; although we may suspect that this work in cultural humility has been reviewed in other countries as well. A common concept that was noted throughout the research was the usage of cultural competence and its shift into cultural humility. The literature that was found showed the growing need for more Cultural Humility training that solidified what it looks like to implement the tenets into the professional realm and how it would translate into working with clients/patients. While, in theory, being culturally humble is an important process, the conversation is needed about how comfortable the providers are at offering the service in order for the overall effectiveness. Many of the articles did not provide opportunities to revisit the participants to see how or if they continued to provide culturally humble services and whether they had access to the tools they need for the communities they serve.

Research Approach

In understanding self-reported levels of confidence and comfort in implementing cultural humility in clinical work, pre and post-tests which were surveys were prepared for potential participants to fill out before and after the training. The pre and post-survey consisted of ten questions measuring the participant's level of confidence and comfort in engaging with patients and coworkers within the tenets of cultural humility. By using a zero to ten scale to answer each question, the participants' answers provided quantitative data gathering. Notable shifts in the levels of the participants were displayed from before and after the training on their awareness and understanding.

Physical artworks and photographs of artworks were collected from consenting participants, with themes being explored through the use of imagery and text. Although there were no verbal interviews conducted to explain the artwork, the student researchers explored similar visual themes and themes in the participants' discussions of the art for qualitative data gathering. Through the art, the student researchers were able to explore how the participants may have culturally identified themselves and further explore if it reflected their awareness and understanding of cultural humility. The research students engaged in two of the three art-based training courses as participants. The student researchers who attended the cultural humility training documented their observations throughout the training. By investigating the various observations, the student researchers explored the similarities and differences of their experiences, feedback, and participation between the sites. Examining the observation notes assisted the student researchers to explore levels of engagement, topics of conversations, and interactions that occurred throughout the training.

Methods

Definition of terms

Cultural Humility vs. Cultural Competence - The literature review defined Cultural Competence as a process and ability to understand, and communicate with people across cultures; and referenced Cultural Humility as a lifelong learning commitment, focused on self-reflect, emphasize in attentive listening, and openness to those of other cultures in a multicultural society.

Comfortable - The study defined comfortable as being able to imply or engage in conversation with clients/patients and colleagues regarding cultural differences/ insensitivities.

Confidence - The study defined confidence as having the ability to address cultural insensitivities when engaging in conversation with colleagues as well as the level of knowledge participants gained regarding the tenets of cultural humility.

Tenets - The study referred to the tenets as the four tenets of cultural humility, developed by Dr. Melanie Tervalon and Dr. Jan Murray-Garcia. The four tenets of cultural humility are as followed: 1. A lifelong process of critical self-reflection and self-critique, 2. Redressing the power imbalances in the patient-provider dynamic, 3. Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations, and 4. Advocating for and maintaining institutional accountability.

Tools - The literature review defined tools as implementations learned during the training.

Experiential - The study defined experiential as the process of letting participants explore and express their individual cultural identities, by creating art using various art materials provided.

Design of Study

The pre and post surveys were conducted at three sites, two mental health facilities and one hospital setting, where participants were encouraged by the two training facilitators to engage in art-making as they dialogue and illustrated the four tenets of cultural humility. Participants engaged in different activities throughout the cultural humility training, where they were provided with various art materials (collage images, colored/patterned paper, markers, glue, scissors) and encouraged to create a book cover representing their cultural identities, engage in making assumptions of the facilitators, discuss biases they discovered, assumptions they made and reflected on these biases and assumptions with their colleagues.

The pre and post surveys collected provided qualitative data from participants including the awareness of their biases brought into sessions with clients, awareness of when they are making assumptions, the challenges in engaging in conversation about cultural considerations, feeling comfortable engaging in difficult conversations with clients about cultural differences, talking to a colleague if they have said something culturally insensitive, having the tools to address cultural insensitive comments with colleagues, having the tools to address cultural considerations in their work with their clients/patients, level of confidence in addressing culturally insensitive comments with colleagues, level of confidence addressing cultural considerations while working with clients/patients, and familiarization with the tenets of cultural humility. After completing a literature review focused on the training models and workshops conducted in cultural humility and cultural competence in various professional fields, clinical (psychology, social work, etc), medical (physicians, nursing), and education (teachers, librarians, tutors) fields, it was observed throughout the literature review, the usage of cultural competence, and its shift to cultural humility; a concept that needs more understanding, research, and practice. This research sought to examine the experience of various professionals' awareness, comfortability, and confidence in implementing the tenets of cultural humility in their clinical work.

Sampling

The two cultural humility art-based facilitators and their university's practicum coordinator collaborated and proposed cultural humility training courses at five of their student practicum sites. As the facilitators contacted the sites to propose the Cultural Humility Art-Based training, their letter described the bases of the training, their contact information, and their references of the training to the four tenets of cultural humility developed by Dr. Melanie Tervalon and Dr. Jan Murray-Garcia. From the five sites that the facilitators contacted, four sites

made contact asking for the training; however, only three were scheduled, with one training occurring in the Spring of 2019. Sites A and B's cultural humility art-based training were scheduled for Fall 2019; Site C contacted the facilitators with interest in wanting to receive this cultural humility art-based training for their staff. Unlike the other placements, Site C was the only site that was not a site for the university's practicums. This served as an opportunity to expose another facility to the Cultural Humility Art-Based training, and the field of Art Therapy. Participants from Site A, B, and C, whose professions varied from therapists, clinicians, staff, or interns at these locations, were randomly invited by their clinical directors/coordinator/supervisors to participate in a 2-3-hour cultural humility art-based training. Participants were given a pre- and post-survey and were informed that the goal of the research was to further investigate comfortability and confidence levels of cultural humility in their clinical work, with clients/patients and colleagues. The survey, identifying information, results of all surveys from all three participating sites will remain anonymous.

Gathering of data

Researchers completed the Institutional Review Board (IRB) basic training course for Social and Behavior Research through the university in order to maintain legal and ethical standards during the course of this research project. The pre- and post-surveys were developed by the facilitators of the training course and then reviewed and revised by the researchers prior to distribution. The facilitators provided the surveys at the beginning and then at the end of the art-based cultural humility training, which contained the same questions. Attached to the surveys were consent forms outlining the research being conducted and provided attendees with options to written consent to (a) participate in the research being conducted on the day of the training; (b)

participate in the follow-up 3-month and 6-month follow up surveys; and (c) have their artwork used in the presentation, publication, and/or public dissemination of the research findings. Attendees could consent to participate in all or part of the research or decline to participate. Those who chose to participate were given time to complete the survey before the surveys were collected by the researchers.

Participants engaged in an experiential art-making activity to define their own personal cultural identity and shared it with colleagues to challenge their comfortability of having these discussions with members

The image shows a digital form for a demographic questionnaire. It is divided into five sections, each with a title and a list of options or a text input field:

- Gender:** Three radio button options: Male, Female, and Other.
- Race/Ethnicity:** Six radio button options: White/Caucasian, Hispanic/Latinx, African American/ Black, Asian/Pacific Islander, Mixed, and Other.
- Age:** Six radio button options: 20-29, 30-39, 40-49, 50-59, 60+, and Not Specified/Other.
- Occupation:** A single-line text input field.
- Name of site where you attended the training:** A single-line text input field.

Figure 1 Demographic Questionnaire Format

of other cultural backgrounds. Participants were asked how their own needs could be met in order to provide culturally humble service to their clients/patients.

Once the data was gathered by the facilitators, the signed consent forms and artwork were stored behind a double lock to ensure the privacy of the participants, in a facilitator's locked storage cabinet in a locked office on the university campus. Researchers developed a method of numerical coding of the participants in order to remove identifiable information and organize the surveys and artwork while the data was being analyzed.

Results

Presentation of Data

The arts-based Cultural Humility training was held in three facilities throughout the greater Los Angeles Area. Two of the facilities (Site A and Site B) were mental health agencies while the third (Site C) was a hospital. The three facilities differed in size, the largest being the hospital. While most of the training lasted two hours, the hospital setting allowed for a three-hour-long training. Surveys were provided to participants at the beginning and end of the training sessions in order to gauge the participants’ experience, confidence, and comfortability with cultural differences and cultural humility. In addition, demographic information, including participants’ age, gender, ethnicity/race, occupation, and written feedback was also collected as part of the survey (figure 1). A three-month follow-up survey was sent to participants in order to gain an understanding of the effectiveness of the study.

Prior to the training, pre-tests were given to the participants to gain a preliminary understanding of the participants’ cultural humility awareness. The pre-tests consisted of ten questions, scaled from zero to ten, and asked participants to rate their levels of comfort and confidence in engaging in cultural considerations and differences when working with clients and colleagues

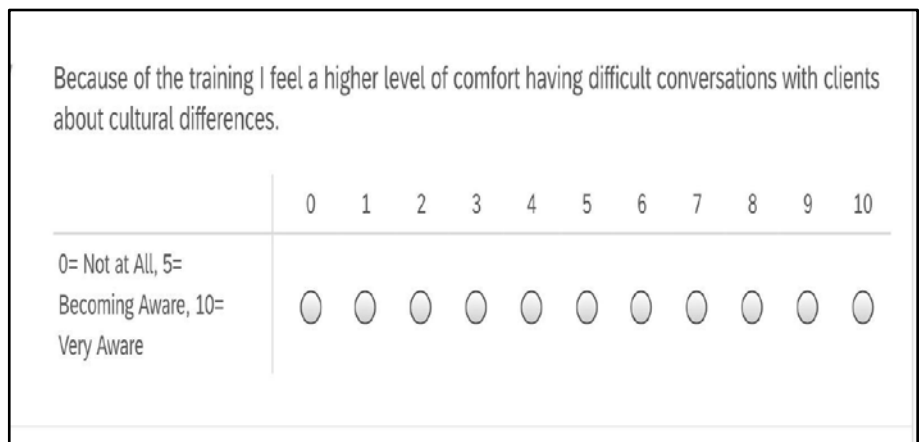


Figure 2 Example of Survey Scaled from Zero to Ten

(figure 2, 3). These same questions were given to the participants immediately after the training

in order to understand its effectiveness, as well as to gauge the participants' level of comfort with practicing cultural humility going forward. At the three-month mark, follow up surveys were sent to the participants via email in order to track how their cultural humility competency has been maintained or put into use since the initial training (figure 4).

The facilitators conducted the art-based training based on their knowledge, experience, and expertise from their training of cultural humility developed by Dr. Melanie Tervalon and Dr. Jan Murray-Garcia. They developed the tenets of cultural humility which include: 1. A lifelong process of critical self-reflection and self-critique, 2. Redressing the power imbalances in the patient-provider dynamic, 3. Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations, and 4. Advocating for and maintaining institutional accountability. By introducing the tenets of cultural humility at the beginning of the arts-based training, the participants were introduced to the differences of cultural humility and cultural competence.

After defining and discussing the proper definitions of biases, assumptions, and privilege, the facilitators provided an open opportunity to reflect on how this can be applied to their work and how it relates back to the tenets of cultural humility, as listed above while working as clinicians or professionals in the mental health field. Participants engaged in an experiential art activity creating a "book cover" to express their own cultural identities. Participants explored various ways and techniques on what and how to artistically illustrate their cultural identities, then were invited to share their art with their colleagues and discussed what they thought was important to display on their book cover. In dialoguing with colleagues on each other's artwork and cultural identities, participants were encouraged to reflect on their biases and assumptions of their own cultural awareness and understanding.

The three-hour training allowed time for an additional art activity in which participants were asked to create an image that discussed what they can do, and what they needed in order to create the change they wanted to see for their cultural work within their agency. The tenets of cultural humility were discussed, and participants were provided an opportunity and safe space to reflect on their own biases, assumptions, and beliefs. Lastly, the facilitators inquired about expanding their knowledge and understanding outside of the training and into their work. The art pieces that were submitted allowed the researchers to explore emerging themes that seemed to resonate within the various pieces and facilitate a dialogue about various cultural aspects they have already or could come into contact with at their agencies, and within their communities. Throughout the three training courses, student researchers observed participants in two of the training courses in order to look for similarities and differences in the engagement, experience, and feedback. Of the three sites where the training was held, four student researchers observed

Q1 -	I am aware of the biases that I bring into my sessions with clients.	Site A and two student researchers observed Site C; there were no student researchers available to conduct observations at Site B. Student researchers observing the cultural humility art-based training were assigned a specific focus on
Q2-	I am aware of when I am making assumptions of clients.	
Q3-	I find it challenging to engage in conversations about cultural considerations.	
Q4 -	I feel comfortable having difficult conversations with clients about cultural differences.	
Q5 -	I feel comfortable talking with a colleague if they say something culturally insensitive.	
Q6-	I feel I have the tools to address culturally insensitive comments appropriately with colleagues.	
Q7 -	I feel I have the tools to address cultural considerations in my work while working with clients/patients.	
Q8 -	I feel a level of confidence in addressing culturally insensitive comments with colleagues.	
Q9 -	I feel a level of confidence in addressing cultural considerations in my work while working with clients/ patients.	
Q10 -	I am familiar with the tenets of cultural humility.	

Figure 3. Pre-Post Survey Questions

what they would observe of the following: facilitators, participants, as well as an overview of the training and the room.

Findings

Four areas of significance were abstracted from the initial data collection which includes; increase in survey scores, time versus engagement in artwork, imagery linked to comprehension of training material and personal expression and lastly, retention of training material. The

Cultural Humility Art-Based training sessions were held at three different locations within Los Angeles county and covered the tenets of cultural

Q1 -	Because of the training, I feel a higher level of comfort having difficult conversations with clients about cultural differences.
Q2-	Because of the training, I feel a higher level of comfort talking with colleagues about culturally insensitive comments.
Q3-	Because of the training, I feel a higher level of confidence in identifying cultural considerations with my clients/patients.
Q4 -	Because of the training, I feel a higher level of confidence in identifying and addressing cultural considerations with my colleagues.
Q5 -	Because of the training, I feel more comfortable using the tenets of cultural humility in my practice.
Q6-	Because of the training, I have continued to use art as a way to culturally self-reflect.
Q7 -	After the training I still find it challenging to acknowledge and engage in conversation about cultural considerations
Q8 -	If still providing services, considering the changes that have occurred with the current Covid-19 pandemic, how are you using cultural humility in your work (i.e. Telehealth, etc)?

Figure 4. Three Month Follow-up Survey

humility. Participants were given surveys at the beginning and end of the training to gauge their prior understanding and gained knowledge and feelings about the discussion that was had about using cultural humility with their peers and clients. 47 Participants completed the surveys and a significant increase in scores was seen between the two tests. This increase in scores indicates

that the training effectively reached the initial goal of the study which was to increase participants' comfort, ability, and confidence in implementing the tenets of cultural humility in their clinical work which as defined earlier, include 1. A lifelong process of critical self-reflection and self-critique, 2. Redressing the power imbalances in the patient-provider dynamic, 3. Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations, and 4. Advocating for and maintaining institutional accountability. An art directive was given as part of the training in which participants created a book cover exploring how they express their own cultural identity. Of those 47 participants, 29 art pieces were collected at the end of the training sessions. 19 pieces used only images to create their responses when 1 piece used only text. This may indicate that participants found it easier to use imagery rather than words to express their cultural identities and obstacles to being more culturally humble in their work. From the dialogue and interactions throughout the training in the art experiential activities, this may have given participants the opportunity to gain more self-awareness, practice verbalizing their own biases and assumptions, and gain a better understanding of others' cultural experiences. Those that did not have their art collected may have preferred to keep their work as a visual reminder of the training's content, may have felt the content of their art was too vulnerable for others to see, or simply took their pieces with them in haste. The three training sessions varied in length, due to the individual site restrictions, which showed to have an impact on the engagement of the participants. The shortest training (Site A) had the most engagement by participants, however, produced the least amount of artwork when compared to the longest training (Site C). Although Site C appeared to have more issues with the focus of participants throughout the training, they produced the most amount of art. The onset of the COVID-19 pandemic delayed the research team's ability to send out three months follow up

surveys and receiving responses from participants, ultimately receiving only 8 responses, thus making that data difficult to analyze and generalize regarding the long-term effectiveness of the training. From the eight 3 month post-surveys that were received, participants reported a higher level of confidence in identifying cultural considerations with their clients/patients and colleagues, felt more comfortable using the tenets of cultural humility in their practice, continued to use art after the training as a way to culturally self-reflect, but still found it challenging to acknowledge and engage in conversation about cultural considerations. The researchers plan to send 6 months and 1 year follow up surveys to further examine the training’s efficacy and longevity.

QUANTITATIVE DATA

Quantitative data collected from the pre- and post-tests were compiled from the responses of 47 participants and analyzed using Qualtrics software.

	Site A	Site B	Site C
Length of Training	2 hours	2 hours	3 hours
Total in Attendance	14	18	35
Research Participants	7	18	22

There was a total of 67 *Figure 5. Participants by Site*

people in attendance at the training courses; 14 attendees at Site A, 18 attendees at Site B, and 35 attendees at Site C. Forty-seven individuals consented to participate in the research (Figure 5).

Of the 47 research participants, 7 participants were from Site A, 18 participants were from Site B, and 22 participants were from Site C. Demographics data collected found that of the 47 participants, 45 identified as female, and two identified as male. Race/ethnicity data showed that 14 participants identified as White/Caucasian, 22 as Hispanic/Latinx, three as African American,

four as Asian American/Pacific Islander, three as Mixed, and one as Other (Figure 6). The

participants' age was divided into

six categories (Figure 7). Of the 47

participants, the most common age

group response (20) was 20-29

years old, followed by 30-39 years

old (16), 50-59 years old (5), 40-49

years old (3), Not Specified (1) and

60 years or older (2). When

analyzed by site, participants from

Site A (6 out of 7) and Site B (8 of

18) were primarily White/Caucasian,

whereas participants from Site C were

primarily Hispanic/Latinx (18 of 22).

Participants were asked to fill in

their job title upon examining the various

titles the researchers were able to discern

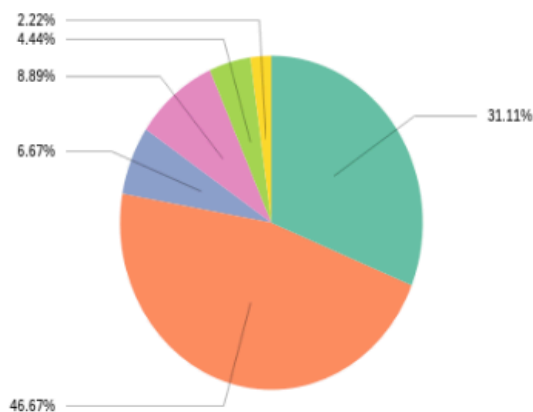
several categories. Although not every site

that participated in the training was a

mental health-specific site all of the

participants in the training identified as

Q4 - Ethnicity:



White/Caucasian Hispanic/Latinx African American Asian/Pacific Islander Mixed Other

#	Answer	%	Count
1	White/Caucasian	31.11%	14
2	Hispanic/Latinx	46.67%	21
3	African American	6.67%	3
4	Asian/Pacific Islander	8.89%	4
5	Mixed	4.44%	2
6	Other	2.22%	1
	Total	100%	45

#	Answer	%	Count
1	White/Caucasian	26.67%	12
2	Hispanic/Latinx	48.89%	22
3	African American	6.67%	3
4	Asian/ Pacific Islander	8.89%	4
5	Mixed	6.67%	3
6	Other	2.22%	1

Figure 6. Ethnicity Data comparing pre and post

someone working in the mental health field. Of the 47 participants, 15 identified as clinical interns or trainees, with one participant identifying as a graduate student. Many of the other participants self-identified as a clinician, specifying their licensure type or job title, 12 participants self-identified as therapists or clinicians, 3 identified as Psychologists, one self-identified as an art therapist, and another identified as a social worker. Out of the 47 participants only 2 identified as supervisors, and 3 identified as facilitators. Five participants identified 3 job titles that were more specific but likely fell into the clinician and therapist category, these titles were in-home counselor (1 participant), child and family specialist (3 participants), and psychological assistant (1 participant).

The participants' mean score for each question was calculated from the pre- and post-tests and compared (Figure 8). The answers were rated on a numerical scale

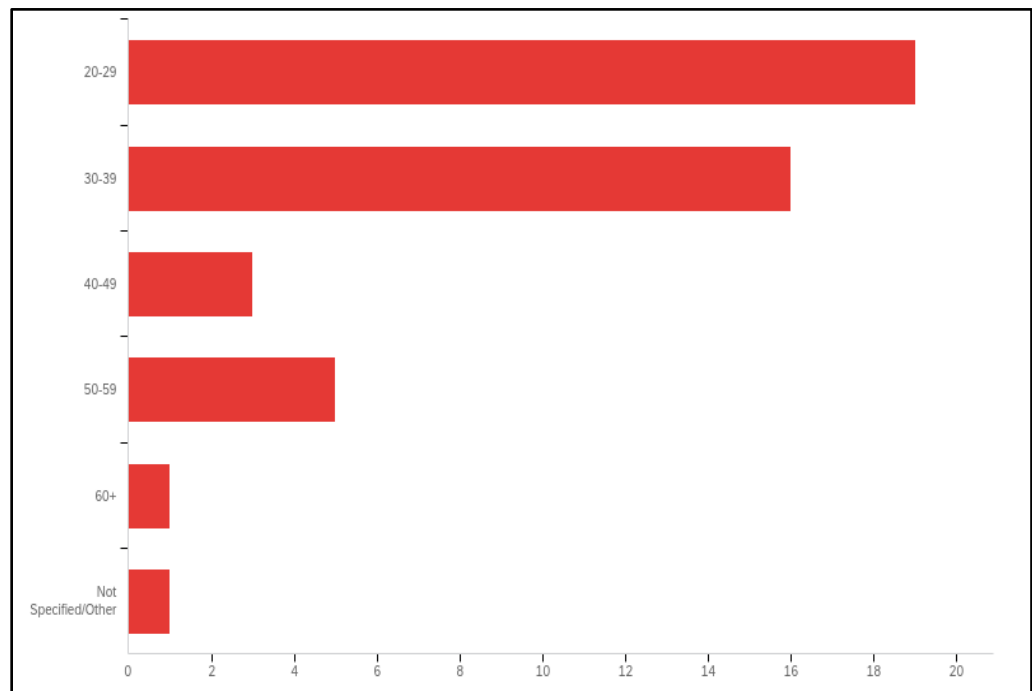


Figure 7. Ages of Participants versus Number of Responses

from zero to 10, with a score to “0” meaning “Not at all aware”, “5” meaning “Becoming aware”, and “10” meaning “Very aware.” Only whole number responses were included in the

calculations. There was an overall increase in the mean scores from pre- to post-test when examining the responses from all three sites. When analyzing the change in score from pretest to post-test per site and by question, all sites showed an increase in mean score for all questions.

QUALITATIVE DATA

During the cultural humility art-based training, the participants engaged in an experiential art directive that allowed them to explore and express their individual cultural identities. The prompt of the directive was, “Using the materials in front of you, create a book cover that represents your cultural identities.” The participants were provided with a list of examples of possible cultural background identifiers and encouraged to explore others that may pertain to them.

Question <i>Answer Scale: 0=Not at all aware, 5=Becoming aware, 10=Very aware</i>	Mean (Pre-Test)	Mean (Post-Test)
1. I am aware of the biases that I bring into my sessions with clients.	8.20	9.16
2. I am aware of when I am making assumptions of clients.	8.16	8.75
3. I find it challenging to engage in conversations about cultural considerations.	3.96	4.57
4. I feel comfortable having difficult conversations with clients about cultural differences.	7.75	8.38
5. I feel comfortable talking with a colleague if they say something culturally insensitive.	7.11	7.89
6. I feel I have the tools to address culturally insensitive comments appropriately with colleagues.	6.54	8.32
7. I feel I have the tools to address cultural considerations in my work while working with clients/ patients.	7.49	8.75
8. I feel a level of confidence in addressing culturally insensitive comments with colleagues.	6.76	8.27
9. I feel a level of confidence in addressing cultural considerations in my work while working with clients/ patients.	7.78	9.00
10. I am familiar with the tenets of cultural humility.	7.17	9.33

Figure 8. Mean of Pre-Test and Post-Test Scores for All Participants

Facilitators gave examples such as race, ethnicity, nationality, region, primary language, age, gender, occupation, sexual identity, class, education, physical ability, body structure, social circumstances, special interests, religion, family, and immigration status. Upon completing their

book covers, participants were invited to share, reflect, and discuss the identifiers they chose with their colleagues in small groups. Participants were also invited to explore any possible biases and assumptions they may have of themselves and others. From these smaller discussions, the larger group was similarly able to discuss their biases and assumptions surrounding their cultural awareness and understanding of cultural factors within their fields.

Although all participants were invited to engage in the art experiential activity, not all of the artworks were submitted. Out of the 47 participants that filled out pre- and post-tests, 29 of

them provided consent for their artwork created during the training. Many of the participants used a mixture of text and imagery in exploring their cultural backgrounds. As illustrated in Figure 9, this participant's focus appeared to use more literal representations of their culture by using symbols, and images with text to describe the drawing. For example, the participant appeared to draw the flags of Cuba and America, also writing in-text "Cuban-American," giving researchers concrete

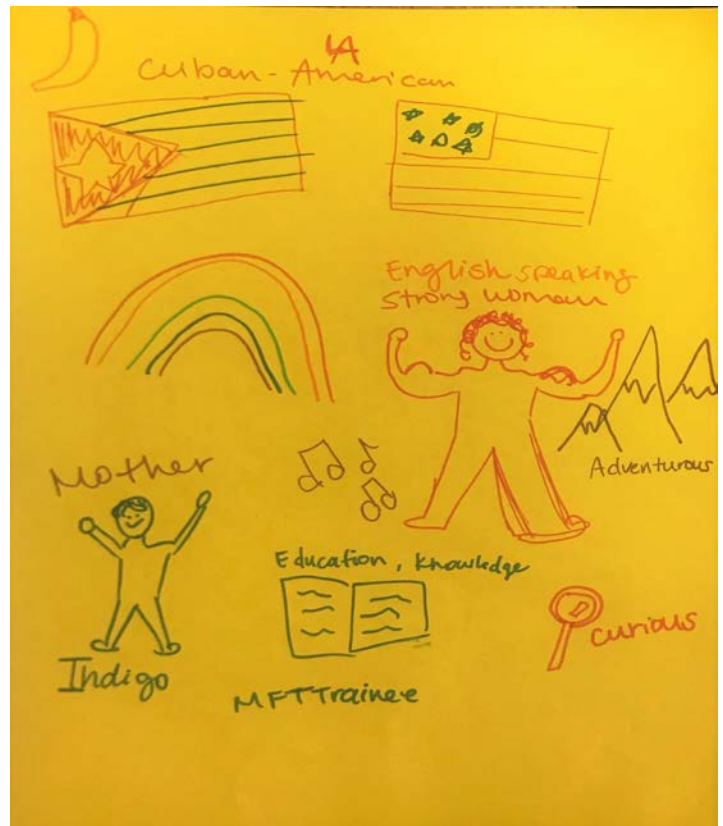


Figure 9. A participant from Site A using imagery and text to describe cultural identifiers.

the various symbols, there appeared to be ten images or symbols describing participants' ethnicity or nationality, eight referencing their gender, six referencing their special interests, four referencing their primary language, four referencing family, four referencing religion, one

referencing their age, one referencing their immigration status, one referencing sexual identity, and one referencing their identification within the culture of disability, specifying they were in a wheelchair. Some parts of the artwork were difficult to categorize due to the abstract and organic shapes and colors and the lack of descriptions; some participants explored their cultural identities beyond the list of examples. There were seven images and/or texts referencing education, three referencing their occupation, two referencing their marital status, and three participants had written their names on their book cover.

The participants were provided the same materials at each training to choose from when making their art. Participants were given an assortment of colored construction paper, various patterned paper with different types of print, Crayola Slip Sticks, thick and thin Crayola washable markers, oil pastels, scissors, and glue sticks. Many participants used construction paper and patterned paper to construct their book cover. Out of all of the artwork that was collected, 19 participants chose to use only images, either drawn or using paper cut-outs, to evoke their response to the art directive with one individual choosing to use only text. Figure 10 was an example of using only images to depict their cultural background. The observer at Site C noted that this participant was the only male amongst the participants and observed the



Figure 10. Participant from Site C presenting another method of artmaking by drawing onto a patterned paper, then gluing it onto a construction paper.

participant seemed to have difficulty in getting started with his drawing, this was evidenced by the participant referencing his phone for what appeared to be images or source material.

At Site B and C, an additional directive was given in which participants were asked to “create a page for your book that represents what you need to create the change you want” and/or “create a page for your book that represents what you can do to create the change you need.” After making their art the participants participated in small group discussions revolving around the topic of change after they have explored the tenets of cultural humility with the facilitators.

At Site C, the observer noted that it appeared that many participants were easily distracted or disengaged in exploring the second directive that was given. With minimal conversations and artmaking, a facilitator attempted to regroup the participants by encouraging small group discussions. However, as exhibited in Figure 11, this participant had written out their thoughts on what may have been needed or can be done to bring about change.

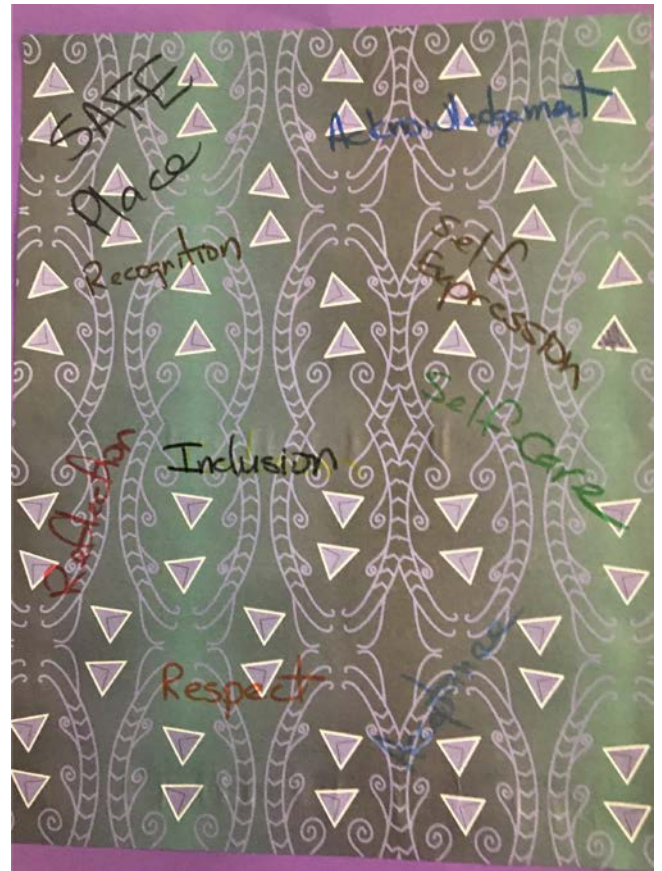


Figure 11. Additional artwork from one participant who seemed to have reflected on the second directive.

Analysis of Data

The quantitative data gathered was analyzed with references to the artworks that were submitted along with the observations that took place during the training. The quantitative data

of the pre- and post-tests provided information regarding the change in levels of comfortability and confidence in their awareness and understandings of cultural humility.

Analysis based on quantitative data showed significantly more female participants than men overall, as well as there being more Hispanic/Latinx at Site C, whereas data presented more White/Caucasian participants at Site A. At Site B, there was more of a variety of White/Caucasian, Hispanic/Latinx, and Asian/Pacific Islander participants.

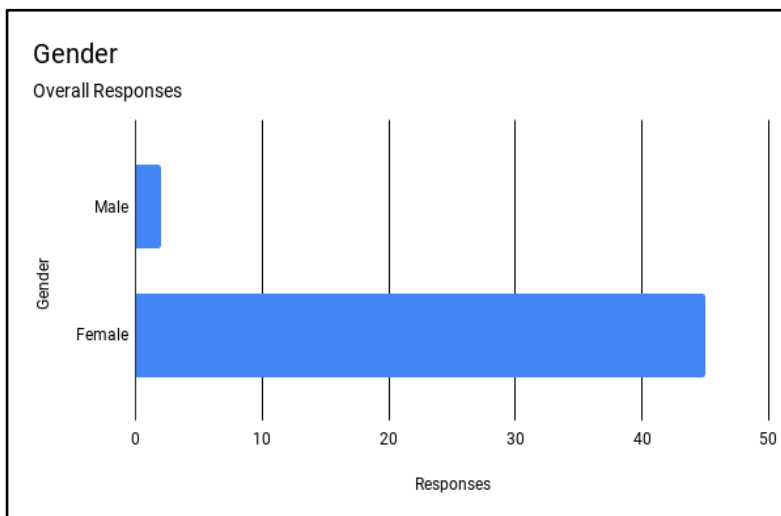


Figure 12. Gender, Overall Responses

Most participants were between the ages of 20-39 and had an occupation title relating to the mental health field ranging from a facilitator, MFT trainees, associates, licensed clinicians, and clinical supervisors. Occupational data showed varying levels of the profession by training site. Site C, the hospital setting with the largest number of participants, reported occupations that had varying levels of education and training, including an MFT trainee, a psychological assistant, program managers, child life specialists, social workers, therapists/counselors, and clinical supervisors. In contrast, those who participated in Site A were reported to all be MFT trainees, with the exception of one participant who was a Ph.D. student. This demonstrates the differences between staffing within public mental health facilities. For Question 1, most participants in the pre-test scored themselves as a 7 out of 10 (score of 0 being “Not at all aware” to score of 10

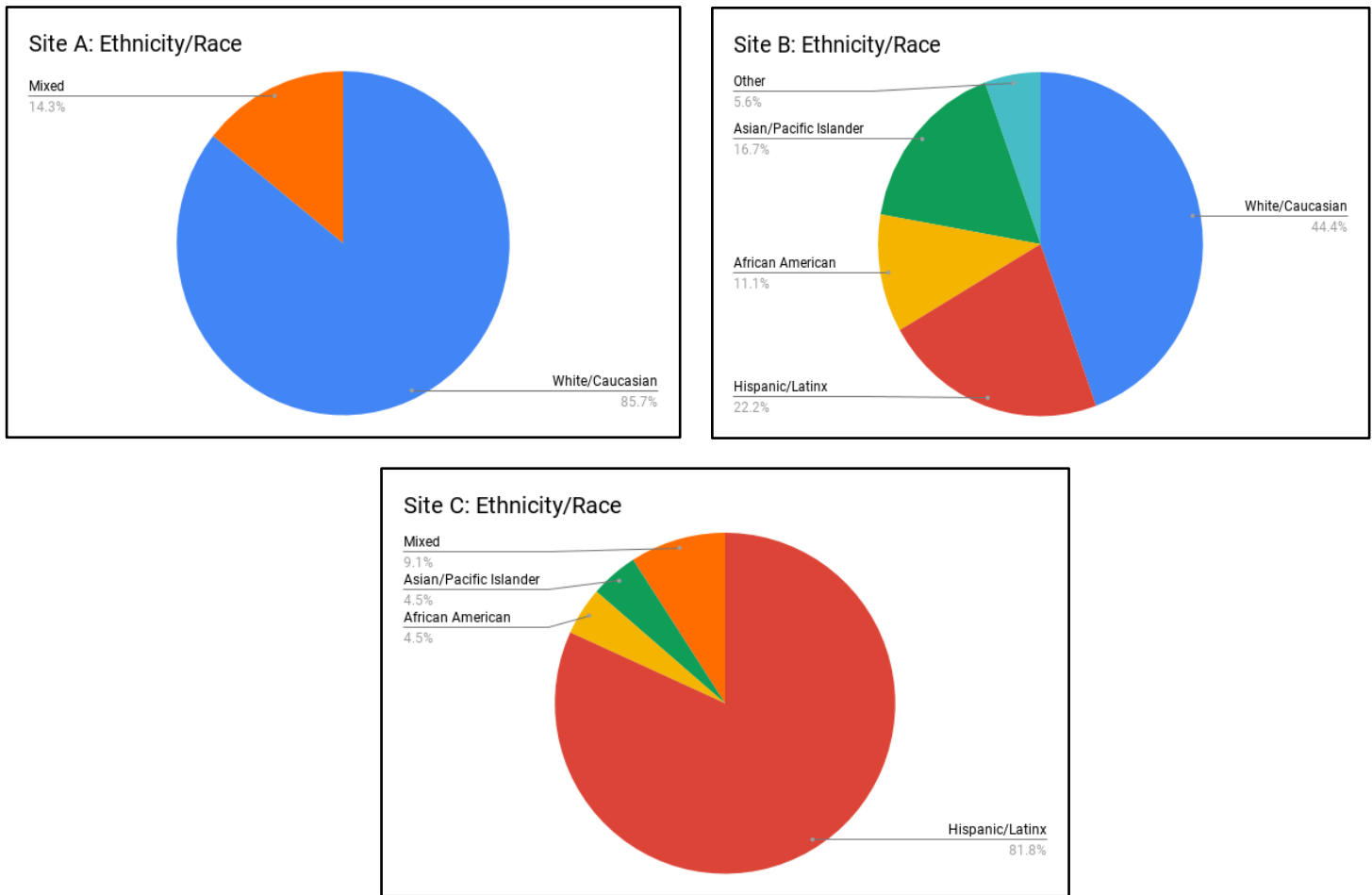


Figure 13-15 Ethnicity and Race categorized by each site

being “Very aware”) for being aware of the biases they bring into sessions with clients; after having the training, in the post-test, most participants scored themselves as an 8 or 9 out of 10 in being aware of their biases with clients, indicating that the training brought greater awareness to their biases.

Additionally, the results showed a slight increase from the pre-test to the post-test in Question 4 and Question 5 in reported comfortability with having difficult conversations with clients and colleagues about cultural differences, respectively. This could be due to an increased awareness of otherwise unknown biases, assumptions, or previously lacking cultural humility in their practices prior to the training. From the dialogue and interactions throughout the training in

the art experiential activities, this may have given participants the opportunity to practice and verbalize their own biases and assumptions. This slight increase in survey results could also indicate that the training brought more awareness and introduction of tools, while also demonstrating a need for more tools in order to become more comfortable having difficult conversations about cultural differences with clients and colleagues. As evidenced in the art and dialogue related to the second art directive, such as Figure 11 given at Site B and Site C, many participants identified needing a change or a shift in the understanding of cultural differences. There was still a significant increase in participants reporting that they have the tools to address culturally insensitive comments appropriately with colleagues and cultural considerations with clients after receiving the training. Providing a safe space for participants to share their own personal experiences through group discussions and the artworks may have allowed for a state of vulnerability and empathy between colleagues. Rosen, McCall, and Goodkind (2017) found that self-reflective assignments helped social work graduate students develop cultural humility. It could be that the self-reflective art directives created in the training similarly helped the participants develop an understanding of cultural humility which is reflected in their post-test responses and the overall increased mean score compared to the pre-test. There was a significant increase in reported levels of confidence addressing cultural considerations and participants' work while engaging with clients after receiving the training. The increase in reported levels of confidence in the post-survey could correlate with the reported increase in familiarity with the tenets of cultural humility after receiving the training. This may have been evident as most participants across the sites presented as engaged and focused in the first half-hour of the training when the facilitators discussed the tenets of cultural humility. Although more tools and more practice of the implementation of the tenants taught in the training may be needed by the

participants, the increase in reported confidence may be contributed to the gained knowledge of the tenets of cultural humility as they are the building blocks of the cultural humility training and ideology being taught. There were generally less reported changes in Site B, which may be related to the wider range in participants' reported ethnicity and race than was found in the other sites. It could be that the ranges in ethnicity had already given them some level of comfort and confidence in practicing cultural humility, such as having difficult conversations with colleagues and clients. They may also have previously received some cultural humility training at their agencies, or the culture of the agency facilitated these types of conversations.

Environmental factors during the training courses may have impacted the effectiveness of the training, such as the physical space where the training was held and the group size. Comparisons between quantitative and qualitative data for the three training sites indicated several differences in the training spaces that may have affected participants' experiences and responses. Site A was held in a small conference room, where desks were arranged in rows to be facing front towards the facilitators. Observers saw a benefit in the facility being small, as participants appeared to be more engaged, taking notes, participating when questions were asked during the art-making process, and discussions; also, it was noted that there was no use of personal mobile devices during the training presentation. Although there were no student observers in Site B, facilitators noted that the training was held in a large conference room. The training at Site C was held in a large conference room, with round tables so participants were able to face each other with snacks and refreshments provided. It was also noted by the observers that participants at Site C appeared less engaged with facilitators and more engaged in their own conversations, and personal mobile devices.

An important aspect of the pre and post-test can be explored through the wording of the questions. A closer look at Question 3 (Figure 3) showed an increase in the participants' scores from pre-test to post-test, implying that after the training the participants found a greater challenge in engaging in conversations about cultural considerations. Given that this particular question does not follow the trajectory of the other answers, our working hypothesis appears to involve the style of the wording of the question. The majority of the questions centered around the positive aspects of cultural humility (i.e. confidence, comfortability, familiarity) whereas Question 3 focused on the challenges. Given the amount of time the participants were given to complete the survey, one possibility is that the question was misread, and the style of wording was unclear to participants thus affecting the responses. It was noted that near the end of the training session at Site A, many of the participants were rushing out of the room for their next appointments or meetings. Considering the time constraints, this may be why the training at Site A resulted in fewer art submissions in comparison to Site B and C.

Although overall quantitative data shows that scores increased from pre- to post-test, Site A showed the largest change from pre- to post-test in Questions 5, 7, 8, and 10, with the participants' post-test mean score nearly 1.5 points higher in their responses for these questions compared to Site C. Question 5 focuses on the comfort of addressing colleagues, while Questions 7, 8, and 10 address confidence and familiarity using cultural humility in their work. This could be due to Site A's participants being all students with beginning experience addressing cultural considerations and cultural differences in their work. The participants at Site C had a wider range of occupations and possibly had diverse training backgrounds or established careers. Prior experience addressing cultural considerations in their work may have given participants at Site C

a base knowledge before entering the cultural humility training compared to the students at Site A, thus resulting in a smaller increase in mean from pre- to post-test for these questions.

In terms of group size, Site A and Site B had nearly half the number of attendees, with 14 people and 18 people in attendance, respectively, compared to Site C, which had 35 people in attendance. Based on this data, it does not appear that group size or facility size had a significant effect on the effectiveness of the training due to participant responses showing an increase in mean for all questions from the pre-test to the post-test.

Conclusion

When looking at the literature review it became apparent that further research into the effectiveness and longevity of Cultural Humility and other cultural models still needs to be done. While there was a plethora of information found regarding cultural humility, other cultural models, and how they can work within the various settings, it was not clear about how the providers could retain the information after the training and integrate it into their personal practice. The research team chose to focus on the long-term implementation of Cultural Humility practices and provided a space to start the conversation on how participants can access the tools they needed to prepare them for how they could implement what they learned after they left the training space. The research team felt that follow up surveys would become an integral factor in assessing if and how the participants used what they learned in their personal practices in order to explore the overall effectiveness of the training.

While the pre-test, post-test, and artwork from the training gave the research team a plethora of information, the three months follow up was interrupted by the COVID-19 pandemic due to subsequent shutdowns and potential loss of work. The surveys that were planned to go out in March were delayed by a few weeks as the research team adjusted to their new environmental

factors and provided time for the facilities to make arrangements to coincide with stay-at-home orders from California's

Governor, Gavin Newsom.

Q4: Pre-Post Question	I feel comfortable having difficult conversations with clients about cultural differences.	7.75	8.38	
3 Month Follow-Up	Because of the training, I feel a higher level of comfort having difficult conversations with clients about cultural differences			9
Q5: Pre-Post Question	I feel comfortable talking with a colleague if they say something culturally insensitive.	7.11	7.89	
3 Month Follow-Up	Because of the training, I feel a higher level of comfort talking with colleagues about culturally insensitive comments.			8.75

Figure 16. Three-month follow-up survey questions

The three-month survey was sent to all 47 participants and acknowledged that they may have been affected by Covid-19 and are no longer working with their clients in the same capacity; however, if they were able, the research team would appreciate a response. Only eight out of 47 participants responded back. Two of the eight responders were members of the research team that had participated in the training. The research team was able to analyze the data and compare two specific questions that were also asked in pre and post surveys (See Figure 16). In both question 4 and question 5, we can see that the mean average has gone up for the 3 months follow up survey. Question 4 went from 7.75 (pre-test) to 8.38 (post-test) to 9.00 (3-month follow up). Question 5 also increased from 7.11 (pre-test) to 7.89 (post-test) to 8.75 (3-month follow up).

In general, all 3-month follow-up questions had a higher mean average, indicating that participants had a higher level of confidence in identifying cultural considerations with their clients/patients (m= 9.63), participants had a higher level of confidence in identifying and

addressing cultural considerations with their colleagues (m= 8.88), participants felt more comfortable using the tenets of cultural humility in their practice (m =9.38), after the training participants had continued to use art as a way to

3 Month Follow-Up Questions	Mean
<i>Answer Scale: 0=Not at all aware, 5=Becoming aware, 10=Very aware</i>	
Because of the training, I feel a higher level of comfort having difficult conversations with clients about cultural differences	9
Because of the training, I feel a higher level of comfort talking with colleagues about culturally insensitive comments.	8.75
Because of the training, I feel a higher level of confidence in identifying cultural considerations with my clients/patients.	9.63
Because of the training, I feel a higher level of confidence in identifying and addressing cultural considerations with my colleagues.	8.88
Because of the training, I feel more comfortable using the tenets of cultural humility in my practice.	9.38
Because of the training, I have continued to use art as a way to culturally self-reflect.	8.75
After the training I still find it challenging to acknowledge and engage in conversation about cultural considerations	4.38
If still providing services, considering the changes that have occurred with the current Covid-19 pandemic, how are you using cultural humility in your work (i.e. Telehealth, etc)?	Comment

Figure 17. Mean Scores from the Three Month Follow up Survey Responses

culturally self-reflect (m= 8.75), and after the training participants still found it challenging to acknowledge and engage in conversation about cultural considerations (m= 4.38). An additional question was added to this survey that directly responded to the health crisis of COVID-19, to inquire about how they were personally utilizing Cultural Humility practices with their clients/patients if they were still providing services. Participants were asked to respond to this final question by adding a comment to list the specific examples they have used and not to be completed as a scale like the previous questions had (See figure 17).

Thus, the limited information we gained from the three-month follow-up survey provided some answers, but due to only 8 participants responding back (and two out of eight participants being from the research team), the results were not significant enough to include definitively in our findings. The information gained from the three months follow-up survey could have provided answers regarding the longevity of participants' retention after the training. Given the fluid nature of the Covid-19 situation, it is possible that further investigation could be completed at the 6 months and 1-year mark. Similarly, information gained from the 6 months and later surveys could provide differences among retention rates between the various sites in order to better respond to the question posed in our literature review as well as inform what areas need to be more refined for future training.

Although the training and subsequent surveys addressed many tenets of cultural humility, they were focused within the work atmosphere. Further investigation into whether participants have implemented cultural humility into their personal lives could provide compelling information. Site B was the most diverse in terms of ethnicity and demonstrated a higher understanding of cultural humility, as well as a higher rate of practicing the tenants of cultural humility in the pre-test. As discussed in the findings section of the paper, it is possible that these differences in population influenced the data received from the pre and post-tests. Although the information provided at each training was the same, site A which also had the youngest population and the most amount of graduate students, associates and trainees in attendance, reported a more significant increase between the pre and the post-tests when compared with sites that had an older and more experienced (within their respective fields) population. This population could have an increased awareness of biases, assumptions, and beliefs as they are currently or recently were students where this information could have been discussed within their

academic program. Should this research be replicated, it may be useful to expand the training to other sites in order to have a wider range of populations and therefore more data to better analyze the differences researchers noted in these sites.

When looking at the initial research question, it appears that the cultural humility art-based training did increase participants' comfortability and confidence to practice the tenants of cultural humility. This is shown by the increase in the mean scores that were recorded from the pre and post-tests as represented by Figure 8 on page 48. There was a positive shift in scores amongst all three sites, particularly on the questions regarding comfortability and confidence in practicing Cultural Humility. This increase continued into the three-month survey as evidenced by figure 16 on page 58. From the pre and post-tests, there was one question (Question 3) that had a greater difference in the score which the research team believes was due to participants misreading the question and scoring it incorrectly. This caused numbers to decrease in post-tests when they may have understood the question better. With the exception of Site, A, many of the sites had extra time available to fill out the post-test. Given this, it would be important going forward that each site is given the same amount of time to fill out their pre and post-tests as not giving the same amount of time for each question could potentially alter the results.

The Cultural Humility art-based training provided a unique experience to the participants in which it provided a safe space to explore their own cultural identities and share their personal experiences amongst their colleagues through the use of art-making. The participants were provided opportunities to verbalize their biases and assumptions towards the facilitators in order to increase their comfortability with addressing those factors when they present themselves in the room with their client or patient. The training highlighted the participants' needs for tools and spaces to have more culturally based discussions and started the conversation on how they could

access those things that were needed. Ultimately, the training increased awareness for the participants that they may have not been introduced to before and role modeled ways to be more culturally humble, as it can impact the relationships, they have with the communities they serve. While further research still needs to be conducted to measure the effectiveness of cultural humility art-based training courses over the span of time, it has become evident through the research and literature review that there is a need for more of these trainings within the helping professions.

References

- Abbott, D. M., Pelc, N., & Mercier, C. (2019). Cultural humility and the teaching of psychology. *Scholarship of Teaching and Learning in Psychology, 5*(2), 169-181. <https://doi.org/10.1037/stl0000144>
- Alvarez-Hernandez, L.R., & Choi, Y, J. (2015) Reconceptualizing culture in social work practice and education: A dialectic and uniqueness awareness approach, *Journal of Social Work and Education, 53*(3), 384–398. <https://doi.org/10.1080/10437797.2016.1272511>
- Andrews, N., Kim, S., & Watanabe, J. (2018). Cultural humility as a transformative framework for librarians, tutors, and youth volunteers: Applying a lens of cultural responsiveness in training library staff and volunteers. *Young Adult Library Services, 16*(2), 19.
- Arrington, D. & Yorgin, P. (2001) Art therapy as a cross-cultural means to assess psychosocial health in homeless and orphaned children in Kiev. *Art Therapy, 18*(2), 80-88. <https://doi.org/10.1080/07421656.2001.10129748>
- Bodlovic, A.& Jackson, L. (2018). A cultural humility approach to art therapy multicultural pedagogy: Barriers to compassion. *The International Journal of Diversity in Education, 19*(1): 1-9. <https://doi.org/10.18848/2327-0020/CGP/v19i01/1-9>
- Burgin, E. (2018). The processing wheel: An arts-based intervention for clinical supervision. *Journal of Creativity in Mental Health. 13*(2), 148-158. <https://doi.org/10.1080/15401383.2017.1403403>
- Butler, P. D., Swift, M., Kothari, S., Nazeeri-Simmons, I., Friel, C. M., Longaker, M. T., & Britt, L. (2011). Integrating cultural competency and humility training into clinical clerkships: Surgery as a model. *Journal of Surgical Education, 68*(3), 222–230. <https://doi.org/10.1016/j.jsurg.2011.01.002>
- Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy, 56*(3), 400-408. <https://doi.org/10.1037/pst0000241>
- Chang, E., Simon, M., Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advance in Health Science Education, 17*, 269-278. <https://doi.org/10.1007/s10459-010-9264-1>
- Coseo, A. (1997). Developing cultural awareness for creative arts therapists. *The Arts in Psychotherapy, 24*(2), 145–157. [https://doi.org/10.1016/S0197-4556\(96\)00063-9](https://doi.org/10.1016/S0197-4556(96)00063-9)
- De Jesús, A., Hogan, J., Martinez, R., Adams, J.,& Hawkins Lacy, T. (2016) Putting racism on the table: The implementation and evaluation of a novel racial equity and cultural competency training/consultation model in New York City, *Journal of Ethnic & Cultural*

- Diversity in Social Work*, 25(4), 300-319
<https://doi.org/10.1080/15313204.2016.1206497>
- Derck, J., Yates, E., Kuo, M., Hwang, C., Sturdavant, W., Ross, P., Finks, J., Sandhu, G. (2018). Exploring the impact factor: Medical students mentoring high school students and cultivating cultural humility. *Health Equity*, 2(1), 15-21.
<http://online.liebertpub.com/doi/10.1089/heq.2017.0025>
- Elias-Juarez, M.A., Knudson-Martin, C., (2016) Cultural attunement in therapy with Mexican Heritage couples: A grounded theory analysis of client and therapist experience, *Journal of Marital and Family Therapy*, 43(1), 100 – 114. <https://doi.org/10.1111/jmft.12183>
- Fisher-Borne, M., Cain, J.M., & Martin, S.L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, 34(2), 165-181. <http://dx.doi.org/10.1080/02615479.2014.977244>
- Foronda, C. L., Baptiste, D. L., Pfaff, T., Velez, R., Reinholdt, M., Sanchez, M., & Hudson, K. W. (2018). Cultural competency and cultural humility in simulation-based education: An integrative review. *Clinical Simulation in Nursing*, 15, 42-60.
<https://doi.org/10.1016/j.ecns.2017.09.006>
- Garvis, S. (2012). These children aren't creative: Insights from beginning teachers on early childhood arts education. *Australasian Journal of Early Childhood*. 37(1), 161 - 165.
<https://doi.org/10.1177/183693911203700119>
- Geerlings, L. R. C., Thompson, C. L., Bouma, R., & Hawkins, R. (2018). Cultural competence in clinical psychology training: A qualitative investigation of student and academic experiences. *Australian Psychologist*, 53(2), 161–170.
<https://electra.lmu.edu:2070/10.1111/ap.12291>
- Hanania, A., (2018) A proposal for culturally informed art therapy with syrian refugee women: The potential for trauma expression through embroidery (Uneproposition d'art-thérapie adaptée à la culture de femmes réfugiées syriennes: Le potentiel dela broderie pour l'expression du traumatisme), *Canadian Art Therapy Association Journal*, 31(1), 33-42.
<https://doi.org/10.1080/08322473.2017.1378516>
- Harvey, R., Lin, I., & Booiman, A. (2015). Multicultural and diversity training considerations for biofeedback practitioners. *Biofeedback*, 43(4), 163-167. <https://doi.org/10.5298/10815937-43.4.05>
- Hook, J.N., Watkins Jr., C.E., Davis, D.E., Owen, J., Van Tongeren, D.R., & Ramos, M.J. (2016). Cultural humility in psychotherapy supervision. *American Journal of Psychotherapy*, 70(2), 149-166.
<https://doi.org/10.1176/appi.psychotherapy.2016.70.2.149>

- Hook, J.N. (2014). Engaging clients with cultural humility. *Journal of Psychology and Christianity*, 33(3), 277-280.
- Huss, E., Kaufman, R., Avgar, A., & Shouker, E. Using art-based research to help visualize community intervention in international aid. *International Social Work*, 58(5), 673-688. <https://doi.org/10.1177/0020872815592686>
- Isaacson, M. (2014) Clarifying concepts: Cultural humility or competency. *Journal of Professional Nursing* 30 (3), 251-258. <http://dx.doi.org/10.1016/j.profnurs.2013.09.011>
- Jackson, L (2020). *Cultural humility in art therapy: The balance of creativity, introspection and advocacy*. Philadelphia, PA: Jessica Kingsley Publications
- Keselman, M., & Awais, Y.J. (2018). Exploration of cultural humility in medical art therapy. *Art Therapy*, 35(2), 77-87. <https://www.tandfonline.com/loi/uart20>
- Lai, N.H., (2011) Expressive arts therapy for mother-child relationship (EAT-MCR): A novel model for domestic violence survivors in Chinese culture. *The Arts in Psychotherapy*, 38, 305-311. <https://doi.org/10.1016/j.aip.2011.08.001>
- Lark, C. V. (2005) Using art as language in large group dialogues: The TRECsm model, *Art Therapy*, 22(1), 24-3. <https://doi.org/10.1080/07421656.2005.10129458>
- Larsen, D. J., Stege, R., King, R., & Egeli, N. (2018). The hope collage activity: An arts-based group intervention for people with chronic pain. *British Journal of Guidance & Counselling*, 46(6), 722–737. <https://doi.org/10.1080/03069885.2018.1453046>
- Lusk, M., Terrazas, S., & Salcido, R. (2017). Critical cultural competence in social work supervision. *Human Service Organizations: Management, Leadership & Governance*, 1-13. <https://doi.org/10.1080/23303131.2017.1313801>
- Marsh, M.B. (2017). *Iraqi refugees and cultural humility: A mental health professional training program*. [Doctoral dissertation, Antioch University, New England]. Antioch University Repository & Archive.
- Mechanic, O. J., Dubosh, N. M., Rosen, C. L., & Landry, A. M. (2017). Cultural competency training in emergency medicine. *The Journal of Emergency Medicine*, 53(3), 391-396. <http://dx.doi.org/10.1016/j.jemermed.2017.04.019>
- Mcniff, S., & Barlow, G. C. (2009). Cross-cultural psychotherapy and art. *Art Therapy*, 26(3), 100–106. <https://doi.org/10.1080/07421656.2009.10129379>
- Monti, D.A., Peterson, C., Shakin Kunkel E.J., Hauck, W.W., Pequignot, E., Rhodes, L., & Brainard, G.C. (2005). A randomized, controlled trial of mindfulness-based art therapy (MBAT) for women with cancer. *Psycho-Oncology*, 15, 363-373. <https://doi.org/10.1002/pon.988>

- Mosher, D.K., Hook, J.N., Captari, L.E., Davis, D.E., DeBlare, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging in diverse clients. *Practice Innovations*, 2(4), 221-233. <http://dx.doi.org/10.1037/pri0000055>
- Owen, J., Jordan II, T.A., Turner, D., Davis, D.E., Hook, J.N., & Leach, M.M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology & Theology*, 42(1), 91-98. <https://doi.org/10.1177/009164711404200110>
- Patallo, B.J. (2019). The multicultural guidelines in practice: Cultural humility training and supervision. *Training and Education in Professional Psychology*, 13(3), 227-232. <http://dx.doi.org/10.1037/tep0000253>
- Perry, R., Maffulli, N., Willson, S., & Morrissey, D. (2011). The effectiveness of arts-based interventions in medical education. *Medical Education*, 45, 141-148. <https://doi.org/10.1111/j.1365-2923.2010.03848.x>
- Rao, S., How, P. C., & Ton, H. (2018). Education, training, and recruitment of a diverse workforce in psychiatry. *Psychiatric Annals*, 48(3), 143-148. <https://doi.org/10.3928/00485713-20180211-01>
- Rosen, D., McCall, J., & Goodkind, S. (2017). Teaching critical self-reflection through the lens of cultural humility: An assignment in a social work diversity course. *Social Work Education*, 36(3), 289-298. <https://electra.lmu.edu:2070/10.1080/02615479.2017.1287260>
- Rubin, S.Y. (2019). Supportive art-making as a therapeutic tool for nurses. *Pediatric Nursing*, 45(2), 95-98.
- Sandeen, E., Moore, K. M., & Swanda, R. M. (2018). Reflective local practice: A pragmatic framework for improving culturally competent practice in psychology. *Professional Psychology: Research and Practice*, 49(2), 142-150. <http://dx.doi.org/10.1037/pro0000183>
- Shepherd, S. M. (2019). Cultural awareness workshops: Limitations and practical consequences. *BMC Medical Education*, 19(1). <http://doi.org/10.1186/s12909-018-1450-5>
- Sloane, H. M., David, K., Davies, J., Stamper, D., & Woodward, S. (2018). Cultural history analysis and professional humility: Historical context and social work practice. *Social Work Education*, 37(8), 1015-1027. <https://doi.org/10.1080/02615479.2018.1490710>
- Tormala, T.T., Patel, S.G., Soukup, E.E., & Clarke, A.V. (2018). Developing measurable cultural competence and cultural humility: An application of the cultural formulation. *Training and Education in Professional Psychology*, 12(1), 54-61. <http://dx.doi.org/10.1037/tep0000183>

- Upshaw, N. C., Lewis, D. E., & Nelson, A. L. (2019). Cultural humility in action: Reflective and process-oriented supervision with Black trainees. *Training and Education in Professional Psychology*. <https://doi.org/10.1037/tep0000284>
- Watkins Jr., C.E., & Hook, J. (2016). On a culturally humble psychoanalytic supervision perspective: Creative the cultural third. *Psychoanalytic Psychology*, 33(3), 487-517. <http://dx.doi.org/10.1037/pap0000044>
- Weinberg, T. (2018) Gaining cultural competence through alliances in art therapy With indigenous clients (La compétence culturelle et son acquisition grâce à des alliances avec des clients autochtones en art-thérapie). *Canadian Art Therapy Association Journal*, 31(1), 14-22. <https://doi.org/10.1080/08322473.2018.1453214>
- Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251–256. <http://dx.doi.org/10.4314/rj.v2i2.27F>