# AN EVALUATION OF THE IMPACT OF AN INTERCULTURAL SERVICE LEARNING EXPERIENCE ON THE DEVELOPMENT OF TRANSCULTURAL SELF-EFFICACY OF NURSING STUDENTS

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## DEDICATION

This work is dedicated to my family. I could not have completed this journey without your unconditional love and support. I hope you know how much I love you and appreciate your patience as I continued my educational journey. Jonathan, you are always there for me, my strength, my best friend, my soul mate, my husband- Thank you for all the encouragement and support. Sarah and Laura—you deserve recognition, your continuing support no matter what your mother decided to do. You have always been my inspiration to be a positive role model and to strive to be a better person. I will always—"love you more"!

I further dedicate this work to the students and faculty who have shared their intercultural experiences with me. As the intercultural experiences have positively changed your life, you have absolutely changed mine. It is my hope and dream that this work will positively impact the lives of those in nursing and the patients that they care for.

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Lynn Marie Schmidt

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The increase in diverse populations with unique, culturally specific needs, along with the lack of diverse healthcare providers to deliver culturally competent care, has escalated the need for non-diverse practitioners to gain the knowledge, skills, and attitudes to deliver culturally competent care. Culturally competent care cannot be offered to patients unless nurses understand how cultural values, attitudes, and beliefs impact patients' response to care. Nurses must develop cultural competence to accurately access, develop, and implement effective nursing interventions.

The purpose of this exploratory, quasi-experimental, pretest-posttest study was to explore the impact of an intercultural service learning experience (domestic or international) on pre-licensure nursing students' perceived development of transcultural self-efficacy. A convenience sample of senior semester nursing students enrolled in a private, faith-based, baccalaureate degree nursing program in the Midwest United States completed the Transcultural Self-Efficacy Tool (TSET), Cultural Competence Clinical Evaluation Tool-Student Version (CCCET-SV), and reflective journals. All students were immersed in an intercultural service learning experience. Eighteen students traveled domestically and 38 traveled internationally.

The data revealed that there was not a statistical difference in TSET scores based on location of the intercultural experience. However, there was a statistically significant difference from pretest to posttest for perceived Cognitive, Practical, and Affective

dimensions of transcultural self-efficacy, in change scores (pretest to posttest), and pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural service learning experience.

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# ABBREVIATIONS

| Abbreviation | Term |
| --- | --- |
| AACN | American Association of Colleges of Nursing |
| ACA | Affordable Care Act |
| ANA | American Nurses Association |
| BSN | Bachelor of Science Nursing |
| CCC | Cultural Competence and Confidence Model |
| CCCET-SV | Cultural Competence Clinical Evaluation Tool-Student Version |
| EBP | Evidence-based Practice |
| IOM | Institute of Medicines of the National Academies |
| IRB | Institutional Review Board |
| NCLEX | National Council of Licensure Examination |
| NLN | National League for Nursing |
| OMH | Office of Minority Health |
| RN | Registered Nurse |
| SL | Service Learning |
| SON | School(s) of Nursing |
| TSE | Transcultural Self-efficacy |
| TSET | Transcultural Self-Efficacy Tool |
| U.S. | United States |
| USDHHS | U.S. Department of Health and Human Services |

# CHAPTER I INTRODUCTION

Nurse educators have an obligation to develop nursing students' professional values congruent with the roles and responsibilities of the professional nurse. Over the past two decades, there has been a tremendous shift in the race and ethnicity of the United States (U.S.) population. Therefore, it is essential for nurse educators to integrate cultural competence knowledge, skills, and attitudes into nursing curriculum to develop successful practitioners who can provide culturally sensitive care to culturally diverse patients. Self-efficacy has been strongly linked to nursing education and students' perceived ability to provide appropriate healthcare. This study extends the research of the impact of an intercultural service learning (SL) experience on nursing students' perceived transcultural self-efficacy (TSE).

In 2013, the U.S. Department of Health and Human Services (USDHHS) expected 30–35 million more people to be added to health insurance rolls in 2014 (USDHHS, 2013). One goal of the Affordable Care Act (ACA) is to increase access to healthcare for communities of color (USDHHS, 2012). Communities of color have a greater incidence of health disparities such as decreased life expectancy, increased infant mortality, and increased prevalence of chronic disease. The increase in diverse populations with unique, culturally specific needs, along with the lack of diverse healthcare providers to deliver culturally competent care, has escalated the need for non-diverse practitioners to gain the knowledge, skills, and attitudes to deliver culturally competent care.

Demographic studies show that the U.S. is becoming more ethnically, racially, and culturally diverse. In a report from the U.S. Census, over one-third of the U.S.

population reported their race and ethnicity as something other than non-Hispanic White, representing a 29% growth over a decade (U.S. Census Bureau, 2011). Projections have been made that by 2042 collectively, the minority populations will become the majority. The *2012 National Healthcare Disparities Report* stated that vulnerable populations, especially racial and ethnic minorities, often receive suboptimal healthcare quality and access in America (USDHHS, 2013).

This dramatic demographic shift, however, is not reflected currently in the nursing workforce, nursing school enrollment, or nursing faculty. According to data from the *2013 National Sample Survey of Registered Nurses (RNs)*, only 19% of RNs represent minority backgrounds (USDHHS, 2014). While this is an improvement from 12.2% in 2004, the increase does not reflect the overall population. The American Association of Colleges of Nursing (AACN) report, *2013–2014 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, indicates that minority enrollment has increased but not enough to reflect the patient population (AACN, 2014). In addition, the AACN reported that nursing faculty reflected less than 10% of underrepresented groups (Siantz, 2011). The lack of parallel growth is a challenge for nurse educators and healthcare professionals alike.

The ACA is a comprehensive health insurance reform designed to ensure that more Americans have access to health care. It has a strong focus on minority health and reducing healthcare disparities. One goal of the ACA is to provide access to care for Hispanics and non-Hispanic Whites who have substantially higher uninsured rates (U.S. Census Bureau, 2011). As this change in access occurs, it is even more important for healthcare providers to be culturally competent.

There are nearly three million nurses practicing in the U.S., making nursing the largest healthcare profession (U.S. Department of Labor, 2014). Nurses assume vital roles in the healthcare system such as:

- Providing high-quality direct patient care across the care continuum
- Assessing and monitoring patients' health status and outcomes
- Planning, tailoring, implementing, and evaluating clinical interventions
- Facilitating self-management strategies so that individuals achieve the highest level of health and adhere to prescribed treatments
- Promoting physical and mental health through patient education and anticipatory guidance. (U.S. Department of Labor, 2014)

Nurses are in a unique position to positively impact healthcare practices. Research findings reveal that positive healthcare outcomes are related to a nurse's ability to successfully communicate with his or her patients (Warren, 2009). Nursing faculty must accept the responsibility to acquire the knowledge, skills, and attitudes necessary to develop nursing educational experiences, both didactic and clinical, and to help students develop the knowledge, skills, and attitudes needed to provide culturally competent care to patients.

The American Nurses Association (ANA) accepted the role of enhancing cultural competence in nursing by developing professional role expectations and competencies and published the following: *Code of Ethics for Nurses with Interpretive Statements* (2015), *Holistic Nursing: Scope and Standards of Practice* (2013), *Nursing's Social Policy Statement: The Essence of the Profession* (2010b), and *Nursing: Scope and Standards of Practice* (2010c). In 2010, the ANA received a grant from the Pfizer Corporation to support nurses' cultural competency (ANA, 2010a). The National League for Nursing (NLN) Think Tank on Diversity recommended the development of the

Diversity Tool Kit to assist administrators and school of nursing (SON) faculty in developing sustainable practices within nursing education to promote the development of cultural competence in nursing (NLN, 2009).

There are culturally diverse individuals across the U.S. unable to attain their highest level of health due to health inequalities, thus resulting in disparities. One cause of the inequalities and disparities are social determinants of health. The World Health Organization describes social determinants of health as “the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels” (World Health Organization, 2013, p. 1). The cost of these disparities due to inadequate or inequitable care is greater than one trillion dollars (LaVeist, Gaskin, & Richard, 2009). Not only is this a significant financial problem, it is negatively impacting local neighborhoods, communities, and society at large (LaVeist et al., 2009).

According to the USDHHS Office of Minority Health (OMH), increasing cultural competence among healthcare providers is one way to diminish the disparities gap (USDHHS OMH, 2013). In May 2013, the OMH updated the national *Culturally and Linguistically Appropriate Services* standards blueprint for health and healthcare organizations that includes the principal standard for governance, leadership, and workforce; communication and language assistance; and engagement, continuance improvement, and accountability (USDHHS OMH, 2013). Increased cultural competence usually leads to culturally congruent care that customizes health care to meet the given patient’s beliefs, cultural values, lifestyles, practices, and traditions.

A role of the USDHHS Agency for Healthcare Research and Quality is to monitor healthcare delivery disparities. In 2010, The Joint Commission developed *Advancing Effective Communication, Cultural Competence, and Patient-and-Family Centered Care: A Roadmap for Hospitals* as a response to research that revealed decreased patient safety, poorer health outcomes, and lower quality of care based on race, ethnicity, language, disabilities, and sexual orientation (USDHHS Agency for Healthcare Research and Quality, 2010).

The AACN (2008a) proposed "the integration of cultural competence in baccalaureate nursing education to support the development of patient-centered care which identifies and addresses the differences in patients' values, preferences, and expressed needs" (p. 1). Cultural competence has been identified as a major measure of quality in nursing care (Salimbene, 1999); therefore, there is a critical need to identify learning interventions that improve cultural competence of nurses.

Nursing faculty are in a position to facilitate the development of cultural competence in students. This can be accomplished by adapting curricula to incorporate concepts that support the development of knowledge, skills, and attitudes into practical strategies to provide culturally competent nursing care. Nurses represent the largest body of healthcare providers (Institute of Medicines of the National Academies [IOM], 2011); therefore, they are at the forefront to identify and address disparities in healthcare (IOM, 2011). A nurse culturally competent can assess, develop, and implement nursing interventions that positively impact patients' healthcare access, quality, and outcomes for culturally diverse patients (IOM, 2010). Thus, there is a critical need to identify learning

interventions that improve cultural competence of nursing students to effectively prepare them to provide quality nursing care.

The first step to developing cultural competence is cultural awareness. Cultural awareness is cultivated by learning about oneself. As students examine and reflect on the diverse perspectives of values, beliefs, lifestyles, and practices of different cultures, they begin to identify their own biases, attitudes, and prejudices (Stokes & Flowers, 2012). Intercultural learning experiences, such as SL and immersion experiences, are one way to gain cultural awareness (Amerson, 2010; Green, Comer, Elliott, & Neubrander, 2011; Hayward & Charrette, 2012; Kulbok, Mitchell, Glick, & Greiner, 2012; Nokes, Nickitas, Keida, & Neville, 2005). Despite the fact that SL and immersion experiences are shown to increase cultural competence, many SON do not incorporate these experiences into their nursing curricula.

The NLN conducted a survey of SON deans and directors. The survey revealed that driving forces for SL and study abroad program development included valued outcomes, global focus of institutions, and limited availability of clinical sites (McKinnon & McNelis, 2011). Despite these identified driving forces, there are barriers and obstacles that prevent more SON from implementing program expansions. The obstacles identified include cost, time, value and interest, logistics and development, and curricula, as well as health and safety (McKinnon & McNelis, 2011).

The need for a culturally diverse healthcare workforce is evident; however, many obstacles exist that prevent that need from becoming an immediate reality. While work continues toward meeting that need, progress can be made in preparing a workforce that although limited in diversity can deliver culturally competent care to clients. Research

has shown that intercultural learning experiences, such as SL and immersion experiences, are effective for increasing students' cultural awareness and competence (Amerson, 2010; Green et al., 2011; Hayward & Charrette, 2012; Kulbok et al., 2012; Nokes et al., 2005).

## Problem Statement and Research Questions

This exploratory, quasi-experimental, pretest–posttest study explores the impact of an intercultural learning experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. This investigation was conducted in the context of a cultural competence curriculum within a Bachelor of Science Nursing (BSN) program, as well as an intercultural clinical learning experience. It addressed the following questions:

### Quantitative Research Questions

1. Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?
2. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?
3. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?
4. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors

(culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience?

5. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)?

**Qualitative Research Questions**

6. How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive)
7. How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)
8. How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)

## Purpose of the Study

The purpose of the study was to explore the impact of an intercultural SL experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. While cultural competence is identified as a critical component of nursing education, little research has been done to determine if a student must travel around the corner or across the globe to increase her/his perceived TSE.

## Significance of the Study

It is the role of nursing faculty to adapt curricula to incorporate concepts that support the development of culturally competent nursing care. Nurses represent the largest body of healthcare providers (IOM, 2011) and, therefore, are at the forefront to identify and address disparities in health care. Culturally competent nurses can assess, develop, and implement nursing interventions that positively impact patients' healthcare access, quality, and outcomes; thus, there is a critical need to identify learning interventions that improve the cultural competence of nurses. If the impact of a domestic intercultural SL experience is similar to an international experience, more SON and nursing students might embrace this unique opportunity. The benefits of a domestic intercultural SL experience include reduced cost to students, faculty, and universities, as well as decreased concerns involving safety and security. In addition, providing care to U.S. citizens exposes students and faculty to diversity within the community, develops community relationships, and increases engagement in the world in which they live.

Formalized education positively influences students' self-efficacy perceptions as determined by the TSE tool (Jeffreys, 2010). However, it is not known if this increased sense of TSE results in better patient care and patient outcomes. An additional research is needed to identify the patient's perception of care as well to investigate the impact of an intercultural (a culture other than one's own) learning experience (international versus domestic) on the development of TSE of senior-level BSN students. Several studies support educational and healthcare experiences that influence nursing students' self-efficacy perceptions (Adams, 2012; Amerson, 2010; Jeffreys & Dogan, 2012; Jeffreys & Dogan, 2013; Larsen & Reif, 2011). A recent survey of SON deans and directors revealed that barriers to providing an intercultural SL experience include lack of

flexibility in nursing curricula, financial burdens to students and the nursing schools, lack of faculty to organize and participate in an intercultural SL experience, and limited time constraints (McKinnon & McNelis, 2011). If students have a transformational experience caring for patients around the corner in a domestic setting, there is a greater likelihood that nursing schools will consider incorporating a similar experience into their curricula.

**Conceptual and Operational Definitions**

*TSE* is “the perceived confidence for performing or learning transcultural nursing skills. It is the degree to which individuals perceive they have the ability to perform the specific transcultural nursing skills needed for culturally competent and congruent care” (Jeffreys, 2010, p. 51).

*Culturally responsive care* is defined as care provided by a nurse or team of nurses that specifically meets a patient’s cultural values, beliefs, and behavior related to social and cultural contexts.

*Health disparities* include religious and spirituality beliefs, gender dynamics, nutrition and dietary preferences, cultural beliefs, educational levels, and socioeconomic status (USDHHS, 2012).

*Social determinants of health* are “the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels” (World Health Organization, 2013, p. 1).

An *intercultural SL experience* is a structured teaching intervention that takes place within a culture other than one’s own, either domestically or internationally.

The *TSE Tool* (TSET) measures and evaluates a learner’s confidence (TSE) for performing general transcultural nursing skills among diverse populations; scores are

reported in three subscales that focus upon the three dimensions of learning: Cognitive, Practical, and Affective (Jeffreys, 2010; see Appendix A).

The *Cultural Competence Clinical Evaluation Tool-Student Version* (CCCET-SV) measures different dimensions of clinical competence behaviors as perceived by students: extent of culturally specific care (subscale 1), cultural assessment (subscale 2), and culturally sensitive and professionally appropriate attitudes, values, and beliefs including awareness, acceptance, recognition, appreciation, and advocacy necessary for providing culturally sensitive professional nursing care (subscale 3) (Jeffreys, 2010; see Appendix B).

## Organization

This research study is presented in five chapters. Chapter I consists of the background, problem statement and research questions, purpose, significance, definitions, and organization. Chapter II provides a comprehensive review of the literature including the areas of historical perspectives, Kolb's experiential learning theory, SL, SL in nursing, self-efficacy, transcultural nursing, cultural competence in nursing education, nursing theoretical models and frameworks for cultural assessment, measurement of cultural competence, the use of the TSET in nursing education, and the state of the science of TSE. Chapter III presents the methodology used in the research study including information related to the subjects, the instruments, data collection, and analysis. Chapter IV presents the results of data analysis and findings that emerged from the study including a section presenting the participant demographics and the descriptive statistics used to analyze the data. Chapter V summarizes the study and findings, conclusions drawn from the findings, discussion, and implications for further research in this area.

# CHAPTER II REVIEW OF THE LITERATURE

This exploratory, quasi-experimental, pretest–posttest study explored the impact of an intercultural SL experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. The purpose of this study was two-fold: (1) to investigate if the location of an intercultural experience impacts TSE and (2) to assess how an intercultural SL experience impacts students' perception of nursing care. A dynamic construct that can change over time, TSE is influenced by formal educational opportunities. Chapter II provides a review of the literature on SL, cultural competence, self-efficacy, and transcultural nursing related to nursing education. The chapter includes a review of the historical perspectives of SL followed by the influence of SL on cultural competence in nursing education and practice and a discussion of transcultural nursing theoretical models and frameworks. The chapter concludes with a critical analysis of literature specific to measurement of cultural competence using the TSET and the CCCET-SV and their use as an educational strategy in nursing education.

## Historical Perspectives

The inception of SL in higher education occurred during the Lincoln administration (1861–1865). The Morrill Homestead initiative (1864) provided land grants to establish colleges throughout the U.S. that focused on developing citizens who would be "educated for the betterment of society." Land grant colleges were conceptualized as a way to provide student development through the transfer of knowledge and active service to influence humanity and civilization. Initially, colleges in engineering, agriculture, and military science were established (National Service Learning Clearinghouse, 2013). In 1903, the University of Cincinnati founded the Cooperative Education Movement that expanded the meaning of service in education,

thereby linking learning, service, and career (University of Cincinnati, n.d.). Dean Herman Schneider arranged for engineering students to alternate academic semesters with professional work experiences as a way to assist students to integrate theory and practice (University of Cincinnati, n.d.). Extending learning beyond the classroom further enhanced students' career preparation by developing professional and interpersonal skills (University of Cincinnati, n.d.). The experiential learning evolved into SL providing students a transition from the classroom to the world (Waterman, 1997).

**Kolb's Experiential Learning Theory**

Kolb (1984) developed the experiential learning theory based on the earlier work of Dewey, Lewin, and Piaget. Kolb believed "learning is the process whereby knowledge is created through the transformation of experience" (1984, p. 38). The cyclical experiential learning theory model (Kolb, 1984) consists of four stages of learning: concrete experience (do), observation and reflection (observe), forming abstract concepts (think), and testing in new situations (plan). During the concrete experience stage, the learner experiences an activity, such as field work or a lab session. The second stage, reflective observation, requires the learner to consciously reflect on the experience. The third stage, abstract conceptualization, involves the learner applying known theory to describe the experience. These three stages lead to the fourth stage, active experimentation, where the learner applies previous knowledge to a current experience (Kolb, 1984). Research and theoretical writings suggest that as learners experience the do, observe, think, and plan process, a reciprocal educational relationship is created between academia and service.

## About SL

Dewey (1916) was one of the earlier proponents of SL pedagogy. Dewey's philosophy of education was based on the belief that instruction and personal experiences already were related. Dewey (1916) believed "an ounce of experience is better than a ton of theory simply because it is only in experience that any theory had vital and verifiable significance" (p. 72). The approach of SL is education that provides experience and education to students and service to the community.

During the 1960s and early 1970s SL programs expanded. The Carnegie Commission of Higher Education (Mayhew, 1973) identified SL as a valuable component to higher education and supported adding SL as a teaching–learning strategy. The National Community Service Act of 1990 authorized grants to colleges and universities to support SL opportunities, thereby reengaging educators, students, and stakeholders (National Service Learning Clearinghouse, 2013). The passing of the act resulted in "hundreds of federally funded SL programs across the country" (Mintz & Liu, 1994, p. 11). Mintz and Liu (1994) assessed lessons learned from past failures and identified essential components for successful SL programs including institutional and stakeholder support, faculty interest, community partnership, student motivation, development, and orientation programs and evaluation.

In higher education, SL experiences provide students opportunities to learn more about the demographics of the community, community needs, and community resources. The students learn from the community and about the community. The academic institution benefits by collaborating with the community partners. The community agencies benefit from the services the students provide and affiliation with the academic

institution. This is a collaborative approach in which the responsibility for learning is shared between the student and faculty (Goldberg & Coufal, 2009). It is important to note that SL is not a transparent learning experience. One does not learn just by the act of "participating" in an SL project. In order for learning to occur the SL must be legitimate, ethical, and useful, and the student must be immersed and engaged in the experience.

Culturally relevant teaching through SL exposes students to diversity and integrates academic content, community partnership, and civic engagement. Butin (2010) described the cultural perspective of SL in higher education as students making meaning within and through the context of SL. Butin explained that "such meaning-making may be understood within the Geertz (1973) term *webs of meaning*—we make sense of who we are with respect to both local and global communities" (Butin, 2010, p. 9). Students in SL experiences have opportunities to learn more about themselves by engaging with those *different* from themselves. Different refers to racial, ethnic, socioeconomic, sexual orientation, and/or religious characteristics. Students have opportunities to engage in the broader world in which they live through SL.

**SL in Nursing**

Often used in nursing education, SL is a pedagogical approach, "a form of experiential education in which students engage in activities that address human and community needs together with structured opportunities for reflection designed to achieve desired learning outcomes" (Jacoby, 1996, p. 5). The SL experience provides nursing students an opportunity to experience first-hand the needs of the client and the community. It is important that SL is not confused with traditional direct client care experiences and volunteerism. Three key tenets that distinguish SL from volunteerism

include the following: (1) A community identifies a need for service or activity; (2) Course learning outcomes are achieved through the identified community need; and (3) Students reflect upon their experiences (Reising et al., 2008). The opportunity to reflect on learning experiences help students connect assumptions formulated prior to their service. Learning does not necessarily occur as a result of an experience; however, intentional reflection on the experience influences cognitive, practical, and affective learning. Incorporating reflection into learning allows students to transfer theories to real experience, relate statistics to people and situations, and identify questions related to the service experience. Intentional reflection on the specific SL experience provides students an opportunity to bridge the gap between theory and practice.

Eyler, Giles, Stenson, and Gray (2001) empirically determined that outcomes achieved from an SL experience included increased personal awareness, improved interpersonal relationships, development of civic engagement/social responsibility, and mastery of academic concepts. These outcomes are consistent with the AACN (2008a) expectations for clinical experiences within baccalaureate nursing programs. The *Baccalaureate Essentials* (AACN, 2008a) describe clinical experience expectations that include "[development of] proficiency in performing psychomotor skills, [application of] professional communication strategies to client and interprofessional interactions, and [acquiring] a professional identity" (AACN, 2008a, p. 33). Incorporating SL into nursing curricula is a way to connect nurses' historical involvement within the community while promoting an understanding of patients' needs specific to individuals, families, and communities.

Some SON have developed creative ways to integrate learning experiences that benefit both students and community members. The literature reflects ongoing efforts by faculty to implement SL into nursing curricula (Bailey, Carpenter, & Harrington, 2002; Callen & Lee, 2009; Delahoussaye, 2001; Hales, 1997; Hamner, Wilder, & Byrd, 2007; Rimer, Schlumberger, Straughn, &Womack, 1998; Ross, 2012; Stallwood & Groh, 2011; White & Henry, 1999). Participation in SL provides nursing students intentional opportunities to engage in learning while impacting student attitudes and beliefs regarding leadership and social justice (Groh, Stallwood, & Daniels, 2011), cultural competence (Amerson, 2010; Nokes et al., 2005), critical thinking, civic engagement (Nokes et al., 2005), and health promotions and research skills (Reising et al., 2008).

Hunt (2007) explored the lived experience of nursing students engaged in SL opportunities within homeless communities. Six themes were identified:

- eye-opening to realize the effects of homelessness on families
- feeling of intense emotions that are sometimes hard to express
- realizing families who are homeless are both different from and similar to families who have housing
- challenging and transforming assumptions, perceptions, and stereotypes
- the importance of reflection
- discovering new and different aspects of the nursing role. (p. 277)

Similarly, Loewenson and Hunt (2011) revealed that students experience transformational learning by gaining a greater understanding of social justice and advocacy in practice through SL. While some evidence exists to support the implementation of SL into nursing education, the lack of robust research in measuring the concepts and instruments used in its implementation reveals SL in nursing is not at the level of evidence-based practice (EBP; Engebretson, Mahoney, & Carlson; 2008; Stallwood & Groh, 2011). Consisting of seven steps, EBP: cultivates a spirit of inquiry,

asks a clinical question, searches for evidence, critically appraises the evidence, integrates the evidence with clinical expertise and patient preference and values, evaluates the outcomes of the practice decisions or changes based on evidence, and disseminates EBP results (Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2010). In order for the implementation of SL to reach the higher level of EBP, more research is needed to identify concepts and to develop instruments to measure SL within nursing education and to document the impact SL has on students' self-efficacy and clients receiving care.

**Self-Efficacy**

Self-efficacy is defined as "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (Bandura, 1986, p. 391). In order for an individual to achieve a desired outcome, one needs to believe in an innate personal ability to perform the action. If the action is perceived to be of benefit but the individual doubts his or her ability to perform the action, there is a decreased likelihood that the behavior will change (Bandura, 1977; Rosenstock, Strecher, & Becker, 1988; Sharma & Romas, 2007; Wood, 2008).

Self-efficacy can be influenced by direct experience, vicarious experiences, or verbal persuasion (Bandura, 1986). Self-efficacy is a fundamental concept in nursing education and can narrow the theory–practice gap (Kuiper, Pesut, & Kautz, 2009). Nursing research has revealed a link between self-efficacy and development of clinical skills (Bambini, Washburn, & Perkins, 2009; Goldenberg, Andrusyszyn, & Iwasiw, 2005; Kuiper, Murdock, & Grant, 2010; Wagner, Bear, & Sander, 2009). Bandura (1986) reported that people will pursue tasks and situations in which they feel they are

competent to perform and avoid those they believe exceed their capabilities. Self-efficacy is a continuous, dynamic change over time in response to new experiences and information such as education. It is a mediator and predictor of performance behaviors and outcomes (Bandura, 1997; Jeffreys, 2010; Jeffreys & Smodlaka, 1999). Because nurses increasingly have greater exposure to diverse groups of patients, it is necessary for educators to prepare students to work effectively within a diverse cultural atmosphere.

**Transcultural Nursing**

The concept of transcultural nursing was established more than 40 years ago. Madeleine Leininger, founder and leader of the field, reformulated the *culture* construct from anthropology and *care* from nursing to develop *culture care*. Leininger defined transcultural nursing as:

> A substantive area of study and practice focused on comparative cultural caring, values, beliefs, and practices of individuals or groups of similar or different cultures. Transcultural nursing's goal is to provide culture specific and universal nursing care practices for the health and well-being of people or to help them face unfavorable human conditions, illness or death in culturally meaningful ways. (2002, p. 58)

In a vastly growing multicultural society, nurses care for a more culturally diverse patient population; therefore, it is important for nurses to understand cultural dimensions and how these dimensions influence health, wellness, illness, recovery, and health maintenance.

When nurse educators use the pedagogical approach of SL for teaching cultural competence, students have the opportunity to share their experiences, express their thoughts, and interpret meanings regarding their actual experiences of cultural issues within nursing practice. This transformative learning experience increases each student's awareness of cultural issues impacting health care, as well as understanding the impact of

culturally congruent nursing care. The formalized learning opportunity guides the development of knowledge, skills, and attitudes into practical strategies to provide culturally competent nursing care.

## Cultural Competence in Nursing Education

The demographic shift of the U.S. population is resulting in an increasingly diverse, multicultural society (U.S. Census Bureau, 2011). The changing composition of the population creates a challenge for nurses in the 21st century to deliver culturally competent nursing care. One place for students to begin learning the preferred health practices of patients from diverse cultures are in a SON. In order for nurses to provide high quality care, they must be able to effectively administer culturally specific nursing care that is customized to fit cultural values, beliefs, traditions, practices, and lifestyle (Leininger & McFarland, 2002). The IOM (2003) reported that to meet the needs of the 21st century health system all health professionals should be educated to provide patient-centered care that "[identifies, respects, and cares] about patients' differences, values, preferences, and expressed need" (p. 4).

The Association of American Colleges and Universities, the AACN, the Commission of Collegiate Nursing Education, and the National League for Nursing Accrediting Commission have added cultural competence education to educational standards for educational programs (Andrews & Boyle, 2012). In response to the IOM 2003 report, the AACN developed the *Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses* (2008b). The tool kit was designed as a resource for nurse educators to increase awareness about health and healthcare disparities and to help faculty implement cultural competencies in baccalaureate nursing education. The five key competencies essential for baccalaureate nursing graduates are:

- Competency 1: Apply knowledge of social and cultural factors that affect nursing and health care across multiple contexts.
- Competency 2: Use relevant data sources and best evidence in providing culturally competent care.
- Competency 3: Promote achievement of safe and quality outcomes of care for diverse populations.
- Competency 4: Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities.
- Competency 5: Participate in continuous cultural competence development. (AACN, 2008b, p. 2)

Each competency is supported with a rationale of importance, description of what content should be included, and examples of integrative learning strategies. There are additional recommendations identifying the importance of organizational commitment and leadership, as well as faculty commitment and involvement. The AACN Tool Kit (2008b) is a framework that can assist nursing faculty to integrate cultural competence into nursing curricula to increase awareness of disparities in health and health care, social justice, and globalization.

The NLN identified diversity as one of the four core values (i.e., caring, integrity, diversity, and excellence). The NLN expanded the definition of diversity to include "affirming the uniqueness of and differences among persons, values, and ethnicities, and to include the development of a culture where individuals and institutions move beyond simple tolerance to embrace and celebrate the richness of our differences" (NLN, 2009, p. 1). The NLN's Nursing Education Workforce Development Advisory Council was tasked with identifying EBP resources to enhance patient diversity in nursing curricula. Members of the task force included representatives in the disciplines of higher education, nursing, and other healthcare professionals. The tool kit is divided into two sections: administration and faculty (NLN, 2009).

In 1975, the Transcultural Nursing Society was established by Dr. Madeleine M. Leininger to enhance the quality of culturally congruent, competent, and equitable care resulting in improved health and well-being for people worldwide. One focus of the professional organization was to ensure that nurses have resources to provide EBP related to cultural competence in practice, education, research, and administration as well as direct care provisions for individuals, communities, organizations, and society. "The goal of transcultural nursing practice is to promote health and well-being of individuals and populations by reducing health and care disparities through culturally congruent and competent approaches at the multilevel contexts of care" (Douglas & Pacquiao, 2010, p. S64). Educational preparation in transcultural nursing enhances the practice of culturally competent care.

The 2010 ACA is one of the broadest health care overhauls since 1965. Several provisions contained in the ACA potentially affect the health of racial and ethnic minorities. The law reorganized the federal infrastructure to reduce health disparities and encourage increased cultural competence for healthcare providers. Nursing needs to be transformed to provide safe, quality, patient-centered, accessible, and affordable care. The change in health care has prompted nurse educators to fundamentally improve nursing curricula and clinical experiences to meet the needs of the increasingly changing society.

**Nursing Theoretical Models and Frameworks for Cultural Assessment**

There are numerous theoretical models and frameworks developed by the discipline of nursing to integrate evidence-based nursing knowledge related to cultural competence into education, administration, and practice. When studying cultural systems in nursing practice, it is important to include *emic* and *etic* perspectives of the culture.

Emic refers to the intrinsic cultural distinctions that are shared and meaningful to members of a given society (Pike, 1954). The etic perspective is that of the outsider, such as healthcare professionals (Pike, 1954). For many decades, nurses have recognized the importance of acknowledging the cultural diversity of patients and their families. Nurse scholars continue to develop and refine cultural theories, models, and assessment frameworks.

## The Theory of Culture Care Diversity and Universality

In order to understand cultural care, a systematic review of contemporary transcultural healthcare and nursing models is helpful. In the 1950s, while Leininger was working with emotionally disturbed children, she noted cultural differences between patients and nurses. In 1991, Leininger developed the theory of culture care diversity and universality. The theory was derived from both anthropology and nursing principles. The focus of the theory is describing, explaining, and predicting nursing similarities and differences related primarily to human care and caring for human cultures (Leininger & McFarland, 2002). The theory includes factors such as technological; religious and philosophical; kinship and social; cultural values, beliefs, and lifeways; political and legal; economic; and educational that influence individuals, families, and groups in health and illness (Leininger & McFarland, 2002). The goals of the theory are to discover, document, interpret, and explain factors influencing care as it relates to culturally based care and to explain the interdependence of the phenomena of *care* and *culture* that can lead to therapeutic outcomes for the patient, family, and community (Douglas & Pacquiao, 2010).

**The Process of Cultural Competence in the Delivery of Healthcare Services**

During the same decade that Leininger's theory was developed, Campinha-Bacote developed the culturally competent model of care based on four constructs: cultural awareness, cultural knowledge, cultural skill, and cultural encounters (Campinha-Bacote, 2002). In 1998, the model was revised to become the model of cultural competence in the delivery of healthcare services, adding the concept of cultural desire (Campinha-Bacote, 2002). The model was further refined by Campinha-Bacote to emphasize that each patient has values, beliefs, and practices which must be considered when providing nursing care. In addition, a nurse must continually assess his/her abilities to meet the cultural needs of patients, families, and communities (Campinha-Bacote, 2002). The emphasis of Campinha-Bacote's model is on the process of *becoming* culturally competent, not a state of *being* culturally competent. The purposes of the model are to (1) provide a framework for delivering culturally responsive health care, (2) provide a framework for teaching cultural concepts to health professionals, (3) provide a framework for guiding culturally sensitive research, (4) impact the elimination of health disparities, (5) improve the quality of healthcare delivery, (6) augment the body of knowledge in transcultural nursing, (7) respond to the continually changing culturally and ethnically diverse population, and (8) define the process of becoming a culturally competent healthcare professional (Douglas & Pacquiao, 2010).

### Giger and Davidhizar's Transcultural Assessment Model

In 1988, Giger and Davidhizar developed the transcultural assessment model to help undergraduate nursing students assess and provide care for culturally diverse patients (2002). The model includes six cultural phenomena that shape nursing care: communication, space, social organization, time, environmental control, and biological variations. Giger and Davidhizar (2002) believed that while not all cultures are the same, they share the same organizational factors. The purpose of their model is to provide nursing students with a method of assessing a patient's culturally unique characteristics and behavior (Douglas & Pacquiao, 2010).

### The Purnell Model for Cultural Competence

The Purnell (2002) model for cultural competence is used with multidisciplinary healthcare team members as a clinical assessment tool. The metaparadigm concepts include global society, community, family, and person. An individual's cultural heritage is determined by beliefs, values, and practices. The 12 domains of Purnell's (2002) model include overview/heritage, communication, family roles and organizations, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, healthcare practices, and healthcare practitioners. When healthcare members provide care, they must look at themselves, their patients, the patients' communities, their colleagues, and their employment setting (Purnell, 2002).

The purpose of the model is to (1) provide a framework for all healthcare professionals to learn concepts and characteristics of culture; (2) explain historical perspectives that define circumstances that affect a person's cultural worldview; (3) provide a model that links the most central relationships of culture; (4) interrelate

characteristics of culture that promotes and facilitates the delivery of competent health care; (5) provide a framework that reflects human characteristics that reflect motivation, intentionality, and meaning; (6) provide a meaningful structure for analyzing cultural data; and (7) understand the individual, family, or group within the unique ethnocultural environment (Douglas & Pacquiao, 2010).

**Andrews/Boyle Transcultural Nursing Assessment Guide**

Andrews and Boyle's transcultural nursing assessment guide provides an overview of transcultural concepts that are fundamental for culturally competent nursing care. These concepts include cultural affiliations, values orientation, communication, health-related beliefs and practices, nutrition, socioeconomic considerations, organizations providing cultural support, education, religion, cultural aspects of disease incidence, bicultural variations, and development considerations across the lifespan (Sagar, 2012). The knowledge, attitudes, beliefs, and skills of a nurse will impact the development of the nurse's cultural competence, as well as developing the nurse's ability to provide culturally competent care for individuals, families, and communities. A cultural self-assessment yields an awareness of one's own cultural attitudes, beliefs, values, and practice that can reveal ethnocentric tendencies and cultural stereotypes. Verbal and nonverbal communication, technology, and environment are significant influences that impact the nurse–patient relationship. Cultural competence skills include both psychomotor and behavioral skills (Andrews & Boyle, 2012).

There are a variety of theories, models, and cultural assessment guides related to the development of cultural competence in the clinical setting, academia, and healthcare organizations. The theories, models, and cultural assessment guides are all holistic in

nature and guide current situations in health care and the implications in nursing practice, nursing education, and nursing administration. As previously stated, the purposes of each model differ; therefore, Jeffreys' cultural competence and confidence model was used for this research because it examines the multidimensional factors involved in the process of learning cultural competence to identify, develop, guide, and evaluate cultural competence educational innovations (Jeffreys, 2010).

## Cultural Competence and Confidence Model

Similar to previously mentioned models and frameworks, Jeffreys' cultural competence and confidence (CCC) model (see Figure 1) is a multidimensional framework for teaching cultural competence in nursing and health care. The CCC model is used to explain, describe, influence, and predict the phenomena of nurses developing cultural competence. Furthermore, the CCC addresses factors that influence learning, motivation, persistence, and commitment for cultural competency development (Jeffreys, 2010). The CCC model was derived from Bandura's (1997, 1986, 1993) theory of self-efficacy. According to Jeffreys (2010), transcultural nursing skills are cognitive (knowledge outcomes, intellectual abilities and skills, practical) motor skills or practical application of skills and are affective (attitudes, values, and beliefs). Cognitive, practical, and affective learning processes related to nursing students' TSE can change over time and may be influenced by formal educational opportunities. Cultural competence is a multidimensional learning process that includes a dynamic interaction between past experiences and observations that influence the development of cultural competence and TSE. Jeffreys (2010) explains the TSE pathway as an individualized process influenced by actual performance, role models, encouragement of others, and physiological indices

such as sweating. The basis of the theoretical model is that resilient nursing students will be motivated to continue their cultural competence development. Low-confidence individuals are poorly motivated and reluctant to develop cultural competence; whereas overly confident individuals may be unaware of their weaknesses, underestimate the importance of cultural competence, or may not even acknowledge the need for cultural competence nursing skills.

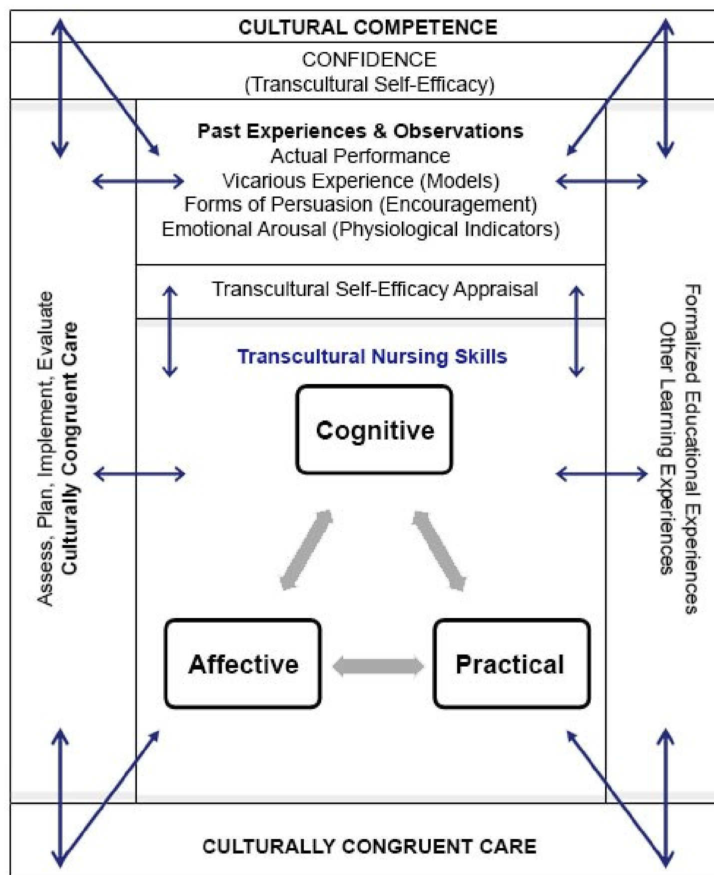


*Figure 1*. Jeffreys' CCC Model. M. R. Jeffreys, 2010, *Teaching Cultural Competence in Nursing and Health Care*. Copyright 2010 Springer Publishing. Used with permission (Appendix C).

According to Bandura (1977), learning and motivation for learning are related directly to self-efficacy perceptions. Empirical evidence supports that self-efficacy

significantly influences a student's effort, action, persistence, and performance outcomes. In order for academia to promote cultural competence and to increase TSE, it is necessary to assess each student's TSE. The TSET was developed to assess (1) the perceived transcultural nursing skills that students believe they have the ability to perform with more confidence; (2) the perceived transcultural nursing skills that students believe they have the ability to perform with less confidence; (3) the differences in TSE perceptions between novice and advanced nurses; and (4) the changes in TSE perceptions following formalized educational experiences and/or other learning experiences (Jeffreys, 2010). Jeffreys' (2010) cultural competence model was selected as the theoretical framework for the research study based on its focus on education and educational strategies.

There are 14 assumptions that support the CCC Model. Several underlying assumptions derived from nursing, education, and psychology preceded the development of TSET:

1. Cultural competence is an ongoing, multidimensional learning process that integrates transcultural skill in all three dimensions (cognitive, practical, and affective), involves TSE (confidence) as a major influencing factor, and aims to achieve culturally congruent care.
2. A dynamic construct, TSE, changes over time and is influenced by formalized exposure to culture care concepts (transcultural nursing).*[1]
3. The learning of transcultural nursing skills is influenced by self-efficacy perceptions (confidence).**[2]
4. The performance of transcultural nursing skill competencies is directly influenced by adequate learning of such skills and by TSE perceptions.**
5. The performance of culturally congruent nursing skills is influenced by self-efficacy perceptions and by formalized educational exposure to transcultural nursing care concepts and skills throughout the educational experience.**

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[1] Single asterisks (*) denote assumptions empirically tested.
[2] Double asterisks (**) denote assumptions currently under study.

6. All students and nurses (regardless of age, ethnicity, gender, sexual orientation, lifestyle, religion, socioeconomic status, geographic location, or race) require formalized educational experiences to meet cultural care needs of diverse individuals.*
7. The most comprehensive learning involves the integration of cognitive, practical, and affective dimensions.
8. Learning in the cognitive, practical, and affective dimensions is paradoxically distinct yet interrelated.*
9. Learners are most confident about their attitudes (affective dimension) and least confident about their transcultural nursing knowledge (cognitive dimension).*
10. Novice learners have lower self-efficacy perceptions than advanced learners.*
11. Inefficacious individuals are at risk for decreased motivation, lack of commitment, and/or avoidance of cultural considerations when planning and implementing nursing care.
12. Supremely efficacious (overly confident) individuals are at risk for inadequate preparation in learning the transcultural nursing skills necessary to provide culturally congruent care.
13. Early interventions with at-risk individuals will better prepare nurses to meet cultural competency.**
14. The greatest change in TSE perceptions will be detected in individuals with low self-efficacy (low confidence) initially, who have then been exposed to formalized transcultural nursing concepts and experiences.* (Jeffreys, 2010, p. 53–54).

Higher education has benefited from SL for over a century and a half. Increased diversity, both globally and locally, intensified the need for healthcare providers to identify models of healthcare delivery and health education to effectively respond to the changing needs of populations. The previously mentioned transcultural theoretical models and frameworks have influenced nursing curricula, practice guidelines, and organizational cultural competence.

## Measurement of Cultural Competence

A variety of instruments are used to measure the cultural competence of healthcare providers. These are the most commonly used: cultural awareness scale, cultural competence assessment, cross-cultural adaptability inventory, cultural self-efficacy scale, cross-cultural evaluation tool, inventory for assessing the process of

cultural competence among healthcare professionals-revised, TSET, and CCCET-SV (Douglas & Pacquiao, 2010). Each of these tools has established reliability and validity, and each tool measures different factors. The cultural awareness scale measures general educational experiences, cognitive awareness, behaviors/comfort with interaction, and patient care/clinical issues. The cultural competence assessment measures cultural competence behaviors, cultural awareness and sensitivity, and cultural diversity experiences. The cross-cultural adaptability inventory measures emotional resilience, flexibility/openness, perceptual acuity, and personal autonomy. The cultural self-efficacy scale measures knowledge of cultural concepts, cultural patterns, and skills with transcultural nursing functions. The cross-cultural evaluation tool measures cross-cultural interaction. The cultural competence among healthcare professionals-revised measures cultural awareness, knowledge, skill, encounters, and desire. The TSET measures recognition, kinship and social factors, professional nursing care, cultural background and identity, lifecycle transitional phenomena, awareness of cultural gap, communication, self-awareness, and appreciation. The CCCET-SV is a tool for gathering descriptive data about the clinical practicum/site concerning the presence of diversity and health disparity problems.

Assessment of nursing students' cultural competence is important to acquire data and to determine the effectiveness of teaching/learning strategies. Each of the previously mentioned tools has established reliability and validity to ensure the efficacy of the data gathered. Additionally, the tools have been used in nursing research in the practice, educational, and administration setting.

Further research is needed to determine if the lack of standardized measurement is a barrier to the assessment of healthcare professionals' abilities to provide culturally competent care to diverse patients. A limited number of tools evaluate the impact of cultural competence training. The existing tools lack independent rater instruments or items that evaluate learners' cultural competence skills (Gozu et al., 2007).

A limited amount of research exists that discusses the development of cultural competence among pre-licensure nursing students to prepare them for the professional nursing role (Jeffreys, 2010; Kardong-Edgren et al., 2010). The existing instruments, including the TSET and CCCET-SV, have limitations. However, the TSET provides the researcher with an assessment tool to measure the student's perceived self-efficacy of knowledge, attitude, and skills related to transcultural nursing care; the student's perceived confidence of learning or performing transcultural nursing care; and the student's confidence level of transcultural nursing skills experienced during the nursing clinical experiences, the type of clinical experiences, and the intercultural SL experience. The TSET also documents the demographic factors that influence TSE. The CCCET-SV provides the researcher with an assessment tool to measure the extent that culturally specific care is provided by students during nursing school clinical practicums and intercultural SL experiences; the frequency that cultural assessments are implemented during clinical practicums throughout nursing school and intercultural SL experiences; and the extent that culturally sensitive and professionally appropriate attitudes, values, or beliefs change during clinical practicums and intercultural SL experiences.

## The Use of the TSET and CCCET-SV in Nursing Education

Knowledge of cultural competence is one important component of nursing education curricula. A principle concern is to investigate teaching strategies that enhance the ability of nursing students to provide culturally competent care, as well as measure the outcome of didactic and clinical learning experiences. The TSET (Jeffreys, 2010) was designed to measure the influence of cultural competence curriculum (didactic) on nursing students' TSE (confidence). The CCCET-SV was designed to measure culturally specific care provisions, cultural assessment, and the development of affective learning within the clinical practicum experience (Jeffreys & Dogan, 2013).

Jeffreys and Dogan (2013) studied a purposive sample of second semester nursing student (*N* = 161) enrolled in a 15-week medical–surgical course. The CCCET-SV was administered three times: fall 2007, spring 2008, and fall 2008. The results indicated a Content Validity Index of 0.91, and reliability coefficients provided evidence for internal consistency (Jeffreys & Dogan, 2013).

## Findings of Integrative Review

To further verify the use of the TSET, an integrative review of its use within nursing curricula was performed for this study. A literature search using online bibliographic databases including CINAHL Plus with Full Text, ProQuest Nursing & Allied Health Source, OVID, Web of Knowledge, and Google Scholar was completed to identify research studies using the TSET in nursing school settings (see Appendix D). The following keywords were identified and explored: TSE; transcultural self-efficacy tool; experimental design; quasi-experimental design; cultural competence; self-efficacy; teaching; and nursing education. Inclusion criteria for the review included any research

design or methodology measuring TSE; subjects who were students enrolled in nursing school, TSE measured using the TSET; and the article was published in English. The date of publication was not limited. Articles were excluded if they were not research reports or were not published in a peer-reviewed journal. Three hundred eighty-nine articles were identified initially. Of those, 385 did not meet the criteria for the purpose of the review. Four articles met the inclusion criteria and were selected for review.

A second, hand-search review method technique was applied. The reference lists of the four identified articles were reviewed. There were no additional articles identified that met the inclusion criteria. ProQuest Dissertations & Theses A & I yielded 20 dissertations, and four referred to TSE. Jeffreys' "Teaching Cultural Competence in Nursing and Health Care" (2010) identified a research report. The completed literature search yielded four journal articles, three dissertations, and one research report to be reviewed (see Appendix D). One of the dissertations referenced one of the already included research articles; therefore, seven studies were reviewed.

**Aim/purpose**. All seven of the studies included in the integrative review focused on nursing students' perceptions of their TSE following an educational intervention as measured by the TSET (see Appendix E). Study aims varied with different types of educational interventions. One-semester classroom interventions included case study methodology (Blackstock, 2003) or transcultural nursing course (Adams, 2012; Ferguson, 2007; Jeffreys & Dogan, 2012). Experiential educational interventions included SL (Amerson, 2010) or short term immersion (Larsen & Reif, 2011). Two studies compared and contrasted first and seventh semester students (Lim, Downie, & Nathan, 2004) and associate degree nurses (Jeffreys & Dogan, 2012).

**Method/design.** The Study Design and Implementation Assessment Device was used to appraise the studies (Cooper, 2010). A mixed-criteria approach was used to draw causal inferences regarding the effectiveness of formalized educational interventions on students' perceived TSE. The four levels used to determine effectiveness were fit between concepts and operations, clarity of causal inference, generality of findings, and precision of outcome estimation (Cooper, 2010).

The intervention studies reviewed for the analysis included quasi-experimental, pretest–posttest design (Adams, 2012; Amerson, 2010; Jeffreys & Dogan, 2012; Larsen & Reif, 2011), non-experimental correlational descriptive design (Blackstock, 2003; Lim et al., 2004), and a cross-sectional survey design (Ferguson, 2007). The Jeffreys and Dogan (2012) study employed a cross-sectional arm that included first and fourth semester students. The first semester students completed the TSET during fall 2007 or spring 2008 then again during the final six weeks of the spring 2009 or the fall 2009 semester. The first semester students on the cross-sectional study were aggregated into the longitudinal study.

In the Larsen and Reif (2011) study, both the experimental and control groups completed the TSET. The experimental group consisted of students who completed the TSET online one week prior then immediately after their immersion experience. The control group completed the TSET at the same time. Amerson's (2010) study administered the TSET at the beginning and completion of the semester. The students participated in an SL experience with local and international communities. The students who participated in the international experience self-selected. Adams and Nevel (2010) administered the TSET pretest–posttest to examine the influence of a transcultural

nursing course on BSN students' TSE during an academic semester. Teaching/learning interventions included lecture, discussion, brainstorming, videos, DVD, book review of *The Spirit Catches You and You Fall Down*, a cultural meal, and a guest speaker.

A non-experimental, correlational, descriptive design was implemented in two studies. Lim et al. (2004) assessed a convenience sample of first and fourth year pre-licensure nursing students in a western Australian university. First-year students had experiences limited to nursing theory and one observational clinical experience. The fourth-year students engaged in extensive theory in relation to holistic care, including transcultural nursing, with many clinical experiences in a variety of nursing contexts. Blackstock (2003) assessed senior-level nursing students enrolled in a community health home care experience at a historical black college in North Carolina. Ferguson (2007) implemented a cross-sectional survey design to determine the TSE of graduating seniors in central and northern areas of Illinois taking a National Council of Licensure Examination (NCLEX) review course. The types of intervention included classroom lecture, clinical, community setting, international setting, SL, and immersion experiences. The educational level of the students varied from those enrolled in first-semester nursing courses to those enrolled in nursing courses the final semester (see Appendix E).

Although each of the studies was quantitative, none was a true experimental design with randomization, control, and manipulation features. Each study used a non-randomized purposive sampling technique, which is a limitation of each of the studies. All of the research designs used primary and/or secondary analysis.

While each of the research studies contributed to the expansion of knowledge regarding the use of the TSET in nursing education, it is important to note the weaknesses

related to the study design. A quasi-experimental, pretest–posttest design is a practical approach in a clinical or educational setting. However, it is important to recognize that possible threats to internal validity may include testing, maturation, and mortality (Polit & Beck, 2012). A non-experimental correlational descriptive design was implemented for this study to help explain the characteristics of the relationships that exist among nursing students' didactic and clinical experiences during nursing school. A limitation to non-experimental correlational research is selection bias; therefore, studies are weak in the ability to support causal inferences (Polit & Beck, 2012). A cross-sectional survey design collected data regarding TSE at the time of NCLEX testing. The results would be beneficial if further research was completed after graduates completed a year of nursing practice; however, without this additional data, the findings from Lim et al. (2004) and Blackstock (2003) may be misleading or ambiguous (Polit & Beck, 2012).

**Sample/setting**. The sample population of the articles that met inclusion criteria consisted of nursing students. A majority of the samples consisted of students enrolled in associate degree nursing or BSN nursing programs (Adams, 2012; Amerson, 2010; Blackstock, 2003; Jeffreys & Dogan, 2012; Larsen & Reif, 2011; Lim et al., 2004). Ferguson (2007) examined graduated nursing students preparing to take the NCLEX. Four of the studies occurred in the U.S. (Adams, 2012; Blackstock, 2003; Ferguson, 2007; Jeffreys & Dogan, 2012), one in Australia (Lim et al., 2004), two multisite studies included Guatemala and the U.S. (Amerson, 2010), and one included Port Elizabeth, South Africa, and Juarez, Mexico, and the U.S. (Larsen & Reif, 2011). The sample sizes

ranged from 14 to 203 participants. Samples were all purposive or convenience. None were randomized, raising concerns about bias and, thus, limiting generalizability.

Age, gender, and race/ethnicity of the samples reported were representative of the nursing profession in the U.S. In all studies, the majority of the participants were female and under 30 years of age. The largest race/ethnicity group studied was White (Adams, 2012; Amerson, 2010; Ferguson, 2007; Jeffreys & Dogan, 2012; Lim et al., 2004). Blackstock (2003) reported 89% Black (non-Hispanic).

The results of studies based in the U.S., reflect the USDHHS survey, *The Registered Nurse Population* (2010). The percentage of RNs working full-time and under 30 years of age is more than 75%. In 2008, the racial and ethnic distribution of the RN population was 83.2% White non-Hispanic and 16.8% non-White or Hispanic. In 2008, 6.6% of all RNs were males. As reported in Chapter I, the dramatic demographic shift in the U.S. population is not reflected in the nursing workforce. While minority enrollment in nursing schools has improved, it has not increased sufficiently to reflect the diversity of the patient population. Moreover, nursing faculty from underrepresented groups are less than 10% (USDHHS, 2010).

Representativeness is a significant concern in quantitative research. In order for the results to be generalizable, the sample must accurately reflect the target population (Polit & Beck, 2012). The demographic results of the studies located were similar to the RN workforce population in regards to age, gender, and race/ethnicity. In order for researchers to achieve statistical conclusion validity, a power analysis can be used to estimate the sample size needed (Polit & Beck, 2012). The sample size ranged from 14 to

203 participants; studies with fewer participants risk greater sampling error (Polit & Beck, 2012).

**Interventions tested**. The interventions tested were formalized educational experiences that varied by study. Jeffreys and Dogan (2012) studied a cultural competence curriculum within an associate degree nursing program. Interventions included lecture, nursing skills lab, and clinical experiences. Larsen and Reif (2011) studied all students who participated in a course that covered content related to African American health, Native American health, and border culture, followed by 14 students (experimental group) completing an immersion experience in South Africa and 25 students not completing (control group) an immersion experience. The immersion experiences were two to three weeks in length and each student was exposed to the foreign culture along with healthcare issues and concerns experienced by the indigenous population. In Amerson's (2010) study, students participated in a project in Guatemala and worked with multidisciplinary teams as part of a medical mission in rural villages. Ferguson (2007) examined recent graduates from diploma, associate, or baccalaureate degree nursing programs enrolled in an NCLEX review course. Students were asked to identify different approaches to teaching cultural aspects of providing patient care.
Lim et al. (2004) compared a group of first-year students with limited nursing theory and one observational clinical with fourth-year students who had extensive theory in relation to holistic care and several clinical experiences. Blackstock's (2003) interventions included students enrolled in a community health nursing course who participated in a local SL project. All students completed a cultural assessment and developed a culturally appropriate plan of care. Students worked within the local community to interview key

informants to learn the emic view of healthcare issues within the community and worked with community leaders to develop a plan for education and implementation. Lastly, the Adams (2012) study included course content such as lecture, discussion, brainstorming, video, DVD, book review, and guest speakers. While these research articles concluded that formalized learning interventions do impact cultural competence of nursing students, the studies lacked rigor, standardization of the learning experience, and gender bias.

**Effectiveness of interventions**. The results of the studies reviewed support the conclusion that TSE is a dynamic construct that changes over time. The four quasi-experimental, pretest–posttest studies showed a trend toward the effectiveness of a formalized learning experience in the classroom, skills lab, and clinical experience (both domestic and international) in positively affecting students' perceptions of TSE (Adams, 2012; Amerson, 2010; Jeffreys & Dogan, 2012; Larsen & Reif, 2011). The study by Jeffreys and Dogan (2012) revealed a statistically significant difference on the Cognitive subscale $t(-1.97)$, $p < .05$ in the cross-sectional arm and statistically significant differences on all subscales in the longitudinal arm: Cognitive $t(5.32)$, $p < .05$; Practical $t(3.09)$, $p < .05$; and Affective $t(2.75)$, $p < .05$ (Appendix E). In the cross-sectional study, the semester in the program and previous healthcare experience were the two demographic factors that were significant predictors of TSE (Appendix E). Advanced students' scores were higher than that of novice students across all subscales in both the cross-sectional and longitudinal study.

Larsen and Reif (2011) found that students who participated in an immersion experience had significantly higher posttest TSET scores compared to the control group that did not participate in an immersion experience (Appendix E). Larsen and Reif (2011)

also identified a significant increase in each subscale score: Cognitive ($t(-3.44)$, $p < 0.001$); Practical ($t(-2.84)$, $p = 0.007$); and Affective ($t(-2.09)$, $p = 0.044$). The number of cultural selective courses had no correlation with pretest–posttest scores. The students who participated in the immersion experience had more confidence in their cognitive, practical, and affective cultural competence. These results indicated that the students' TSE increased following an immersion experience.

Amerson (2010) analyzed pretest–posttest sub-scale scores using a paired-samples *t*-test. An increase from pretest to posttest scores was identified. Cognitive ($t(-10.96)$, $p < .001$); Practical ($t(-8.03)$, $p < .001$); and Affective ($t(-5.40)$, $p < .001$). The results indicated that SL was an effective pedagogy for teaching cultural competence.

Adams (2012) found that nursing students' TSET scores changed significantly from pretest to posttest. An increase from pretest to posttest scores was identified. Cognitive ($t(-140.77)$, $p < .000$); Practical ($t(-11.47)$, $p < .000$); and Affective ($t(-9.54)$, $p < .000$). Students' knowledge and awareness of cultural issues in nursing were favorably influenced by the various teaching strategies.

Lim et al. (2004) found a significant difference on TSET between first and fourth year students: Cognitive ($t(-3.2)$, $p < 0.001$); Practical ($t(-2.7)$, $p < 0.008$); and Affective ($t(-2.1)$, $p < .04$). These findings suggested that a difference in the self-efficacy of first-year and fourth-year students existed, with the fourth-year students being more confident.

Blackstock (2003) used the TSET to measure students' level of confidence in their knowledge and understanding of the ways cultural factors may influence nursing care (Cognitive), conducted interviews with people who were culturally different in order

to learn about their values and beliefs (Practical), and rated nursing attitudes, beliefs, and values (Affective). The mean scores for Cognitive ($M$ = 170.45) and Practical ($M$ = 179.55) were similar. The mean score for the Affective subscale was higher ($M$ = 254.41). Overall, the students reported they were confident in delivering cultural care. It is important to note that 81.8% of the participants were African American. The results indicate that gender, marital status, age, race, previous educational degrees, and area where majority of life was spent were not significant contributors of any of the subscales.

The results of the inclusion studies substantiate that formalized learning interventions in the classroom, skills lab, and clinical experience do positively influence the development of nursing students' TSE over time. Cognitive, Practical, and Affective domains increased after cultural competence education. In addition, students reported TSE scores increased after an immersion experience.

**Other limitations of reviewed studies**. Sample size and lack of random selection in the studies reviewed created potential threats to validity. These studies focused on individual nursing program interventions and outcomes as a result of a formalized educational intervention. Sample sizes ranged from 6 to 203. The limited sample sizes were typically due to the number of students enrolled in a given nursing program or evaluated course.

Experimental mortality is another potential threat to validity. Some students who completed the TSET at the beginning of a nursing program or nursing course did not successfully complete the program or opted not to complete the TSET; therefore, their

results were eliminated from the studies, which could bias the findings of the studies reviewed.

Limitations of subjective instruments are widely discussed (Adams, 2012; Amerson, 2010; Blackstock, 2003; Ferguson, 2007; Jeffreys & Dogan, 2012; Larsen & Reif, 2011; Lim et al., 2004). The TSET is a self-reporting measurement and, as such, students may not respond truthfully about their perceptions and feelings regarding culturally/ethnically diverse patients. The results from the studies reviewed could be related to students' desire to answer "appropriately"—not necessarily honestly. It is recommended that the TSET be administered at the beginning of the nursing curriculum to establish baseline data of students' cultural competence prior to nursing education interventions.

**Review of CCCET-SV**. The CCCET-SV was adapted from the TSET (Jeffreys, 2010). The foundation of the TSET is students' perception of their knowledge; whereas, the CCCET-SV assesses the students' self-evaluation of clinical cultural competence. One study regarding the CCCT-SV was found—a pilot study to provide evidence of reliability and validity of the CCCT-SV (Jeffreys & Dogan, 2013).

The TSET and CCCET-SV are reliable and valid instruments designed to measure the influence of cultural competence on nursing students' perceived TSE. Both instruments have been applied to test formalized educational experiences. Previous study results support that TSE is a dynamic construct that changes over time. While the TSET and CCCET-SV have limitations such as being self-reporting measurements and student responses could be related to the students' desire to answer "appropriately," the instruments are effective measurements of TSE and can positively contribute to nurse

educators' understanding of the impact of cultural competence education in the classroom and clinical setting.

## State of the Science

The cultural evolution occurring within the U.S. is impacting healthcare professionals more than ever before. Culturally competent nursing care promotes patient satisfaction, treatment compliance, and overall patient outcomes. The first step to providing culturally competent care is to understand factors involved in the process of learning cultural competence. Confidence in learning or performing transcultural nursing skills, or TSE, is an influencing factor in identifying ways to increase cultural competence. The TSET is an instrument used by educators to assess a student's perceived TSE. The TSET also is used as a tool to determine the effectiveness of formalized learning interventions. Cultural competence is a multidimensional lifelong learning process that should thread throughout the nursing curricula.

## Conclusion

As a pedagogy, SL is not new in higher education or in nursing. Many disciplines have incorporated features of SL into their curricula after the Carnegie Commission on Higher Education (Mayhew, 1973) identified it as an effective teaching–learning concept. As the U.S. population continues to become more diverse, nursing students have a greater opportunity to experience intercultural SL around the corner as well as across the globe. The AACN (2008a) has expanded the essentials of nursing education to include cultural competence.

There are a variety of theoretical models and frameworks related to transcultural nursing and cultural competence. For this study, the researcher selected Jeffreys' Cultural Competence and Confidence Model (2010) as the theoretical framework because of its

educational underpinnings and incorporation of the construct of transcultural self-efficacy. The literature search results confirmed the use of TSET and CCCET-SV as the optimal instruments to study the impact of an intercultural SL experience, domestic or international, on pre-licensure nursing students' TSE.

This study used the TSET to identify inefficacious and supremely efficacious individuals (TSET scores of 1–2 and 9–10, respectively), the CCCET-SV to identify descriptive data regarding the clinical practicum concerning the presence of diversity and health disparity problems, and qualitative questions to gain insight of how the intercultural SL experience changes students' perception of nursing care and professional role. The results of the research will be used to develop strategies to facilitate learning, to guide teaching and inform education research, and to evaluate the effectiveness of an intercultural SL experience.

# CHAPTER III METHODOLOGY

This chapter provides information about the methodology for this study. Included herein are the statement of the problem, study design, sample, procedure, protection of human subjects, variables, and instruments. The chapter concludes with the research aims, hypotheses, and data analyses for each research question.

## Statement of the Problem

This research study examined the impact of an intercultural SL experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. The aim of the study was to test the research questions that relate to students' perceived TSE and clinical competence behaviors as a result of an intercultural SL experience. Variables were measured using the TSET (Jeffreys, 2010; Jeffreys & Dogan, 2012), the CCCET-SV (Jeffreys, 2010; Jeffreys & Dogan, 2013), a demographic questionnaire, and reflective journal responses. The goal of this study was to add to the body of knowledge in nursing education by examining the impact of an intercultural learning experience (domestic or international) on pre-licensure nursing students' perceived development of TSE.

## Study Design

This study used a comparison, non-equivalent group, quasi-experimental, pretest–posttest design to explore the impact of an intercultural SL experience on students' perceived TSE. The investigation was conducted at a Midwestern U.S. private university in a traditional BSN program within the context of a cultural competence curriculum which included an intercultural clinical learning experience. Students' perceived TSE was measured using the TSET and CCCET-SV. Subject scores on these tests were compared between and within the locale (domestic or international) of the

intercultural SL experience. Students self-selected the location of the intercultural SL experience—as a result, randomization was not possible.

## Sample

A convenience sample of senior nursing students enrolled in a private, faith-based, traditional BSN program was the purposive, target population for this research. The population was selected because the students recently had completed a required course in the curriculum that emphasized the value of human diversity and the application of knowledge of cultural, racial, socioeconomic, religious, and lifestyle variations to health-related situations. Typically the class enrollment in this program is approximately 30 students.

Using Lipsey (2002) power tables, a two-tailed testing using an $\alpha = .05$, $\beta = .20$, and effect size of .50, 65 students from each location (domestic or international) is needed for a robust sample. Due to the small sample size ($N = 30$) of students enrolled in a single class, two years of student data were included in the study ($N = 60$). Because the sample was a convenience sample of two cohorts, to ensure the results were valid and reliable for the two groups it was necessary to ensure homogeneity of variance. A nonparametric Levene *F* Test was used to determine homogeneity for the study. According to Nordstokke and Zumbo (2010), the nonparametric Levene *F* Test is more robust when testing for variance differences when samples are skewed and sample size unequal. Pretest and posttest scores from Cohort 2013 and Cohort 2014 are statistically similar enough to put Cohort 2013 and 2014 into one group (see Table 1).

Table 1

*Test of Homogeneity of Variances*

| Test Median | Levene Statistic | *df*1 | *df*2 | Significance |
|---|---|---|---|---|
| Pre_difference_median | .168 | 1 | 54 | .683 |
| Post_difference_median | .002 | 1 | 54 | .965 |

After verifying homogeneity of variance between samples from Cohort 2013 and Cohort 2014, the data was collapsed for aggregate analysis. This researcher has noted that sample means will be affected by extreme scores due to the small sample.

**Protection of Human Subjects**

Protection of the human subject participants in this study followed the Indiana University–Purdue University Indianapolis Institutional Review Board (IRB; see Appendix F) and Anderson (Indiana) University policies and procedures for exempt research. Students were given the opportunity to complete the TSET and CCCET-SV (pretest and posttest) during class time. Participation did not impact students' course grade. The role of the researcher was to analysis and report data.

**Study Procedure**

The SON administers the TSET and CCCET-SV to assess culturally congruent teaching–learning strategies that address students' diverse cultural values and beliefs. The purpose of the assessments is to develop a baseline of learners' needs, values, attitudes, and skills concerning transcultural nursing; to identify general transcultural skills perceived with more confidence and less confidence; to identify differences within groups and between groups; to identify at-risk individuals; to evaluate the effectiveness of specific teaching interventions; and to assess changes in TSE perceptions over time.

The results are used to support the achievement of expected individual student outcomes identified in course, unit, and/or program objectives.

Following IRB approval for exempt status for this study, informed consent was obtained from the students prior to their participation in the study (see Appendix G). Student consent was obtained for the purpose of the researcher's use of data collected for the course for research purposes and to collect demographic information simultaneously. During the consent process, participants were informed of the purpose of the study, the procedures of the study, and the risks and benefits of participation. Students were assured that confidentiality would be maintained, that their course instructor would not be informed of who did or did not participate, and that they could withdraw at any time without penalty. The students were told verbally that the TSET and CCCET-SV were assessments of how well the nursing curriculum and intercultural SL experiences were achieving the goal of teaching culturally competent nursing care to students. Further, they were assured their responses were not a reflection on their performance and would not affect their grade. After students signed the informed consent form (Appendix G), they separated it from the survey prior to submitting the completed documents. Sixty students were recruited for the study, and 60 students signed the informed consent form in agreement and separated it from the survey prior to submitting the completed document.

The researcher used a personal coding system to ensure anonymity and match questionnaires (see Appendix H). The principal investigator used double data entry to check for accuracy. The course instructor administered the pretest at the end of the fall semester after the conclusion of NURS 4470, before the students began NURS 4540. The

posttest was administered at the end of the spring semester following the intercultural SL (domestic or international) experience.

NURS 4470 Seminar in Nursing is a required four-credit lecture course offered the first semester of the senior year. Course objectives include identifying the universal characteristics of a culture; developing an awareness of similarities and differences in cultures; and analyzing the impact of culture on ethical/ legal issues affecting health care (see Appendix I). Course work consisted of classroom lecture, assigned readings, class participation, exam questions, and developing an intercultural healthcare study proposal. The proposal guidelines instructed students to include objectives; a description of the setting, cultural events, and interactions; a specific topic and review of literature; and the risks and benefits of the experience. The objectives related to cultural, topic, and personal goals to accomplish in the cultural setting. The setting of the intercultural SL experience was to be described in regards to place and people; students were required to describe the geography, history, political system, healthcare system, and economic environment of the intercultural location (domestic or international). The aspects related to people included customs, language, family structure, educational system, holidays, values, religious practices, health beliefs, morbidity/mortality patterns, average life expectancy, and other relevant health statistics.

In the project, students described how they would interact with people from the culture and indicated the events they hoped to attend and/or to participate in. Planned living arrangements were discussed, including the advantages and disadvantages of that environment. Each student identified an aspect of healthcare that aroused her/his

curiosity. A literature review that synthesized, compared, and contrasted nursing articles related to the topic of interest was completed prior to the intercultural SL experience.

Each student completed an action plan prior to the intercultural SL experience. The action plan included who, what, where, when, and with whom. Students identified questions they would ask related to the review of literature topic. They specified what observations they would make and the people with whom they would interact. An observation guide, survey, or other data collection instrument was required for the final paper. Students described the hazards or risks they believed they would experience entering the culture and the greatest benefit of the experience.

NURS 4540 Intercultural Health Care is a three-credit hour course offered the second semester of the senior year. Course objectives (see Appendix J) included:

- Developing an awareness of similarities and differences in culture;
- Identifying ways of assessing healthcare-related cultural characteristics through studying transcultural health assessment;
- Utilizing theoretical concepts related to cultural care, diversity, and universality;
- Examining the healthcare delivery system of another culture;
- Actively participating in an intercultural SL experience;
- Valuing the importance of sharing experiences with members of another culture;
- Analyzing the impact of culture on ethical/ legal issues affecting health care;

- Understanding the dynamic within and between professional, community, consumers, and political organizations in another cultural setting;
- Examining the application of concepts and theories of physical, social, behavioral sciences, and the liberal arts within another cultural setting;
- Comparing and contrasting spirituality practices in various cultures;
- Adapting health care to accommodate environmental factors and to enhance patient outcomes;
- Adapting communication skills to effectively interact with those of another culture;
- Demonstrating the ability to deliver evidenced based nursing care in a culturally sensitive manner;
- Adapting teaching/learning process to provide health care in another culture.

Course work consisted of classroom lecture, assigned readings, class participation, quizzes, exams, as well as a final paper generated from the proposal developed in NURS 4470, and a reflective journal.

Throughout the intercultural SL experience, each student kept a reflective journal that was submitted to the trip leader. The reflective journal was not a simple log of daily activities; the purpose of the reflective journal was to document feelings and reactions to experiences that occurred during the intercultural SL experience. As stated in Chapter II, incorporating reflection into learning allowed students to transfer theories to real experience, relate statistics to people and situations, and identify questions related to the

service experience. Intentional reflection on the specific experience provided students an opportunity to bridge the gap between theory and practice.

## Variables and Instruments

This study used a demographic data sheet (see Appendix K) and the self-reported TSET and CCCET-SV instruments to collect data for testing the hypothesis that the intervention would positively impact the development of TSE in nursing students who participated in an intercultural learning experience. Students were required to keep a reflective journal throughout the intercultural learning experience, which included responses to several semi-structured questions based on the setting and experience (see Appendix L). The responses to three specific questions—(1) How has the intercultural experience influenced students thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive); (2) How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical); and (3) How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition and advocacy? (Affective)—were reviewed for thematic content analysis.

### Demographic Data Sheet

Students completed a demographics data sheet (see Appendix K). Data gathered included current course enrolled in, age, gender, race/ethnicity, previous healthcare experiences, primary language, and birth country. Jeffreys (2010) recommended that researchers collect demographic data (1) to assess whether the sample is representative of the target population; (2) to compare and contrast TSE perceptions between samples; (3) to examine differences within groups; and (4) to substantiate the underlying

assumptions within the CCC model. The demographic data sheet was used for this study to assess the sample for representativeness of the target population, compare and contrast TSE perceptions between samples, and examine differences within groups.

**TSET**

The TSET is an 83-item questionnaire used to measure and evaluate a learner's confidence for performing general transcultural nursing skills among diverse populations. It contains three subscales: Cognitive, Practical, and Affective. The TSET was developed to evaluate and measure several TSE concepts. First, it establishes a baseline of nursing students' skills. Second, it identifies general transcultural skills students perceive they can perform with more or less confidence and whether they are inefficacious individuals or supremely efficacious individuals. Parallel changes in intercultural SL experience for both domestic and international travel would support that students do not need to travel across the globe to gain experience with caring for diverse patients (Jeffreys, 2010).

Respondents rated their individual level of confidence using a 10-point scale ranging from 1 (*not confident*) to 10 (*totally confident*). The Cognitive subscale asked respondents to rate how confident they are about their cultural knowledge of patients with different cultural backgrounds. The Practical subscale asked respondents to rate their confidence about interviewing patients of different cultural backgrounds to learn about their values and beliefs. The Affective subscale addressed values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy (Jeffreys, 2010).

The psychometric properties of the TSET have been identified by Jeffreys (2010). Content validity was established by six doctorally prepared nurses certified in

transcultural nursing. Construct validity was determined by a contrasted group approach and factor analysis. Criterion-related validity results indicate statistically significant differences in TSE perception between semesters. Cronbach's alpha was used to determine internal consistency and ranged from .92 to .98 (Jeffreys, 2010), indicating the questionnaire items correlate with each other and reflect the same concept. Stability was determined using test-retest with results ranging from .63 to .75, suggesting moderate stability (Jeffreys, 2010). The information obtained from the TSET was informative in answering the research questions 1, 2, and 3: (1) Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?; (2) Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?; and (3) Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?

**CCCET-SV**

The CCCET-SV is an 83-item questionnaire adapted from the TSET containing three subscales measuring different dimensions of clinical competence behaviors as perceived by students: Extent of culturally specific care (Subscale 1), Cultural assessment (Subscale 2), and Culturally sensitive and professionally appropriate attitudes, values, and beliefs including awareness, acceptance, recognition, appreciation, and advocacy necessary for providing culturally sensitive professional nursing care (Subscale 3). The

participants completed the CCCET-SV pretest (prior to the intercultural SL experience) and posttest (within two weeks after completing the intercultural SL experience). The CCCET-SV collected at posttest specifically reflected the intercultural SL experience.

The CCCET-SV used a 10-point response scale—Subscale 1 (Provision of culture-specific care): 1 (*Not at all*) to 10 (*Totally*); Subscale 2 (Cultural assessment): 1 (*Never*) to 10 (*Always*); and Subscale 3 (Cultural sensitivity): 1 (*Not at all*) to 10 (*To a great extent*). In addition, respondents had the option of selecting A (*Clinical area not available*) or B (*Diverse clients not available*). The CCCET-SV was used to identify areas of strengths, weaknesses, and gaps and to evaluate change following intercultural SL experience (Jeffreys & Dogan, 2013).

The psychometric properties of the CCCET-SV have been identified by Jeffreys (2010). Three content validity experts reviewed the CCCET-SV. The Content Validity Index was .091, indicating the experts found the items highly relevant and representative of the domain. Reliability (Cronbach's alpha) for the total CCCET-SV was 0.99, and each subscale ranged from 0.97 to 0.98 (Jeffreys, 2010). The data obtained from the CCCET-SV Subscale 3 was informative in answering research questions 4 and 5: (4) Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience?; and (5) Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)?

**Reflective Journal**

One method used by educators to foster learning is reflective journaling. Journaling is a transformative process that intentionally directs students to notice, interpret, respond, and reflect. This process of reflection develops critical thinking and self-understanding as students grow in and through their learning. "Learners need to have opportunities to tell their stories about events to meld experiential learning with theoretical learning" (Horton-Deutsch, Sherwood, & Armstrong, 2012, p. 169). The reflective journaling is used as a learning activity to guide students to develop self-analysis and increase awareness of their environment.

Students begin the journaling process on the first day of the trip. They are encouraged to chart their reflections on entering a culture unlike their own as well as to discuss their comfort level and anticipation of things to come. Journaling is completed daily while immersed in the culture. At the end of the trip students report a synopsis of the entire experience.

The journal is submitted as soon as the trip is over. Students are allowed to be candid in the journal as they are follow the guidelines. Students receive feedback on the journal for following the guidelines and submitting it on time. Freedom and openness is encouraged in the journaling process; therefore, the content is not assessed a score or grade. Three of the journal responses were analyzed at the macro level (domestic or international experience) and micro level (across the group) to answer research questions 6, 7, and 8: (6) How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive); (7) How has the intercultural experience influenced students' confidence in

interacting with culturally diverse patients to learn more about their values and beliefs? (Practical); and (8) How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition and advocacy? (Affective).

## Research Aims and Hypotheses

The aim of the study was to explore the impact of an intercultural learning experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. Five research questions were used to test the null hypotheses that there would be no difference in the perceived TSE of pre-licensure students in the students who traveled around the corner and the students who traveled across the globe:

1. Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?
2. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?
3. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?
4. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitude, values, and beliefs) following an intercultural SL experience?

5. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriates attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)?

Three qualitative questions were used to gain a greater understanding of how the intercultural SL experience impacted the students' understanding of cultural competence and their perception of nursing care and professional practice.

6. How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive)
7. How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)
8. How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)

**Data Analysis for Research Questions**

Descriptive and inferential statistics were used to determine pre-licensure nursing students' perceived TSE and the influence of an intercultural SL experience on students' perceived TSE. SPSS Version 22 was used for all data analysis. Before analysis began, frequencies were run on all survey questions to determine accuracy and consistency.

## Demographic Data

Demographic data were analyzed using descriptive statistics. The focus of the results describe, compare, and characterize the relationship of variables in the sample. Data were organized to clearly identify each variable: age, gender, race/ethnicity, previous health care experiences, primary language, the country of birth, and location of intercultural SL (domestic or international) experience.

## TSET

The reliability of the TSET was determined using Cronbach's alpha. Scores reflect Total TSET, Cognitive subscale, Practical subscale, and Affective subscale. Scores in the low range indicate inefficacious results in low confidence levels and lower persistence, motivation, and goal commitment. High scores indicate supremely high self-efficacy results in overconfidence and may indicate that the individual is unaware of weaknesses, overestimates abilities, and/or overrates strengths. Both ends of the continuum identify at-risk individuals (inefficacious or supremely efficacious), which may result in poor nursing outcomes causing culturally incongruent care. Individuals with low self-efficacy may avoid cultural assessments and supremely efficacious may not see the need to accommodate cultural tasks. The *t*-test results answer research questions 1, 2, and 3: (1) Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?; (2) Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?; and (3) Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure

BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?

**CCCET-SV**

CCCET-SV reliability was determined using Cronbach's alpha. Scores reflected a total CCCET-SV, Subscale 1 (Extent of culturally specific care), Subscale 2 (Cultural assessment), and Subscale 3 (Culturally sensitive and professionally appropriate attitudes, values, and beliefs including awareness, acceptance, recognition, appreciation, and advocacy necessary for providing culturally sensitive professional nursing care). The *t*-test results answer research questions 4 and 5: (4) Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience?; and (5) Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)?

**Reflective Journal**

Qualitative data analysis involves the breaking down of data gathering through coding procedures then looking at the emerging categories, themes, and pattern. The coding procedure for the analysis included (1) classifying the participants' responses into general categories, (2) grouping the sorted responses into evolving themes, and (3) reading the responses several times to clarify and identify themes (Merriam, 2009; Streubert-Speziale & Carpenter, 2003). The themes that emerged repeatedly became the

overarching themes. Analysis was conducted at both the micro level (domestic or international experience) and macro level (across the group) to answer research questions 6, 7, and 8: (6) How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive); (7) How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical); and (8) How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)

## Summary

This chapter described the methodology used in this research study. A detailed account of the participant recruitment and statistical methodology was provided. Each of the instruments used in the study—the TSET, CCCET-SV, and journal reflections—were described. The research plan including questions, instruments, data collection, and data analysis is summarized in Table 2. Results of the data analysis and implications for the research questions are presented in the following chapter.

Table 2

*Research Plan: Questions, Instruments, Data Collection, Data Analysis*

| Research Question | Instrument | Independent Variable | Dependent Variable | Data Analysis |
|---|---|---|---|---|
| 1. Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience? | TSET | Location (Categorical Variable) | Total TSET Post (Continuous Variable) | *t*-test groups |
| 2. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience? | TSET | Intercultural experience (Categorical Variable) | Pre-knowledge cognitive, pre-knowledge practical, pre-knowledge affective WITH post-knowledge cognitive, post-knowledge practical, post-knowledge affective (Continuous Variable) | *t*-test pairs |
| 3. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)? | TSET | Location (Categorical Variable) | Change scores cognitive, change scores practical, change scores affective (Continuous Variable) | *t*-test groups |

Table continues

| | | | | |
|---|---|---|---|---|
| 4. Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience? | CCCET-SV Subscale 3 | Intercultural experience (Categorical Variable) | Pre-practical Affective means WITH Post-practical Affective means (Continuous Variable) | *t*-test pairs |
| 5. Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)? | CCCET-SV Subscale 3 | Location (Categorical Variable) | Change score Practical Affective means (Continuous Variable) | *t*-test groups |
| 6. How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive) | Reflective journal | | | Content analysis |
| 7. How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical) | Reflective journal | | | Content analysis |
| 8. How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective) | Reflective journal | | | Content Analysis |

# CHAPTER IV FINDINGS

This exploratory, quasi-experimental, pretest–posttest study investigated the impact of an intercultural SL experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. Additionally, the study was designed to explore the association between selected students' demographics and their reported TSE. The purpose of this chapter is to present the statistical analysis of the data obtained from the pre-licensure BSN students using a demographic questionnaire, TSET, and CCCET-SV (Jeffreys, 2006). Five quantitative research questions were tested. Data were analyzed using SPSS version 22. Qualitative analyses of reflective journal responses are also presented.

## Sample Demographics

The sample was comprised of senior-semester nursing students enrolled in a private, faith-based, baccalaureate degree nursing program in the Midwest region of the U.S. Students were recruited over a two-year period. The 60 students who agreed to participate in the study were administered the demographic questionnaire, TSET, and CCCET-SV as a pretest after completion of NURS 4470 and again after completing an intercultural experience. The final sample for the study was 56 participants; one student did not complete the semester and three students were absent the day the posttest was administered.

The majority of the sample was Caucasian, U.S. born, and English-first language females under the age of 25. See Table 3 for specifics of the sample.

Table 3

*Study Participant Demographic Characteristics (N = 56)*

| Variable | | Frequency | Valid Percent |
|---|---|---|---|
| Gender | Female | 50 | 89.3 |
| | Male | 6 | 10.7 |
| Age | Under 25 | 47 | 83.9 |
| | 25–29 | 3 | 5.4 |
| | 30–34 | 2 | 3.6 |
| | 40–44 | 4 | 7.1 |
| Race/Ethnicity | Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai) | 1 | 1.8 |
| | Black/African American | 2 | 3.6 |
| | Hispanic/Latino | 1 | 1.8 |
| | White/Caucasian | 51 | 91.1 |
| | Multiracial | 1 | 1.8 |
| Is English your first language? | Yes | 53 | 94.6 |
| | No | 3 | 5.4 |
| Do you speak a language other than English fluently? | Yes | 7 | 12.5 |
| | No | 49 | 87.5 |
| Were you born in the United States? | Yes | 54 | 96.4 |
| | No | 2 | 3.6 |
| Previous healthcare experience | None | 35 | 62.5 |
| | CNA | 8 | 14.3 |
| | EMS | 2 | 3.6 |
| | Other | 11 | 19.6 |
| Location of intercultural experience | Domestic | 18 | 32.1 |
| | International | 38 | 67.9 |

**The TSET**

The TSET was used to measure and evaluate learners' confidence for performing general transcultural nursing skills among diverse populations. Cronbach's alpha was used to determine internal consistency. The range for this study was 0.913 to 0.986,

which is consistent with Jeffreys' (2010) results of 0.92 to 0.98. The pretest and posttest Cronbach's alpha are described in Table 4.

Table 4

*TSET Reliability (Cronbach's alpha)*

| Instrument | Pretest | Posttest |
|---|---|---|
| TSET Total | .985 | .970 |
| TSET Cognitive | .977 | .975 |
| TSET Practical | .986 | .913 |
| TSET Affective | .958 | .959 |

The TSET is calculated for a total score and three subscale scores: Cognitive, Practical, and Affective. The Cognitive Subscale measured the respondents' knowledge about cultural factors influencing nursing care. Respondents measured how confident they were when interviewing clients of different cultural backgrounds than themselves to learn about their values and beliefs in the Practical Subscale. The Affective Subscale measured the respondents' confidence in knowledge of self. The pretest data for the TSET total sample ($N = 56$, $M = 556.6$, $SD = 104.7$) depicts the baseline for all participants and is comprised of both the domestic group ($n = 18$, $M = 578.7$, $SD = 108.3$) and the international group ($n = 38$, $M = 546.1$, $SD = 102.7$). The posttest data for the TSET total sample ($N = 56$, $M = 677.2$, $SD = 84.6$) depicts scores after the intercultural SL experience for all participants and is comprised of both the domestic group ($n = 18$, $M = 679.1$, $SD = 95.7$) and the international group ($n = 38$, $M = 676.3$, $SD = 80.1$). Table 5 reports the descriptive statistics of the pre- and post-TEST (Total, Cognitive, Practical, and Affective) scores, including possible ranges for each outcome.

Table 5

*Descriptive Statistics for the TSET Total & Subscales: Cognitive, Practical, and Affective*

| Subscale | *N* | *M* | *SD* | Score Range | Upper 95% *M* | Lower 95% *M* |
|---|---|---|---|---|---|---|
| Cognitive | | | | 0–250 | | |
| Pretest | 56 | 152.4986 | 42.54934 | | 165.9683 | 142.1724 |
| Posttest | 56 | 185.6455 | 29.09283 | | 192.7752 | 178.1929 |
| Practical | | | | 0–280 | | |
| Pretest | 56 | 177.2876 | 45.79733 | | 189.4966 | 167.2987 |
| Posttest | 56 | 214.4479 | 38.30490 | | 224.6564 | 202.7115 |
| Affective | | | | 0–300 | | |
| Pretest | 56 | 226.8142 | 31.96116 | | 235.3090 | 220.2424 |
| Posttest | 56 | 252.8160 | 25.31936 | | 261.2918 | 246.5208 |
| Total | | | | 0–830 | | |
| Pretest | 56 | 556.6004 | 104.65994 | | 584.6285 | 528.5723 |
| Posttest | 56 | 677.1963 | 84.57933 | | 699.8467 | 654.5458 |

A composite score of each subscale created a self-efficacy strength score (Jeffreys, 2010). The self-efficacy strength score was used to determine changes over time, compare within groups, and compare demographic variables. Nursing students' composite subscale scores were higher than Jeffreys' respective subscales as presented in Table 6.

Table 6

*Nursing Students' Perceived Self-Efficacy Strength Scores: Pretest–posttest*

| Subscale | *M* |
|---|---|
| Cognitive Subscale | |
| Jeffreys Composite Score | 5.60 |
| Intercultural Experience Pretest | 6.29 |
| Intercultural Experience Posttest | 7.81 |

Table continues

| | |
|---|---|
| Practical Subscale | |
| Jeffreys Composite Score | 6.50 |
| Intercultural Experience Pretest | 7.34 |
| Intercultural Experience Posttest | 7.91 |
| Affective Subscale | |
| Jeffreys Composite Score | 7.0 |
| Intercultural Experience Pretest | 7.29 |
| Intercultural Experience Posttest | 8.71 |

Part I (Cognitive Subscale) of the TSET was used to measure how knowledgeable the students are about the ways cultural factors may influence nursing care. This subscale included health histories, interviews, physical examinations, informed consent, pain relief and comfort, diet and nutrition, and hygiene. The scores can range from 0 to 250. In this study, the pretest scores ranged from 53–225, with a mean score of 152.49. The posttest scores ranged from 120–240, with a mean score of 185.64. The scores were further categorized into Low (0–90), Medium (91–184), and High (185–250). These groups are included for descriptive purposes only and no inferences were drawn concerning them.

Part II (Practical Scale) of the TSET was used to measure how confident the students are about interviewing clients of different cultural backgrounds from their own to learn about their values and beliefs. This subscale included language preference, level of English comprehension, meaning of verbal communication, meaning of nonverbal behaviors, religious practices and beliefs, and ethnic food preferences. The scores can range from 0 to 280. The pretest scores ranged from 78–265, with a mean score of 177.28. The posttest scores ranged from 135–293, with a mean score of 252.81. The scores were further categorized into Low (0–101), Medium (102–206), and High (207–280).

Part III (Affective Subscale) of the TSET was used to measure how knowledgeable students are about themselves and clients of different cultural

backgrounds. The questions focus on awareness, acceptance, appreciation, recognition, and advocacy of clients of different cultural backgrounds than themselves. The subscale scores can range from 0 to 300. The pretest scores ranged from 164–276, with a mean score of 226.81. The posttest scores ranged from 189–290, with a mean score of 252.81. The scores were further categorized into Low (0–101), Medium (10– 206), and High (207–280); all pretest and posttest scores are reflected in Table 7.

Table 7

*TSET Range (N = 56)*

| Subscale | Low (Inefficacious) Number of responses(%) | Medium Number of responses(%) | High (Supremely Efficacious) Number of responses(%) |
|---|---|---|---|
| Cognitive | 0–90 | 91–184 | 185–250 |
| Pretest | 4(7.1%) | 35(71.4%) | 16(21.5%) |
| Posttest | 0(0%) | 29(51.8%) | 27(48.2%) |
| Practical | 0–101 | 102–206 | 207–280 |
| Pretest | 3(5.4%) | 37(71.4%) | 16(23.2%) |
| Posttest | 0(0%) | 19(33.9%) | 37(66.1) |
| Affective | 0–108 | 109–221 | 222–300 |
| Pretest | 0(0%) | 22(39.3%) | 34(60.7%) |
| Posttest | 0(0%) | 8(14.3%) | 48(85.7%) |

**The CCCET-SV**

The CCCET-SV was used to measure and evaluate learners' cultural competence in the clinical practicum. Cronbach's alpha was used to determine internal consistency. The range was from 0.973 to 0.987, which is consistent with Jeffreys' and Dogan's (2012) results of 0.97 to 0.98. Due to a large number of A (*Area not available*) and B (*Diverse clients not available*) responses, the actual number of valid cases [CCCET-SV Total: Pre *n* = 13 (23.2%), Post *n* = 18 (32.1%); Subscale 1: Pre *n* = 14 (25%), Post *n* = 22 (39.3%); Subscale 2: Pre *n* = 20 (35.7%), Post *n* = 36 (64.3%); Subscale 3:

Pre $n$ = 13 (23.2%), Post $n$ = 51 (91.1%)] entered into the reliability analysis was low. The A and B responses are important from a curricular standpoint because these responses provide information that can help SON to evaluate clinical experiences and offer insight into clinical practicum changes. The pretest–posttest Cronbach's alphas are described in Table 8.

Table 8

*CCCET-SV Reliability (Cronbach's alpha)*

| Instrument | Pretest | Posttest |
|---|---|---|
| CCCET-SV Total | .986 | .987 |
| CCCET-SV Subscale 1 | .979 | .980 |
| CCCET-SV Subscale 2 | .984 | .973 |
| CCCET-SV Subscale 3 | .982 | .977 |

The CCCET-SV was used to explore the following: To what extent is culturally specific care provided by students during the clinical practicum and during an intercultural SL experience? Which cultural assessments are implemented more frequently and less frequently during the clinical practicum and intercultural SL experiences? To what extent do culturally sensitive and professionally appropriate attitudes, values, or beliefs change during the clinical practicum and intercultural SL experience? Subscale 1 was examined to answer to what extent is culturally specific care provided by students during the clinical practicum and during an intercultural SL experience. Responses ranged from 1 (*Not at all*) to 10 (*Totally*). The following tables present the rank ordering for the five highest ranking items and the five lowest ranking items in the clinical practicum (Pretest; Table 9) and intercultural SL experience (Posttest; Table 10). Most frequently, during the clinical practicum culturally specific care was provided for pain and relief and during the intercultural SL experience for

physical examination. During the clinical practicum culturally specific care was provided least with regard to life support and resuscitation and during the intercultural experience for informed consent.

Table 9

*CCCET-SV PreSubscale 1: Most Frequently and Least Frequently Provided Culturally Specific Nursing Care, Ranked Ordered by Means (Five Highest/Five Lowest) and Select Item Responses (N = 56)*

| Rank | Items | *M* | *SD* | *n*(%)(A)[a] [Clinical] | *n*(%)(B)[b] [Diverse] | *n*(%)(1) Not at all | *n*(%)(10) Totally |
|---|---|---|---|---|---|---|---|
| 5 Highest Items (Most Frequently Provided) | | | | | | | |
| 1 | Pain & relief | 6.36 | 2.477 | 1(1.8) | 12(1.4) | 1(1.8) | 4(7.1) |
| 2 | Safety | 6.15 | 2.591 | 4(7.1) | 13(23.2) | 1(1.8) | 4(7.1) |
| 3 | Patient teaching | 6.14 | 2.381 | 2(2.6) | 15(26.8) | 1(1.8) | 3(5.4) |
| 4 | Hygiene | 6.08 | 2.377 | 2(3.6) | 15(26.8) | 1(1.8) | 3(5.4) |
| 5 | Pregnancy | 6.00 | 3.094 | 6(10.7) | 14(25) | 3(5.4) | 4(7.1) |
| 5 | Birth | 6.00 | 2.787 | 5(8.9) | 15(26.8) | 4(7.1) | 3(5.4) |
| 5 Lowest Items (Most Frequently Provided) | | | | | | | |
| 1 | Life support & resuscitation | 3.42 | 2.948 | 18(32.1) | 14(25) | 11(19.6) | 1(1.8) |
| 2 | Sexuality | 3.70 | 3.010 | 17(30.4) | 12(21.4) | 11(19.6) | 0(0) |
| 3 | Diagnostic tests | 4.57 | 2.924 | 12(21.4) | 14(25) | 8(14.3) | 0(0) |
| 4 | Grieving & loss | 4.61 | 3.201 | 15(26.8) | 13(23.2) | 7(12.5) | 0(0) |
| 5 | Dying & death | 4.71 | 3.041 | 14(25) | 13(23.2) | 8(14.3) | 0(0) |

[a]Are not available. [b]Client not available.

Table 10

*CCCET-SV PostSubscale 1: Specific Nursing Care, Ranked Ordered by Means (Five highest/Five lowest) and Select Item Responses (N = 56)*

| Rank | Items | *M* | *SD* | *n*(%)(A)[a] [Clinical] | *n*(%)(B)[b] [Diverse] | *n*(%)(1) Not at all | *n*(%)(10) Totally |
|---|---|---|---|---|---|---|---|
| 5 Highest Items (Most Frequently Provided) | | | | | | | |
| 1 | Physical examination | 7.91 | 2.348 | 7(12.5) | 2(3.6) | 2(3.6) | 14(25) |
| 2 | Pain relief & comfort | 7.60 | 2.517 | 7(12.5) | 2(3.6) | 2(3.6) | 14(25) |
| 3 | Diet & nutrition | 7.32 | 2.165 | 11(19.6) | 1(1.8) | 0(0) | 8(14.3) |
| 4 | Patient teaching | 7.21 | 2.620 | 8(14.3) | 1(1.8) | 2(3.6) | 11(19.6) |
| 5 | Health history | 7.19 | 2.598 | 5(8.9) | 3(5.4) | 2(3.6) | 10(17.9) |
| 5 Lowest Items (Least Frequently Provided) | | | | | | | |
| 1 | Informed consent | 4.86 | 3.155 | 16(28.6) | 2(3.6) | 10(17.9) | 4(7.1) |
| 2 | Grieving & loss | 5.33 | 2.966 | 17(30.4) | 13(23.2) | 5(8.9) | 5(8.9) |
| 3 | Life support & resuscitation | 5.41 | 2.982 | 17(30.4) | 12(21.4) | 6(10.7) | 4(7.1) |
| 4 | Dying & death | 5.54 | 2.883 | 17(30.4) | 3(5.4) | 6(10.7) | 5(8.9) |
| 5 | Rest & sleep | 5.78 | 2.904 | 14(25) | 2(3.6) | 5(8.9) | 6(10.7) |

[a]Are not available. [b]Client not available.

Tables 11 and 12 provide information for determining the five cultural assessments most frequently and least frequently implemented during the clinical practicum (Pretest; Table 11) and intercultural SL experience (Posttest; Table 12). The most frequently conducted cultural assessment for the clinical practicum was racial background and identity; the intercultural SL experience was religious practices and

beliefs. The least frequent cultural assessment was world view (philosophy of life) for the clinical practicum and aging for the intercultural experience.

Table 11

*CCCET-SV PreSubscale 2: Most and Least Frequently Performed Cultural Assessments, Rank Ordered by Item Means (Five Highest/Five Lowest) and Select Item Responses (N = 56)*

| 5 Highest Mean Items (Most Frequently Assessed) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rank | Items | *M* | *SD* | *n* (%) (A)[a] [Clinical] | *n* (%) (B)[b] [Diverse] | *n* (%) 1 (*Not at all*) | *n* (%) 10 (*Totally*) |
| 1 | Racial background & identity | 5.37 | 2.954 | 6(10.7) | 12(21.4) | 5(8.9) | 4(7.1) |
| 2 | Level of English comprehension | 5.06 | 2.9 | 7(12.5) | 14(25) | 4(7.1) | 4(7.1) |
| 3 | Ethnic background & identity | 5.03 | 2.795 | 6(10.7) | 12(21.4) | 5(8.9) | 2(3.6) |
| 4 | Socioeconomic background | 4.92 | 2.689 | 6(10.7) | 11(19.6) | 5(8.9) | 2(3.6) |
| 5 | Language preference | 4.82 | 3.117 | 8(14.3) | 15(26.8) | 6(10.7) | 5(8.9) |
| 5 Lowest Mean Items (Least Frequently Provided) | | | | | | | |
| 1 | World view (philosophy of life) | 3.00 | 2.550 | 10(17.9) | 12(21.4) | 13(23.2) | 1(1.8) |
| 2 | Role of elders | 3.23 | 2.418 | 12(21.4) | 13(23.2) | 13(23.2) | 0(0) |
| 3 | Folk medicine tradition & use | 3.26 | 2.569 | 13(23.2) | 12(21.4) | 11(19.6) | 1(1.8) |
| 4 | Ethnic food preferences | 3.50 | 2.828 | 11(19.6) | 13(23.2) | 13(23.2) | 1(1.8) |
| 5 | Role of children | 3.53 | 2.782 | 10(17.9) | 13(23.2) | 13(23.2) | 1(1.8) |

[a]Are not available. [b]Client not available.

Table 12

*CCCET-SV PostSubscale 2: Most and Least Frequently Performed Cultural Assessments, Rank Ordered by Item Means (Five highest/Five Lowest) and Select Item Responses (N = 56)*

| 5 Highest Mean Items (Most frequently assessed) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rank | Items | *M* | *SD* | *n* (%) (A)[a] [Clinical] | *n* (%) (B)[b] [Diverse] | *n* (%) 1 (*Not at all*) | *n*(%) 10 (*Totally*) |
| 1 | Religious practices & beliefs | 7.44 | 2.296 | 6(10.7) | 2(3.6) | 1(1.8) | 11(19.6) |
| 2 | Religious background & identity | 7.22 | 2.361 | 3(5.4) | 2(3.6) | 0(0) | 12(21.4) |
| 3 | Traditional health & illness beliefs | 7.12 | 2.214 | 5(8.9) | 2(3.6) | 0(0) | 9(16.1) |
| 4 | Ethnic background & identity | 7.06 | 2.170 | 4(7.1) | 2(3.6) | 1(1.8) | 12(21.4) |
| 5 | Ethnic food preferences | 6.96 | 2.758 | 5(8.9) | 4(7.1) | 4(7.1) | 12(21.4) |
| 5 Lowest Mean Items (Least frequently provided) | | | | | | | |
| 1 | Aging | 5.87 | 2.576 | 6(10.7) | 3(5.4) | 2(3.6) | 4(7.1) |
| 2 | Role of elders | 5.89 | 2.604 | 6(10.7) | 5(8.9) | 4(7.1) | 5(8.9) |
| 3 | Role of children | 5.91 | 2.687 | 5(8.9) | 5(8.9) | 5(8.9) | 5(8.9) |
| 4 | Financial concerns | 5.94 | 2.719 | 5(8.9) | 2(3.6) | 6(10.7) | 5(8.9) |
| 5 | Acceptable sick role behavior | 5.96 | 2.689 | 6(10.7) | 2(3.6) | 4(7.1) | 6(10.7) |

[a]Are not available. [b]Client not available.

Tables 13 and 14 depict information for determining the extent to which culturally sensitive and professionally appropriate attitudes, values, or beliefs changed during the clinical practicum (Pretest; Table 13) and the intercultural SL experience (Posttest; Table 14). Client's/patient's decisions based on cultural beliefs ranked highest for the clinical practicum and the intercultural SL experience. Least change was reported for importance of home remedies and folk medicine for the clinical practicum and intercultural SL experience.

Table 13

*CCCET-SV PreSubscale 3: Change in Attitudes, Values, and Beliefs, Rank Ordered by Item Means (Five highest/Five lowest) and Select Item Responses (N = 56)*

| Top 5 Items with the Highest Means (Most Changed) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rank | Items | *M* | *SD* | *n*(%) (A)[a] [Clinical] | *n*(%) (B)[b] [Diverse] | *n*(%) 1 (*Not at all*) | *n*(%) 10 (*Great extent*) |
| 1 | Client's/ patient's decisions based on cultural beliefs | 7.94 | 2.214 | 0(0) | 0(0) | 1(1.8) | 16(28.6) |
| 2 | Need to prevent cultural imposition | 7.88 | 2.221 | 0(0) | 0(0) | 1(1.8) | 16(28.6) |
| 3 | Culture-specific care | 7.86 | 2.483 | 0(0) | 0(0) | 1(1.8) | 17(30.4) |
| 4 | Cultural sensitivity & awareness | 7.80 | 2.334 | 0(0) | 0(0) | 0(0) | 15(26.8) |
| 5 | Interaction with people of different cultures | 7.78 | 2.200 | 0(0) | 0(0) | 0(0) | 14(25) |

Table continues

| Top 5 Items with the Lowest Means (Least Changed) | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | Importance of home remedies & folk medicine | 5.77 | 2.564 | 0(0) | 0(0) | 2(3.6) | 4(7.1) |
| 2 | Impact of political factors on health care practices | 6.27 | 2.430 | 0(0) | 0(0) | 3(5.4) | 4(7.1) |
| 2 | Interaction between nursing, folk, & professional systems | 6.27 | 2.368 | 0(0) | 0(0) | 2(3.6) | 3(5.4) |
| 3 | Traditional caring behaviors | 6.36 | 2.409 | 0(0) | 0(0) | 3(5.4) | 2(3.6) |
| 4 | Differences in perceived role of the nurse | 6.44 | 2.5 | 0(0) | 0(0) | 3(5.4) | 4(7.1) |
| 5 | Impact of roles on health care practices | 6.61 | 2.197 | 0(0) | 0(0) | 1(1.8) | 3(5.4) |

[a]Are not available. [b]Client not available.

Table 14

*CCET-SV PostSubscale 3: Change in Attitudes, Values, and Beliefs, Rank Ordered by Item Means (Five highest/Five lowest) and Select Item Responses (N = 56)*

Top 5 items with the Highest Means (Most Changed)

| Rank | Items | *M* | *SD* | *n*(%) (A)[a] [Clinical] | *n*(%) (B)[b] [Diverse] | *n*(%) 1 (*Not at all*) | *n*(%) 10 (*Great extent*) |
|---|---|---|---|---|---|---|---|
| 1 | Client's/ patient's decisions based on cultural beliefs | 9.13 | 1.674 | 0(0) | 0(0) | 0(0) | 33(58.9) |
| 2 | Culture specific care | 9.11 | 1.702 | 0(0) | 0(0) | 0(0) | 34(60.7) |
| 3 | Cultural sensitivity and awareness | 9.07 | 1.582 | 0(0) | 0(0) | 0(0) | 32(57.1) |
| 3 | Interaction with people of different cultures | 9.07 | 1.620 | 0(0) | 0(0) | 0(0) | 31(55.4) |
| 4 | Cultural-specific health care | 8.98 | 1.624 | 0(0) | 0(0) | 0(0) | 33(58.9) |
| 5 | Need to prevent cultural imposition | 8.91 | 1.730 | 0(0) | 0(0) | 0(0) | 28(50) |
| 5 | Need to prevent ethnocentric views | 8.91 | 1.632 | 0(0) | 0(0) | 0(0) | 27(48.2) |

Table continues

| Top 5 Items with the Lowest Means (Least Changed) | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | Importance of home remedies & folk medicine | 7.58 | 2.105 | 0(0) | 0(0) | 0(0) | 14(25) |
| 2 | Client's refusal of treatment based on beliefs | 7.89 | 1.988 | 0(0) | 0(0) | 0(0) | 17(30.4) |
| 3 | Impact of roles on health care practices | 7.93 | 1.757 | 0(0) | 0(0) | 0(0) | 13(23.2) |
| 4 | Inadequacies in the U.S. health care system | 8.07 | 1.934 | 0(0) | 0(0) | 0(0) | 18(32.1) |
| 5 | Impact of political factors on health care practices | 8.16 | 1.844 | 0(0) | 0(0) | 0(0) | 18(32.1) |

[a]Are not available. [b]Client not available.

Table 15 presents the comparison of responses to B (*Diverse client not available*). Pretest responses to B (*Diverse client not available*) ranged from 12.5% to 26.8%. In comparison, the posttest responses ranged from 0% to 10.7%. The intercultural SL experience provided an opportunity for the nursing students to perform general transcultural nursing skills among diverse populations.

Table 15

*Comparison of Pretest–Posttest Response B (Diverse Client Not Available)*

| Question Description | Pretest B-Diverse Client Not Available *n*(%) | Posttest B-Diverse Client Not Available *n*(%) |
|---|---|---|
| Pre health history | 13(23.3) | 3(5.4) |
| Physical examination | 12(21.4) | 2(3.6) |
| Informed consent | 11(19.6) | 2(3.6) |
| Health promotion | 12(21.4) | 3(5.4) |
| Illness prevention | 12(23.2) | 3(5.4) |
| Health maintenance | 12(21.4) | 3(5.4) |
| Health restoration | 12(21.4) | 3(5.4) |
| Safety | 13(23.2) | 3(5.4) |
| Exercise & activity | 12(21.4) | 2(3.6) |
| Pain relief & comfort | 12(23.2) | 2(3.6) |
| Diet and nutrition | 15(26.8) | 1(1.8) |
| Patient teaching | 15(26.8) | 1(1.8) |
| Hygiene | 15(26.8) | 1(1.8) |
| Anxiety & stress reduction | 14(25) | 3(5.4) |
| Diagnostic tests | 14(25) | 3(5.4) |
| Blood tests | 12(21.4) | 3(5.4) |
| Pregnancy | 14(25) | 3(5.4) |
| Birth | 15(26.8) | 3(5.4) |
| Growth & development | 11(19.6) | 2(3.6) |
| Aging | 12(21.4) | 2(3.6) |
| Dying & death | 13(23.2) | 3(5.4) |
| Grieving & loss | 13(23.2) | 3(5.4) |
| Life support & resuscitation | 14(25) | 3(5.4) |
| Sexuality | 12(21.4) | 2(3.6) |
| Rest & sleep | 11(19.6) | 2(3.6) |
| Language preference | 15(26.8) | 6(10.7) |
| Level of English comprehension | 14(25.0) | 5(8.9) |
| Meaning of verbal communication patterns | 13(23.2) | 3(5.4) |
| Meaning of nonverbal behaviors | 14(25.0) | 4(7.1) |
| Meaning of space & touch | 14(25.0) | 4(7.1) |

Table continues

| | | |
|---|---|---|
| Time perception & orientation | 14(25.0) | 4(7.1) |
| Racial background & identity | 12(21.4) | 3(5.4) |
| Ethnic background & identity | 12(21.4) | 3(5.4) |
| Socioeconomic background | 11(19.6) | 2(3.6) |
| Religious background & identity | 12)21.4) | 2(3.6) |
| Educational background & interests | 13)23.2) | 2(3.6) |
| Religious practices & beliefs | 12(21.4) | 2(3.6) |
| Acculturation | 13(23.2) | 4(7.1) |
| World view (philosophy of life) | 12(21.4) | 3(5.4) |
| Attitudes about healthcare technology | 13(23.2) | 3(5.4) |
| Ethnic food preferences | 13(23.2) | 4(7.1) |
| Role of elders | 13(23.2) | 5(8.9) |
| Role of children | 13(23.2) | 5(8.9) |
| Financial concerns | 13(23.2) | 2(3.6) |
| Traditional health & illness beliefs | 11(19.6) | 4(7.1) |
| Folk medicine tradition & use | 12(21.4) | 3(5.4) |
| Gender role & responsibility | 12(21.4) | 2(3.6) |
| Acceptable sick role behaviors | 10(17.9) | 2(3.6) |
| Role of family during illness | 10(17.9) | 5(8.9) |
| Discrimination & bias experiences | 10(17.9) | 4(7.1) |
| Home environment | 11(19.6) | 2(3.6) |
| Kinship ties | 10(17.9) | 4(7.1) |
| Aging | 10(17.9) | 3(5.4) |
| Insensitive and prejudicial treatment | 8(14.3) | 0(0) |
| Differences in perceived role of the nurse | 7 (12.5) | 0(0) |
| Traditional caring behaviors | 7(12.5) | 0(0) |
| Professional caring behaviors | 7(12.5) | 0(0) |
| Comfort and discomfort felt when entering a culturally different world | 8(14.3) | 0(0) |
| Interaction between nursing, folk, and professional systems | 10(17.9) | 0(0) |
| Differences between cultural groups | 8(14.3) | 0(0) |
| Similarities between cultural groups | 8(14.3) | 0(0) |
| Client's refusal of treatment based on beliefs | 10(17.9) | 0(0) |
| Interaction with people of different cultures | 9(16.1) | 0(0) |
| Cultural sensitivity and awareness | 9(16.1) | 0(0) |

Table continues

| | | |
|---|---|---|
| Cultural-specific healthcare | 8(14.3) | 0(0) |
| Role of family in providing healthcare | 9(16.1) | 0(0) |
| Client's world view (philosophy of life) | 9(16.1) | 0(0) |
| Inadequacies in the U.S. healthcare system | 8(14.3) | 0(0) |
| Importance of home remedies & folk medicine | 8(14.3) | 0(0) |
| Impact of roles on healthcare practices | 7(12.5) | 0(0) |
| Impact of values on healthcare practices | 7(12.5) | 0(0) |
| Impact of socioeconomic factors on healthcare practices | 8(14.3) | 0(0) |
| Impact of political factors on healthcare practices | 8(14.3) | 0(0) |
| Need for cultural care preservation/ maintenance | 8(14.3) | 0(0) |
| Need for cultural care accommodations/negotiation | 8(14.3) | 0(0) |
| Need for cultural care repatterning/restructuring | 8(14.3) | 0(0) |
| Need to prevent ethnocentric views | 7(12.5) | 0(0) |
| Need to prevent cultural imposition | 7(12.5) | 0(0) |
| Client's decisions based on cultural beliefs | 7(12.5) | 0(0) |
| Culture-specific care | 7(12.5) | 0(0) |

## Reflective Journaling

Students were required to keep a reflective journal during the intercultural SL experience. The goal of reflective journaling is to help students gain self-awareness, improve personal growth, and increase critical thinking (Billings & Halstead, 2012; Horton-Deutsch et al., 2012). Reflection furthers thinking and awareness that can change practice. Three reflective questions were based on Jeffreys' (2010) cultural competence and confidence model for learning dimensions of cultural competence: Cognitive,

Practical, and Affective. Content from each learning dimension was analyzed to identify subthemes (Polit & Beck, 2012).

After analysis of the TSET and CCCET-SV results from the first year of data, the researcher wanted to gain a greater understanding of the impact of an intercultural experience as described by students. To gain this insight, the research included the reflective journal responses from the second-year participants. Responses were reread several times to decide the most appropriate code for each subtheme (Merriam, 2009; Streubert-Speziale & Carpenter, 2003). Analysis was conducted at both the macro level and micro level.

## Testing of Research Questions

### Research Question 1

Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?

Nursing students' TSE was determined by using the posttest TSET composite scores. In order to compare scores between pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience an independent samples *t*-test was conducted. The dependent variable (continuous) was the total composite of the TSET posttest. The independent variable (Categorical-2 categories) was the location (domestic or international). The Levene's Test for Equality of Variances ($F = 1.294$, $p = .260$) suggested the variances are roughly equal and the assumption of homogeneity of variance is tenable. This test was not found to be statistically significant, $t(54) = .116$, $p = .908$. The results suggest that students who

traveled domestically compared to the students who traveled internationally were not statistically significantly different in their perceived TSE at posttest (Table 16).

Table 16

*t-Test Total TSET Posttest and Location (N = 56)*

| Location of trip | *n* | *M* | *SD* |
|---|---|---|---|
| Domestic | 18 | 679.111 | 95.74715 |
| International | 38 | 676.2892 | 80.11924 |

Levene's Test for Equality of Variance *t*-test for Equality of Means

| *F* | *Sig.* | *df* | Sig. (2-tailed) | Mean Difference |
|---|---|---|---|---|
| 1.294 | .260 | 54 | .908 | 2.82190 |

**Research Question 2**

Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?

A paired samples *t*-test was performed to determine if there was a difference from pretest to posttest scores for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience. This test was found to have a statistically significant increase in posttest scores for all three dimensions: Cognitive $t(55) = -6.634$, $p = .000$; Practical $t(55) = -2.633$, $p = .011$; Affective $t(55) = -6.940$, $p = .000$. The effect size for this analysis was found to exceed Cohen's convention for a large effect for the Cognitive ($d = .99$) and Affective ($d = .97$). The Cohen's $d$ for the Practical score was a medium effect ($d = .41$). The results suggest that students' perceived Cognitive (Pretest $M = 6.2936$, $SD = 1.73524$; Posttest $M = 7.8159$, $SD = 1.27931$), Practical (Pretest $M = 7.3422$, $SD = 1.42815$; Posttest

*M* = 7.9187, *SD* = 1.31588), and Affective (Pretest *M* = 7.2985, *SD* = 1.86268; Posttest *M* = 8.7190, *SD* = .86753) increased significantly for students in both the domestic and international SL groups (Table 17).

Table 17

*Pretest and Posttest Subscale Scores (N = 56)*

| Subscale | Pretest–Posttest | *M* | *SD* | *t* | *d* | Sig. (2-tailed) |
|---|---|---|---|---|---|---|
| Cognitive | Pre | 6.2936 | 1.73524 | -6.634 | 55 | .000 |
| | Post | 7.8159 | 1.27931 | | | |
| Practical | Pre | 7.3422 | 1.42815 | -2.633 | 55 | .011 |
| | Post | 7.9187 | 1.31588 | | | |
| Affective | Pre | 7.2985 | 1.86268 | -6.940 | 55 | .00 |
| | Post | 8.7190 | .86753 | | | |

**Research Question 3**

Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?

In order to compare change scores for pre-licensure BSN students' perceived Cognitive, Practical, and Affective dimensions based on the type of intercultural SL experience (domestic or international) an independent samples *t*-test was conducted. The Levene's Test for Equality of Variances (Cognitive: *F* = 0.20, *p* = .888; Practical: *F* = 1.965, *p* = .167; Affective: *F* = .20, *p* = .650) suggested the variances are roughly equal and the assumption of homogeneity of variance is tenable. The Cognitive change score *t*(54) = -.356, *p* = .723 and Affective change score *t*(54) = -.903, *p* = .371 were not found to be statistically significant. However, the Practical change scores *t*(54) = -2.548, *p* = .014 did reach statistical significance. The results indicate that

students' change scores in the Cognitive and Affective dimensions were not significantly different between groups; however, the Practical dimension was significantly different between groups (Table 18).

Table 18

*Cognitive, Practical, and Affective Change Scores with Location (N = 56)*

| Subscale | Subscale | *n* | *M* | *SD* |
|---|---|---|---|---|
| Cognitive | Domestic | 18 | 1.3884 | 1.77293 |
| | International | 38 | 1.5659 | 1.72939 |
| Practical | Domestic | 18 | -.1970 | 1.28345 |
| | International | 38 | .9421 | 1.67486 |
| Affective | Domestic | 18 | 1.1514 | 1.52942 |
| | International | 38 | 1.5477 | 1.53635 |

| Subscale | *t* | *df* | Sig. (2-tailed) | Mean Difference |
|---|---|---|---|---|
| Change score Cognitive | -.356 | 54 | .723 | -.17754 |
| Change score Practical | -2.548 | 54 | .014 | -1.13916 |
| Change score Affective | -.903 | 54 | .371 | -.39629 |

**Research Question 4**

Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience?

A paired samples *t*-test was performed to determine if there is a difference from pretest to posttest scores for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience. Students were found to have a statistically significant increase in posttest scores for subscale 3: $t(53) = -3.212$, $p = .002$.

The effect size for this analysis was a medium effect (*d* = .419). The results suggest that students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) increased for students in both domestic and international SL groups (Table 19).

Table 19

*CCCET-SV Pretest and Posttest Subscale C: Clinical Competence Behavior Scores (N = 56)*

| Subscale | *M* | *SD* | *t* | *d* | Sig. (2-tailed) |
|---|---|---|---|---|---|
| Pre Subscale C | 6.929 | 1.74971 | -6.559 | 54 | .000 |
| Post Subscale C | 8.5273 | 1.38220 | | | |

**Research Question 5**

Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international)?

In order to compare change scores for pre-licensure BSN students' perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic or international), an independent samples *t*-test was conducted. The Levene's Test for Equality of Variances ($F = .330$, $p = .586$) suggested the variances are roughly equal and the assumption of homogeneity of variance is tenable. Results indicate that there was a statistically significant difference in the change scores based on groups (Table 20). The Cohen's *d* of .7430835 reflected that the location of the trip evidenced a small effect size

upon the perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs).

Table 20

*CCCET-SV Subscale 3 and Location (N = 56)*

| Subscale C | Location | *n* | *M* | *SD* |
|---|---|---|---|---|
| Clinical Competence Behaviors | Domestic<br>International | 18<br>38 | .7465<br>2.0812 | 1.93818<br>1.64191 |
| **Subscale** | *t* | *df* | Sig. (2-tailed) | Mean Difference |
| Change score Competence Behaviors | -2.680 | 54 | .010 | -1.33464 |

The reflective responses for questions 6, 7, and 8 were documented. Responses for the domestic intercultural SL experience were highlighted in yellow (and in this publication denoted in SMALL CAPS for printing purposes). Common themes were determined by categorizing repeated concepts identified within the student's response. Content analysis was performed on journal responses related to the Cognitive, Practical, and Affective learning dimensions to identify prominent themes and patterns regarding the students' perception of how the intercultural experience influenced their thought/beliefs about cultural knowledge of patients with different cultural backgrounds from their own. Responses were divided into macro level (across the group) and micro level (domestic or international experience).

**Research Question 6**

How has the intercultural experience influenced students' thoughts/beliefs about students' cultural knowledge of patients with different cultural backgrounds? (Cognitive)

Building rapport, communication, and cultural competence were subthemes identified at the macro level (see Appendix M). At the micro level, the subthemes identified for the international trip experience included world view and nursing care.

Nursing students learn the importance of establishing trust within the nurse–patient relationship throughout the nursing curriculum. Rapport building is an interpersonal communication skill that was introduced at the beginning of the first-semester sophomore year through didactic content which included the skills of listening, active listening, ineffective listening, reflection, and clarification. Students continued developing communication skills throughout the nursing curriculum.

Trust is critical to effectively meet the needs of the patient and to improve patient satisfaction with nursing care. Building a trusting nurse–patient relationship is more complicated when caring for a diverse population. The students who traveled domestically identified building rapport as an important component of cultural knowledge. One student expressed:

> We need to be sensitive to how we approach situations. We need to take the time to build a rapport with our patients and show we care if we want to be a good influence and a good care giver. We must earn the right to speak.

Nursing students need to develop skills that increase their ability to respond effectively to the cultural needs of each patient. Through reflection of the student's thoughts and beliefs, an increased awareness developed of how these traits and concerns impacted culturally congruent nursing care. The students gained an understanding of the traditions, values, and beliefs of the culturally diverse patient and knowledge of variables that affect patient outcomes.

Similarly, another student stated:

> Patients with different cultural backgrounds may have different needs, but one thing that is for sure is when you care for someone and are sincere, the patient feels that. Although you may not have the answer right then and there, the relationship/bond with the patient trumps any doubts/worries the patient may have. I realize now the importance of developing trust and rapport with patients of any cultural background.

Likewise, a student who traveled internationally commented:

> This taught me that even the smallest amount of knowledge gained about a culture can make all the world of difference. It has motivated me to seek out more information on how to bridge cultural gaps, especially within the healthcare field.

And another student related the experience of recognizing that there is not a *right* or *wrong* way of thinking:

> This experience has changed my thoughts about cultural knowledge of patients with different cultural backgrounds in that I discovered our differences arise in our upbringing. I learned that I think the things I think because of the culture I was raised in. Likewise, others have learned through patterns. Their cultural background is just as valid as mine and I learned there is not 'right' or 'wrong' way to think. I respect the difference in cultural backgrounds and will work to change my actions to better care for my intercultural patients. I also learned that we are so similar too. People are people no matter where they're from.

Throughout the nursing school curriculum, students gain knowledge regarding the importance of rapport building as a critical component in creating effective treatment strategies.

Communication is a complex process in nursing education. Nursing students learn the basic elements of the communication process: source, message, channel, receiver, and feedback (Potter, Perry, Stockert, & Hall, 2013). Verbal and nonverbal communication skills are introduced in the sophomore level and practiced throughout the nursing program. Students are evaluated each semester on the successful use of therapeutic communication in the classroom, lab, and clinical setting.

Effective communication may be even more challenging when caring for patients from other cultures. Students explore their own cultural values and beliefs before learning about other cultures. The intercultural SL experiences, both domestic and international, reinforced the importance of effective communication. A student who traveled domestically conveyed:

> Finding the right way to communicate with patients from different cultural backgrounds is key. You don't want to offend them and make them shut down; you want to gain their trust in hopes for them to provide the information necessary to help them. I didn't realize how hard it would be to communicate with the residents.

Traveling across the globe provided the students with the experience of being part of the minority culture. This shift changed students' thoughts regarding communication as one student shared:

> The intercultural experience has helped me to put myself in the place of a minority culture patient. It was me who spoke a different language than the rest. They couldn't understand was I was trying to say. I felt their frustration. That was probably the most difficult part, not their specific cultural belief/backgrounds. I learned to rely more on nonverbal communication. I definitely gained awareness about different cultures. I know that there are different ways to do things other than how we do them here.

Another student disclosed, "To be honest, I discovered that there is a great deal about other cultures that I will never understand or grasp. BUT in India, the few communicative methods without words proved to be invaluable." Communication between nurse and patient must be a priority when providing care. One international traveler imparted:

> Experiencing the healthcare in Uganda has helped me better understand how to communicate effectively with those that are less familiar with healthcare. Many of the patients we came into contact with did not understand the education we were giving. Therefore, we needed to word things more simply for them to understand. I think this will carry over into my practice here in the states and remind me that many people do not understand medical jargon.

Clearly explaining medical terminology, clinical procedures, and pharmacological treatments in ways that patients can understand is one of the challenges nurses encounter (Warren, 2009). This is especially true when caring for patients from a culture unlike one's own. Past experiences and personal perceptions do positively influence effective communication, which impacts healthcare outcomes.

Caring for culturally diverse patients assist students' attainment of cultural competence. Increased cultural competence usually leads to culturally congruent care, which customizes health care to meet a given patient's beliefs, cultural values, lifestyles, practices, and traditions. Prior to the intercultural experience, students completed a course wherein the objectives included identifying the universal characteristics of a culture, developing an awareness of similarities and differences in cultures, and analyzing the impact of culture on ethical/legal issues affecting health care (see Appendix I). Course work consisted of classroom lecture, assigned readings, class participation, and exam questions, as well as writing an intercultural healthcare study proposal. The intercultural SL experiences provided students with opportunities to reflect on their own values, beliefs, and cultural heritage in order to have an awareness of how these concepts may impact the nursing care they provide. Students who traveled domestically and internationally increased their cultural knowledge.

The domestic intercultural SL experience revealed a deficit of knowledge of other cultures, as one student stated:

> I now understand I have a huge deficit of knowledge on other cultures. There are so many things you just cannot learn from articles and researching. The most important thing I learned about dealing with different cultural is to be honest about my lack of knowledge on their culture. The American Indian people were very understanding and loved

> telling me about their culture. I think they appreciated my wiliness [*sic*] to learn.

Another domestic traveler conveyed:

> I realized that while I understand other cultures, I'm not all knowing of that culture. I thought I know a lot about southern culture, especially the poor-subgroup, but I was surprised everyday by something new. I need to continue learning throughout care of that culture.

The international travelers also expressed the impact of learning experience on cultural competence knowledge:

> I realized that I knew a lot less about the culture than I thought I did. Privacy was a very big deal there, even with the close quarters. It also helped me see why people of Indian culture are the way they care, which was nice.

Another student disclosed:

> The cultural experience taught me that it's very important to be culturally competent and to provide culturally competent care as a nurse. I also learned that it takes continual learning to provide culturally competence care. Even if you study a culture, there are so many different beliefs and values that you learn something new each day.

The intercultural experiences provided the students with a clinical experience that offered an opportunity to obtain cultural information and apply the new knowledge in a patient care setting.

One assumption of Jeffreys Cultural Competence Model is that TSE is a dynamic construct that changes over time and is influenced by formalized exposure (Jeffreys, 2006). This is exemplified by one student's response:

> Personally for me, traveling to India and experiencing a new culture was not new to me. Working in Kenya, Korea, in India or here in the U.S. for me has been a cultural experience. The new place and people did influence my world view and also my perspective on global healthcare. It's always difficult to walk out of comfort zones and interact with patient from different backgrounds. India was another step to becoming more cultural competent.

Likewise, another student commented:

> I have had a variety of intercultural experiences and each one has widened my view of the world and enlarged my heart for different people. I no longer see a cultural tradition that is different from mine as “weird,” but now embrace it as a difference. I’m far less judgmental of my patients and open to learning about their culture and embracing them.

Thoughts regarding world view are not limited to cultural differences. Traveling internationally provided the students opportunities to experience how similar cultures are. One student voiced, “The intercultural experience changed my thoughts and beliefs of cultural knowledge of patients of different cultures in that I learned how similar we all are.” The intercultural experiences afforded the students opportunities to experience the similarities and differences between and within cultures.

The students who traveled internationally identified that the intercultural experience influenced their thoughts/beliefs about cultural knowledge regarding nursing care. One student shared:

> The intercultural trip has inspired my creativity within the nursing process. Having to accommodate multiple religious backgrounds in the care that was given in India made me get more resourceful with my interventions. It made me realize that I need to be open to new suggestions and new ways of treating patients. Nursing isn’t a “cookie cutter/textbook/ job” and I have to be ready to quickly adapt to any scenario.

Not only did the international experience provide learning opportunities for applying the nursing process, it also provided insight into patient compliance. One student responded:

> Prior to going to Uganda it was very difficult to understand why the disease transmission rate is so high, and why people do not receive medical care, despite all of the medical teams who go to Africa to help. I witnessed firsthand—such as with dental hygiene—if something is not a part of their culture, the natives would listen respectfully, but would not act on it.

Traveling internationally provided the nursing students opportunities to observe and gain knowledge about other cultures views and practices.

Regardless of the location of the intercultural experience, students recognized that the intercultural experience expanded their knowledge regarding other cultures. Even though students completed an intercultural healthcare proposal prior to the intercultural experience, the *lived experience* of the trip revealed that the classroom lectures, written assignments, class participation, and written exams just could not provide the same knowledge as that of an actual intercultural experience.

**Research Question 7**

How has the intercultural experience influenced your confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)

Over time during formalized learning opportunities, TSE changes. The intercultural experience provided the students opportunities to interact with culturally diverse patients, which positively influenced their confidence in interacting with culturally diverse clients. Analysis of the content revealed subthemes at the macro and micro level (see Appendix N).

The *Baccalaureate Essentials* (AACN, 2008a) describe clinical experience expectations that include "[developing] proficiency in performing psychomotor skills, [applying] professional communication strategies to client and interprofessional interactions, and [acquiring] a professional identity" (p. 33). At a macro level, both groups identified building rapport and communication as subthemes. Students who traveled internationally identified nursing care and cultural competence as micro subthemes.

Faculty evaluate students on their practical therapeutic communication skills in the lab and clinical setting throughout the nursing program. Transcultural nursing's goal

is to provide culture specific and universal nursing care practices for the health and well-being of people or to help them face unfavorable human conditions, illness, or death in culturally meaningful ways (Leininger & McFarland, 2002).

All students reported that the intercultural SL experience influenced their confidence in building rapport and communicating with culturally diverse patients. Nursing students have many opportunities to build rapport with patients in the clinical setting; the intercultural SL experience provided the students an opportunity to interact with culturally diverse patients, which enhanced their confidence. One student who traveled domestically shared:

> Before our intercultural trip, I was a bit weary of interacting with people different than my own race because I wanted to be cautious in making sure I did not unintentionally offend someone. Experiencing how a relationship can grow gives me hope that although a relationship with a patient may start out rough, there is still an opportunity to make good out of it and to never give up.

It is not necessary to travel across the globe to develop confidence in rapport building skills. One student conveyed, "It allowed me to open up more about myself and in return they would open up as well. There has to be a level of vulnerability and honesty which can shake a person's confidence."

Students traveling across the globe also experienced opportunities to build rapport with patients. One student noted:

> Honestly, the more time I spent with Ugandans, the more confident I felt. It certainly felt nerve-wracking at first. And seemed like such a hard task; however after a while you begin to understand that they are people too, just with different views and language. Also, surprisingly many were SO open about their lives and were extremely friendly. Conversations became laid back and easy over time. I gained a lot of knowledge.

In a similar manner,

> I feel far more confident in interacting with culturally diverse patients. I love cultures and talking about differences and similarities so I have no reserve when it comes to learning about one's beliefs and values. This experience has influenced my confidence in interactions by increasing it and changing the way I go about attaining information. In this way, I can respectfully gather information that will allow me to provide the best care possible to my patients.

The intercultural SL experience provided all students occasions to build their confidence in building rapport with culturally diverse patients. Students endured the lived experience of feeling vulnerable and building trust with patients unlike themselves. The intercultural trip allowed students time to be uncomfortable, yet to overcome the sense of uncertainty, to, therefore, develop rapport-building skills.

Nursing practice utilizes therapeutic communication skills between the nurse and the patient. As with most nursing skills, practice builds confidence. The intercultural trips allowed the nursing students to practice communication skills with culturally diverse patients. One student from the domestic trip stated:

> My confidence is much higher. Before I thought people of different cultures would get very offended by my lack of knowledge. On the contrary, the people are eager to have someone to talk about their culture, people are so proud of where they came from! So now I know I don't have to fear asking the right or wrong questions. People are much more forgiving than I previously thought and genuinely wanted to help me understand more about their culture.

The intercultural SL experiences provided opportunities for nursing students to develop therapeutic communication skills when caring for culturally diverse patients.

Communication occurs both verbally and nonverbally. Students who traveled internationally noted an opportunity to practice nonverbal communication skills. One student replied:

> My confidence has improved when communicating with culturally diverse patients. I have learned to focus on nonverbal communication instead of verbal. I also figured out that care that matches their beliefs instead of our beliefs has better results. It doesn't hurt to ask questions. They are glad/proud to share things that they believe in.

One student shared, "Nonverbal communication speaks volumes even with a language barrier, and should be assessed for every patient." The international intercultural SL experience provided the students an opportunity to practice nonverbal communications skills because the students did not speak the native language of the patient.

At-risk individuals and inefficacious (low confidence) or supremely efficacious (overly confident) nurses may provide culturally incongruent care. The intercultural SL experience afforded the students opportunities to self-reflect. One student disclosed:

> I am less confident now than I was before the experience, but I see that as a good thing. My ideas of cross-cultural communication somehow gave me confidence that the language barrier was a small thing to be conquered. I was wrong. I was not very proficient or skilled in communicating with people in India. This realization is not discouraging, however, because I see it as a larger learning opportunity.

The Practical learning dimension focuses on practical application of skills. The intercultural SL experience provided opportunities for nursing students to practice communication skills (verbal and nonverbal) necessary to interview patients from different cultural backgrounds about their values and beliefs. One student conveyed:

> Through this experience I have gained a lot of confidence in communication. I am also more confident in my nursing knowledge than I was before. I think that learning more about their values and beliefs helped me to make better connections and to make the information we taught easier for them to understand.

Similarly, another student recounted:

> The experience in Uganda significantly boosted my confidence in speaking to others about their values and beliefs. I found that when asking individuals questions about these personal matters, there was nothing to lose—the person would either refuse to tell me or I would gain significant

> knowledge on a topic. Patients from all backgrounds understand/acknowledge the importance for healthcare professional to ask questions about their values and beliefs.

The intercultural SL experience promoted learning opportunities to enhance nursing skills and values needed to effectively communicate with culturally diverse patients. The students gained knowledge and understanding to better serve culturally diverse patients.

According to Jeffreys (2010), transcultural nursing skills include practical–motor skills or practical application of skills. Students reported that the international intercultural experience provided opportunities to develop and gain confidence in providing nursing care. One student made this comment regarding nursing care:

> I felt like this experience has me realizing that as we go into other cultures or hospital rooms of people of culturally diverse patients, we need to keep in mind their culture….We can educate them and teach them but we cannot change the entire way in which they or their culture functions. We need to take a step back and not superimpose our thoughts, beliefs, and values on them, but work together to develop a suitable way of life for them all which giving the best care.

Similarly, a student commented:

> Each patient needs to be treated as an individual. Asking patients about their preferences is important. Modesty was a huge deal in Uganda. For example, I have to give a male patient two shots in his gluts. He was very anxious and seemed nervous about there being two women in the room. I asked them to step out once I had my supplies set up. He thanked me afterwards for providing him privacy because he was afraid to ask.

A different student disclosed:

> I am now more confident about asking my patients more private questions that would be a part of their beliefs. During HIV/AIDS testing in the clinics we had to ask many people if they were sexually active and how many partners they had. Some were offended or hesitant in answering honestly because of their values and beliefs; we had to remind them that the information is private.

Another respondent noted that the importance of gaining an understanding of the culture enhances nursing skills:

> My confidence increased after visiting Africa. I have learned that I should not be afraid of taking care of a person with a different cultural background. Instead, if I ever have a patient in the future with a different cultural background, I will do research on their culture like I did before going to Africa. Knowing about different cultural backgrounds definitely will always increase my confidence while interacting with culturally diverse patients.

Cultural competence has been identified as a major measure of quality in nursing care (Salimbene, 1999). Therefore, there is a critical need to identify learning interventions that improve cultural competence of nurses. One student responded, “I feel confident to walk into a patient of a different culture’s room and best meet their needs and inquire how I can incorporate their values into their care.” The international intercultural SL experiences provided an opportunity for nursing students to interact with culturally diverse patients.

Students who traveled internationally reported the intercultural SL experience influenced their cultural competence confidence. One student reported, “I feel more confident with each cultural interaction I experience. I feel confident to learn about any cultures values and beliefs. I also learned that being respectful and sensitive to their value and beliefs is important.” The experience enhanced the students’ thoughts regarding patients’ values and beliefs. One student conveyed, “I believe I have a deeper interest to understand my patient’s values and beliefs. I deeply desire to meet them where they are in their life and fully embrace their cultures.”

Nurses are patient advocates and cultural competence is especially important in nursing practice. One student shared:

> I felt like this experience has me realizing that as we go into other cultures or hospital rooms of people of culturally diverse patients, we need to keep in mind their culture….We can educate them and teach them but we cannot change the entire way in which they or their culture functions. We need to take a step back and not superimpose our thoughts, beliefs, and

> values on them, but work together to develop a suitable way of life for them all which giving the best care.

Likewise, a student commented:

> Every interpersonal [experience], whether it is or not an intercultural experience should challenge us to learn about our patient's values and beliefs concerning cultural awareness. Going to India was another reminder for me that intercultural and interpersonal interaction and competency is important. More so important in the nursing profession. Leaning about another culture and meeting new people has grown more confidence.

The international students reported a positive change in confidence when providing care to culturally diverse patients. Students that were removed from the comforts of the U.S. reported the importance of understanding patients' values and beliefs and the impact of that on cultural awareness.

The intercultural SL experiences positively impacted the students' confidence in interacting with culturally diverse patients. All students reported in their reflections that the intercultural experience influenced their confidence in building rapport and communicating with patients. The students who traveled internationally identified greater confidence in nursing care and cultural competence.

**Research Question 8**

How has the intercultural experience influenced your values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)

The Affective learning dimension focuses on attitudes, values, and beliefs. Affective learning includes self-awareness, awareness of cultural differences, acceptance, appreciation, recognition, and advocacy. Content analysis was performed on journal responses to identify themes and patterns at the macro level (across groups) and the micro

level (domestic or international experiences; see Appendix O). Knowledge, building rapport, and nursing care were identified at the macro level. At the micro level, the domestic travelers identified listening and the international travelers identified awareness.

The first step to developing cultural competence is cultural awareness. Cultural awareness is cultivated by learning about oneself. As students examine and reflect on the diverse perspectives of values, beliefs, lifestyles, and practices of different cultures, they begin to identify their own biases, attitudes, and prejudices (Stokes & Flowers, 2012).

All of the intercultural experiences resulted in an ability for students to recognize cultural differences thereby increasing their knowledge regarding those differences. A domestic traveler conveyed:

> I have a much stronger calling to learning more about culture. Seeing the way the Navajo man lit up when I talked to him about his background made me think of how therapeutic it is to meet each patient where they are. It was important to the Navajo man that I recognized he was from another culture and wanted to learn more. In learning more about a patient's culture we can better understand their wished [*sic*] and advocate for them more effectively.

Cultural difference may influence the expectations that patients and nurses have of each other. A student who traveled internationally noted:

> I think through my experience I have learned to value aspects of other cultures that I thought I wouldn't. For example, I was able to recognize and appreciate the devotion that the Sikh's and Hindu's have to their god(s). Although I do not share the same beliefs, I appreciate their dedication and initiative in the worship and practices. I think a lot of people, myself included, in the Christian faith can learn to be more devout like them. The trip also influenced my attitude on acceptance. I learned to accept that what I might have planned or expected may not happen. This was a great realization and I enjoyed my trip more because I learned to be flexible and appreciate what I have and the examination of self.

When students are given the opportunity to move out of their comfort zones into unfamiliar experiences, they are provided opportunities to identify their own values,

beliefs, and attitudes along with experiencing how values, beliefs, and attitudes of people from a different culture can impact patient outcomes and satisfaction.

The intercultural SL experiences provided the students and patients an opportunity to share common experience that can help to establish relationships between the patient and the nurse. The domestic intercultural experience provided opportunities for students to interact with culturally diverse children. One student commented, "I have always grown up in a very accepting home, if this trip did anything, it made me realize how important it is to mentor kids at a young age and provide them resources sooner rather than later." If students do not have a chance to understand their own cultural beliefs and how it affects them, it is more difficult to understand how it could affect someone from a different culture. The international SL experience helped a student to recognize the value of being different. That student reported:

> I've always believed that people of different cultures are valuable. However, this trip was a way to enact on it and meet them at their level of attitudes, and beliefs. I recognize that it is important for different cultures to stay different as well.

The trips allowed students to interact and build relationships with patients from different cultures. Reading about other people's culture and history, listening to them share their stories, and noticing the differences in communication style assisted the students in discovering their own values, beliefs, and attitudes and how that impacts their cultural awareness.

The last macro level concept, related to the Affective learning dimension, is nursing care. The consequences of a lack of cultural awareness are multiple. It can bring about misunderstandings, a lack of compliance, and other factors that negatively influence patients' health outcomes. The intercultural SL experiences positively impacted

all students. One domestic traveler noted the importance of being mindful of those different from ourselves:

> I feel that we need to be mindful of each person's diversity. Even if I feel we share a similar background, a small difference can change one's world and thought process. Being a good nurse means being aware of not our own beliefs, attitudes, and values but being mindful of those different than our own. We must always advocate for all our patients and recognize their needs may be different than what we think they might need or want. We must be aware and accept these differences as long as they are not harmful.

One indicator of cultural awareness is to move beyond one's own values, beliefs, and attitudes and respect that of people from diverse cultures. Another student stated:

> There is a need to give all cultures relevance and be sensitive to individual needs based on culture, beliefs, values, etc. It is wrong to put your own beliefs, values, expectations on anyone, and instead ask about needs, preferences, that will promote a person's well-being.

The international travel experience enforced the feelings of being a minority. One comment was:

> My beliefs on how to acculturate myself have changed because I became aware of the amazing fact that I would/will never fit in in India. This is a fact that I think I needed to learn in order to truly value the experience. My skin means I will always be a foreigner in that world. This idea has given me motivation to ensure that I am an advocate for those who feel foreign here in the U.S. My nursing practices and compassions for the powerless have only grown because of this experience. Being foreign makes you feel lost and exposed and I will do my best to make sure none of my patients feel like that under my care.

The trip also revealed the importance of cultural awareness, acceptance, appreciation, recognition, and advocacy. A student responded:

> I realized on this trip that there is definitely need for cultural competence, awareness, acceptance, appreciation, and recognitions in the healthcare setting. We need to advocate for patients wishes and include them in decisions about their care. Seeing how things are done in a different culture opened my eyes to possible expectations and cultural norms in healthcare. It is definitely like a different world but we must uphold our

> patient's values and make them as comfortable with their setting as possible.

Listening to patients is fundamental to providing better care and improved patient outcomes. Nursing students have a chance to develop listening skills in the simulation and clinical setting. However, there are limited occasions for students to interact with culturally diverse patients. The intercultural experiences offered students opportunities to interact with patients unlike themselves. One student who traveled domestically shared this regarding listening, "It is important to respect and listen to others even if we do not agree or understand, for patients, it is our job to respect them and their beliefs even if we may hold different beliefs." Active listening can eliminate barriers to the delivery of health care.

Lack of awareness about cultural differences may make it challenging for nurses and patients to achieve the best possible outcomes. The international intercultural SL experience enhanced students' awareness of values, attitudes, and beliefs concerning cultural differences. One student responded:

> It affirmed my attitudes and beliefs to make others more culturally aware. It helped me to be more accepting of my peers from different backgrounds. It made me appreciate of my own culture and opportunities. It helped me recognize areas I need to improve physically, mentally, and spiritually.

Likewise, another student replied:

> This experience has opened my eyes and painted a new outlook on life and realize that each day is a day that we can only treasure. The Ugandan people have little to nothing, homes that I could not imagine calling home but they have it all. Their love for one another over flows forms their every being. In spite all things...even if they didn't have a scrap of food, no clothing, dirt floors, they gave all the glory to the Lord. That had shaped to realize how much in abundance I have! Uganda didn't need me…I need Uganda. My outlook on life will forever be changed.

Traveling internationally allowed the nursing students to identify their own values, beliefs, and attitudes, as well as learning about other cultures values, beliefs, and attitudes.

Culturally competent care cannot be offered to patients unless nurses understand how cultural values, attitudes, and beliefs impact patients' response to care. Nurses must develop cultural competence to accurately access, develop, and implement effective nursing interventions. The intercultural SL experiences provided the students opportunities to begin asking questions and establishing relationships with diverse patients.

## Summary

In this chapter, the plan for data analysis was provided. A description of the instruments (the TSET, the CCCET-SV, and reflective journal responses) and the analysis of the data derived from them were given; each of the eight research questions was addressed.

The findings from the first question demonstrated that students who traveled domestically compared to the students who traveled internationally were not statistically significant different in their perceived TSE at posttest. Results from the second question revealed that there was a statistically significant difference in students' perceived TSE for all three learning dimensions for both domestic and international SL experiences. Research Question 3 revealed the Cognitive change scores and Affective change scores were not found to be statistically significant between the groups; however, the Practical change scores were statistically significantly different between the groups.

The CCCET-SV was used to answer research Questions 4 and 5. The results of Question 4 demonstrated a statistically significant increase in students' perceived clinical

competence behaviors (culturally sensitive and professionally appropriate attitudes values, and beliefs) for both domestic and international SL experiences. The findings from research Question 5 demonstrated a statistically significant increase difference in change scores in the Clinical competence behaviors subscale between the groups.

Overall, the quantitative results for this sample indicate that it was not necessary to travel across the globe to positively change a student's perceived TSE. However, the qualitative results revealed a difference in responses at the macro and micro level.

The reflective journal responses provided the students opportunities to identify what was gained from the clinical experience, which further contributes to their ongoing clinical knowledge development (Tanner, 2006). The results from research Question 6 demonstrated that all intercultural experiences influenced students' cultural knowledge related to building rapport, communication, and cultural competence. However, only the international travelers identified changes in world view and nursing care. The findings from research Question 7 demonstrated all intercultural experiences influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs. Both experiences, domestic or international, identified building rapport and communication as practical skills. The international travelers noted nursing care and cultural competence. The conclusions from research Question 8 identified changes in students' values, attitudes, and beliefs in relation to cultural awareness, acceptance, appreciation, recognition, and advocacy; both groups reported knowledge, building rapport, and nursing care. The domestic travelers identified listening as an Affective dimension; the international travelers noted awareness. Overall, these results suggest

students' perceived TSE increases after an intercultural trip, regardless of whether the location is domestic or international.

The final chapter will summarize and discuss the research findings presented in Chapter IV in relation to the impact of an intercultural SL experience on a nursing student's perceived TSE. In addition, it will explain the implications for nursing education and recommend further research for nurse educators.

# CHAPTER V SUMMARY, DISCUSSION, AND CONCLUSIONS

Chapter V contains the summary of the study, a discussion of the findings, implications for nursing education, an overview of the limitations, and recommendations for further research. Discussion will begin with a brief summary of the purpose and the research questions. Discussion will progress to the interpretation of the findings in regards to the research questions. Implications for nursing education, limitations, recommendations, and the conclusion will be addressed.

## Summary of the Purpose of the Study

The purpose of this study was to explore the impact of an intercultural SL experience (domestic or international) on pre-licensure nursing students' perceived development of TSE. Cognitive, practical, and affective learning processes related to nursing students' TSE can change over time and are influenced by formal educational opportunities. Cultural competence is a multidimensional learning process that includes a dynamic interaction between past experiences and observations that influence the development of cultural competence and TSE. While cultural competence is identified as a critical component of nursing education, little research has been done to determine the impact of intercultural experiences on nursing students' perceived development of TSE. It is essential for nurse educators to integrate cultural competence knowledge, skills, and attitudes into nursing curricula to develop successful practitioners who can provide culturally sensitive care to culturally diverse patients.

Jeffreys' cultural competence model (2010) was selected as the theoretical framework for the research study based on its focus on education and educational strategies. It is a multidimensional framework for teaching cultural competence in nursing and health care. The CCC model is used to explain, describe, influence, and

predict the phenomena of nurses developing cultural competence. Furthermore, the CCC addresses factors that influence learning, motivation, persistence, and commitment for cultural competency development (Jeffreys, 2010).

The population was selected because the students recently had completed a required course that emphasized the value of human diversity and the application of knowledge of cultural, racial, socioeconomic, religious, and lifestyle variations to health-related situations. A convenience sample of senior nursing students enrolled in a private, faith-based, baccalaureate degree nursing program in the Midwest region of the U.S. was chosen. All students were immersed in an intercultural SL experience. Eighteen students traveled domestically and 38 traveled internationally. The SON administers to students the TSET and CCCET-SV to assess culturally congruent teaching–learning strategies that address students' diverse cultural values and beliefs. The results are used to support the achievement of expected student outcomes identified in course, unit, and/or program objectives.

This study looked at five quantitative research questions to identify a difference in the students' perceived TSE following travel around the corner (domestic) or across the globe (international). The first question asked, "Is there a statistically significant difference in pre-licensure BSN students' perceived TSE at posttest based on the location (domestic or international) of the intercultural SL experience?" The results to this question demonstrated there was not a statistically significant difference in perceived TSE at posttest based on the location of the experience; however, students in the domestic experience group had slightly higher scores at posttest than students in the international group.

The second question addressed, “Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students’ perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience?” The results from the TSET found there was a statistically significant increase in scores from pretest to posttest scores for all three dimensions: Cognitive, Practical, and Affective.

Question 3 inquired, “Is there is a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students’ perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience (domestic or international)?” The results indicate that students’ change scores in the Cognitive and Affective dimensions were not significantly different between the domestic and international groups; however, the Practical dimension between the groups was significantly different.

The CCCET-SV was used to answer research Questions 4 and 5. Question 4 inquired, “Is there a statistically significant difference from pretest to posttest for pre-licensure BSN students’ perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience?” The results determined there was a statistically significant increase in scores from pretest to posttest.

The fifth quantitative question probed, “Is there a statistically significant difference in change scores (pretest to posttest) for pre-licensure BSN students’ perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience (domestic

or international)?" The results showed a statistically significant difference in change scores between the groups.

In addition, participants were asked to respond to reflective journal questions concerning how the intercultural experience influenced their Cognitive, Practical, and Affective dimensions. Question 6 asked, "How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive)." Building rapport, communication, listening, and cultural competence were subthemes identified at the macro level. The micro level subthemes identified for the international trip experience include world view and nursing care.

The seventh question investigated, "How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)." The findings showed all experiences identified building rapport and communication as practical skills. The international travelers noted increased confidence in nursing care and cultural competence.

The eighth and final question addressed, "How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)." The responses identified changes in students' values, attitudes, and beliefs in relation to cultural awareness, acceptance, appreciation, recognition, and advocacy. Both groups stressed knowledge, building rapport, and nursing care. The domestic travelers acknowledged listening as an Affective dimension, and the international travelers' identified awareness.

## Discussion of the Findings

One goal of nursing curricula is to prepare pre-licensure students to provide culturally competent care. This can be accomplished by identifying learning interventions that improve cultural competence of nursing students to effectively prepare them to provide quality nursing care. While intercultural experiences such as SL and immersion experiences are one way to gain cultural awareness (Amerson, 2010; Green et al., 2011; Hayward & Charrette, 2012; Kulbok et al., 2012; Nokes et al., 2005), a limited amount of research exists in the development of cultural competence among pre-licensure nursing students to prepare them for the professional nursing role (Jeffreys, 2010; Kardong-Edgren et al., 2010).

Results from the first question on difference in perceived TSE at posttest between groups was an important first step. The TSET was used as a tool to measure the influence of cultural competence curriculum and intercultural SL experience on nursing students' TSE (Jeffrey, 2010). The findings from this question revealed that a student does not need to travel across the globe, rather, simply around the corner, to experience a transformative learning intervention that increases a student's perceived TSE.

This distinction of location is important because major obstacles to international SL identified in the NLN SON deans and directors survey included cost, time, value and interest, logistics and development, and curriculum, as well as health and safety, as obstacles (McKinnon & McNelis, 2011). Essentially every obstacle identified is addressed and either simplified or made more economically feasible by a domestic experience. Because it is considered advantageous to the student and their future patients to improve students' perceived TSE, nursing programs are obligated to try to provide such experiences for their students' learning—it is in everyone's best interest to do so as

efficiently as possible. Nursing curricula are quite challenging for both students and educators on many different levels—not the least of which is the need to prepare for and pass the NCLEX examination. Domestic travel is less expensive. Shorter travel distance maximizes time efficiencies. Additionally, immunizations are unnecessary and inherent logistics likely are easier domestically. Domestic travel is probably more secure for the health and safety of both students and faculty as recent events abroad have highlighted— from violence in the Middle-East to Ebola in Africa. The value of the intercultural experience is maintained as students learn primarily to increase their TSE and yet learn more about the demographics of the community in which they are serving and the community needs and its resources.

The second question examined if there was a difference from pretest to posttest on perceived Cognitive, Practical, and Affective dimensions of TSE following an intercultural SL experience. Results showed a statistically significant increase in posttest scores for all three dimensions: Cognitive, Practical, and Affective. This is important as the main aspect of this question was answered in the affirmative—indeed students showed improvement in all three dimensions. This is the bottom line: intercultural SL is an overall worthwhile learning experience.

This research study also used the TSET to identify inefficacious and supremely efficacious individuals (TSET scores of 1–2 and 9–10, respectively). As reported by Jeffreys (2010), inefficacious individuals (under-confident) are at risk for decreased motivation, lack of commitment, and/or avoidance of cultural considerations when planning and implementing nursing care, and supremely efficacious (overly confident) individuals are at risk for inadequate preparation in learning the transcultural nursing

skills necessary to provide culturally congruent care. The overall mean responses for the TSET pretest and posttest were all in the medium range. Affective scores were the highest, followed by Practical; Cognitive scores were the lowest. These findings are consistent with Jeffreys' (2010) findings that suggested learners are most confident about their attitudes (Affective dimension) and least confident about their transcultural nursing knowledge (Cognitive dimension).

The third question on difference in change scores on perceived Cognitive, Practical, and Affective dimensions of TSE based on the type of intercultural SL experience also was answered using the TSET. The Cognitive change score and Affective change score were not different in relation to the location of the experience; however, the Practical change score was significantly different between the groups. The importance of this lies in the fact that regardless of the location of the experience, students' responses indicated that their perceived confidence about their knowledge concerning the ways cultural factors may influence nursing care was not different. Likewise, there was not a difference in the Affective responses related to attitudes, values, and beliefs based on location. However, the Practical scores did reveal a difference between locations. The students who traveled internationally reported their rate of confidence for interviewing clients of different cultural background to learn about their values and beliefs was higher. This information is noteworthy; the findings may suggest that faculty members directing the domestic trip need to seek out greater opportunities for students to interview clients in order to learn about their values and beliefs.

The three reflective journal responses provide an evaluation of how the intercultural experience influenced students' knowledge, confidence, values, and beliefs.

The first journal question asked, “How has the intercultural experience influenced students’ thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive).” The findings suggest that all students expressed an increase in knowledge related to “building rapport,” “communication,” “listening,” and “cultural competence.” Both domestic and international intercultural experiences allowed students opportunities to engage and interact with culturally diverse patients. The results revealed only that international travelers identified “broaden[ed] world view” and “considerations in nursing care.” Nursing faculty leading domestic trips need to be intentional in promoting discussions and providing learning experiences that foster development of knowledge—tying together the impact of personal characteristics, background experiences, and life situations that influence knowledge of world views. Perhaps traveling domestically fosters a greater feeling of cultural similarities than differences. In addition, there needs to be greater opportunities to provide nursing care.

The second reflective response, “How has the intercultural experience influenced students’ confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)” indicated that regardless of the location, the experience promoted student confidence in “building rapport” and “communication.” Students learned that their lack of knowledge was not offensive but provided an opportunity to build rapport. The clinical situations in culturally diverse locations allowed students opportunities to practice and improve their communication skills. The students and patients focused on the similarities of their values and beliefs. The international travelers increased their confidence in providing nursing care and cultural competence. The experience increased confidence in incorporating the patient’s values and beliefs into

the nursing care. Cultural competence increased with the chance to educate and inform patients while maintaining the patient's values and beliefs.

The final reflective journal response was, "How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy? (Affective)." Knowledge, building rapport, and nursing care were identified at the macro level. Students have an increased desire to learn more about a patient's cultural values and beliefs. The importance of advocacy was heightened. For effective communication and quality patient care, it is necessary to build rapport with all patients. The intercultural experiences provided the students opportunities to move outside their comfort zones, and actively engage with patients and families from different cultural backgrounds, both domestically and internationally.

The domestic travelers noted the importance of engaging in "listening" and "communication." Traveling across the globe to live in another culture increased the students' responsiveness of the importance in cultural awareness. The student responses revealed there is a component of being *out of one's own comfort zone* that results in the gain of a greater appreciation for cultural difference and how they impact one's values, attitudes, and beliefs.

The reflective journal responses were instrumental in exposing the different clinical and cultural experience within the various locations. While there were notable differences between the trips, the TSET, CCCET-SV, and reflective journal responses provided essential information for the nursing faculty and community stakeholders for future experiences.

The CCCET-SV was administered to students to evaluate cultural competence in the clinical practicum. The fourth question that examined the difference from pretest to posttest of perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) following an intercultural SL experience showed a statistically significant increase over time. All students reported an increase in their culturally sensitive and professionally appropriate attitudes, values, and beliefs, including awareness, acceptance, recognition, appreciation, and advocacy during the clinical experience. The value of this information to nursing education is to gain baseline data including strengths, weakness, and/or gaps in the intercultural SL experiences and to evaluate change in each individual student following an intercultural SL experience and, therefore, to extrapolate that knowledge to a given clinical practicum in order to provide effective remedies when necessary.

The final quantitative question exploring difference in change scores of perceived clinical competence behaviors (culturally sensitive and professionally appropriate attitudes, values, and beliefs) based on the type of intercultural SL experience revealed a statistically significant difference between the groups. Overall, the independent samples *t*-test indicated a statistically significant relationship between the international SL experience and the development of new or further development of awareness of oneself, awareness of different cultural backgrounds, greater acceptance of differences and similarities between cultural groups, greater appreciation of cultural beliefs of healthcare practices, greater awareness of the extent of the disparity to access to quality healthcare, and more commitment to advocacy for culture specific care.

When planning a domestic intercultural SL experience it is imperative to identify a target community that is significantly different from that of the students themselves. The two domestic trips included in this study were the Jewish population in Indiana and an orphanage in Georgia. While these trips did accomplish the primary goal of improving students' perceived TSE, the locations did not provide a difference in cultures as was felt to be experienced by an international group. This may explain why there was a statistically significant difference between the groups.

Over the past two decades, there has been a tremendous shift in race and ethnicity of the U.S. population. Therefore, it is essential for nurse educators to integrate cultural competence knowledge, skills, and attitudes into nursing curriculum to develop successful practitioners who can provide culturally sensitive care to culturally diverse patients. The goal of nursing curricula and clinical experiences is not to only impart knowledge but also to gain sensitivity and understanding of each patient's needs, values, and beliefs, which includes improved cultural competence of the nurse. This study supports adding domestic intercultural SL experiences into nursing curricula. This may be achieved efficiently and effectively, while minimizing development and logistic requirements, overall cost, time commitment, and safety and health issues, all the while maintaining value and interest. This results in a far more satisfying career for the nurse and most importantly, ultimately better care for each and every patient that each nurse serves.

## Implications for Nursing Education

Nurse educators have been charged by several nursing organizations and accrediting bodies to provide educational experiences, both didactic and clinical, to help students to develop the knowledge, skills, and attitudes needed to provide culturally

competent care to patients. The findings of this study contribute to the understanding that formalized education positively influences students' self-efficacy perceptions. Additionally, findings from this study indicate that an intercultural SL experience does positively impact pre-licensure BSN students' perceived TSE, regardless of the location of the experience. Results also indicate that in preparation of an intercultural SL experience nursing faculty need to be intentional is arranging clinical experiences that influence students' Cognitive, Practical, and Affective dimensions of TSE.

A recent survey of SON deans and directors revealed that barriers to providing an intercultural SL experience included lack of flexibility in nursing curricula, financial burden to students and the nursing schools, lack of faculty to organize and participate in intercultural SL experiences, and limited time constraints (McKinnon & McNelis, 2011). These results demonstrate that a domestic intercultural SL experience is less challenging to incorporate into nursing curricula due to the proximity of the location. Traveling domestically is less expensive for students, faculty, and universities. Working with local stakeholders provides students and faculty members opportunities to learn more about the demographics of the community and the community needs, as well as community resources specific to the region where they live and practice.

Some students and faculty members may have a preconceived notion that international travel is more exciting. Perhaps they look forward to the challenges of language barriers, different food choices, alternate lodging arrangements and conditions, and potentially more exotic customs and practices. The author wishes to acknowledge there are benefits to international travel, however, not everyone is interested in traveling abroad or can afford it during the college years. It is challenging to find time within the

academic year to meet the additional burdens required of international travel. There are diverse communities within our own borders that can provide opportunities to the students to not only expand their cultural competency but help to meet the desired challenges noted during international travel.

One proposed model for implementation of a domestic intercultural trip starts with identifying an individual faculty member or committee interested in SL and cultural competence to serve with enthusiasm and commitment. Administration support is essential. Schools must identify mentors with experience in developing SL intercultural trips. Appropriate community/communities that meet basic criteria of accessibility, proximity, and cultural diversity must be identified. Stakeholders within the greater community must be located. Course scheduling that allows students and faculty to be away from campus for the duration of the experience must be arranged. Recognition of accomplishing this worthwhile learning experience should be reflected in the awarding of credit hours toward graduation requirements.

## Limitations of the Study

Several limitations were identified in this study. One limitation was the absence of baseline data regarding nursing students' entry level knowledge of cultural competence. Baseline data would serve as a comparison of the development of knowledge, skills, and attitudes into practical strategies to provide culturally competent nursing care. With baseline data, nursing faculty could focus educational interventions targeting the Cognitive, Practical, and Affective dimensions in the classroom and clinical setting earlier in the nursing program.

Due to the small sample size and location of the SON in this study, the results may not be generalizable to other nursing students and nursing programs. However, the

results of this study may be applicable to future students enrolled in the nursing program and can be used to support the achievement of expected individual student outcomes identified in course, unit, and/or program objectives.

Participants in this study were not randomly selected. Students self-selected the location of the intercultural experience. This selection is often related to the intention to travel internationally, the desire to travel with friends, the affordability of the trip, and local proximity due to family and work constraints. Furthermore, students enrolled in a faith-based university often participate in mission experiences prior to entering into college. The mission of Anderson (Indiana) University SON is "educating individuals committed to competence and compassion in the nursing profession, serving God and society" (Anderson University SON, 2014, para 1). Inherent in the sample selection is the fact that responding students are necessarily skewed towards a liberal arts education, which may limit extrapolation of the data to students of large public institutions.

The population of this study was limited to students enrolled in Anderson University's SON program. The majority of the respondents was Caucasian, U.S. born, and English-first language females under the age of 25. Again, the results are not generalizable to other nursing students and programs.

Finally, this study does not include longitudinal data. While the results indicated there was not a statistically significant difference in perceived TSE at posttest based on the location of the trip, it is not known what impact the experience will have on future nursing practice.

## Recommendations for Further Research

Recommendations for further research include assessing baseline data of nursing students' entry level knowledge of cultural competence. Early assessment would provide nursing faculty important information on areas of weaknesses. Formalized learning experiences could be adapted earlier in the curricula to target the Cognitive, Practical, and Affective dimensions in the classroom and clinical practice.

As previously stated, the sample was homogenous. An area of further research would be to replicate the study with more male and minority students as well as a wider age range. Culturally diverse student responses may shed a broader light on the impact of nursing curricula on nursing students' perceived TSE.

Research needs to be conducted using a larger sample size. This study will continue, adding cohorts to the existing study. However, expanding the study to other students enrolled at larger public institutions could increase generalizability.

These results indicate that students' perceptions of TSE have increased with an intercultural experience. However, we do not know if this increased sense of TSE results in better patient care and patient outcomes. Future research needs to explore the patient's perception of and actual delivery of care.

Finally, another aspect to be investigated is the length of time the impact on perceived TSE lasts. A longitudinal study would begin to answer this question. At the institution where the study was conducted, alumni nursing students will be requested to complete the TSET and CCCET-SV one year, three years, and five years after the intercultural SL experience. This data will provide insightful information regarding the duration of the impact of the intercultural SL experience.

## Conclusion

The findings from this research contribute to the work of previous researchers in the area of cultural competence in nursing education. It expands on previous works describing teaching interventions which facilitate formalized learning experiences that target the Cognitive, Practical, and Affective dimensions in the classroom and clinical practice. It also reveals that students do not need to travel across the globe, simply around the corner, to positively impact their perception of TSE.

The practicality of this investigation lies in the fact that it will support SON in their ongoing efforts to provide improved educational opportunities for the students. This shows that it is possible to save time, energy, and expense, while still achieving desired outcomes. The trip model described herein can serve as a template for motivated nursing programs to implement an exceptionally worthwhile addition to their curricula.

In conclusion, despite the limitations, this study uncovered useful information about intercultural SL experiences and the impact of pre-licensure BSN students' perceived TSE and clinical competence behaviors based on location of the intercultural experience. Purposeful reflective journaling added a greater dimension to the data by allowing students to provide unscripted responses. It contributes to the growing body of knowledge related to how nursing programs can positively impact a nursing student's TSE.

APPENDIX A

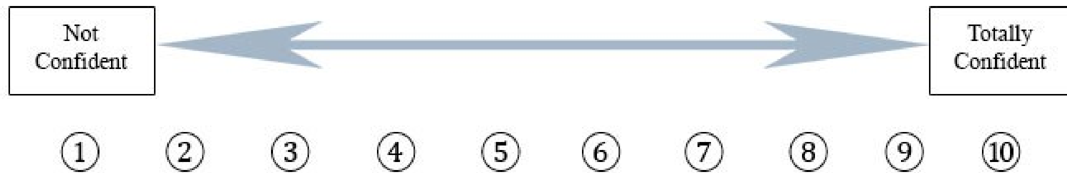
TRANSCULTURAL SELF-EFFICACY TOOL (TSET)

Throughout your nursing education and nursing career, you will be caring for clients of many different cultural backgrounds. These clients will represent various racial, ethnic, gender, socioeconomic, and religious groups.

Cultural difference exists in healthcare needs, caring, and curing practices. Knowing and understanding cultural factors related to client care helps establish a theoretical foundation for providing culture-specific nursing care.

**Part I:** *Among clients of* ***different*** *cultural backgrounds, how knowledgeable are* ***YOU*** *about the ways cultural factors may influence nursing care?*

Please use the scale below and mark your response accordingly.




**You know and understand** the ways **cultural factors** may influence **nursing care** in the following areas:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(1)** | health history and interview | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(2)** | physical examination | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(3)** | informed consent | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(4)** | health promotion | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(5)** | illness prevention | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(6)** | illness maintenance | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(7)** | health restoration | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(8)** | safety | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(9)** | exercise and activity | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(10)** | pain relief and comfort | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(11)** | diet and nutrition | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(12)** | patient teaching | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(13)** | hygiene | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(14)** | anxiety and stress reduction | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(15)** | diagnostic tests | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(16)** | blood tests | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(17)** | pregnancy | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(18)** | birth | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(19)** | growth and development | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(20)** | aging | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(21)** | dying and death | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(22)** | grieving and loss | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(23)** | life support and resuscitation | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(24)** | sexuality | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(25)** | rest and sleep | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**Part II:** *The most effective way to identify specific cultural factors that influence client behavior is to conduct a cultural assessment of each client. This is best done by interview.*

**Right NOW,** how confident are **YOU** about **interviewing clients of different cultural backgrounds** to learn about their values and beliefs?

Rate your degree of confidence or certainty for each of the following **interview topics.** Please use the scale below and mark your response accordingly.

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

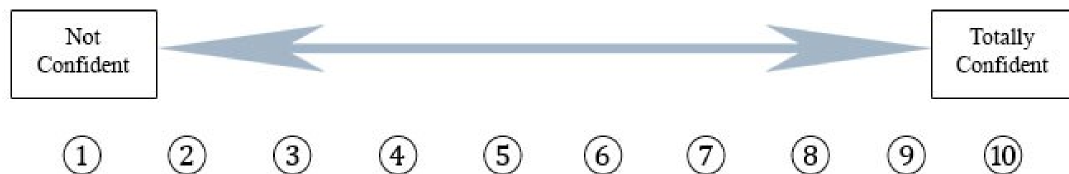
**Interview clients of different cultural backgrounds** about:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(26)** | language preference | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(27)** | level of English comprehension | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(28)** | meaning of verbal communication | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(29)** | meaning of nonverbal behaviors | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(30)** | meaning of space and touch | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(31)** | time perception & orientation | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(32)** | racial background & identity | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(33)** | ethnic background & identity | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(34)** | socioeconomic background | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(35)** | religious background & identity | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(36)** | educational background & interest | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(37)** | religious practices & beliefs | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(38)** | acculturation | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(39)** | world view (philosophy) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(40)** | attitudes about health care technology | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(41)** | ethic food preferences | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(42)** | role of elders | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(43)** | role of children | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(44)** | financial concerns | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(45)** | traditional health & illness beliefs | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(46)** | folk medicine tradition & use | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(47)** | gender role & responsibility | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(48)** | acceptable sick role behaviors | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(49)** | role of family during illness | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(50)** | discrimination & bias experiences | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(51)** | home environment | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(52)** | kinship ties | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(53)** | aging | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**Part III:** ***As a nurse who will care for many different people, knowledge of yourself is very important.***

Please rate **YOUR** degree of confidence or certainty for each of the following items. Use the scale below and mark your response accordingly.




① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

**(A) About yourself**, you are **AWARE OF:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(54)** | **YOUR OWN** cultural heritage and belief systems | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(55)** | **YOUR OWN** biases and limitations | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(56)** | difference within **YOUR OWN** cultural group | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**(B) Among clients of different cultural backgrounds,**

You are **AWARE OF:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(57)** | insensitive and prejudicial treatment | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(58)** | differences in perceived role of the nurse | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(59)** | traditional caring behaviors | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(60)** | professional caring behaviors | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(61)** | comfort and discomfort felt when entering a culturally different world | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(62)** | interaction between nursing, folk, and professional systems | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

You **ACCEPT:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(63)** | differences between cultural groups | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(64)** | similarities between cultural groups | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(65)** | client's refusal of treatment based on beliefs | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

You **APPRECIATE:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(66)** | interaction with people of different cultures | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(67)** | cultural sensitivity and awareness | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(68)** | culture-specific health care | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(69)** | role of family in providing health care | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(70)** | client's world view (philosophy of life) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

You **RECOGNIZE:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(71)** | inadequacies in the U.S. health care system | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(72)** | importance of home remedies & folk medicine | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(73)** | impact of roles on health care practices | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(74)** | impact of values on health care practices | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(75)** | impact of socioeconomic factors on health care practices | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(76)** | impact of political factors on health care practices | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(77)** | need for cultural care preservation/maintenance | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(78)** | need for cultural care accommodation/negotiation | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(79)** | need for cultural care repatterning/restructuring | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(80)** | need to prevent ethnocentric views | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(81)** | need to prevent cultural imposition | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

You **ADVOCATE:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(82)** | client's decisions based on cultural benefits | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(83)** | culture-specific care | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

APPENDIX B

CULTURAL COMPETENCE CLINICAL EVALUATION TOOL-STUDENT VERSION (CCCET-SV)

Throughout your career, you will be caring for clients of many different cultural backgrounds. These clients will represent various racial, ethnic, gender, socioeconomic, and religious groups. Culturally specific care requires that you know, understand, and identify cultural factors related to client care and conduct your nursing practice accordingly.

**Part I:** *For clients of **different** cultural backgrounds, to what extent did you provide **culturally specific care** during the clinical practicum?*

Please use the scale below and mark your response accordingly.

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

If the opportunity to provide care in the listed area was unavailable, please mark A.

If the opportunity to provide care in the listed area was available, but diverse clients were unavailable, mark B.

During this semester's clinical practicum, you provided **culturally specific care** in the following areas: (Mark one choice for each item.)

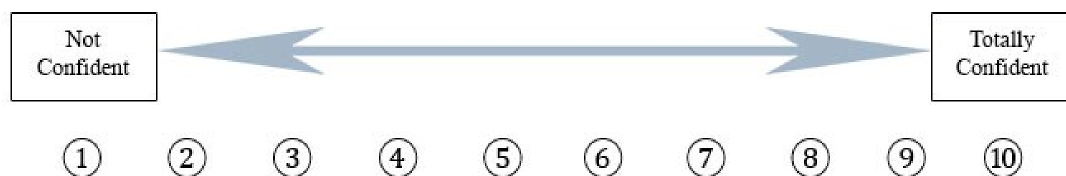
| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(1)** | health history and interview | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(2)** | physical examination | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(3)** | informed consent | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(4)** | health promotion | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(5)** | illness prevention | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(6)** | illness maintenance | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

| **(7)** | health restoration | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(8)** | safety | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(9)** | exercise and activity | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(10)** | pain relief and comfort | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(11)** | diet and nutrition | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(12)** | patient teaching | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(13)** | hygiene | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(14)** | anxiety and stress reduction | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(15)** | diagnostic tests | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(16)** | blood tests | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(17)** | pregnancy | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(18)** | birth | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(19)** | growth and development | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(20)** | aging | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(21)** | dying and death | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(22)** | grieving and loss | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(23)** | life support and resuscitation | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(24)** | sexuality | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(25)** | rest and sleep | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**Part II:** *The most effective way to identify specific cultural factors that influence client behavior is to conduct a cultural assessment.*

How frequently did you assess clients of different cultural backgrounds about each cultural factor during the clinical practicum?

Please use the scale below and mark your response accordingly.




If the opportunity to conduct an assessment of the listed area was unavailable, please mark A.

If the opportunity to conduct an assessment of the listed area was available, but diverse clients were unavailable, mark B.

During **your clinical practicums**, you assessed clients of different backgrounds about: (Mark one choice for each item.)

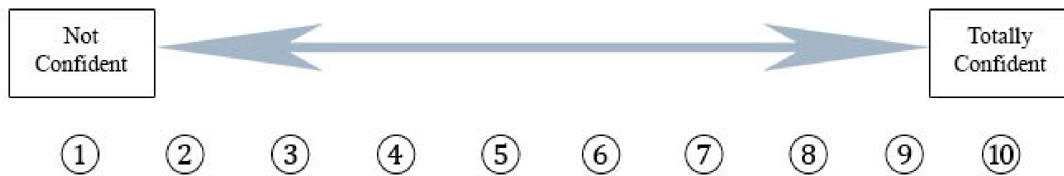
| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(26)** | language preference | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(27)** | level of English comprehension | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(28)** | meaning of verbal communication | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(29)** | meaning of nonverbal behaviors | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(30)** | meaning of space and touch | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(31)** | time perception & orientation | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(32)** | racial background & identity | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(33)** | ethnic background & identity | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(34)** | socioeconomic background | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(35)** | religious background & identity | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(36)** | educational background & interest | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(37)** | religious practices & beliefs | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(38)** | acculturation | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(39)** | world view (philosophy) | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(40)** | attitudes about health care technology | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(41)** | ethic food preferences | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(42)** | role of elders | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(43)** | role of children | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(44)** | financial concerns | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(45)** | traditional health & illness beliefs | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(46)** | folk medicine tradition & use | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(47)** | gender role & responsibility | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(48)** | acceptable sick role behaviors | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

| (49) | role of family during illness | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(50)** | discrimination & bias experiences | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(51)** | home environment | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(52)** | kinship ties | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(53)** | aging | (A) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**Part III:** *What affective learning outcomes did you gain as a result of your clinical practicum this semester?*

Specifically, to what extent did you develop new, culturally sensitive and professionally appropriate attitudes, values, or beliefs OR further develop culturally sensitive and professionally appropriate attitudes, values, and beliefs about the items below?

For Section A, please use the scale below and mark your response accordingly. (Mark one choice for each item.)

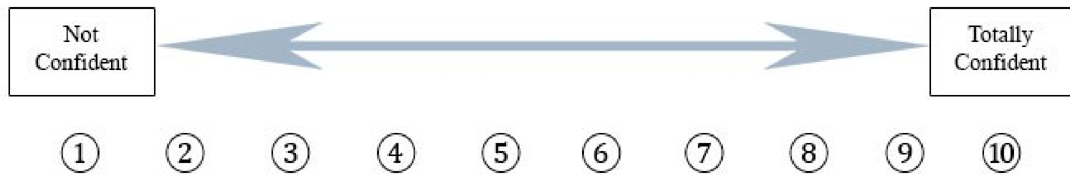



① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

**(A) About Yourself**: As a result of this semester's clinical practicum, you developed a greater **AWARENESS OF**:

| **(54)** | **YOUR OWN** cultural heritage and belief systems | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **(55)** | **YOUR OWN** biases and limitations | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(56)** | difference within **YOUR OWN** cultural group | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

For Section B, please use the scale below and mark your response accordingly. (Mark one choice for each item.)



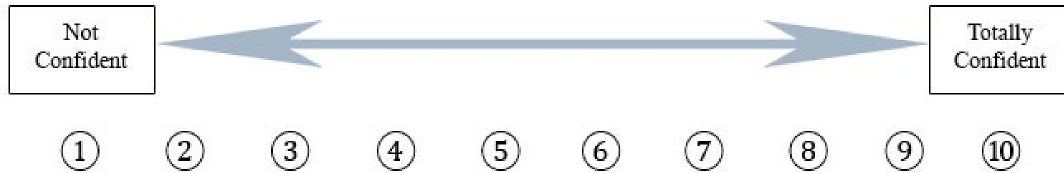

**(B) Among clients of different cultural backgrounds,**

As a result of your clinicl practicums, you became **MORE AWARE OF:**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(57)** | insensitive and prejudicial treatment | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(58)** | differences in perceived role of the nurse | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(59)** | traditional caring behaviors | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(60)** | professional caring behaviors | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(61)** | comfort and discomfort felt when entering a culturally different world | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(62)** | interaction between nursing, folk, and professional systems | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

As a result of your clinical practicum, you became **MORE ACCEPTING OF**:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(63)** | differences between cultural groups | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(64)** | similarities between cultural groups | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(65)** | client's refusal of treatment based on beliefs | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |




As a result of your clinical practicum, you became **MORE APPRECIATIVE OF:**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(66)** | interaction with people of different cultures | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(67)** | cultural sensitivity and awareness | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(68)** | culture-specific health care | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(69)** | role of family in providing health care | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(70)** | client's world view (philosophy of life) | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**Among clients of different cultural backgrounds,**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(71)** | inadequacies in the U.S. health care system | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(72)** | importance of home remedies & folk medicine | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(73)** | impact of roles on health care practices | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(74)** | impact of values on health care practices | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(75)** | impact of socioeconomic factors on health care practices | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(76)** | impact of political factors on health care practices | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(77)** | need for cultural care preservation/maintenance | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(78)** | need for cultural care accommodation/negotiation | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(79)** | need for cultural care repatterning/restructuring | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(80)** | need to prevent ethnocentric views | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(81)** | need to prevent cultural imposition | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

As a result of your clinical practicums, you became a **MORE COMMITTED ADVOCATE FOR**:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **(82)** | client's decisions based on cultural benefits | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **(83)** | culture-specific care | (B) | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

APPENDIX C

PERMISSION TO USE

**Order Details**

**Teaching cultural competence in nursing and health care**

Billing Status:

**N/A**

| | | | |
|---|---|---|---|
| **Order detail ID:** | 66605368 | **Permission Status:** | **Granted** |
| **ISBN:** | 978-0-8261-1787-8 | **Permission type:** | Republish or display content |
| **Publication Type:** | Book | **Type of use:** | Thesis/Dissertation |
| **Publisher:** | Springer Publishing Company | | |
| **Author/Editor:** | Jeffreys, Marianne | | |

View details

**Order License Id:**

3599441216045

**Note:** This item was invoiced separately through our **RightsLink service.** More info**$ 0.00**

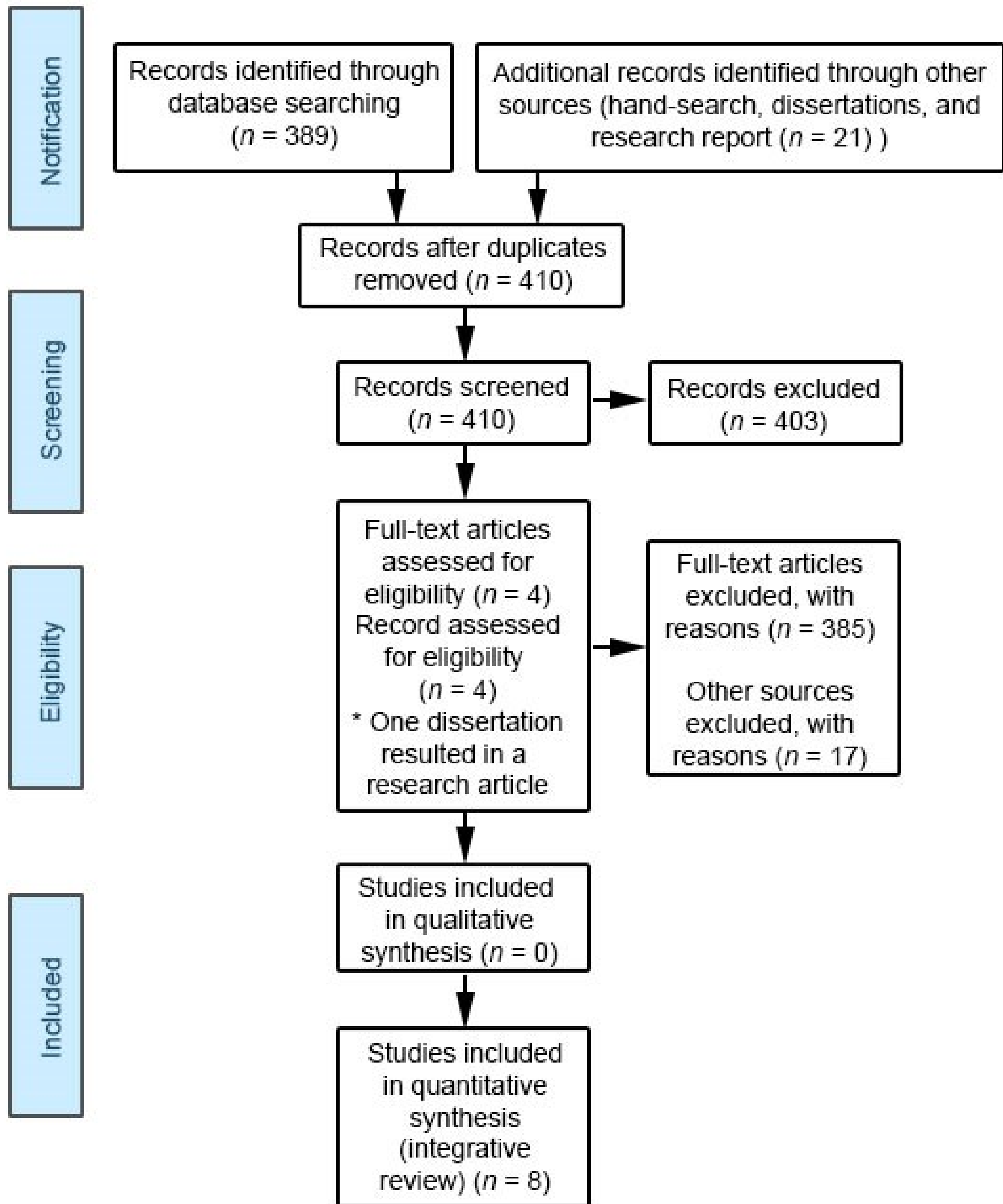
Lynn Schmidt PhD, RN
Associate Professor/Associate Dean/Graduate Coordinator
Anderson University School of Nursing 1100 E. Fifth St, Anderson, IN 46012

*What does the Lord require of you?*

*To act justly, to love mercy, and to walk humbly with your God. Micah 6:8*

APPENDIX D

PRISM DIAGRAM



# APPENDIX E

## AN INTEGRATIVE REVIEW OF NURSING STUDENTS' PERCEIVED TRANSCULTURAL SELF-EFFICACY

| Article | Aim/Purpose | Design/Methods | Sample/Setting | Teaching Strategies | Findings | Limitations Identified by Author |
|---|---|---|---|---|---|---|
| Jeffreys, M. R., & Dogan, E. (2012)<br>Evaluating the influence of cultural competence education on students' transcultural self-efficacy perceptions | 1. To evaluate the influence of cultural competence education on the TSE of associate degree nursing students following integrated cultural competence education.<br>2. Compare and contrast findings between cross-sectional design and a longitudinal design | Quasi-Experimental; pretest–posttest design with a longitudinal arm and a cross-sectional arm | Public northeastern U.S. university<br>Associate degree nursing students<br>Purposive cross-sectional novice (first) and advanced (fourth) semester.<br>$n = 147$ Cross-Sectional<br>$n = 36$ Longitudinal | **Longitudinal Arm**: TSET administered at the beginning of the semester to all students enrolled in the first semester nursing course fall 2007 or spring 2008.<br>TSET was again administered approximately 18 months later during the last six weeks of the last semester spring 2009 or fall 2009. Personal coding system used to match questionnaires, anonymity maintained<br>**Cross-Sectional Arm**: Fourth semester students completed TSET anonymously during the last six weeks of the fall 2007 semester.<br>All students completed a demographic data sheer (DDS) | TSE is influenced by formalized education and other learning experiences. Advanced students' TSET scores were higher for all subscales in both study arms. Cultural competence education throughout the curriculum leads to positive change in self-efficacy perceptions. None of the demographic variables predicted change. Semester was the sole predictor. All students regardless of background benefit (and require) formalized cultural competence education. | Sample size limitations did not permit testing possible mediational interactions between demographic variables, and semester.<br>Longitudinal study: small sample size and high mortality rate. However advantages outweigh discarding data.<br>Cross-sectional changes in particular students could not be assessed. Limited in demonstrating the significance of changes based on consistent educational interventions given to the same group of students. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Larsen, R., & Reif, L. (2011)<br>Effectiveness of cultural immersion and cultural classes for enhancing nursing students' transcultural self-efficacy | 1. To determine the effect of educational interventions, short-term immersion, and culture classes on nursing students' transcultural self-efficacy. | Quasi-Experimental; two-group pretest-posttest design | Small, four-year, liberal arts institution in the Midwest<br>Undergraduate nursing students<br>Convenience sample<br>*n* = 39; *n* = 14 immersion experience, *n* = 25 not completing an immersion experience (control group) | Students participating in the immersion experience completed the TSET online one week before and immediately after their immersion experience.<br>Students in the control group completed the TSET at the same times. | A short-term immersion experience positively affects transcultural self-efficacy. | Limited sample size, self-selection of students into the study group, use of a self-report instrument, and use of a homogeneous convenience sample |
| Amerson, R. (2010)<br>The impact of service- learning on cultural competence<br>Dissertation (2009)<br>The influence of international service- learning on cultural competence in baccalaureate nursing graduates and their subsequent practice | To evaluate self-perceived cultural competence following the completion of service-learning projects in local and international communities. | Quasi-Experimental; pretest–posttest design | BSN students enrolled in a community health nursing course following the completion of service-learning projects with local and international communities<br>Convenience sample<br>*n* = 60; *n* = 54 students assigned to seven clinical sections in groups of six to eleven students; *n* = 6 one week international experience in Guatemala. | TSET was administered at the beginning and completion of the semester. | Service-learning experiences provide an opportunity for students to gain a better understanding of the cultural values and beliefs of patient, family, and community | No control group was used to evaluate self-efficacy perceptions for students not involved in service-learning projects. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Ferguson, P. (2007)<br>Dissertation: Transcultural self-efficacy in graduating nursing students | To examine (a) students perceptions of their capacity to provide culturally relevant care and the relationship between (b) student perceptions of what they experienced in nursing school and their capacity to provide culturally relevant care | Cross-sectional survey design | Graduating seniors in the central and northern area of Illinois taking a National Council of Licensure Examination (NCLEX) review course.<br>*n* = 203 | Graduate from nursing school | Students from both Associate Degree Nursing (ADN) Programs and Baccalaureate of Science in Nursing (BSN) programs perceive themselves as having the ability to care for people in a culturally diverse society. | Students were senior nursing students from central Illinois; therefore the results cannot be generalized to all nursing colleges and schools. Personal biases and beliefs cannot be accounted for |
| Lim, J. L., Downie, J., & Nathan, P. (2004)<br>Nursing students' self- efficacy in providing transcultural care | (1) Identify first year (semester two) and fourth year (semester seven) undergraduate nursing students' perception of self-efficacy in performing transcultural nursing skills. (2) Determine if there was a difference between the first and fourth year students' | Non-experimental correlational descriptive design | Convenience sample of first year (semester two) and fourth year (semester seven) undergraduate nursing students of a pre-registration nursing program in a Western Australian University<br>*n* = 109 first year students<br>*n* = 90 fourth year students | First-year students had experience limited nursing theory and one observational clinical experience. The fourth-year students had engaged in extensive theory in relation to holistic care, including transcultural nursing, with many clinical experiences in a variety of nursing contexts. | Fourth-semester students exposed to increased theoretical information and clinical experience had a more positive perception of their self-efficacy in providing transcultural nursing skills than first year students. Age, gender country of birth, languages spoken at home and previous work experience did not influence the students' perception of self-efficacy in performing transcultural care. | Limitations were not addressed in the article |

| | | | | | | |
|---|---|---|---|---|---|---|
| | perception of self- efficacy in performing transcultural nursing.<br>(3) Examine demographic variables in relation to undergraduate nursing students' perception of self-efficacy and the provision of transcultural nursing skills | | | | | |
| Blackstock, S. L. (2003)<br>Dissertation: An examination of senior nursing students' perceptions of culturally competent nursing practices and their self-efficacy in delivering quality healthcare to culturally diverse patients | To examine senior nursing students' perceptions of cultural competence for community health nursing practice within the home and their levels of self-efficacy, using case study methodology | Non-experimental correlational descriptive design | Senior level nursing students enrolled in a nursing program at a historical Black college in North Carolina<br>*n* = 22 | Community health home care experience | Qualitative data yielded three categories related to nursing students' perceptions of cultural competence: (a) knowledge or cognitive attributes, (b) disposition or affective attributes, (c) skills or practical attributes. TSET revealed that students' level of self-efficacy were higher on the affective subscale, compared to the Cognitive and Practical subscales | Participants were from a historical Black College in North Carolina; therefore, the results could not be generalized. The research was not unknown to the students; this could have affected the way students responded. Additionally, sample size, and students self-reported |

| | | | | | | |
|---|---|---|---|---|---|---|
| Adams, T. M. & Nevel, K. M.<br><br>Research report-date not provided)<br><br>Appraisal of BSN students' transcultural self-efficacy using Jeffreys' transcultural self-efficacy tool | To examine the influence of a transcultural nursing course on baccalaureate nursing students' transcultural self-efficacy during an academic semester | Quasi-experimental; pretest–posttest design | BSN nursing students<br><br>$N = 58$ | Lecture, discussion, brainstorming, videos, DVD, book review of *The Spirit Catches You and You Fall Down*, cultural meal and guest speaker | The results supported that the assessment of transcultural self-efficacy is dynamic and changes following effective transcultural nursing educational strategies. | Not addressed in the report |

APPENDIX F

IRB APPROVAL

Id: 102168
From: admin
Recipients: ammcneli, lyschmid, slbenken
Channel: KC Notification Channel
Producer: Notification System
Type: FYI
Priority: Normal
Send Date: 2014-05-06T12:05:30.000-04:00
Removal Date: none

**Title: Protocol 1404831769** Exempt

**Content:**
**The IRB protocol number 1404831769, Principal Investigator McNelis, Angela has had the action "Protocol Exempt" performed on it.**
**The action was executed by Erny, Richard C. Additional information and further actions can be accessed through the Kuali Coeus system.**

APPENDIX G

INDIANA UNIVERSITY INFORMED CONSENT STATEMENT

**The Impact of an Intercultural Service Learning Experience on Transcultural Self-Efficacy for Second Semester Senior Nursing Students Attending a Baccalaureate Nursing Program**

You are invited to participate in a research study to examine the impact of an intercultural service learning (SL) experience on transcultural self-efficacy (TSE) in second semester senior nursing students who attend a baccalaureate nursing program (BSN). The study will also seek to determine if there are differences in students perceptions of TSE based upon their personal characteristics and type of intercultural SL experience. You were selected as a possible subject because you are enrolled in NURS 4540 Intercultural Health Care. NURS 4540 is a required course in the nursing curriculum at Anderson University School of Nursing. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Lynn M. Schmidt, Doctoral Student at Indiana University, and Associate Professor at Anderson University.

**STUDY PURPOSE**

The purpose of the study is to determine if the location of an intercultural trip impacts transcultural self-efficacy (TSE) in second semester senior nursing student who attends a private faith-based baccalaureate nursing program in the Midwest of the United States. Transcultural self-efficacy is defined as the students' perceived self-confidence concerning transcultural nursing. This may involve: Understanding the cultural factors which may influence nursing care, the interview skills necessary to complete an interview with a client from another culture, and/or the students' values, attitudes and beliefs toward client from another culture.

**NUMBER OF PEOPLE TAKING PART IN THE STUDY:**

If you agree to participate, you will be one of approximately 72 students enrolled in NURS 4540 during the 2012-2013 and 2013-2014 school years who will be participating in this research.

**PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things:
Complete the 83-item Transcultural Self-Efficacy Tool as a pretest to the intercultural SL experience and a post-test within two weeks after the intercultural SL experience. TSET is designed to measure and evaluate learner's confidence (transcultural self-efficacy) for performing general transcultural nursing skills among diverse populations. Scores are reported in three subscales that focus upon the three dimensions of learning: Cognitive, Practical and Affective.

The Cultural Competence Clinical Evaluation Tool- Student Version (CCCET-SV) is an 83- item questionnaire adapted from the TSET, containing three subscales measuring different dimensions of clinical competence behaviors as perceived by students: Extent of culturally specific care (Subscale 1), Cultural assessment (Subscale 2), and Culturally sensitive and professionally appropriate attitudes, values, and beliefs including awareness, acceptance, recognition, appreciation, and advocacy necessary for providing culturally sensitive professional nursing care (Subscale 3). THE CCCET-SV will be completed prior to the intercultural SL experience and within two weeks after the

intercultural Sl experience. The CCCET-SV posttest specifically reflects the intercultural SL experience. The approximate time for completion of the TSET and CCCET-SV is 30 minutes. The course instructor will specify the dates for participants to complete the surveys during class time.

**RISKS OF TAKING PART IN THE STUDY:**
The researcher feels there are no risks in participating in the pretest and posttest of the study.

**BENEFITS OF TAKING PART IN THE STUDY:**
You will not benefit personally from taking part in the study. The overall benefit to participation that is reasonable to expect is that other nursing students and nursing programs may benefit in the future from what is learned as a result of this study.

**CONFIDENTIALITY**
The Questionnaire Cover Sheet for Personal Coding System will be used for anonymity and matching pre and post experience questionnaires (Cultural Competence Education Resource Toolkit, 2010)
In published reports, there will be no information included that will make it possible to identify you. Research records will be stored securely and only approved researchers will have access to the records.
Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. The Questionnaire Cover Sheet for Personal Coding System will be used for anonymity and matching pre and post experience questionnaires.
Organizations that may inspect and/or copy the research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, the Anderson University Human Research Participants Committee.

**COSTS**
There is no cost for participation.

**COMPENSATION**
You will not be reimbursed for your time and participation in this study.

**CONTACTS FOR QUESTIONS OR PROBLEMS**
For questions about the study contact the researcher Lynn M. Schmidt, at765-641-4388. If you cannot reach the researcher during regular business hours (i.e. 8:00AM-5:00PM), please call the IU Human Subjects Office at (317) 278-3458 or Anderson University Human Research Participants Committee at 765-641-4474.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

**VOLUNTARY NATURE OF STUDY**
Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with Anderson University School of Nursing

**SUBJECT'S CONSENT**
In consideration of all of the above, I give my consent to participate in this research study.
I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.
**Subject's Printed Name:_______________________________________________**
**Subject's Signature**:_______________________________________________
**Date**:________

(Must be dated by the subject)

# APPENDIX H

# PERSONAL CODING SYSTEM

**Questionnaire Cover Sheet for Personal Coding System**

**Purpose:** This page will create a unique code that will **only** be used to match your questionnaires together.
**Confidentiality:** Participants will not be identified using information provided. Respondents will remain anonymous.

*Please fill-in the circles below using pen or pencil. Do not use × or ✓ on the form.*

1. The first 2 letters of your mother's maiden name (Example: Smith would be SM):
2. The month that your mother was born.
3. The number of siblings (brothers and sisters) you had when you were 18 years old. (Example: 2 brothers and 1 sister would be 3. If you have 0 siblings, write 0). (If more than 9, please mark 9.)
4. The number of brothers who were OLDER than you when you were 18 years old.
5. The number of brothers who were YOUNGER than you when you were 18 years old.
6. The number of sisters who were OLDER than you when you were 18 years old.
7. The number of sisters who were YOUNGER than you when you were 18 years old.

| 1. | | 2. | 3. | 4. | 5. | 6. | 7. |
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| Ⓑ | Ⓑ | ○ Feb | ① | ① | ① | ① | ① |
| Ⓒ | Ⓒ | ○ Mar | ② | ② | ② | ② | ② |
| Ⓓ | Ⓓ | ○ Apr | ③ | ③ | ③ | ③ | ③ |
| Ⓔ | Ⓔ | ○ May | ④ | ④ | ④ | ④ | ④ |
| Ⓕ | Ⓕ | ○ Jun | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ |
| Ⓖ | Ⓖ | ○ Jul | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ |
| Ⓗ | Ⓗ | ○ Aug | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ |
| Ⓘ | Ⓘ | ○ Sep | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ |
| Ⓙ | Ⓙ | ○ Oct | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ |
| Ⓚ | Ⓚ | ○ Nov | | | | | |
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APPENDIX I

NURS 4470 COURSE CHARACTERISTICS

**ANDERSON UNIVERSITY SCHOOL OF NURSING**
**NURS 4470 - UNIT II**
**UNIVERSAL CHARACTERISTICS OF INTERCULTURAL NURSING**

| OBJECTIVES | CONTENT | LEARNING ACTIVITIES |
|---|---|---|
| 1. Develop cultural competence in the practice of nursing. (C.O.5,6) | I. Cultural Competence<br>A. Definition<br>B. Cultural awareness | Review Purnell Model for Cultural Competence p. 21 |
| 2. Demonstrate an understanding of cultural competence. (C.O. 6) | 1. Unconsciousness incompetence<br>2. Conscious incompetence<br>3. Conscious competence | |
| 3. Synthesize cultural awareness, knowledge, skills, encounters, and desire while practicing nursing. (C.O. 6,7,12) | 4. Unconscious competence<br>5. Interacting styles<br>a. overt racism<br>b. covert racism<br>c. cultural ignorance<br>d. color blind<br>e. culturally-liberated<br>C. Cultural knowledge<br>1. World view<br>2. Illness causation | |
| 4. Identify common biological variations among various ethnic groups. (C.O. 5) | 3. Interacting styles<br>a. acculturated interpersonal<br>b. culturally immersed | Purnell & Paulanka, Chapt. 1 |
| 5. Identify prominent values/beliefs evident in the culture. (C.O. 5 | c. traditionally interacting style<br>d. bi-cultural interacting style<br>4. Biological Variations<br>5. Belief system variations | |

| | | |
|---|---|---|
| 6. Discuss how a culture is assessed using the Purnell and Paulanka frameworks. (C.O. 5,6)<br><br>7. Deliver cultural competent nursing practice. (C.O. 5,6)<br><br>8. Recognize the importance of understanding other cultures and the impact this knowledge will have on the nurse's practice. (C.O.6,12) | D. Cultural skill<br>1. Assessment models<br>a. Purnell's model for Cultural Competence<br>b. Leininger<br>2. Assessment techniques | Purnell and Paulanka p. 7-20.<br><br>Cultural Competency in Baccalaureate Nursing Education document from American Association of Colleges of Nursing (AACN) |
| | E. Cultural encounters<br>F. Cultural desire | Use Cultural Competency in Baccalauretate Nursing Education from AACN |
| 9. Relate common characteristics of the physical environment in which the student will be practicing. (C.O. 7)<br>10. Recognize relevant environmental factors that affect health wellness illness patterns. (C.O. 7) | II. Concept of environment<br>A. Physical environment<br>1. climate<br>2. topology<br>3. location<br>4. resources<br>5. relationship to illness patterns | |
| 11. Describe how cultural behavior, or how one acts in a certain situation, is acquired in a social setting. (C.O. 6,7)<br>12. Compare and contrast the American family system with that of the chosen culture. (C.O. 5,6)<br><br>13. Describe significant social organizational groups within the chosen culture. (C.O. 6,7)<br>14. Compare the societal effect of the listed groups in American society and in the chosen cultural group. (C.O. 6,7) | B. Social environment<br>1. family systems<br><br>a. definitions<br>b. characteristics<br>c. orientation<br>d. functions<br>2. other systems<br>a. education<br>b. economics<br>c. religion<br>d. politics | |
| 15. Advocate for the significance these societal groups may have on the way patients relate to the health care system. (C.O. 7) | e. technology<br>f. social welfare<br>g. roles and relationships | Case Studies: |

| | | |
|---|---|---|
| 16. Integrate appropriate nursing intervention techniques used by the nurse to develop positive communication in the nurse-patient relationship.<br>17. Understand the significance of non-verbal communication. (C.O. 6)<br>18. Explain the significance of the structure and format of names in various cultural groups. (C.O5,6) | h. communication patterns | Holtz, C. (2013). *Global Health Care,* Jones and Barlett. |
| 19. Understand the significant role that culture plays in the understanding and perception of time. (C.O. 6)<br>20. Describe the significance of the measurement of time and the relationship to intercultural nursing care. (C.0. 6) | 3. Time | |
| 21. Discuss factors that influence spatial behavior. (C.O. 6)<br>22. Recognize the culture's definition of personal space and relate its significance to planning care for the patient. (C.O. 6 | 4. Spatial considerations | |
| 23. Appraise the chosen culture's definition of health, disease, illness. (C.O. 6,7) | III. Concepts of Health<br>A. Concepts and definitions<br>1. health<br>2. disease<br>3. illness | |
| 24. Recognize various types of cultural folk health practices and their impact on health-seeking behaviors. (C.O. 6,7)<br>25. Identify the connection between the cultural values and the society's health behaviors. (C.O. 6,7) | B. Health Belief Systems<br>1. magicoreligious<br>2. biomedical<br>3. holistic<br>C. Art and practice of healing<br>1. prevention<br>2. health promotion<br>3. diagnosis<br>4. treatment<br>5. practitioners<br>D. Choice of healing systems | Discuss variations within our own culture |

| Objectives | Content | Readings |
| --- | --- | --- |
| 26. Articulate biological differences among individuals in various racial groups. (C.O. 5,6)<br>27. Relate the importance of biological differences among racial groups and how this may affect the provision of nursing care. (C.0. 5,6) | IV. Concept of people<br>A. Biological variations | Purnell & Paulanka, Chapter 3: African-American<br><br>Chapter 4: The Amish |
| 28. Explain how susceptibility to disease may differ among patients in different racial/cultural groups. (C.O. 5,6) | B. Common illnesses<br>C. Lifestyle or activities of daily living<br>D. Taboos<br>E. Diet | |
| 29. Analyze how the nurse can overcome cultural barriers when practicing nursing and become sensitive to the needs of the patient. (C.O. 6,12) | V. Concept of Nursing<br>A. Educational preparation<br>B. Acculturation between nurse and patient | |
| 30. Demonstrate leadership in addressing behavior that is insensitive, lacks cultural understanding, or reflects prejudice in order to improve adherence to professional standards of respect and civility.(C.O.12) | C. Obstacles in the nurse/client relationship<br>D. Cultural sensitivity in the nurse/patient relationship | |

APPENDIX J

NURS 4540 COURSE CHARACTERISTICS

**ANDERSON UNIVERSITY SCHOOL OF NURSING**
**NURS 4540 UNIT I**
**DEVELOPMENTAL DIMENSIONS OF INTERCULTURAL NURSING**

| OBJECTIVES | CONTENT | LEARNING ACTIVITIES |
|---|---|---|
| 1. Describe the rituals of birth practiced within the chosen culture. (C.O. 1,12)<br>2. Explain the cultural significance of the rituals of birth. (C.O.1,12,15)<br>3. Identify the cultural significance of bearing children. (C.O.1,14, 15) | I. Intercultural nursing care of the childbearing woman<br>A. Rituals of birth | |
| 4. Compare the pre and post natal care of mothers within the culture with the American system. (C.O. 1,2,5) | B. Pre and Post natal care | Purnell and Paulanka—p. 43-44 |
| 5. Examine the child bearing system within the chosen culture paying particular attention to the infant mortality rate. (C.O. 1, 3, 5,10) | | |
| 6. Identify the predominant methods used to increase or decrease the number of children born within the culture. (C.O. 1, 4, 10) | C. Fertility issues | |

| | | |
|---|---|---|
| 7. Examine the role of the various family members within the cultural system. (C.O.1, 2, 4) | II. Intercultural nursing care of children<br>A. Family and culture | Article—To be assigned. |
| 8. Identify racial, ethnic, and sexual differences in the normal pattern of growth and development. (C.O.1,2, 6) | B. Normal growth and development | |
| 9. Compare and contrast the American view on aging with that identified within the chosen culture. (C.O. 1,5)<br>10. Describe how the culture influences the way persons view aging, how it affects the adaptation to alterations in health that often accompany aging. (C.O.1,2,3, 5, 6) | III. Intercultural nursing care of the elderly<br>IV. Cross-cultural variations in perspectives of aging.<br>V. Cross-cultural sensitivity to the developmental aspects of aging. | Purnell and Paulanka: selected reading from various chapters on enthnicity |
| 11. Identify the demographic information concerning aging for the chosen cultural group. (C.O. 10) | A. Percentage of population considered aged | |
| 12. Identify how the dying process varies across cultural groups. (C.O.1, 2, 11) | B. Cross-cultural variations in the dying process. | Death with dignity: Purnell & Paulanka p. 44-46, reading from various chapters on death rituals by ethnicity |
| 13. Participate in intercultural nursing care appropriate to developing clients. (C.O.1, 2, 3, 4, 5, 6, 11, 12, 13, 14, 15) | VI. Implementing cross cultural nursing care with patients/clients who are developing. | The Purnell Model for Cultural Competence |
| 14. Adapt the nursing care plan to reflect their understanding of cultural differences. (C.O.1, 5, 7, 8, 9, 12, 13, 14, 15) | VII. Adaption of nursing care to develop a cultural sensitivity. | |

# NURS 4540 Unit TWO
## HEALTH DEVIATION CHARACTERISTICS OF INTERCULTURAL NURSING

| OBJECTIVES | CONTENT | LEARNING ACTIVITIES |
|---|---|---|
| 1. Appreciate intercultural differences in the patient's health deviation patterns. (C.O. 1,3)<br>2. Describe how biological variations in the patient effect health deviation patterns. (C.O.1,2,3, 8)<br>3. Describe how lifestyle variations within the culture effect health deviation patterns. (C.O.1, 2, 3,8)<br>4. Distinguish how patients from other cultures vary in their perception of pain. (C.O.1,2,3,6) | I. Intercultural nursing variations in physical illness.<br><br>A. Biocultural variations<br><br>B. Lifestyle variations | Purnell and Paulanka Chapter 1<br><br>Selected chapters from Purnell and Paulanka based on ethnic group discussed<br><br>Group discussion |
| 5. Explain the cultural differences in the patient's perception of vulnerability. (C.O.1,3,13) | C. Vulnerability | Case Study on vulnerability |
| 6. Identify how cultures vary in their view of the relationship between the mind and the body. (C.O. 1, 2, 3, 6)<br>7. Examine cultural differences in the expression of emotions and distress. (C.O. 1,2,3,6) | II. Intercultural nursing variations in mental health nursing<br>III. Variations in expression of emotions and distress.<br>A. Variations in the cause of mental health deviations. | Review magico-religious, wholistic and biomedical models of healthcare delivery – group discussion |
| 8. Examine ways spiritual care can be incorporated within the nursing care plan. (C.O. 1,2, 6 11,13)<br>9. Identify how moral issues are affected by cultural considerations. (C.O 11, 13) | B. Spiritual Variations<br>C. Incorporation of religion with nursing care.<br>D. Cultural variations in moral dilemmas. | |

| | | |
|---|---|---|
| 10. Discuss the role of the local, national, and international health care care system in promoting the chosen culture's health. (C.O. 8, 9) | IV. Health Care System<br>A. Local<br>B. National<br>C. International | Purnell and Paulanka: Chinese Americans, chapter 7<br><br>Purnell and Paulanka: People of Mexican Heritage, chapter 18 |
| 11. Adapt the nursing care plan to reflect the understanding of cultural differences. (C.O.4,6, 12, 13, 14, 15)<br>12. Demonstrate culturally sensitive nursing care (C.O.4,6, 11, 12, 13,14, 15) | IV. Implement culturally sensitive nursing care<br>A. Adaption of nursing care plan<br>B. Demonstration of culturally sensitive nursing care. | |
| 13. Value the importance of providing effective nursing care to patients from another culture. (C.O. 1,2, 4, 5, 6, 13, 14, 15) | C. Valuing culturally sensitive nursing care | Cultural, Ethic, and Racial Diseases and Illnesses p. 373- 370 – Purnell & Paulanka |
| 14. Investigate through the research process one cultural difference. (C.O. 10) | D.Expanding knowledge about culturally sensitive nursing care. | Purnell & Paulanka: p. 45-46 and selected readings on various cultures' view on spirituality |

# APPENDIX K

# DEMOGRAPHIC DATA SHEET

Demographic Data:

1. Gender
   - Female
   - Male
2. Age
   - Under 25
   - 25-29
   - 30-34
   - 35-39
   - 40-44
   - 45-49
   - 50-54
   - 55-59
   - 60 and over
3. Which of the following categories best describes you?
   - American Indian or Alaskan Native
   - Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai)
   - Other Asian
   - Black or African American
   - Hispanic or Latino
   - Native Hawaiian or Other Pacific Islander
   - White
   - Multiracial
   - Other
4. Is English your first language?
   - Yes
   - No
5. Do you speak a language other than English fluently?
   - Yes
   - No
6. Were you born in the United States?
   - Yes
   - No
7. Previous health care experience:
   - None
   - CNA
   - LPN
   - EMS
8. Prior Experience with direct participation or observation of a cultural other than your own:
   - No experience
   - Experience within the United States with a culture other than self
   - International experience with a culture other than self
9. Location of your Intercultural Experience NURS 4540____________________________________

# APPENDIX L

## REFLECTIVE JOURNAL

ANDERSON UNIVERSITY SCHOOL OF NURSING
NURS 4540 Reflective Journal

Throughout your intercultural service learning (SL) experience, you are to keep a reflective journal which will be submitted to your trip leader with your final paper. A reflective journal is sometimes referred to as a learning log and utilized to document feelings and reactions to your experience. It is not to be used as a simple log of your daily activities. The number of entries is trip dependent and your trip leader will discuss the appropriate number with your group. The journal will be worth 10 points or 10% of your grade in NURS 4540.

Based on your setting and experience, the following questions or statements need to be answered or addressed through your journaling experience.

1. Describe an excellent example of intercultural communication from either your intercultural experience or a clinical experience in the hospital.
2. How has the intercultural experience influenced your thoughts/beliefs about your cultural knowledge of patients with different cultural backgrounds?
3. How has the intercultural experience influenced your confidence in interacting with cultural diverse patients to learn about their values and beliefs?
4. How has the intercultural experience influenced your values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition, and advocacy?
5. How would you describe the impact of the intercultural experience on you personally?
   Professionally?
6. How will this experience influence your nursing practice?
7. What advice would you give to students traveling on future trips?

# APPENDIX M

## CONTENT ANALYSIS OF SUBTHEMES AT MACRO AND MICRO LEVEL

**Research Question 6. How has the intercultural experience influenced students' thoughts/beliefs about their cultural knowledge of patients with different cultural backgrounds? (Cognitive)**

Responses from the domestic trip are denoted in SMALL CAPS.

### Themes

*Build Rapport*

- "WE NEED TO BE SENSITIVE TO HOW WE APPROACH SITUATIONS. WE NEED TO TAKE THE TIME TO BUILD A RAPPORT WITH OUR PATIENTS AND SHOW WE CARE IF WE WANT TO BE A GOOD INFLUENCE AND A GOOD CARE GIVER. WE MUST EARN THE RIGHT TO SPEAK."

- "PATIENTS WITH DIFFERENT CULTURAL BACKGROUNDS MAY HAVE DIFFERENT NEEDS, BUT ONE THING THAT IS FOR SURE IS THEN WHEN YOU CARE FOR SOMEONE AND ARE SINCERE, THE PATIENT FEELS THAT. ALTHOUGH YOU MAY NOT HAVE THE ANSWER RIGHT THEN AND THERE, THE RELATIONSHIP/BOND WITH THE PATIENT TRUMPS ANY DOUBTS/WORRIES THE PATIENT MAY HAVE. I REALIZE NOW THE IMPORTANCE OF DEVELOPING TRUST AND RAPPORT WITH PATIENTS OF ANY CULTURAL BACKGROUND."

- "This taught me that even the smallest amount of knowledge gained about a culture can make all the world of difference. It has motivated me to seek out more information on how to bridge cultural gaps, especially within the healthcare field."

- "This experience has changed my thoughts about cultural knowledge of patients with different cultural backgrounds in that I discovered our differences arise in our upbringing. I learned that I think the things I think because of the culture I was raised in. Likewise, others have learned through patterns. Their cultural background is just as valid as mine and I learned there is not 'right' or 'wrong' way to think. I respect the difference in cultural backgrounds and will work to change my actions to better care for my intercultural patients. I also learned that we are so similar too. People are people no matter where they're from."

*Communication*

- "FINDING THE RIGHT WAY TO COMMUNICATE WITH PATIENTS FROM DIFFERENT CULTURAL BACKGROUNDS IS KEY. YOU DON'T WANT TO OFFEND THEM AND MAKE THEM SHUT DOWN; YOU WANT TO GAIN THEIR TRUST IN HOPES FOR THEM TO PROVIDE THE INFORMATION NECESSARY TO HELP THEM. I DIDN'T REALIZE HOW HARD IT WOULD BE TO COMMUNICATE WITH THE RESIDENTS."

- "MY INTERCULTURAL EXPERIENCE HELPED CONFIRM THAT WHEN PROVIDING PATIENT CARE IT IS IMPORTANT TO LISTEN AND NOT BE JUDGMENTAL WHEN PROVIDING CARE. IT IS IMPORTANT AS NURSES THAT WE DON'T JUDGE AND PROVIDE DIFFERENT CARE TO OTHERS OF A DIFFERENT BACKGROUND. WE NEED TO PUT OUR PAST EXPERIENCES ASIDE AND PROVIDE CARE WITH AN OPEN HEART AND MIND."

- "The intercultural experience has helped me to put myself in the place of a minority culture patient. It was me who spoke a different language than the rest. They couldn't understand was I was trying to say. I felt their frustration. That was probably the most difficult part, not their specific cultural belief/backgrounds. I learned to rely more on nonverbal communication. I definitely gained awareness about different cultures. I know that there are different ways to do things other than how we do them here."

- "To be honest, I discovered that there is a great deal about other cultures that I will never understand or grasp. BUT in India, the few communicative methods without words proved to be invaluable."

- "The experience opened my eyes to how many small details of life look different in another culture. I will certainly ask more specific questions in my assessment of patients from different cultural backgrounds and be less apt to make assumptions."

- "Experiencing the healthcare in Uganda has helped me better understand how to communicate effectively with those that are less familiar with healthcare. Many of the patients we came into contact with did not understand the education we were giving. Therefore, we needed to word things more simply for them to understand. I think this will carry over into my practice here in the states and remind me that many people do not understand medical jargon."

- "It has taught me to be more open and to not worry if my expectations are met. It has also taught me to listen to patients more and to reflect on what they are saying rather than assessing too fast. I also learned that no matter how hard you research, there is always something to learn."

*Cultural Competence*

- "I NOW UNDERSTAND I HAVE A HUGE DEFICIT OF KNOWLEDGE ON OTHER CULTURES. THERE ARE SO MANY THINGS YOU JUST CANNOT LEARN FROM ARTICLES AND RESEARCHING. THE MOST IMPORTANT THING I LEARNED ABOUT DEALING WITH DIFFERENT CULTURAL IS TO BE HONEST ABOUT MY LACK OF KNOWLEDGE ON THEIR CULTURE. THE AMERICAN INDIAN PEOPLE WERE VERY UNDERSTANDING AND LOVED TELLING ME ABOUT THEIR CULTURE. I THINK THEY APPRECIATED MY WILINESS [*sic*] TO LEARN."

- "I REALIZED THAT WHILE I UNDERSTAND OTHER CULTURES, I'M NOT ALL KNOWING OF THAT CULTURE. I THOUGHT I KNOW A LOT ABOUT SOUTHERN CULTURE, ESPECIALLY THE POOR-SUBGROUP, BUT I WAS SURPRISED EVERYDAY BY SOMETHING NEW. I NEED TO CONTINUE LEARNING THROUGHOUT CARE OF THAT CULTURE."

- "I realized that I knew a lot less about the culture than I thought I did. Privacy was very big deal there, even with the close quarters. It also helped me see why people of Indian culture are the way they care, which was nice."

- "The cultural experience taught me that it's very important to be culturally competent and to provide culturally competent care as a nurse. I also learned that it takes continual learning to provide culturally competence care. Even if you study a culture, there are so many different beliefs and values that you learn something new each day."

- "It is important to be sensitive to the patient's cultural heritage and not press one's own beliefs or behaviors onto a patient."

*World view*

- "Personally for me, traveling to India and experiencing a new culture was not new to me. Working in Kenya, Korea, in India or here in the U.S. for me has been a cultural experience. The new place and people did influence my world view and also my perspective on global healthcare. It's always difficult to walk out of comfort zones and interact with patient from different backgrounds. India was another step to become more cultural competent."

- "I have had a variety of intercultural experiences and each one has widened my view of the world and enlarged my heart for different people. I no longer see a cultural tradition that is different from mine as 'weird,' but now embrace it as a difference. I'm far less judgmental of my patients and open to learning about their culture and embracing them."

- “My experience in Uganda has made me a lot more appreciative of other cultures and has increased my understanding of why patients do the things they do.”

- “The intercultural experience changed my thoughts and beliefs of cultural knowledge of patients of different cultures in that I learned how similar we all are.”

*Nursing Care*

- “The intercultural trip has inspired my creativity within the nursing process. Having to accommodate multiple religious backgrounds in the care that was given in India made me get more resourceful with my interventions. I made me realize that I need to be open to new suggestions and new ways of treating patients. Nursing isn’t a ‘cookie-cutter/textbook/job’ and I have to be ready to quickly adapt to any scenario.”

- “Every person values different things and that needs to be tied into our considerations of nursing care.”

- “I have also influenced the way that I view our ways of providing care in America. Just because we do things differently than in Uganda does not make their ways inferior to ours. Who are we to say that there is a right or wrong was to practice medicine. It has taught me to have respect for other culture’s views and practices.”

- “Prior to going to Uganda it was very difficult to understand why the disease transmission rate is so high, and why people do not receive medical care, despite all of the medical teams who go to Africa to help. I witnessed firsthand—such as with dental hygiene—if something is not a part of their culture, the natives would listen respectfully, but would not act on it.”

- “This experience has made me want to learn so much more about other cultures. It is so important to have knowledge about these cultures when providing nursing care.”

- “I have developed a new appreciation of the knowledge and education in which I have received and with that was able to education a population lacking in all aspects of medical care.”

- “I saw the importance of explaining things thoroughly, educating well, and providing privacy.”

APPENDIX N

CONTENT ANALYSIS OF JOURNAL RESPONSES TO IDENTIFY THEMES AND PATTERNS

**Research Question 7. How has the intercultural experience influenced students' confidence in interacting with culturally diverse patients to learn more about their values and beliefs? (Practical)**

Responses from the domestic trip are denoted in SMALL CAPS.

**Themes**

*Building Rapport*

- "IT ALLOWED ME TO OPEN UP MORE ABOUT MYSELF AND IN RETURN THEY WOULD OPEN UP AS WELL. THERE HAS TO BE A LEVEL OF VULNERABILITY AND HONESTY WHICH CAN SHAKE A PERSON'S CONFIDENCE."
- "THERE NEED TO BE A RESPECTFUL, GENTLE APPROACH WHEN INTRODUCING YOURSELF TO CHILDREN FROM DIFFERENT CULTURES OR SOCIOECONOMIC BACKGROUNDS, FINDING WAYS TO GAIN TRUST AND ACCEPTANCE."
- "BEFORE OUR INTERCULTURAL TRIP, I WAS A BIT WEARY OF INTERACTING WITH PEOPLE DIFFERENT THAN MY OWN RACE BECAUSE I WANTED TO BE CAUTIOUS IN MAKING SURE I DID NOT UNINTENTIONALLY OFFEND SOMEONE. EXPERIENCING HOW A RELATIONSHIP CAN GROW GIVE ME HOPE THAT ALTHOUGH A RELATIONSHIP WITH A PATIENT MAY START OUT ROUGH, THERE IS STILL AN OPPORTUNITY TO MAKE GOOD OUT OF IT AND TO NEVER GIVE UP."
- "I would definitely say that I am more confident in interacting with culturally diverse patients. This experience allowed for time of being uncomfortable and absorbing information about very different values and beliefs than my own. Practice builds confidence."
- "It raised my confidence in being able to interact with culturally diverse patients. I feel I have a better understanding as to how to interact with a different culture."
- "I would say this experience served to enhance the confidence I already has with other cultures. I love learning about other cultures, especially when it comes to food!"

- “Honestly, the more time I spent with Ugandans, the more confident I felt. It certainly felt nerve-wracking at first. And seemed like such a hard task; however after a while you begin to understand that they are people too, just with different views and language. Also, surprisingly many were SO open about their lives and were extremely friendly. Conversations became laid back and easy over time. I gained a lot of knowledge.”

- “At first I was very hesitant to converse with the patients on an in-depth level. But as I became more adjusted to the community, I learned how much of an impact I could have just by showing an interest in the patient and wanting to learn about their culture. I felt more respected y patients after this, so it was important to see the impact even showing a subtle interest in the culture could have on my interaction with the patient. These people are proud of their culture and want to share it.”

- “I feel far more confident in interacting with culturally diverse patients. I love cultures and talking about differences and similarities so I have no reserve when it comes to learning about one’s beliefs and values. This experience has influenced my confidence in interactions by increasing it and changing the way I go about attaining information. In this way, I can respectfully gather information that will allow me to provide the best care possible to my patients.”

*Communication*

- “MY CONFIDENCE IS MUCH HIGHER. BEFORE I THOUGHT PEOPLE OF DIFFERENT CULTURES WOULD GET VERY OFFENDED BY MY LACK OF KNOWLEDGE. ON THE CONTRARY, THE PEOPLE ARE EAGER TO HAVE SOMEONE TO TALK ABOUT THEIR CULTURE, PEOPLE ARE SO PROUD OF WHERE THEY CAME FROM! SO NOW I KNOW I DON’T HAVE TO FEAR ASKING THE RIGHT OR WRONG QUESTIONS. PEOPLE ARE MUCH MORE FORGIVING THAN I PREVIOUSLY THOUGHT AND GENUINELY WANTED TO HELP ME UNDERSTAND MORE ABOUT THEIR CULTURE.”

- “I THINK THE INTERCULTURAL EXPERIENCE HELPED TO BETTER MY THERAPEUTIC COMMUNICATION SKILLS.”

- “I LEARNED TO LISTEN AND TO FIND VALUES AND BELIEFS WE HAD IN COMMON AND FOCUS ON THOSE. WE ALL HAVE SOMETHING WE CAN LEARN FROM EACH OTHER.”

- “My confidence has improved when communicating with culturally diverse patients. I have learned to focus on nonverbal communication instead of verbal. I also figured out that care that matches their beliefs instead of our beliefs has better results. It doesn’t hurt to ask questions. They are glad/proud to share things that they believe in.”

- “I am less confident now than I was before the experience, but I see that as a good thing. My ideas of cross-cultural communication somehow gave me confidence that the language barrier was a small thing to be conquered. I was wrong. I was not very proficient or skilled in communicating with people in India. This realization is not discouraging, however, because I see it as a larger learning opportunity.”

- “Through this experience I have gained a lot of confidence in communication. I am also more confident in my nursing knowledge than I was before. I think that learning more about their values and beliefs helped me to make better connections and to make the information we taught easier for them to understand.”

- “Nonverbal communication speaks volumes even with a language barrier, and should be assessed for every patient.”

- “This trip definitely made me more confident about interacting with culturally diverse patients. It showed me that I actually know a lot more than I thought I did, and that no matter what culture patients belong to, we are all human. It does not have to be frightening and I realized that attitude has a lot to do with it. The language barrier was also not as bad as I had expected; when you have to communicate with people, you find ways to get across those barriers.”

- “The experience in Uganda significantly boosted my confidence in speaking to others about their values and beliefs. I found that when asking individuals questions about these personal matters, there was nothing to lose—the person would either refuse to tell me or I would gain significant knowledge on a topic. Patients from all backgrounds understand/acknowledge the importance for healthcare professional to ask questions about their values and beliefs.”

*Nursing Care*

- “I feel confident to walk into a patient of a different cultures room and best meet their needs and inquire how I can incorporate their values into their care.”

- “I am now more confident about asking my patients more private questions that would be a part of their beliefs. During HIV/AIDS testing in the clinics we had to ask many people if they were sexually active and how many partners they had. Some were offended or hesitant in answering honestly because of their values and beliefs; we had to remind them that the information is private.”

- “My confidence increased after visiting Africa. I have learned that I should not be afraid of taking care of a person with different cultural background. Instead, if I ever have a patient in the future with a different cultural background, I will do research on their culture like I did before going to Africa. Knowing about different cultural backgrounds definitely will always increase my confidence while interacting with culturally diverse patients.”

- “Each patient needs to be treated as an individual. Asking patients about their preferences is important. Modesty was a huge deal in Uganda. For example, I have to give a male patient two shots in his gluts. He was very anxious and seemed nervous about there being two women in the room. I asked them to step out once I had my supplies set up. He thanked me afterwards for providing him privacy because he was afraid to ask.”

*Cultural Competence*

- “Every interpersonal, whether it is or not an intercultural experience should challenge us to learn about our patient’s values and beliefs concerning cultural awareness. Going to India was another reminder for me that intercultural and interpersonal interaction and competency is important. More so important in the nursing profession. Leaning [*sic*] about another culture and meeting new people has grown more confidence.”

- “I felt like this experience has me realizing that as we go into other cultures or hospital rooms of people of culturally diverse patients, we need to keep in mind their culture….We can educate them and teach them but we cannot change the entire way in which they or their culture functions. We need to take a step back and not superimpose our thoughts, beliefs, and values on them, but work together to develop a suitable way of life for them all which giving the best care.”

- “I feel more confident with each cultural interaction I experience. I feel confident to learn about any cultures values and beliefs. I also learned that being respect and sensitive to their value and beliefs is important.”

- “I believe I have a deeper interest to understand my patient’s values and beliefs. I deeply desire to meet them where they are in their life and fully embrace their cultures.”

APPENDIX O

ANALYSIS TO IDENTIFY THEMES AND PATTERNS ACROSS MACRO AND MICRO LEVELS

**Research Question 8. How has the intercultural experience influenced students' values, attitudes, and beliefs concerning cultural awareness, acceptance, appreciation, recognition and advocacy? (Affective)**

Responses from the domestic trip are denoted in SMALL CAPS.

**Themes**

*Knowledge*

- "I HAVE A MUCH STRONGER CALLING TO LEARNING MORE ABOUT CULTURE. SEEING THE WAY THE NAVAJO MAN LIT UP WHEN I TALKED TO HIS ABOUT HIS BACKGROUND MADE ME THINK OF HOW THERAPEUTIC IT IS TO MEET EACH PATIENT WHERE THEY ARE. IT WAS IMPORTANT TO THE NAVAJO MAN THAT I RECOGNIZED HE WAS FROM ANOTHER CULTURE AND WANTED TO LEARN MORE. IN LEARNING MORE ABOUT A PATIENTS CULTURE WE CAN BETTER UNDERSTAND THEIR WISHED [*sic*] AND ADVOCATE FOR THEM MORE EFFECTIVELY."

- "I think through my experience I have learned to value aspects of other cultures that I thought I wouldn't. For example, I was able to recognize and appreciation [*sic*] the devotion that the Sikh's and Hindu's have to their god(s). Although I do not share the same beliefs, I appreciate their dedication and initiative in the worship and practices. I think a lot of people, myself included, in the Christian faith can learn to be more devout like them. The trip also influenced my attitude on acceptance. I learned to accept that what I might have planned or expected may not happen. This was a great realization and I enjoyed my trip more because I learned to be flexible and appreciate what I have and the examination of self."

- "It opened my heart to loving and appreciating a country and a group of people. Caring for the Indian population is something I am more aware of and will now be able to recognize and advocate for more easily. When you care about something more—personally—it is easier to show that professionally and in your work."

- "This intercultural experience did influence my values, attitudes, and beliefs concerning cultural awareness. I became more knowledgeable about a culture I did not know. My values were strengthened, such as respect, love, and compassion and I was very appreciative of the changes it made to my life."

*Listening*

- "IT IS IMPORTANT TO RESPECT AND LISTEN TO OTHERS EVEN IF WE DO NOT AGREE OR UNDERSTAND, FOR PATIENTS, IT IS OUR JOB TO RESPECT THEM AND THEIR BELIEFS EVEN IF WE MAY HOLD DIFFERENT BELIEFS."

*Building Rapport*

- "I HAVE ALWAYS GROWN UP IN A VERY ACCEPTING HOME, IF THIS TRIP DID ANYTHING, IT MADE ME REALIZE HOW IMPORTANT IT IS TO MENTOR KIDS AT A YOUNG AGE AND PROVIDE THEM RESOURCES SOONER RATHER THAN LATER."

- I've always believed that people of different cultures are valuable. However, this trip was a way to enact on it and meet them at their level of attitudes, and beliefs. I recognize that it is important for different cultures to stay different as well."

*Nursing Care*

- "I FEEL THAT WE NEED TO BE MINDFUL OF EACH PERSON'S DIVERSITY EVEN IF I FEEL WE SHARE A SIMILAR BACKGROUND, A SMALL DIFFERENCE CAN CHANGE ONE'S WORLD AND THOUGHT PROCESS. BEING A GOOD NURSE MEANS BEING AWARE OF NOT OUR OWN BELIEFS, ATTITUDES, AND VALUES BUT BEING MINDFUL OF THOSE DIFFERENT THAN OUR OWN. WE MUST ALWAYS ADVOCATE FOR ALL OUR PATIENTS AND RECOGNIZE THEIR NEEDS MAY BE DIFFERENT THAN WHAT WE THINK THEY MIGHT NEED OR WANT. WE MUST BE AWARE AND ACCEPT THESE DIFFERENCES AS LONG AS THEY ARE NOT HARMFUL."

- "THERE IS A NEED TO GIVE ALL CULTURES RELEVANCE AND BE SENSITIVE TO INDIVIDUAL NEEDS BASED ON CULTURE, BELIEFS, VALUES, ETC. IT IS WRONG TO PUT YOUR OWN BELIEFS, VALUES, EXPECTATIONS ON ANYONE, AND INSTEAD ASK ABOUT NEEDS, PREFERENCES, THAT WILL PROMOTE A PERSON'S WELL-BEING.

- "My beliefs on how to acculturate myself have changed because I became aware of the amazing fact that I would/will never fit in in India. This is a fact that I think I needed to learn in order to truly value the experience. My skin means I will always be a foreigner in that world. This idea has given me motivation to ensure that I am an advocate for those who feel foreign here in the U.S. My nursing practices and compassions for the powerless has only grown because of this experience. Being foreign makes you feel lost and exposed and I will do my best to make sure none of my patients feel like that under my care."

- “I realized on this trip that there is definitely need for cultural competence, awareness, acceptance, appreciation, and recognitions in the healthcare setting. We need to advocate for patients wished [*sic*] and include them in decisions about their care. Seeing how things are done in a different culture opened my eyes to possible expectations and cultural norms in healthcare. It is definitely like a different world but we must uphold our patient’s values and make them as comfortable with their setting as possible.”

- “This trip made me take notice of all the people in India who need nurses to advocate for their well-being.”

- “I found myself working hard to discover medical issues maybe they didn’t even know they had because they didn’t know to ask. I acted as an advocate for them medically, helping in any way I could, but they also gave so much back to me as well.

*Awareness*

- “It affirmed my attitudes and beliefs to make others more culturally aware. It helped me to be more accepting of my peers from different backgrounds. It made me appreciate of my own culture and opportunities. It helped me recognize areas I need to improve physically, mentally, and spiritually.

- “The trip showed me that just because we are taught in America a skill it doesn’t make it the best or right way. I learned to accept different approaches, skills, and even learned new information. It really gave me appreciation of other cultures and raised my awareness.”

- “I am far more accepting and appreciated of other cultures after traveling to another continent. I have a deep desire to learn what makes a culture a culture and am interested in respecting each culture. The advocacy piece is huge to this as well; I believe that as one learns about injustices within other cultures—than the then can choose to take a stand for their patients and their culture.”

- “This experience has taught me that my culture is not the only way of doing things. Being aware of other cultures and accepting them is a great way to form friendships with other people. Those people can help you grow in many ways. Our cultures is not the only right way of doing things and in healthcare, we need to be advocates for our patients that do things differently.”

- “This trip has *absolutely* made me more appreciative of the Ugandan’s joyful culture full of so much faith and love for one another.”

- “This experience has opened my eyes and painted a new outlook on life and realize that each day is a day that we can only treasure. The Ugandan people have little to nothing, homes that I could not imagine calling home but they have it all. Their love for one another over flows forms their every being. In spite all things…even if they didn’t have a scrap of food, no clothing, dirt floors, they gave all the glory to the Lord. That had shaped to realize how much in *abundance* I have! Uganda didn’t need me… I need Uganda. My outlook on like will forever be changed.”

- “I believe I grew to appreciate and love their cultural differences as the trip went on. I have a great deal of admiration for the Ugandan culture. I hope to include more of their values, especially *family*, in my own life. They take care on each other.”

- “My values, attitude, and beliefs concerning cultural awareness, acceptance, appreciation, recognitions, and advocacy were challenged everyday while in Africa. I realize some of the things that I value in the U.S. such as material things, don’t mean as much to me after visiting Africa. Even though I have always valued God, the African culture praised him so much even though they do not have anything that increased my religious beliefs a lot.”

- “The intercultural experience reminded me again of why culture is important. You can gain so much insight by getting to know people of other cultures. Not only do you learn about their life and culture, but you can learn about and appreciate your own culture in a new way.”

- “It has made me want to become more culturally aware. This is something that will continue throughout my life and there will never be a time when I know everything there is to know. It also taught me more about having respect and appreciation for other cultures. I was also sad to see how they viewed our culture as being so superior to their own. They could not see how much they had to offer us and did not see themselves as valuable, which was hard for me to see.”

- “Spiritually regarding HIV/AIDSA patients, I found that my assumptions regarding this diagnosis in Africa were totally skewed. When thinking of Africa, it is common to assume the HIV/AIDS is so common that it must be accepted. I found that HIV has such a stigma attached to it in Uganda. Because of this, I believe it is necessary that we advocate for the culture and provide them with thorough education tools. These families are not ‘okay’ with their diagnosis. They need to be supported, encouraged, accepted, and appreciated.”

- “At first the culture was very foreign to me, and I was very aware of the differences, but after a few days immersed in the culture, things improved and were more acceptable. Once I had a better attitude towards the trip, I was able to appreciate the culture. Now that I have returned home, I recognize the vast beauty of the country, as well as the dire need of the country, and wish to advocate for them. It became apparent that a positive attitude and outlook on other cultures is key.”

- “Through this experience I have come to the conclusion that cultural awareness should be more widely taught. I think everyone needs to understand, accept, recognize, and appreciate, as much as they can, cultural differences. I would gladly advocate for cultural awareness because, with migration trends, we will be taking care of more and more culturally diverse people. I also value these differences and believe others should at least be aware of them.”

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# CURRICULUM VITAE

## Lynn Marie Schmidt

### Education

| Institution | Degree | Date Awarded |
|---|---|---|
| Indiana University | PhD Nursing Science | 2015 |
| Ball State University | Masters of Science in Nursing | 2010 |
| Ball State University | Bachelor of Science in Nursing | 2007 |
| Henry Ford Hospital School of Nursing | Registered Nurse | 1986 |

### Appointments

| Institution | Rank | Inclusive Dates |
|---|---|---|
| Anderson University | Associate Dean School of Nursing | 2014–Present |
| Anderson, IN | Associate Professor | 2015–Present |
| | Assistant Professor/Graduate Coordinator | 2010–2013 |
| Ball State University<br>Muncie, IN | Instructor | 2008–2010 |

### Professional

| | | |
|---|---|---|
| Mt. Pleasant Township<br>School Corp., Yorktown, IN | RN | 2001–2008 |
| Muncie Otolaryngology,<br>Muncie, IN | RN | 2003–2008 |
| Midland Otolaryngology<br>Midland, MI | RN | 1990–1991 |
| Henry Ford Hospital<br>Detroit, MI | RN | 1986-1990 |

### Licensure

State of Indiana
State of Michigan

### Professional Organization Memberships

American Association of Colleges of Nursing
Indiana Organization of Nurse Executives
National League for Nursing
Sigma Theta Tau International
Transcultural Nursing Society

### Professional Development

ATI National Nurse Educator Summit — April 2015

Collaborative Institutional Training Initiative (CITI Program):
Social/Behavioral Researchers Stage 2 — January 2015

Indiana Nursing Summit: One Voice — October 2014

CCNE Workshop of Writing Self-Studies October 2014

NLN Educational Summit September 2014

Sigma Theta Tau International & NLN Nursing Education
Research Conference April 2014

Sigma Theta Tau 42nd Biennial Convention November 2013

NLN Educational Summit September 2013

Certified Nurse Educator (CNE) Examination Review Course
Indiana University May 2013

Nursing Informatics Boot Camp, IU Health North May 2013

American Association of Colleges of Nursing (AACN)
Doctoral Education Conference January 2013

National League of Nursing (NLN) Education Summit September 2012

Sigma Theta Tau International (STTI) Nursing Education Research
Conference June 2012

Midwest Nursing Research Conference April 2012

AACN Master's Education Conference March 2012

AACN Fall Semiannual Meeting October 2011

NSN Education Summit September 2011

QSEN Faculty Development Institute September 2011

AACN Master's Education Conference February 2011

36th Annual Nursing Research Conference Clarian Health December 2010

**Teaching**

NURS 2130 The Nursing Profession (BSN), co-coordinator
NURS 3390 Nursing Research (BSN), course coordinator
NURS 4560 Nursing Leadership (BSN), clinical instructor
NURS 5010 Introduction to Graduate Nursing (MSN), course coordinator
NURS 6140 Diversity in Healthcare (MSN), course coordinator
NURS 6150 Issues in Higher Education (MSN), course coordinator
NURS 6220 Nursing Theory (MSN), course coordinator
NURS 6240 Nursing Research (MSN), course coordinator
NURS 103 Cultural Diversity (BSN), course coordinator
NUR 404 Community Health (BSN), clinical instructor

**Publications & Presentations**

6th International Symposium on Service-Learning May 2015

The Impact of an Intercultural Service-Learning Experience
Midwest Nurse Research Society April 2015

Driving Forces, Obstacles, & Opportunities
NLN Educational Summit September 2013

Global Service Learning in Schools of Nursing Policy and Curricular Issues, NLN New York June 2013

**Institutional Service**

Anderson University Graduate Council, Co chair 2014–2015
Anderson University School of Nursing Graduate Curriculum, Chair
First Year Experience Advisory Council, Member
MSN Informatics Advisory Board, Chair
Strategic Enrollment Plan, Graduate & Adult Studies Work Team

Anderson University Graduate Council, Co chair 2013–2014
Anderson University School of Nursing Graduate Curriculum, Chair
First Year Experience Advisory Council, Member
MSN Informatics Advisory Board, Chair

Anderson University Graduate Council, Co chair 2012–2013
Anderson University School of Nursing Graduate Curriculum, Chair
MSN Informatics Advisory Board, Chair
Anderson University President's Dinner, hosted by the School of Nursing 2013

Anderson University Graduate Council, Co chair 2011–2012
Co-Coordinator of Graduate Catalog Revisions for 2012–2014 catalog year
Anderson University School of Nursing Graduate Curriculum, Chair
Falls Departmental Initiative Committee, Member
MSN Informatics Advisory Board, Chair

Anderson University Graduate Council, Member 2010–2011
Special Assignment "Guidelines for Developing New Graduate Degree Program"
Anderson University Process Model Task Force, Member

**Department Service**

Advising: 26 BSN students, 31 MSN 2014–2015
AU SON Discovery Day September 26, 2014
CCNE Self Study

Professor Schmidt advised 28 undergraduate students and 34 graduate students during the 2013-2014 academic year 2013-2014
Attended SOAR sessions on April 26, 2014 and July 19, 2014
AU SON Discovery Day September 27, 2013
AU Scholars' Day- Advise departmental honors students with poster presentation
Collaborated with the Nurse Recruiter and RN-BNS Director
AU SON PEP- Standard I & III
Aligned professional nursing standards and guidelines (QSEN, BSN Essentials, NCLEX-RN) with AU SON Curriculum
The impact of an intercultural (domestic or international) service learning experience on AU BSN students' perceived transcultural self-efficacy (PhD research)

Academic Advising, 22 undergraduate and 42 graduate students 2012–2013
SOAR sessions- 8/12, 4/6/13, 4/27/13, 5/13, and 6/13
AU SON Discovery Days 9/12
AU SON Alumni Night 10/12
Co- Coordinator of the BSN Handbook Revisions
Development of the MSN Informatics curriculum
AU Scholars' Day- Advise departmental honors students with poster presentation

Academic Advising- 24 undergraduate and 51 graduate students 2011–2012
SOAR sessions- 8/11, 1/12, 5/12, and 7/12
AU SON Discovery Days 10/11
AU SON Open House 3/12
Curriculum revision to BSN, RN-BSN, and MSN Nursing Research
classes to meet QSEN standards.
AU Scholars' Day- Advise departmental honors students with poster presentation

Anderson University School of Nursing Graduate Curriculum, Chair 2010–2011
Anderson University School of Nursing Research, Member