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Assessing the Long-Term Effects of a Cultural Immersion Experience on Nursing Practice

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ASSESSING THE LONG-TERM EFFECTS OF A CULTURAL IMMERSION EXPERIENCE ON NURSING PRACTICE

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ABSTRACT

Cultural immersion has been identified as a preferred method of teaching cultural competence in undergraduate nursing education. Multiple qualitative and quantitative studies have shown that baccalaureate nursing students enjoy international learning experiences and, based on self-efficacy evaluations, feel they have increased cultural competency following immersion experiences. However, there is little evidence to indicate concepts learned during undergraduate cultural competency course work is retained or integrated into nursing practice after leaving the milieu of academia.

To inform future cultural competency educational efforts, I conducted a qualitative phenomenological study to provide a baseline of evidence regarding the impact of a cultural immersion experience to the Navajo Nation during baccalaureate nursing education. Following Institutional Review Board approval, information was gathered from 13 semi-structured interviews of registered nurses who have been in practice for one to three years. The interviews were transcribed and data analysis completed using both inductive and deductive coding and content analysis processes to interpret findings and develop a narrative of participants' experiences.

The five themes that emerged from the interviews indicate that participants had gained cultural competency skills which they attributed to learning during their cultural immersion experience to the Navajo Nation as an undergraduate nursing student. Further, they were able to give evidence of specific ways in which they implement those skills in their current practice as a registered nurse. The results of this study provide direction for additional research and inform nursing educators' efforts to produce a culturally competent workforce to meet the needs of an increasingly diverse population in the United States.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Background and Significance

Cultural competence is increasingly seen as a phenomenon of interest in nursing professional literature, education, and practice settings. It is considered so important that current directives from accrediting agencies for both education and practice settings mandate that cultural competence training is provided in both educational and practice settings. Furthermore, many professional organizations including the American Association of Colleges of Nursing (AACN), 2008, National League of Nurses (NLN), 2009, and the American Nurses Association (ANA), 2001, have issued position statements on the importance of understanding culture. The first provision of the ANA Code of Ethics for nursing states: "A fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual. Nurses take into account the needs and values of all persons in all professional relationships" (ANA, 2001, p.7).

Common terminology used in discussing, understanding, and using cultural information lies on a continuum. Cultural sensitivity lies on one end of the continuum and is defined as requiring that one be aware and acknowledge the differences found in individuals from a culture different from one's own (Robinson, Bowman, Ewing, Hanna, & Lopez-DeFede, 1997). The other extreme on the continuum is cultural competence, which denotes the ability to effectively work within the specific culture of clients (Campinha-Bacote, 1999). Somewhere in the middle lies cultural humility, which refers to the ability to be open to cultural nuances when working with clients of other cultures and willingness to take responsibility for the results of interactions (Isaacson, 2014). This study used a semi-structured interview process allowing practicing nurse

participants to express, in their own words, how they feel their undergraduate cultural immersion experience had influenced their ability to interact with clients of other cultures.

The importance of this topic in the delivery of clinical care has initiated nursing education to instruct students on the process of addressing culture when delivering nursing care. A variety of methods have been employed in recent years to teach cultural skills to nursing students. These methods fall into three broad categories: classroom techniques, cultural encounters, and immersion programs. Classroom techniques to teach cultural information may be presented in stand-alone classes or embedded across the curriculum (Mesler, 2014). Approaches may include focusing on specific attributes of several cultures (Delpech, 2013) or presentation of general principles of investigating cultures other than one's own (Delaney & Kaspin, 2011).

Cultural encounters include any method arranged by the instructor designed to expose students to individuals of diverse cultural populations. Examples could include guest lecturers and clinical encounters with clients from different cultures (Long, 2012). Two distinct types of cultural immersion experiences are identified in nursing education literature. Total immersion occurs when the student(s) lives in a different cultural setting, usually from one week to one semester (Long, 2012). Pseudo-immersion occurs when students visit a cultural setting for day activities but return to their own homes at night (Mesler, 2014). However, the long-term effectiveness of any of the different educational methods had not been broadly studied.

Support for the immersion experience as a preferred method of teaching cultural content can be found in the literature (Levine, 2009; Frenk, et al., 2010; Silvestri-Elmore, Alpert, Kawi & Feng, 2017). Levine (2009) reported that a multicultural experience increased students' ability to honor the values found in a community from a culture other than their own. Silvestri-Elmore and colleagues (2017) indicated that their findings support cultural immersion over stand-alone

courses or integration of cultural concepts throughout the curriculum. Further, cultural immersion experiences are being offered in more nursing programs to counter the limitations found in classroom models for cultural education (Hart, Cavenaugh, & Douglas, 2015). Some researchers point to self-examination by students, regarding cultural context as a particular benefit of immersion experiences, lending some support for immersion as a preferred method of teaching this content in the nursing curriculum (Smith-Miller, Leak, Harlan, Dieckmann and Sherwood, 2010). The Lancet Commissions strongly supported the need for cultural immersion experiences in the education of all health professionals, noting that students and their hosts are significantly impacted by the exchange (Frenk, et al.,2010).

Measures employed in the literature when discussing the effectiveness of cultural competency education are generally subjective. Self-efficacy tools are a standard method of evaluation used in studies of cultural immersion experiences (Allen, Smart, Odom-Maryon, & Swain, 2013; Amerson, 2010; Isaacson, 2014; St. Clair & McKenry, 1999). As student participants are readily available during the educational process, these evaluations are administered immediately following the completion of the immersion experience. The accuracy of self-perception is often biased as it may be influenced by a variety of factors including how strongly the participants desired the specific experience, how they view themselves, and how they want others to perceive them (Allen, Smart, Odom-Maryon, & Swain, 2013; Mesler, 2014). Although it might provide useful information, evaluation of self-efficacy in regards to cultural competence after participants have been in nursing practice had not been widely studied.

Baccalaureate nursing programs that have included cultural immersion experiences as part of the curricula have demonstrated positive effects, through self-efficacy tools, on personal and educational experiences of students (Isaacson, 2014; Allen, Smart, Odom-Maryon & Swain,

2013). However, little is known about the long-term effect of immersion experiences on the professional practice of nurses. Mixer (2008) noted that although education in cultural competence is now mandated by many health profession education accrediting bodies, there is little evidence as to the efficacy of cultural education or substantial support in the literature for any particular method of teaching the topic. The high cost of immersion experiences concerning finances, University and College of Nursing resources, and faculty time warrant an investigation of how or whether cultural immersion experiences during undergraduate nursing studies influence the clinical practice of nurses and whether international and domestic immersion experiences vary in impact.

Problem Statement

Baccalaureate nursing programs that include cultural immersion experiences in the curricula have demonstrated short-term positive effects on personal and educational experiences of students, specifically during the educational process (Isaacson, 2014; Allen, Smart, Odom-Maryon & Swain, 2013). The literature identifies a variety of international and domestic immersion experiences that are offered by many nursing programs. Nevertheless, little was known about the long-term effect of immersion experiences on the professional practice of nurses. Mixer (2008) noted that although education in cultural competence is now mandated by many health profession education accrediting bodies, there is little evidence as to the efficacy of cultural education or strong support in the literature that any particular method of teaching the topic is superior to the others. Most significantly, there is a dearth of research concerning the impact of cultural competency education on the nurse who is in practice. How or whether these types of experiences influence the clinical behaviors of nurses after they move into the workforce is unknown.

Purpose and Design of Study

This study employed a qualitative phenomenological research designed to explore the lived experience of practicing nurses as they engaged in patient care with individuals of different cultures. All participants had a 24-day cultural immersion experience to the Navajo Nation during the senior year of their baccalaureate nursing program. The purpose of this qualitative study was to understand how practicing nurses interpret their experience of an immersion experience during undergraduate baccalaureate nursing studies and how these experiences have influenced their nursing practice since matriculation from school. This is an essential first step in determining if immersion experiences, during the baccalaureate educational process, met their intent of improving care at the bedside for clients from cultures different than their care providers.

Study Aim and Research Question

The bulk of research and writing on cultural learning focuses on education's short-term effects on students' skill in cultural competence. This is usually measured while the students are still within the educational milieu. However, it was unclear if benefits continue over the long term or translated into improved practice behaviors. Therefore, this study aimed to explore the long-term effects of an emersion experience with the Navajo population on practicing nurses' clinical practice.

This research used phenomenology, a qualitative method, to answer the following research question: How does a Navajo immersion experience influence baccalaureate nursing practice in the workplace?

Definition of Terms

Polit & Beck (2004) explain that concepts used in a study need to be clearly defined and explicated. In the literature and position statements reviewed as background for this study, several concepts were repeatedly discussed. Dictionary definitions of these concepts inadequately convey the theoretical and conceptual meanings that underpin this study and the related literature that will be discussed in this dissertation. The following terms are used and/or operationalized within the context of this study; definitions are provided as a reference.

Cultural Sensitivity

Cultural sensitivity requires an awareness that culture has an impact on values, learning and behaviors (Robinson, Bowman, Ewing, Hanna, & Lopez-DeFede, 1997). Kratzke and Bertolo (2013) explain the process of developing cultural sensitivity includes self-examination of beliefs, values, and personal biases. The culturally sensitive individual recognizes that differences and similarities exist between all cultural groups. The first step toward awareness, or sensitivity, is acknowledging and honoring the differences in others.

Cultural Competence

Cultural competence is a set of congruent behaviors, attitudes, and polices, integrated into a system, agency, or among professionals which enables the system, agency, and/or professions to work effectively in transcultural situations (Cross, Bazron, Dennis & Isaacs, 1989). Campinha-Bacote (1999) clarified that definition, adding that cultural competence includes the ability to work effectively within the cultural context of clients. The culturally competent healthcare provider provides care to patients with diverse values, beliefs, and behaviors; tailoring care to meet patient's social, cultural, and linguistic needs (Bettencourt, Green, & Carillo, 2002). This is the most commonly cited definition used in current nursing and healthcare scientific

writing (Garneau & Pepin, 2015). The literature cited on cultural competence concur that this skill is a desirable attribute for practicing nurses.

Cultural Humility

Cultural humility may be a more desirable outcome of nursing education than either cultural competency or cultural sensitivity. "Competency" often denotes mastery of a skill set. It is unlikely that one can truly become "competent" in a culture that is not their primary culture. It is unlikely that one can become utterly congruent within a culture they were not raised in. Practicing cultural humility, therefore, focuses on a willingness to be open to the culture of another and implies that one is willing to take responsibility for the outcomes of interactions with others (Isaacson, 2014).

Self-efficacy

Self-efficacy is a term coined within the psychological community to refer to an individual's assessment about having obtained a specific skill set or mastery over knowledge content. Self-evaluations are believed to vary in veracity depending on the circumstances in which the knowledge or skills will be used, the amount of energy expended to gain the knowledge and how relevant the knowledge or skill is to the individual (Bandura, 1997). Bandura (1993) believed self-efficacy, a concept he developed, could be used to predict motivation to implement learned skills in situations requiring performance. In other words, as self-efficacy relates to cultural competence, if a motivated person feels confident in their knowledge of a culture and their ability to implement cultural competency skills, that person can usually be expected to perform better. Self-efficacy tools were used in all cultural competence research articles that reported quantitative results evaluated for this literature review (Allen,

Smart, Odom-Maryon, & Swain, 2013; Amerson, 2010; Isaacson, 2014; Mesler, 2014; St. Clair & McKenry, 1999).

Chapter Summary

Accrediting bodies and professional organizations have issued the mandate to provide cultural content as part of the nursing curriculum in baccalaureate nursing programs in this country. Cultural immersion programs have proven to be a widespread practice to meet this mandate. Current literature indicates students enjoy cultural immersion programs and self-efficacy evaluations indicate that students feel more confident in their cultural skills following these experiences. However, little research had been done to evaluate the long-term effects of cultural immersion. It was unknown if this method of teaching cultural competence skills carries into the practice of alumni after graduation. This study provided initial evidence regarding this gap in nursing literature by describing how nurses feel their 24-day immersion experience in the Navajo Nation had affected them and their nursing practice.

CHAPTER II

DISCUSSION OF RELATED LITERATURE

This dissertation focuses on the effects of a cultural immersion experience during baccalaureate nursing education may have on registered nurses after they enter into practice. An automated literature search was originated in March 2015 and repeated in May 2016. Limitations included English language, full text references from academic journals, journals, dissertations, and books. Databases used included CINAHL, MEDLINE, Academic Search Premier, Health Source: Nursing/Academic Edition, and PsychINFO. The Boolean/Phrase used was (student*) AND (nurs*) AND (cultur*) AND (Immersion*), resulting in 97 articles. Articles were reviewed for relevance and specificity to the topic of long-term effects of a cultural immersion experience during professional schooling after the nurse had been in practice for at least two years. Only one article met that aim. For this reason, articles were re-evaluated looking at the effects of a cultural immersion experience as well as the long-term effects of cultural education. Only fifteen articles and one editorial met these criteria. Nine articles specifically investigated immersion experiences in baccalaureate education; five articles addressed the process of teaching cultural competence to nursing students. In January 2019 the search was repeated to update from March 2016 to January 2019. One hundred 40 articles were retrieved, seven of which were usable and cited in this study.

A broader view was taken to lay a foundation from which to address a gap in the nursing literature. This review, therefore, explored current nursing research literature discussing common practices, including cultural immersion experiences, to presenting cultural competence information to nursing students, challenges related to using immersion as a method of teaching cultural competence, the impact of cultural immersion experiences during baccalaureate

education, and the impact a cultural immersion experience may have on nurses after they enter into practice.

The literature suggests immersion experiences may lead to increased self-efficacy related to cultural competence among students. However, the bulk of research and writing on the subject focuses on education's short-term effects on students' skill in cultural competence. Cultural competency is usually measured while the students are still within the educational milieu. It was unclear if benefits continue over the long term or translate into improved practice behaviors.

Because the number of articles related to cultural immersion experiences in nursing education was so limited, manuscripts were divided into cultural competency education and immersion experiences. This chapter will discuss both. The cultural competency education section includes definitions used in the literature to explain concepts related to the topic, the modalities used to teach cultural competency in nursing, the outcomes of cultural immersion experiences, and challenges related to providing cultural education to undergraduate nursing students. A discussion of the implications for nursing education. The chapter closes with a summary of the literature findings.

How Nursing Education Teaches Cultural Competence

The American Association of Colleges of Nursing (2008) included cultural competence as an outcome of baccalaureate nursing education. Five specific competencies were set forth:

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 the best evidence in providing culturally competent care

Competency 3: Promote the achievement of safe and quality outcomes of care for diverse populations

Competency 4: Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities

Competency 5: Participates in continuous cultural competence development.

Although five specific measures are included in their position statement, the organization was not prescriptive in how to achieve those outcomes. Conventional methods of teaching cultural competence to undergraduate nursing students fall into three broad categories: immersion programs, cultural encounters, and classroom techniques. In the United States, a history of recent immigration from Asia, Africa, and Spanish America and a quest for cultural inclusion patterns has fueled the nursing profession's pursuit for a culturally competent care model. Though methods of instruction are different, all try to achieve this goal. However, research supporting the effectiveness of these different educational methods is minimal.

Cultural Immersion Programs

Immersion programs can be divided into two distinct types of experiences. In the first type of experience, students live in a different cultural setting; usually, the duration is from one week to a full semester (Long, 2012). The second type of experience is termed "pseudo-immersion" (Mesler, 2014). This experience allows the student to return home at night while visiting the cultural setting for an extended day activity. The cultures encountered during both of these experiences can be extremely varied. International programs are prevalent for both types of immersion and may include travel to countries in Africa, Asia, Europe, and Central and South America. Immersion cultures closer to home include American Indian reservations, Appalachia, among migrant populations, in more differentiated religious groups like the Hutterites in South Dakota, rural populations, and immigrant populations located in areas near to the schools of nursing (Lipson & Desantis, 2007; St. Clair & McKenry, 1999).

Cultural Encounters

Cultural encounters can be arranged in a variety of ways during nursing education (Long, 2012). Clinical experiences may include contact with patients from different cultures and/or guest lecturers from diverse populations may be invited to speak. One university used visiting nursing students from Africa and Europe to facilitate cultural awareness in students (Torsvik & Hedlund, 2008). Clinical encounters with clients from different cultural populations increase student comfort and confidence in caring for patients from diverse cultures (Long, 2012). Guest lecturers are recognized by the American Association of Colleges of Nursing as a viable way to present cultural competency content to baccalaureate nursing students (American Association of Colleges of Nursing, 2008). Simulated cultural encounters may also be used. Long (2012) notes the safety of the controlled environment for students in simulation experiences. In this setting, students can practice skills without fear of causing harm to real patients. Simulation can incorporate standardized patients who represent different cultures. Students can be exposed to different cultural health practices, practice culturally sensitive assessment skills, and practice communication skills in a safe environment.

Classroom Techniques

Classroom techniques included distinct classes on cultural competency, research and writing assignments, and the process of embedding cultural competency information across the curriculum. Mesler (2014) reviewed the commonly used methods of coursework to teach cultural competency, including stand-alone courses and embedding cultural information across the curriculum.

Stand-alone courses can be offered as a required class within the nursing curriculum, or students may take a class associated with social sciences to meet cultural competence education

requirements. In both nursing and social science courses students may discuss specific attributes of different cultures such as language, art/music, traditional and modern healthcare practices, time orientation, healthcare taboos and imperatives, education, traditions surrounding life events such as birth, marriage, and death, socio-economic-political structures, etc. (Delpech, 2013). Alternatively, the courses may focus on general principles of investigating another culture than one's own (Delaney & Kaspin, 2011).

Some nursing programs attempt to embed cultural information across the curriculum (Caffrey, Neander, Markle, & Stewart, 2005). An example of this technique would be the inclusion of a case study about a Pacific Islander diabetic patient during a medical-surgical course. The case study may be developed over several class periods or may be as simple as an online module with a post-quiz included as a homework assignment outside of the classroom. Evaluation techniques could include written papers, oral presentations, and classroom discussions.

Outcomes of Immersion Experiences

The common thread demonstrated in the literature measuring the outcomes of immersion programs was the students' reported decreased anxiety when dealing with clients from other cultures. Although many of the immersion programs were carried out in other countries, in some cases the immersion experiences were in domestic settings, such as a Native American Indian reservation, rural Appalachia, or with a specific high-risk population. In other situations, the immersion experience included service-learning opportunities for the students (Amerson, 2010). The duration of the immersion experience could be as short as one week or could last an entire term. Many immersion programs required "culture classes" as a prerequisite to the immersion

experience (Larsen & Reif, 2011). For many students, the immersion experience was their first experience of perceiving themselves as a minority person.

Students also learned that unfamiliarity with the language compounded the development of cultural awareness. Almost universally, students reported increased confidence in working with those of different cultures than their own after the immersion program was completed. Some researchers also believe that immersion experiences may have added value if the destination presents a client population encountered by students at home (Smith-Miller, et al., 2010). Immersion experiences during undergraduate nursing education serve to strengthen basic communication skills and give student opportunity to practice foreign language skills (Ryan, Twibell, Brigham & Bennett, 2000; Smith-Miller et al., 2010).

Short-term Effects

Self-efficacy scales were used in many studies to identify the short-term effects of immersion on students. Pre- and post-immersion self-efficacy scores showed significant increases in the students' perception of their cultural competency in many cases (Allen, Smart, Odom-Maryon & Swain, 2013; Larsen & Reif, 2011; Caffrey, Neander, Markle & Stewart, 2005). Larsen and Reif (2011) found that compared to a control group, students who had an immersion experience scored higher on self-efficacy evaluations than students who were taught cultural competency content in the classroom setting. These self-efficacy scores indicated students believed they were culturally competent (St. Clair & McKenry, 1999). Paradoxically, while students considered themselves culturally competent after an immersion experience, qualitative analysis of journal entries, in one case at least, demonstrated evidence of continued negative stereotypical views of the immersion culture (Isaacson, 2014).

It is not unreasonable to conclude that value-laden thought processes and stereotyping impacted the quality of care provided. St. Clair and McKenry (1999) found that an immersion experience of even two weeks in duration decreases ethnocentrism to a much higher degree than a pseudo-immersion experience. These findings have been challenged by researchers who propose that as students discuss and compare experiences, the degree of difference may be minimal.

An additional benefit of immersion experiences was the students' report of pointed self-examination. Students were able to investigate their own culture; examine habits and belief systems, and discover that functionality and biases are inherent in every culture. For example, one group of researchers asserted that through an immersion experience may not increase cultural competency, it did contribute to students' personal growth and broadened their understanding of multicultural care (Smith-Miller, Leak, Harlan, Dieckmann and Sherwood, 2010). Students became more aware of how material resources and educational opportunities in this country influence attitudes and healthcare outcomes (Ingulli, Doutrich, Allen, & Dekker, 2014). Further, students reported that being immersed in another culture helped them to have a better understanding of the challenges culture can impose on individuals. The immersion experience also increased sympathy with client struggles with healthcare systems, lifestyle choices, and barriers to implementing recommendations of healthcare providers (Ryan, Twibell, Brigham & Bennett, 2000).

Long-term Effects

There was a dearth of research on long-term effects of cultural immersion experiential education after nursing students matriculate into practice. In fact, most researchers did not evaluate students after the immediate post-immersion experience. Although the stated goal of

immersion programs was to enhance students' cultural competency as they move into practice, long term outcomes had not been studied (Allen, Smart, Odom-Maryon & Swain, 2013; Larsen & Reif, 2011). One study did investigate the effects of a cultural immersion experience on registered nurses returning to school to obtain a baccalaureate degree. However, the evaluation assessed only the immediate post-immersion perceptions and was completed while the students were still in the academic milieu (Adamshick & August-Brady, 2012).

Levine (2009) followed a group of ten nursing students after they had been in practice and showed a continued appreciation of the transforming quality of an immersion experience even after they had been in practice up to 13 years. Levine (2009) indicated that after an immersion program, students valued others and were more accepting of differences than they had been previously. Ingulli, Doutrich, Allen, and Dekker (2014) reported the immersion experience led the participants to seek continued opportunities to impact cultures outside their own through involvement with non-governmental organizations (NGOs). Although these findings are interesting, they did not address the concern of this study: How does an immersion experience impact nursing practice in the workplace?

Ingulli et al. (2014) recognized that gap and conducted a small qualitative study (n=4) to determine if an immersion experience had any impact on professional practice. She admitted to not reaching saturation with this small sample but stated that nurses did report a continued contextualization of culture from the immersion experience that followed into their professional practice. This is an area rich for further study.

Outcomes Summary

Several outcomes were found to be present in more than one article reviewed. Students experienced an increased self-efficacy in regards to cultural competency. They also tended to

perceive themselves as being more culturally sensitive and aware of cultural nuances and better able to respond appropriately to clients from a different culture. One concrete outcome that impacted interactions in the clinical setting was that students reported feeling less anxious about transcultural encounters with clients.

In summary, immersion experiences changed students in personal ways they found satisfying. Students often reported they felt they were culturally competent, had increased awareness of the needs of clients from other cultures than their own, and felt more comfortable interacting with those from other cultures. However, the literature did not address if or how immersion experiences influence nursing practice at the bedside. Personal self-satisfaction did not necessarily reflect increased awareness or concern that led to improved care for clients.

Challenges Related to Cultural Immersion as a Teaching Modality

Academic Challenges

A significant challenge in providing cultural immersion experiences, and indeed, all cultural education is the lack of faculty prepared to teach this content effectively. Esposito (2013) succinctly highlighted this critical flaw in current practices of nursing education when she found that very few faculty members had the training to prepare them for teaching transcultural nursing. In fact, many of them felt uncomfortable teaching this content in the nursing curriculum. Therefore, faculty who undertake teaching in these cultural immersion programs need to have not only mastered the content and concepts of cultural competency but also have experience in navigating international travel as well as the ability to guide culturally inexperienced students in unfamiliar settings (Levine, 2009).

A second major challenge is that the majority of students have little or no experience traveling outside of the United States and limited personal experience with a second language

(Allen, Smart, Odom-Maryon & Swain, 2013). Student exposure to other cultures or languages before entering baccalaureate studies were predominantly related to vacations. Few students have cultural experiences in a healthcare setting before the immersion experience provided as part of the nursing education program.

Final challenges related to the burden immersion programs are to institutions and faculty. Substantial time commitments are usually required for faculty to develop and implement immersion experiences away from home. Cost of these methods and programs must take into consideration not only the financial outlay in preparing materials, staffing, and logistics of immersion programs but the physical and psychological toll of these efforts on faculty. Delpech (2013) discussed the challenges of pre-, intra-, and post-immersion program processes. Before taking students to the immersion experience site, research into the site is needed. Local support in the form of a host liaison must be obtained, logistical needs such as housing and transportation are finalized, and clinical activities are prearranged using the host liaison as a mediator. Students must also be prepared for the experience. This preparation often took the form of a culture class and included information about the environment, but also coaching in culturally appropriate behaviors, dress, communication, and the student role in healthcare and education situations. The immersion experience was physically demanding as faculty dealt with jet lag, language barriers, climate changes, culture shock, and keeping up with a group of energetic students. Post-immersion processes included debriefing meetings with students. Faculty also invested time in follow-up with the host liaison and others who facilitated the success of the immersion program.

Lack of Accepted Educational Standards

More challenging is the lack of educational standards for teaching cultural competence content (Lipson & DeSantis, 2007). It is not surprising that the outcome of many programs are so diverse.

Lipson & DeSantis, 2007 note little consensus in nursing programs on what should be taught, how it should be taught, and how it should be measured. Esposito (2012) concurs, reporting there have been significant advances in developing concepts, theories, and research methods related to cultural competence in nursing. However, she also stated faculty teaching cultural competence to nursing students feel unprepared both educationally and experientially to teach on the topic. As they investigated multiple programs across the United States, they discovered anecodotally, not measured, reports of success in teaching cultural competence Lipson & Desantis (2007). For example, A University of Washington professor cites success with graduates hired to positions requiring the use of cultural skills. Program faculty from the University of California, San Francisco report their graduates have been consulted as cultural experts in their work environments. Another program reported that student journals indicated they are changing the way they interact with clients because of their cultural competency education. The content of coursework, the method of delivering content, and the anecdotal outcomes differ in each program. Lack of standards in both content and measurement made it impossible to determine the effectiveness of cultural competency programs in nursing education.

Also, mandates by a variety of professional organizations have led to the haphazard implementation of programs that lack evidence to support the methods employed or the delineation of clear outcomes (Esposito, 2012; Mixer, 2008). Although cultural competency tools are available, it would be helpful to see the implementation of a standard tool or tools across the

profession to measure cultural competency. Mastery of knowledge base could be determined similary to the methods found in other nursing content areas such as obstetrics or pharmacology. Self-efficacy evaluation could be used as an adjunct, but should not be the primary measure of competency. Demonstrated competence is a better measure of ability, but little empirical data discussing measuring the acquisition of cultural competence was found in nursing literature.

Usefulness of Research Findings

In many ways, review of the literature posed more question than answers. The findings of improved self-efficacy were well documented in regards to the immediate outcome of immersion experiences. However, the meaning of those self-efficacy findings, as well as the translation into practice outcomes, are still unclear. Measuring self-efficacy testing may not be the optimal variable for evaluating the outcomes of cultural education. When students overestimate their cultural competency, the measurement of self-efficacy is inflated and not useful (Isaacson, 2014). Other studies concur that students significantly under- or over-estimate the degree of cultural competency skills they possess both before and after immersion experiences (Caffrey, Neander, Markle, and Stewart, 2005).

Most studies evaluating cultural immersion experiences have a limited number of participants, due to the nature of clinical education. The study participants are also convenience samples. This occurred because immersion was limited to only some nursing schools, and among a student population who can financially afford the experience. Analysis of the costs and benefits of short-term immersion are needed to determine if this is an efficient and effective way to provide cultural education for students (Larsen & Reif, 2011).

There is also a need to determine whether cultural immersion experiences have a lasting effect on cultural competence (Larsen & Reif, 2011). Isaacson (2012) noted that many facilities

insisted nursing staff receive cultural competency training annually, which could lead to a sense of false security. Although training may occur, actual behaviors demonstrating cultural sensitivity and awareness of the needs of clients may be sadly lacking. A study using registered nurses returning to school to obtain a baccalaureate degree points to this problem, as those students expressed concern over the lack of caring nursing values and sensitivity to individual clients of different cultural backgrounds in the workplace (Adamschick & August-Brady, 2012).

Although immersion experiences are generally very satisfying to students, satisfaction is not cultural competency. It is essential to link cultural training and the immersion experience to improved cultural competency in the work environment. It is unclear from the descriptions of the cultural immersion experiences how and if behavioral changes occur that carry over into nursing practice. A salient research direction would be to determine precisely how elements of immersion experiences lead to cultural competence (Ingulli, Doutrich, Allen & Dekker, 2014). If practicing nurses can identify what they do differently as a result of an educational immersion experience, educators can evaluate these programs more effectively.

Researchers also stated much current research findings on cultural education in nursing cannot be generalized due to the narrow definition of nursing in developed countries. For instance, students in the United States tend to define nursing in a way that is colored by the technological and cultural attributes of this country (Smith-Miller et al., 2010). Nurse-to-patient ratios, access to equipment and supplies, information systems and interdisciplinary collaboration are part of the nursing culture. There is a misconception that nursing is dependent on these trappings in the current student populations in developed countries. It is unknown if the ethnocentric definition of nursing, a critical component of the profession, changes after a cultural experience.

Theoretical Support

Theoretic support is not usual or required for qualitative research. Nevertheless, Leininger's (1991) Theory of Culture Care Diversity and Universality and Dewey's (1938) Experiential Continuum had a strong influence during this inquiry.

Madeleine Leininger (1991) believed that healthcare outcomes were predicated on caring; health, cure, and wellbeing cannot exist without caring and are closely tied to cultural phenomena. Leininger postulated that care is the "essence of nursing" (Leininger & McFarland, 2006, p.3). Caring and culture are embedded within each other (Leininger & McFarland, 2006). These concepts are pointedly relevant to this study. As society becomes more diverse, nurses will be caring for individuals, families, and groups from cultures different than their own. Without an understanding of culture, nurses would be unable to comprehend how their clients view health, healthcare treatments, and the healthcare environment. The caring of nurses is communicated through behaviors that others recognize as caring through the lens of culture. It is generally thought that communication patterns, client compliance with treatment plans and treatment outcomes are more likely to be improved when interactions and interventions are congruent with the culture of the client (Schim Doorenbos, Benkert, & Miller, 2007).

Dewey (1938) noted that each experience, current, and past, influences the impact and perceptions of future experience. Student learning experiences related to culture have the potential of influencing future experiences in which the individual is faced with situations and clients of other cultures. Cultural competence involves more than a technical skill set and the cultural competence proficiency a nurse possesses changes over time (Cruellar, 2016). Dewey (1938) also suggests there may be optimal timing of some experiences which will most strongly influence the achievement of learning outcomes. No research literature was found to point to a

specific time in the nursing curriculum to present cultural content. Although the summer months are a typical time for these programs to take place, Cruellar (2016) offered no support for choosing that time frame except to insinuate it was a convenient choice.

Chapter Summary

Cultural competence should be a dynamic and evolving state in professional nursing practice (Isaacson, 2014). Multiple articles show a variety of modalities have been investigated by nursing education and in professional practice settings by educators, researchers, accrediting boards, and policymakers in the last several decades to meet the directive to make nursing culturally competent (Long, 2012). There is a dearth of literature about the long-term effects of cultural education on students as they move into practice. Many articles tout lived immersion and study abroad programs, which seem to show much promise. Regardless of the length of the immersion experience, it appeared that anxiety about dealing with those of other cultures was viewed subjectively by subjects as being decreased (Larsen & Reif, 2011; Levine, 2009). However, Long (2012) noted that students graduating from baccalaureate programs still felt unprepared to work in a multicultural society. A single small qualitative study (n=4) reported that these self-efficacy findings might have an impact even after the students move into practice as nurses (Ingulli, Doutrich, Allen & Dekker, 2014). It was understandable that little research had been done to determine if cultural competence is achieved by nursing students as they move into practice. The cost and difficulty of pursuing such research are significant. After completing educational programs, students may move from the immediate area of the University they graduated from and often do not update contact information which would facilitate follow-up inquiry on the long-term effects of the educational experiences. However, ensuring adequate

training in cultural competence that persists into the practice arena should be a goal for nursing education.

CHAPTER III

RESEARCH DESIGN AND METHODS

This chapter provides information on the methods used for this study and support for the design and methods. The following sections are included: (a) qualitative method (b) sample, (c) human subjects' protection considerations, (d) research procedures, (e) data collection, (f) data analysis, (g) establishing trustworthiness, and (h) chapter summary.

Qualitative Methods

Creswell (2014) described four approaches to qualitative research: ethnography, grounded theory, narrative research, and phenomenology. Each method was most applicable to a specific type of inquiry. Ethnography focused on everyday behaviors, language, and habits of a specific cultural group. This method of inquiry required the researcher to participate in the culture being studied over a significant period. Grounded theory focused on concepts, not people with the goal of deriving a generalizable theory. Narrative research told the life story and experiences of an individual or a small group, generally focusing on a single viewpoint.

Phenomenology examined the essence of a lived experience shared by a group of individuals. Qualitative researchers who used phenomenology embraced the notion that reality cannot always be explained by cause and effect or that which was perceived only through the five limited senses (Streubert & Carpenter, 2011). Qualitative researchers use phenomenology when they are interested in not only the experiences of participants but in how people make sense of their lives and how they use experiences to make sense of their world. This type of qualitative design allows for in-depth exploration of a central phenomenon (Creswell, 2008).

This phenomenological study was structured to allow nurses to describe the impact of a 24-day cultural immersion experience in the Navajo Nation during their undergraduate studies

and determine if and how they feel the immersion experience had influenced their professional clinical practice (Dewey, 1938). While nursing students often report an immersion experience during their nursing program has a positive effect on their perceptions of cultural competence (Ingulli, Doutrich, Allen & Dekker, 2014; Adamshick & August-Brady, 2012; Levine, 2009; and St. Clair & McKenry, 1999), this study focused on perceptions of registered nursing alumni of a 24-day immersion experience on their practice. The end-product of cultural education at one Mountain West university was to ensure nurses "respect the inherent worth, dignity, and human rights of every individual" (ANA, 2001, p.7) and honor the needs and values of others. This study explored if practicing nurses, alumni of this university, felt there was any long-term impact of this type of education on their practice.

Phenomenologic Design

This study used a qualitative phenomenological approach, a method of inquiry commonly used in psychology and philosophy and now is becoming a popular method of research in nursing. Qualitative research can be a method of establishing experiential effects that applyu to the less than ideal settings of practice (Johnson & Schoonenboom, 2016). Phenomenological questions focus on both the concrete and essential nature of a shared lived experience VanManen, 1990). A unique aspect of phenomenology is that researchers describe the lived experiences of participants whom all have experienced the phenomena in question. Therefore, the phenomenologic approach is well suited to exploring a research problem when individuals' common or shared experiences of a phenomenon are important (Creswell, 2014).

Phenomenology was chosen for this study and focused on investigating the lived experience of nurses who participated in a university undergraduate immersion program and how they integrated their cultural understandings into bedside clinical practice. Data was gathered

through an interview process (Creswell, 2014) with the researcher focused on the meaning participants found in their 24-day immersion experience in the Navajo Nation, taking a subjective approach to the information gathered. This method was most congruent with investigating how nurses experience and interpret their undergraduate immersion experiences and integrate their understandings into bedside clinical practice. The constructed stories created from the recollections of the participants were analyzed to answer the research question: How does a Navajo immersion experience impact and influence baccalaureate prepared nurses as they practice in the workplace? This study asked participants to reflect on the immersion experience in the Navajo Nation and tell their personal story about this experience.

Sample

This study's sample was recruited using a purposeful sampling technique from the alumni of an urban, private faith-based university with an undergraduate student population of 27,765 students and a graduate student population of 3,358 students, located in the Mountain West region of the U.S (Forbes, 2016). Over two-thirds of the students spoke a second language. As well, this University supported one of the most extensive study abroad programs in the nation, offering experiences in 50 countries worldwide. Approximately one-fourth of the undergraduate student population was married.

This university has an undergraduate Bachelor of Science in Nursing (BSN) program that has an enrollment of 72 students each Fall and Winter semester that brings the total admission for one year to 144 students. Seventy-five percent of nursing students come from areas outside of the state in which this research was being conducted; 9% of undergraduate nursing students were male in the years 2010-2015 inclusive (Peery, 2015). Every student in the BSN program was required to take a public and global health course during the spring term in the year they

graduated. Half of the students, therefore, would graduate at the end of the Spring Term and the other half would graduate at the end of the Fall Semester.

For point of reference, the semester naming system in this university was somewhat different from most programs. Instead of a Fall Semester, Spring Semester, and Summer Term (or two shortened Summer Terms), this University has a Fall Semester, Winter Semester, and shorter, compressed Spring and Summer Terms.

Sampling strategy. A purposeful sampling strategy was utilized to identify the research participants. Purposeful sampling method stipulates that participants all have shared the phenomenon or experience being investigated. (Creswell, 2014; Streubert & Carpenter, 2011). Purposeful sampling aided in the selection of participants who were typical for the phenomenon being investigated. Further, purposeful sampling made it possible to obtain "the most information-rich data possible" (Morrow, 2005, p. 255).

Two methods were used to identify nurses who had participated in the Navajo Nation cultural immersion experience within the past four years and who had been in practice for one to three years. Advertising was done through a mass email to the Brigham Young University College of Nursing Alumni Association membership. The Alumni Association Board granted permission to use this resource for this purpose. A demographic tool was emailed to respondents.

C). Those potential participants who self-identified on the demographic tool as having participated in the 24-day Navajo Nation cultural immersion cohort were further evaluated according to the inclusion/exclusion criteria for this study

Selection of participants. Participants were selected from the population of matriculated nursing students from a private faith-based university who had completed a Bachelor of Science in Nursing (BSN) program and participated in a 24-day cultural immersion experience in the

Navajo Nation. However, to be eligible to participate in this study the participants needed to be licensed and in practice as an RN for one to three years. Benner's (1982) novice to expert theory indicates that nurses may not be able to self-evaluate the effects of educational experiences accurately immediately upon assuming their new professional role. It takes time for theoretical and experiential learning to become a seamless, complete knowing of concepts. However, the further from an event an individual moves, the harder it is to ascertain cause and effect. Over time, other factors may also influence perceptions, making it difficult to attribute professional cultural perceptions and behaviors to the immersion experience. Therefore, the chosen time limitations may serve to minimize the effect of other influencing factors, but still be close enough to the immersion experience to allow the participants to have accurate recollections of the cause/effect influence of the immersion experience.

Sample size. Criteria for sample size was non-specific in qualitative research using the phenomenological approach (Polit & Beck, 2004). However, Creswell (2014) indicates that this approach usually requires three to ten participants to reach saturation or to reach the point at which further investigation no longer generates new and different responses within the group. Fifty-four to sixty participants graduated within the time frame required for this study and participated in the Navajo Nation cultural experience. It was desirable to have 12 to 18 of the potential participants respond to the recruitment call and meet the criteria for inclusion, although less may be required to achieve saturation. A larger number of eligible participants was allow for the possibility of attrition without compromising the findings. Although the nursing profession continues to have a high female to male ratio, the gap is slowly narrowing. Therefore, it was helpful to ensure that both genders were strongly represented.

Site and rationale for site selection. The private faith-based University College of

Nursing, located in the Mountain West region of the United States has a broad cultural immersion program, sending approximately 150 students to seven international and four domestic locations each spring. The site chosen for this study was the Navajo Nation. Multiple factors played into this choice. The Navajo Nation is unique in that it has all of the characteristics of an international site, as noted below, but because it is situated within the national borders of the United States, cost for the experience was affordable to a significant number of students, enlarging the participant pool for the study.

Located in the four corners area where Colorado, Utah, Arizona and New Mexico meet, the Navajo Nation is the second largest federally recognized tribe within the United States with greater than 300,000 enrolled tribal members (US Census Bureau, 2015). Although the Nation resides within the borders of the United States, the Navajos live in a semi-autonomous nation-within-a-nation possessing a unique culture and language. Healthcare, political, and financial structures are also specific to the Native American populations.

Most Navajo tribal members are bilingual, learning Navajo as their primary language, but being educated in the public school system in English. As the American Indian populations receive healthcare through the United States federal systems, language barriers related to English-as-a-second-language (ESL) contribute to healthcare disparities. An Office of the General Counsel report indicated that language barriers contribute to limited access to health care and health disparities among all Native American groups (U.S. Commission on Civil Rights, 2004). Native American clients find it burdensome, and sometimes impossible to comprehend and complete the massive amounts of forms required for medical reimbursement under existing healthcare delivery systems. A further finding of that report was that linguistically appropriate interactions were essential to reduce language-mediated healthcare disparity.

Disease-related healthcare disparities, as reported by the Indian Health Services (2010), are significant. Indian Health Service (IHS) is an agency within the Department of Health and Human Services that is responsible for providing medical and public health services to members of federally-recognized Native American Tribes and Alaska Native people. Mortality rates stemming from unintentional injuries including motor vehicle accidents, diabetes mellitus Type 2, chronic liver diseases, and assault are double or more than double the rates found in the US population as a whole (Indian Health Services, 2010). The second leading cause of death among children and young adults aged 10-24 years in this population is suicide (Devi, 2011). Suicide is 82% higher than in a comparably aged group of all other races in the United States (Devi, 2011). Additionally, incidences of influenza and pneumonia, renal diseases, and septicemia are significantly higher than the national average. Among the top 15 causes of mortality and morbidity in the United States, the Navajo rank lower only in heart/cardiovascular diseases including hypertension, Alzheimer's disease, and Parkinson's disease. Healthcare disparities among the Native American populations, including the Navajo Nation, have not just persisted for a few decades, as is common in many U.S. minority groups in the United States, but have been strikingly present for the last five centuries (Jones, 2006).

The Navajo Nation presented a unique cultural experience for nursing students who seek to gain cultural insights through an immersion experience. The placement of the site, which was close to home for students attending this private, faith-based university, saved students the cost of travel to other continents. Participants identified language differences, genetic and racial attributes such as hair, eye, and skin color, social and educational differences, and healthcare disparities as elements that caused them to identify the Navajo people as a culture other than their own.

A unique feature of this immersion experience was that one of the program instructors was herself a member of the Navajo tribe, having been born and raised in Chinle, Arizona. Because of her insider status, she was able to allow students to observe and participate in the culture in a manner that outsiders are seldom able to access. This was a modified immersion experience. Students did not live with native families but resided in a house within the community that was identical to that of natives. They experienced the diet, transportation, religious and healthcare service exposure identical to the local tribal members. Twelve to fourteen hours of each weekday and eight to twelve hours of each weekend day were spent engaged in activities within the Navajo culture. The students worked side-by-side with native nurses and aides in community health, inpatient, and outpatient healthcare modalities. They integrated within the community on Sundays. Other service activities students participated in included community clean-up activities directed by the native community health organization, community health risk assessments, and home visits with community health nurses. Students taught health topics in community and public school environments. Students were also given opportunities to participate in native healing rituals including exposure to a sweat lodge, herbalists, and sand painting practitioners. At the end of each day, a clinical debriefing meeting was held by the instructor to facilitate learning and to allow a forum for discussion when students may experience stress related to their experiences and cultural encounters that were unfamiliar or distressing.

Inclusion Criteria

1. The participant recruits will have participated in a 24-day immersion experience to the Navajo Nation during the Spring term of the final year of their baccalaureate education at the selected private faith-based university.

2. The participants' first undergraduate degree will be a baccalaureate degree with a major in Nursing (BSN).
3. Participants will have the equivalent of one to three years (1800 to 5400 hours) of direct patient care.
4. Participants will be fluent in English.

Exclusion Criteria

1. Participant recruits who have a BSN but have not worked.
2. Participant recruits who have less than the equivalent of one year (1800 hours) or more than the equivalent of three years (5400 hours) work experience.
3. Participant recruits who are Native Americans.
4. Participant recruits who are conversant in the Navajo language.
5. Participant recruits raised on Navajo Nation lands.

Human Subjects Protection Considerations

Institutional Review Board (IRB) approval (Appendix A) was obtained through the University of Nevada Las Vegas before recruitment of participants. The study was declared "exempt" by the IRB. Because the participants' names and contact information was obtained from Nurses Alumni Association, collaboration between BYU IRB and University of Nevada Las Vegas IRB occurred. The risk to the participants was anticipated to be minimal. All information was treated confidentially. Voluntary and informed consent was obtained from all participants in this study. The signed informed consent document was kept in a securely locked cabinet in the researcher's office. Multiple types of data were collected including field notes, audio tapes, and demographic sheets. An identification designation identified participants and their data. No participant name was on any hard copy data. Raw paper-based data was securely

stored in the researcher's office in a locked cabinet. A bonded transcriptionist transcribed audio recordings. Original audio recordings were returned to the researcher and securely stored in a locked cabinet in the researcher's office. All raw data will be destroyed as per the requirements of the IRB (usually in 3-5 years). No raw data was available to anyone other than the primary investigator, researcher, and CITI trained research assistant who had agreed to maintain the confidentiality of data. The research assistant assisted in verifying accuracy of transcription and in coding data. No unanticipated effects on participants became apparent as a result of this study. Approval of the IRB was obtained before amending or altering the procedures or scope of the research or implementing any changes in the approved consent document.

Procedures

Recruitment. Recruitment for participants occurred after IRB approval was obtained. A letter of invitation to participate in the study was mailed or emailed to members of the Nursing Alumni Association who graduated from the BSN program between December 2012 and April 2015 (Appendix B) Although email was the preferred method, contact was determined by the contact information available. The follow-up letter or email of the invitation was again sent out one week later. Specific information about the criteria for eligibility, time commitment, protection of confidentiality and contact information for the researcher/interviewer was included in the letter.

Consent. Nurses who agreed to participate in the study and meet the inclusion/exclusion criteria were given a copy of a consent form which included consent for participation and consent to be audio-recorded at the beginning of the first meeting with the researcher. The researcher verbally informed participants of the methods that were used to protect personal information at the first meeting. Any questions concerning the study and confidentiality of

information were answered at that time. Participants were also informed that their consent may be withdrawn at any time, there was no penalty for withdrawal from the study, and researcher replied to any subsequent questions about the consent and confidentiality processes via phone or email depending on the participant's preference. The researcher retained a signed copy of the consent. A duplicate hard copy of the consent was given to participants at the first interview.

Participant compensation. A ten-dollar Visa gift card was offered to each participant after completion of the interviews to compensate the participants for their time. Compensation was given at the end of data collection to minimize attrition.

Researcher CITI training. The researcher completed and documented CITI training before applying for approval from IRB and was knowledgeable of the ethics, standards, and regulations involved in human subjects research. The Graduate Student Research Assistant (RA) also completed CITI training and was supervised in all aspects of the research participated in with the researcher.

Data Collection

After IRB approval was obtained, a mailing was generated soliciting participants from the BYU Alumni Nursing Association rolls of matriculated students meeting the inclusion/exclusion parameters. After informed consent for the study was completed and consent for audio recording of the interview obtained, the participants completed a written demographic tool (Appendix C). The method of interview was face-to-face, one-on-one interviews with the primary researcher. Interviews took place in a neutral, public, but quiet setting agreed upon by both participant and researcher. Open-ended questions were used in a semi-structured interview lasting no longer than 90 minutes. Questions focused on the subjects' experiences during the

cultural immersion course and how their perceptions of the cultural immersion experience influence their bedside practice. See *Appendix D* for interview guide.

The researcher kept a reflective journal to record impressions during the interview stage. Howard (2008) recommended this practice as a way to manage researcher bias. Using a broad-to-focused interview process, the researcher encouraged participants to narrate their experience and understandings gained from the immersion experience in the Navajo Nation.

Data collection methods for this study included audio recordings of the interviews, field notes, and reflective journals of the researcher. Also, participants were asked to read the constructed narrative compiled by the researcher which could also result in another short interview.

Semi-structured Interviews

The goal of phenomenology was to find the overall essence of the lived experience and accurately reflect the lived experiences of the participants related to the phenomenon being investigated (Creswell, 2014). In-depth interviews facilitated this process and began with broad questions, determining participants' experiences regarding the phenomenon and the situations which influence their experience of the phenomenon (Creswell, 2014).

The goal of this study was to conduct between twelve and eighteen interviews to ensure a range of shared experiences and reach saturation of data. Therefore, the primary method used for data collection for this study was semi-structured interviews. The interviews lasted up to ninety minutes and were conducted face-to-face in a mutually agreed upon neutral setting. The researcher anticipated being able to conduct face-to-face, in-person interviews. Up to two interviews were done to clarify points and to verify that the interpretation of data was correct were conducted in person.

The first interview allowed the participants to reflect upon their lived experience and tell his/her personal story, highlighting perceptions gained from participating in a cultural immersion experience to the Navajo Nation during undergraduate studies. Additionally, perceptions of how that had influenced their bedside nursing practice were explored (see questions in Appendix D). Therefore, the semi-structured interviews began with a general question: What was your experience like during your global health immersion course in the Navajo Nation? Asking broad questions gave tacit permission for the participants to tell their own story. Then further questioning lead to a more vibrant, detailed description of the phenomenon. The interview followed an interview protocol (see Appendix D) that included the general question as well as open-ended questions that encouraged participants to explore details and find meanings gained from their experience. Follow-up questions were formulated to assist the participant to refocus on the phenomenon being investigated, if needed.

The interviews were recorded using two instruments, a hand-held audio recording device and an audio recording application on an iPad. The iPad was available as a backup in the event the hand-held recorder failed. The researcher used a professional bonded transcription service to transcribe the interviews. After the initial interview, another interview was arranged with three participants for additional review, or member checking (Creswell, 2014).

Reflective Journal

The researcher used a reflective journal to record ongoing personal thoughts, reactions, and interpretations during the interview stage of the project. The journal was used to record thoughts during the interview, using reflectivity to manage bias. Journaling content was integrated into the constructed narratives. The researcher included descriptions and impressions gained from body language, affect, engagement in the interview process and response to follow-

up. This type of information helped enrich the description necessary for this type of research. A detailed record of observations and impressions was utilized during the data analysis process as well.

Field Notes

As part of the journaling process, this record, kept by the researcher, included descriptions of the process of the research (Patton, 2002). Interview times and places, informed consent discussions, demographic data, and activities related to the research process including all communication processes, emails and phone calls were noted.

Data Analysis

A systematic method was employed to examine the data using a content analysis process followed by constructed narrative development. The researcher explored the possible meanings and conflicting perceptions, developing an interpretation of the data gathered from participant responses that described the essence of the phenomenon (Symon & Cassell, 2013). The specific process descriptions are discussed in this section.

Transcription of Data

After the first interviews were completed, data analysis started. A professional bonded transcription service provided a transcription of recorded interviews. The primary researcher and research assistant verified the accuracy of transcription content by comparing audio recording to transcribed data. Additionally, the notes taken by the researcher during the interview process were typed. The researcher reviewed all data collected to get an overall sense of the information.

Theme Identification and Coding

Identification of themes used both deductive and inductive approaches. Usually, the deductive approach used *a priori* process where themes are derived from a theoretical model or

existing literature on the topic of interest (Kodish & Gittelsohn, 2011). For this study, two initial themes were determined using a deductive process within the framework of the literature review. Existing literature, in every case, indicated that participants found the immersion experience to be positive overall. Additionally, every study reviewed found that participants felt they were more sensitive to the cultural needs of others following an immersion experience. However, the literature cautioned researchers using deductive processes to remain open to additional codes or dimensions of codes emerging during the analytic process to avoid limiting the findings, an inductive process (Cresswell, 2013; Lopez & Willis, 2004).

The text in the transcribed narratives was highlighted independently by the primary investigator and a research assistant to reflect coding. The coding process was done independently by both the primary investigator and a graduate research assistant. Coding for research question one (What was your experience like during your global health immersion course in the Navajo Nation?) could address the following themes found in the literature: anxiety provoking (Ryan, Twibell, & Brigham, 2002; Smith-Miller, Leak, Harlan, Dieckmann, & Sherwood, 2010); perceiving oneself as a minority for the first time (Adamschick & August-Brady, 2012; Allen, Smart, Odom-Maryon, & Swain, 2013; Ingulli, Doutrich, Allen & Dekker, 2014; Levine, 2009) ; produced increased confidence in working with other cultures (Allen, Smart, Odom-Maryon & Swain, 2013; Larsen & Reif, 2011; Caffrey, Neader, Markle & Stewart, 2005). Each of these themes had implications on the specific aim of this study, which was to determine how cultural immersion experiences during the undergraduate educational period impact nurses and endure after they are in practice.

The researcher looked for statements in the transcribed data that fit within the identified themes. A table was provided with examples of the types of statements that might fit each theme.

The coding system remained open to any unanticipated themes that emerged. The *a priori* themes chosen were broad and were contained in all the interviews. However, the finding that participants found the immersion experience to be positive did not address the research question. The deductive coding process proved more fruitful for this study.

Bernard & Ryan (2010) suggest the development of a codebook specific to the study being conducted. Codebooks contain three types of codes: structural, theme, and memos. For this study, structural codes could include information about where the interview was conducted, pertinent demographic information on the participant including practice setting the participant works in, and the interview question or topic being addressed. Thematic codes could not only include the theme but could refer to where the specific theme was located in the transcripts. Theme coding included verbatim quotes from participants supporting the thematic topic. Memos could include the researcher's notes about the circumstances/details of the interaction as well as perceptions gained through evaluation of contextual clues including body language and the researcher's thoughts about what was being discussed (Bernard & Ryan (2010).

The accuracy of both content and meaning of interviews was verified by participants after transcription and analysis of the data by the researcher (Polit & Beck, 2004). Participants were invited to review the transcriptions and a synopsis of the researcher's interpretation of their comments. If needed, a follow-up interview was scheduled to aid the researcher in clarifying anything the participants felt was not accurate or needed further explanation. The researcher formulated additional questions to clarify the narrative which could be asked during the follow-up interview, if needed. These questions could follow up on missed details or request elaborations on specific experiences that were not adequately discussed in the first interview.

Constructed Narrative

The original concept of narrative inquiry derives from John Dewey's (1938) notion that life is education, and every experience an individual has will influence any subsequent experience. When people share their personal stories, they often discover knowledge hidden from their conscious selves, revealing personal unrecognized identity traits and clarifying the effects of past experiences on present behaviors (Creswell, 2013). The constructive narrative is a phenomenologic method, which seeks to explain how individuals interpret experiences, and then construct a way to make sense of those experiences in a social context (Schwandt, 2007).

A constructed narrative or compiled essay is derived from multiple data sources. The researcher writes the story from the information the participant(s) provide, but also reflects on how she or he views the participant(s) and the interview process. The researcher's perceptions and analysis of the interview process become part of the story told (Ellis, 2008). In this study, the constructed narrative was created using transcripts from semi-structured interviews, field notes, and the researcher's reflective journal. The constructed narrative explained how the nurses who experienced the Navajo Nation 24-day immersion experience created a way to make sense of that experience and apply it to their professional bedside practice. The data for this study was used to create constructed narratives derived from transcripts from semi-structured interviews.

Limitations

Limitations exist in any study, including this study. The self-selective sampling process was one limitation. While the demographic form and participation in the Navajo Nation cultural immersion experience helped identify appropriate participants, the nurses had the option of participating or not. The lack of participant diversity was a limitation. An additional limitation was the probability of nonobjective reporting, a common characteristic of autobiographical

storytelling. The participants had completed the immersion experience two to four years ago, and so might have lacked the clear remembrance more recent recollections would have elicited. However, phenomenological research does not seek historical truth, but rather the essence of the lived experiences, as the individual perceives it (Creswell, 2014).

Establishing Trustworthiness

Trustworthiness of the interpretation of data in qualitative research can be measured by how accurately the researcher represents the participants' views. Although this was a subjective call, some processes increase the likelihood that an accurate representation may be achieved. Guba & Lincoln (1994) identify four criteria to increase the rigor of qualitative work: credibility, transferability, dependability, and confirmability. Specific processes to improve the trustworthiness of the findings can be incorporated into the qualitative study.

Credibility. Guba & Lincoln (1994) recommend returning to the participant after working with the data to verify that the researcher's interpretation of the data accurately reflects the participant's thought processes. Creswell (2014) describes a similar process, labeling it member checking, which allows the participants to indicate if they feel the researcher's representations of their experiences are true to their experiences.

Dependability. One method to help ensure dependability is through a triangulation process. This criterion cannot be met until after credibility is demonstrated (Streubert & Carpenter, 2011). Phenomenology lends itself to person triangulation. In this process, the findings of one participant are compared to at least two others. As the expressed experiences between subjects agree, triangulation is achieved. There was also, in this study, the possibility to triangulate using time as the measure. If the statements and themes of multiple participants who have been engaged in bedside nursing practice for different lengths of time agree, or nurses who

had their immersion experience in different semesters or cohorts agree, dependability was supported.

Transferability. Transferability occurs independent of the researcher and the research process (Streubert & Carpenter, 2011). It has to do with the likelihood that others will find the study has meaning when applied to similar situations or phenomena.

The strategies listed above for credibility, dependability, and confirmability were implemented to increase the trustworthiness of the results in this proposed research. Transferability could be verified after research was completed, as other researchers cite the study or find meaning as they apply the findings of the research to similar situations and phenomena.

Researcher Positionality

As a nursing educator of 10 years and a member of a minority culture, I bring my own experiences and interpretations of those experiences to the table as I engage in research. My subjective lens created expectations regarding the findings of this study. I expected to have the nurses identify elements of the cultural immersion experience as pivotal in influencing behaviors at the bedside as they provide nursing care to their clients. I expected them to give concrete examples of how significant events during the cultural immersion experience relate to specific incidents that occur in their current practice setting. I did not expect the nurses to necessarily generalize the lessons learned during the immersion experience to working with clients different from those they worked with during the immersion experience. A reflective journal, recording my own values and perceptions helped me to manage my subjective lens, separating my thought processes as I worked with the transcribed interviews. The journal served as an "ongoing record of [the researcher's] experiences, reactions, and emerging awareness of any assumptions or biases that come to the fore" (Morrow, 2005, p. 254).

Summary

This study identified the perceptions nurses report of the impact a 24-day cultural immersion experience in the Navajo Nation had on their nursing practice, through the use of rigorous qualitative methods. Current studies support the use of cultural immersion experiences and demonstrate a perception of positive effects in both personal and educational lives of student nurses (Isaacson, 2014; Allen, Smart, Odom-Maryon & Swain, 2013). However, Mixer (2008) noted the lack of evidence as to the long-term efficacy of cultural education as nursing students matriculate and enter practice. Findings of this study offered insight into the perceptions nurses in practice have gained and affect their patient care practice following a cultural immersion experience. This study broadened understanding of this phenomenon.

CHAPTER IV

RESULTS

The purpose of this study was to explore and understand the lived experience of graduated baccalaureate-prepared nurses as they care for clients of different cultures than their own. Thirteen registered nurses participated in the study. A response rate could not be calculated due to the convenience sampling method used. All interviews were conducted between February 18, 2018 and August 3, 2018. Each interview lasted between 54 and 102 minutes, with an average of 79 minutes. Data analysis resulted in identification of five themes: increased awareness of health disparities and healthcare barriers; recognized distrust of white people, outsiders, others; valued family and tribal traditions; appreciated Navajo preference for Native Medicine vs. Western Medicine; and promoted development of cultural skills. The fifth theme was more easily investigated by dividing it into two sub-themes, which addressed personal impact and professional impact. Almost every participant strongly commented on every theme.

Overview of Participants

For this phenomenological study, thirteen nursing graduates who had been in practice for one to three years were selected purposefully to participate in the study based meeting inclusion criteria for eligible study participants. A fourteenth participant was eliminated from the study when it was found they had been in practice two months beyond the three-year limit. Participants ranged in age from 24 to 35. Eleven participants were females (84.6%) and two were males (15.4%); ten were white (76.9%) and three were from other races (23.1%). Table 4.1 summarizes key demographic characteristics of each participant.

Table 4.1
Summary of Demographic Data

Identifier	Age	Time in Practice (Months)	Gender	Race	Employment Setting	Languages Spoken Fluently (1^0 first)
A	28	35	F	White	Staff RN, Acute Care	English
B	28	28	F	A/PI*	Charge RN, PACU	Chinese, English
C	27	28	F	White	Staff RN, Acute Care	English
D	32	34	M	White	Clinic Manager	English, Spanish
F	35	24	M	Hispanic	Emergency Room	Spanish, English, Russian
G	26	23	F	White	Post-partum	English
H	24	17	F	White	Staff RN, Acute Care	English
I	26	13	F	White	Staff RN, Acute Care	English, Spanish
J	25	16	F	A/PI*	Staff RN, Acute Care	English
K	25	18	F	White	Pediatrics	English
L	27	36	F	White	Travel RN, Acute Care	English
M	27	31	F	White	Physician's Office	English

*A/PI = Asian or Pacific Islander

Narrative Excerpts by Theme

This section will present themes with supporting excerpts from the transcripts related to the themes. Five themes emerged from the data and were categorized based on the research question: How does a Navajo immersion experience influence baccalaureate nursing practice in the workplace? Four themes related to cultural insights the nurses gained during their undergraduate immersion experience in the Navajo Nation. Participants were able to identify environmental factors, financial constraints, social hierarchal norms, communication patterns, traditional healing practices, and historical interactions with the United States government that affect the delivery of healthcare services within the reservation setting. The fifth theme specifically addressed the cultural skills participants gained from the immersion experience. The last theme identified actually was best separated into two subthemes. Participants differentiated

between cultural skills that they apply in the workplace environment and cultural skills they apply to everyday life interactions with people from cultures different than their own.

Each theme is presented with a general overview of how participants were impacted by the topic. Direct quotations with contextual commentary follow to give examples of participant input on the topics. For formatting consistency and ease of reading, each excerpt is presented and punctuated as a complete sentence in this section, even though many are phrases or parts of complex sentences from the transcripts. Quotation marks indicate the actual words of the participants as quoted from the transcripts. Direct quotes may include grammatical errors.

Theme 1: Increased awareness of health disparities and healthcare barriers. All participants described the impact of cultural differences in the Navajo Nation and the physical attributes of the reservation setting that had impact on the health of the people in this community. This theme ties back into the acquisition of cultural sensitivity, as defined in chapter one. Robinson, Bowman, Ewing, Hanna, & Lopez-DeFede (1997) explain that cultural sensitivity skills make practitioners aware of differences and similarities, as well as the impact differences have on behaviors. As students, they were surprised at the prevalence of poverty, isolation, lack of resources and social problems in an area within the borders of the United States. While all commented on at least one factor that contributed to health disparities or barriers to obtaining healthcare, some nurses were acutely aware of several items that impacted the Navajo people and their ability to secure a safe living environment, access health information, and interface with the healthcare systems in their community.

Nine participants commented on the housing in the Chinle area. They stated that because the reservation was within the United States, they anticipated visiting a community much like any other community they had lived in or visited within the country. Participants expected the major

differences would be because of language and the inclusion of medicine men in the healthcare setting. The typical Navajo home, when compared to the living environment they had experienced in this country, was startling. Participants suggested that they felt amenities like electricity, running water, and solid flooring are fundamental necessities in acceptable housing, and would be consistently found in homes in the US. The Navajo reservation housing was more like what they imagined would exist in a third world country. Representative participant statements included the following:

> "If someone were to put you on a plane and [say] 'We're going to somewhere in the world.' and flew you into Chinle, I don't think that you would think you were in America." (D)

> "They [our professors] warned us before we went there 'You will be surprised by the conditions these people live in.' …we would go to patient's homes which were mostly like tents…they were like little huts. Their ground was dirt and they had no running water. I think that within itself was very eye-opening to the conditions that people in the United States live in. It was shocking." (M)

Participants noted that financial poverty was endemic to the Navajo population. No participant commented on any evidence that some members of the community were more financially stable or had access to better food, housing, healthcare, or educational opportunities than any others of the tribe. One example of this recognition included the following observation:

> "being in the Navajo Nation really opened my eyes to poverty in the United States, especially on the reservations." (G)

Education was recognized as being a determinant of health. Participants saw a correlation between deficiencies in education in general, lack of access to health information, and inability to care for the health needs of individuals in the Navajo community. Without the knowledge base, the Navajo people were unable to choose to engage in preventative care and maintain healthy lifestyles. Public educational facilities exist from pre-school through high school, as well as a community college, in the area. Education is free through high school and heavily subsidized for

those who wish to continue on to higher education. But, as noted by Jones (2006), a history of mistreatment often makes the Native American people reluctant to access resources provided by the United States government. One participant observed:

> "They really have a pretty significant historical trauma [related to how the United States government has treated them], not the best schools, education, or any of that…They're closed off…. which makes it harder for the Navajo to accept the teaching [white] nurses and other healthcare providers try to give to their patients." (C)

Participants commented on specific social problems that affect the health of the Navajo people. They felt the prevalence of these issues in the Navajo community directly contributed to the overall poor general health of the Navajo as compared to people they had seen in the communities they grew up in. For one participant, the time of the immersion experience as a student, and the exposure to so many people with chronic, avoidable disease that she could not help, led to a feeling of sadness and helplessness. Significant participant observations included the following:

> "She [the Navajo registered nurse] started talking to me about the problems that they have. A lot of obesity and the alcoholism and the diabetes; she mentioned that there's a lot of sexual problems…being sexually active at a very young age." (F)

> "…two students were going off with one of the nurses for a home health visit on a guy who had some sort of knee surgery… His knee was obviously very severely infected…He actually ended up coding in the ambulance on the way [to the hospital]. They [the patient and family members] didn't realize that all the swelling and redness and pus and everything else that was coming out of his incision site…wasn't a normal part of the healing process." (H)

Participants noticed the physical layout of the Navajo reservation led to significant barriers in accessing healthcare. The reservation is approximately the size of West Virginia. The topography is arid desert with high plateaus, mesas, and mountains with altitudes of over 10,000 feet. Many residents live remotely with dirt roads and, in many cases, poor or no options for long-distance communication and/or transportation. While horses or mules can get over the rough

terrain, a seriously sick person would probably find it impossible to ride an animal for miles to reach care. Motor vehicles were usually very old and in poor repair. Many of the older individuals did not have a current driver's license or know how to drive. Few among the elderly have telephone contact, although many of the youth had cell phones.

> "Little did I know that those three [home] visits would take all day because they live far apart from each other, and so isolated without technology. The roads…just all these crazy, country backroads…off-roading, just driving around. I don't know how people really found their way around. There was no names for a lot of the streets… they had free range animals everywhere…livestock that would just roam [over the roads]." (D)

> "We would go out on community health visits and the person would be very sick…they were harder to bring to the hospital because transportation was an issue. [We visited] a lady who fell. She was outside her home for a couple of days. They found her, after the days that she was outside. Her dog was the only help she had until she was found….it was sad." (F)

Every participant (n=13) recognized barriers to obtaining adequate healthcare for the Navajo people. A variety of elements with the physical environment of the Navajo reservation including distance from the clinic, poor roads, and lack of transportation impeded physical access. A number of factors, including financial status of the Navajo community members, lack of literacy and/or learning opportunities, language and communication disconnects, lack of clean water, lack of sanitation, lack of adequate, affordable, balanced nutritional choices, chronic disease, addictive behaviors, chronic depression, and other social factors further blocked access to healthcare for individuals and families in the Navajo community. Participants were aware that the Navajo people were unable to overcome the barriers that denied them opportunity for a healthy lifestyle and access to the healthcare services they needed. Kratzke and Bertolo (2013) mention a first step toward cultural sensitivity is awareness and acknowledging differences in others. Participants in this study verbalized increased awareness of barriers to obtaining healthcare and health disparities among the Navajo people, evidencing development of cultural sensitivity.

Isaacson (2014) identified cultural humility as perhaps a more desirable outcome of nursing education than cultural sensitivity, which is awareness, or cultural competency, which is congruency within a culture not one's own and which is unlikely to be achieved in more than one or two cultures by any individual. Cultural humility indicates a willingness to be open to another culture, to value its strengths, recognize differences, and to take responsibility for the outcomes of interactions with individuals and groups within another culture (Isaacson, 2014). Themes 2, 3, and 4 demonstrate acquisition of cultural humility by participants of this study.

Theme 2: Recognized distrust of white people, others, outsiders. Most participants commented on the distance the Navajo people maintain from those outside the Native American tribal system. These excerpts address the distrust and distance the Navajo people, especially the elderly, evidenced toward those they perceived as outsiders.

Some participants commented on the body language and communication patterns the Navajo engaged in when around them. Participants were very aware of their status as outsiders in the community. Several stated that the immersion experience was the first time in their life they felt that they did not belong and were immediately noticeable because of their appearance, clothing, language skills, or hair/eye/skin color. Some felt that people were talking about them whenever they did not understand the Navajo language or someone laughed when they were around.

> "The general sense I got from was just that sometimes the people were kind of more private, especially to outsiders….if you were an outsider, especially the older people, liked to be more private." (D)

> "there were [some people] that would just stare and didn't really want to trust [us] and kind of looked at us. I was feeling out of place." (G)

Two participants noticed the deference given to the elderly within the community. They saw that the Navajo treated their Navajo professor with respect and went out of their way to communicate with her, but did not act at all in the same way with the white co-instructor.

Participants perceived that Navajo feel judged by outsiders, especially government representatives. Some participants felt that some of the older Navajo felt that outsiders have no respect for traditional Navajo customs and wisdom and are trying to impose white conventions and values upon them. Conversations between some older Navajo tribal members, the Native professor, and individual students elicited the following comments.

> The elderly tribal members "just lived the way they lived because they didn't want anyone else's help" and "thought it [outside help] would make them less or weak," meaning that they would be negatively judged by outsiders "because they couldn't sustain themselves." (C)

> Because of that perception the older Navajo stayed apart from outsiders as much as possible. They think "we're going to try to take advantage of them…because we're white people." (L)

> The Navajo elder I talked to "doesn't really care to talk to outside people who come in and try to convince us that we need to change our ways." (M)

Minority participants stated they felt more accepted into the Navajo community. One participant was mistaken as a tribal member and spoke about his understanding of how the Navajo felt about outsiders. He commented on how good it felt being part of the community, contrasting the Navajo Reservation experience with his educational experiences. He did not have the same comfortable experience as a minority male in a predominantly white, female schooling experience.

> "Me being [not white] helped. I'm not Navajo… but she [the medicine woman] was a lot more willing to explain to me what she does and her role as a native healer." (J)

> The Navajo welcomed me because the people "actually thought I was Navajo….and they talked to me in Navajo. That made me feel good." (F)

> I understood their point of view because I am a minority, too. "I think everyone should have the opportunity… to be a token [minority] because it's shaped a lot of just who I am." (B)

Many of the participants (n=10) commented on the distance the Navajo kept from the white immersion experience participants and even white health care providers in the clinic. This behavior was more prevalent among the older members of the Navajo community. Participants recognized the historical causes of the mistrust as well as current behaviors by white healthcare providers and governmental administrators that fuel continued suspicion of outsiders in the community. Participants sympathized with the Navajo elder who felt resentment to a white man who came to tell him how to better raise his animals and grow his garden when the Navajo perception is that whites had stolen all arable land from his ancestors. Participants recognized that the older Navajos believed every potential advantage, gift or benefit offered by a white man might hold a hidden agenda that would harm them, their families, or the Navajo people.

Theme 3. Valued family and tribal traditions. Many participants noticed positive cultural and personality traits they saw among the Navajo population as a whole. In particular, participants recognized the strength Navajos find through association with family and members of the tribal community. The shared traditions, native language, and connection to nature and the land also served to strengthen the bond of oneness and solidarity experienced among the Navajo people.

Participants commented on the formal and informal leadership structure they observed within the Navajo community. Family and tribal leaders seemed to be easily identifiable to the participants. However, as reported by one participant, in some cases the traditional head of the family deliberately took a supportive role. There were no incidents where any members of the Navajo tribal community refused to acknowledge leaders or displayed lack of respect for traditional leaders or the elderly in the community that was noted by participants.

> "Disrespect for parents or the older people, that's something that really isn't acceptable, it's not acceptable at all." (F)

> When the elderly grandmother became very ill, "the family member who was sick made the decisions and the head of the family [her oldest son] helped everyone else know what it [the healthcare decision] was, passed it along to the rest of the family." (H)

Several participants appreciated the strong familial ties they observed within the Navajo Nation. The family connections extended across generations and included the deceased. One participant spoke of the strength gained through ties to living relatives and deceased relatives. Other participants stated that those ties extend to the community, traditional practices, their land, and animals. Representative comments from participants included the following:

> I noticed "how important families are. They [the Navajo] find loyalty and strength within their families…people want to connect with their past and they want to connect with their ancestors and their families." (C)

> There is "a real sense of community and wanting to protect and help those in the Navajo Nation." (D)

Some participants commented that, in general, the Navajo people displayed distinctive common personality and behavior traits that were noticeable to them as outsiders of the culture. Behaviors that promoted cohesiveness of the group, as opposed to individualism, were recognized as being particular to the Navajo and valued within their culture. The overall tenor of life was slower paced and not tied to a linear concept of time.

> The Navajo are "very friendly, a lot more humorous, and slower paced" than what is seen in a similar gathering of people seen in my home community or on campus at the university. (G)

> They are "not assertive…they would rather get along with each other than strongly state a different point of view. It's not in their culture to make eye contact" and confront each other. (I)

> "The Navajo really go by their own time. You say 'We'll be there at 5.' Navajos would be like 'yeah, sometime in the afternoon.' I guess… everyone has a different concept of time…" (L)

Two participants noticed behaviors among individuals of the Navajo people that, though isolated, were negative. The researcher feels that these comments show a balanced response that is more realistic. The negatives also indicate these participants may have moved past the honeymoon stage of viewing the immersion experience in a romanticized manner.

> The [older] Navajo grieve that "the Navajo language is dying. "The younger generation just doesn't care" that the language is being lost. (B)

> "The parents would get money from the government and the [child] would go get the money from the parent so they could use the money for themselves and not for the parent." (F)

Participants demonstrated cultural humility, finding much to admire in Navajo cultural practices, which they felt strengthened the community as a whole. Relationships between Navajo family members, the tribal leadership hierarchy, and even members of the Native American community in general were stronger than what participants had experienced in their lives. These interpersonal connections, combined with the slower pace of life and social low-key humor, were viewed as adaptive behaviors that have led to the strong cultural identity and feelings of belonging Navajo tribal members have within their communities.

Theme 4. Appreciated Navajo preference for Native Medicine versus Western Medicine. Most participants very quickly became aware of the general preference the Navajo had for their traditional healing methods and medicine men/women. Participants commented on the more holistic approach taken by the Navajo to promote health and a better outcome among the native patients. Many tribal members specifically sought the inclusion of spiritual and physical rites before turning to Western Medicine practices.

Participants noticed native and western medicine practitioners collaborating in the care of patients in an effort to better meet the needs of Navajo clients. Medicine men/women actually had offices within the clinic and hospital in Chinle. Unlike the Western Medicine practitioners, the

native healers would often meet with their clients in their homes or would go to visit them at the bedside when the client was hospitalized rather than setting up an appointment for the client to come to office of the healer. Two transcript excerpts address these practices.

> "The nurses collaborated with the medicine man because the patient wanted more native practices." (B)

> The Navajo "go to someone to be healed and use alternative medicine… they blend traditional practices with Western medicine." (D)

Participants perceived the Navajo taking a more holistic approach to health care. The spiritual component of medicinal practice is integral to the Navajo healing traditions. Participants noticed the attention native medicine men/ medicine women gave to the spiritual aspects of healing, as opposed to the more focused physical approach that Western Medicine practices implement. The relationship of the native medicine practitioners was viewed as being more spiritual in nature and the connection between the native healer and the patient was more intimate than the relationships seen between the western medicine practitioners and their clients. Local herbs and plants were also used in their healing practices. The following participant statement best sums up how the Navajo utilize medicine men/women, traditional methods, and herbal medicine practices to promote health.

> I noticed "how important relationships are. And not just for a fun, good life but also for healing and for strength…the spiritual component of their culture and how important some of the plants and herbs are and kind of this more holistic approach to medicine that was really important to them." (C)

A number of participants stated that the Navajo people have a strong preference for their traditional healing practices and their own medicine men and medicine women. In some cases, apparently especially among the older population, the preference was coupled with active dislike or distrust of Western Medicine practices.

> The older "Navajo people didn't really believe in modern medicine. The medicine man is their primary source of care." (G)
>
> "Some people were kind of anti-Western medicine.They [the Navajo] refused [Western] medical treatment and instead they had a medicine man come in and do something."(L)

Five participants clearly grasped that the beliefs concerning health and healing might be very different for the Navajo people, commenting on why they thought that might occur. Participants might not understand the beliefs, motivations, or Navajo view on health, but recognized there was another way of looking at those topics than their personal view. Comments that show participants gave value to those alternative thought processes, demonstrating cultural humility, included the following:

> The Navajo have "different motivations" "different beliefs that impact their health." (E)
>
> I found that "there must be a reason behind why people do things or why people do things one way or another or they think one way or another" in regards to their health and choices in care. That wasn't necessarily a bad thing." The Navajo "have a different approach to the whole process of healing." (F)

One participant spoke at length about the training of the traditional medicine man/woman. Usually the future traditional healer is chosen for the role in their teens or pre-teens. They use an apprenticeship pattern in which the future healer spends years shadowing and assisting an experienced medicine man. Apprentice healers are not independent in their own practice as a healer. When the mentoring older healer becomes incapacitated with age or poor health a transition period ensues during which the apprentice gradually assumes the full role of healer within the community. The native healers are committed to their people and often serve as the keepers of tradition as well as providing spiritual and physical health-related support to the Navajo people. Because of the lengthy training and the dedication required by both the mentor and the medicine man/woman in training, the number of healers is dwindling in the Navajo community. The participant noted: "medicine man, that's really a dying art." (I)

Every participant (n=13) noted the importance of traditional medicinal practices in the Navajo community. Participants appreciated the integration of spiritual, herbal, and physical modalities seen in the Navajo traditional healthcare practices. Although western medicine clinics are available on the reservations, traditional healthcare providers have offices in the governmentally run Indian Health Services facilities. Practicing side-by-side with their MD counterparts, the Navajo medicine men/women collaborate to meet the needs of their Navajo clients. Younger Navajo clients often avail themselves of both types of services, while the geriatric-aged clients may patronize only the traditional healthcare providers. Participants came to recognize that the Navajo people believe that spiritual health is more important than physical comfort. Additionally, participants came to realize that to effectively meet the healthcare needs of diverse populations it is essential to understand how health is defined within the culture of the people they are working with.

Theme 5. Promoted development of cultural skills. Participant comments under this theme also address cultural humility behaviors. However, using the working definition set forth by Campinha-Bacote (1999), this theme bridges a gap by also addressing cultural competency skills. Cultural competence includes the ability to work effectively within the cultural context of the client (Campinha-Bacote, 1999). Other nurse researchers believe that culturally competent nurses individualize patient care to meet social, cultural and linguistic needs (Bettencourt, Green, & Carillo, 2002). Every participant spoke at length about how the immersion experience in the Navajo Nation affected them, often identifying specific behaviors they have adopted to address the needs of patients with diverse values, beliefs, and behaviors. Each participant felt the experience promoted the development of their cultural skills. Concepts like “respectful,” “non-judgmental,” “sensitive,” “empathetic,” “accepting,” and “understanding” were mentioned

repeatedly. The researcher found this theme was the one most easily identified in the transcripts. Participants felt the immersion experience changed their behaviors and thought processes in regards to their interactions with people from other cultures. However, when quotes were pulled from the full transcripts and contextualized, it became apparent that two sub-themes were actually present: the impact on each participant as an individual and the impact on each participant as a practicing nurse. Divided into these two sub-themes, the data is rich with meaning for the participants.

Sub-theme A. Personal impact. All but one of the participants discussed the importance of trying to be aware of the point of view of other people. Understanding included the realization that different languages may have concepts that cannot be directly translated, which led to the realization that communication is key in understanding someone from a culture other than one's own. The outlier participant talked instead, of now being aware of how her grandmother and parents, who were immigrants to the United States, must have struggled as they tried to immerse themselves and their families into the American melting pot. (B) Several insightful participant statements demonstrate participants understand the importance of considering the perspective of others in any interactions involving someone from a different culture.

> The immersion experience started my "learning how to respond or think about other cultures. It's not helpful unless you can think about it from their perspective, to understand." (A)

> "…you really can't understand what the other person is going through unless you're in their position and have seen it from their point of view. There is a kind of gap [in my understanding] because of the language, but also just the culture of the Navajo Nation. [It's important to] try to understand…to find a common place where we can communicate." (C)

> My immersion experience "gave me a lot of perspective on how much I don't know… because of language barriers or education barriers or just if we think one way is better, like Western medicine versus holistic. I think there might be a lot of things that are missing in my understanding [of people from other cultures.]" (J)

The initial days in the immersion experience were very stressful for some participants. They had never had the opportunity of being in a cultural setting where they were not the majority, did not speak the primary language, and/or did not have someone culturally similar to themselves around to readily communicate with. Several participants stated that since the immersion experience they feel more comfortable and confident speaking to people from cultures other than their own. Participant statements included the following:

> "It's nice and refreshing to talk to people who aren't the same as you. It [the immersion experience] has impacted me, because maybe I seek out different people more so than I would have before. I feel less intimidated to talk to people that are different from me." (E)

> "My immersion experience helped me to always be curious and to be unassuming and to go in with an open mind when I'm interacting with anyone, but especially those of a different culture than my own." (C)

The non-minority (white) participants were unanimous in noting the immersion experience had specific effects on them personally. Every Caucasian participant stated the immersion experience made them "more tolerant," "open minded," and/or that the immersion experience helped them to be "less judgmental," or to "not judge." Every Caucasian participant stated they felt "more empathy," "more compassion," or were "more sensitive" to people since their immersion experience in the Navajo Nation. One participant summed the changes up in these words: "It [the immersion experience] helped me be more of a complete person…a better person. I appreciate differences… yes." (C)

The three minority students agreed that even though the immersion experience did not significantly change their behaviors toward people from other cultures than their own, they felt they had empathy or understanding toward the Navajo people because they had the similar experience of being part of a minority group in the United States. Their comments included the following thoughts.

> "I think I probably empathized with the [Navajo] people more because I understood, at least in part, of what they were feeling [dealing with whites]." (F)

> "I was lucky growing up that I got to see a bunch of different…people who were raised differently… I was immersed in multiple cultures [which] made me more flexible [and] more open minded…it helps me have compassion for people." (B)

> "I've always been someone who has noticed culture and noticed different practices. I don't think it [the immersion experience] makes me that much different than I was before. I definitely learned a lot more about the Navajo people. I wouldn't say it would have changed my interactions. I mean, generally I'm pretty open" to people from other cultures than my own." (J)

Most participants (n=12) felt they have implemented a more culturally-accepting and culturally-curious attitude in their lives since their cultural immersion experience in the Navajo Nation. They have learned to actively investigate others' point of view. This attitude has led them to feel more comfortable interacting with people from cultures other than their own. Minority participants (n=3) all expressed empathy and some understanding of the attitudes they felt the Navajo people must feel as minorities in the greater United States population. Each participant feels their personal attitudes and/or behaviors towards people of cultures other than their own has been impacted by the immersion experience.

Sub-theme B. Professional impact. Culturally competent behaviors are desirable in nursing and healthcare fields (Bettencourt, Green, & Carillo, 2002). Professionals who work effectively in transcultural situations, possessing cultural competency skills, are able to incorporate behaviors, attitudes, and implement policies that facilitate interactions between healthcare systems and clients from diverse cultural backgrounds (Cross, Bazron, Dennis & Issacs, 1989). All thirteen participants commented about the impact the cultural immersion experience in the Navajo Nation has had on their professional practices as nurses. Some mentioned specific concepts including advocacy and improving education when working with individuals from cultures other than their own. Others talked simply about being more aware or

sensitive to differences in perception their clients many have and the importance of addressing those differences with empathy.

Some participants mentioned education as an area they focus more on now in their professional practice. Participants recognized that education has to be provided in a way that the client can understand and apply to their particular circumstances. In conjunction with education, they also often commented on the necessity of respecting the client's right to make their own decisions about health care after receiving accurate information. The following are examples of participant comments on including appropriate client education into practice.

> "It's your responsibility as a nurse to educate as best you can, but when it comes down to it, those patients are entitled to make their own decisions… And you have to respect that." (B)

> I know "how important educating our patients is. I have made education a very large part of my practice as a nurse… [I'm] a lot more proactive about educating. I give them (my patients) everything that they need to know…and they [make] the decision, and I [have] to support that." (H)

> "…if I have a patient who does have a different belief system it [the immersion experience] helped me become more aware…gave me a lot of perspective on …education barriers. I now provide like the best education. It's important to send families home set up for success." (L)

The immersion experience made some participants consider the need to incorporate advocacy into their professional repertoire. Supporting the choices of the client were again mentioned.

> I "look for ways to advocate for patients [and feel] more confident and competent in order to advocate for a patient. I connect with other people better." (A)

> The best practice is "advocating for your patients but then respecting their wishes. I teach the people that I train, it's your responsibility as a nurse to advocate and to educate. Those patients are entitled to make their own decisions if they're capable." (B)

> I've become "more sensitive to what they [my clients] want and what their goals are and what they feel like they need as opposed to projecting what I think they need or projecting what I think is best for them…advocating." (L)

Participants recognized that sometimes being an advocate is difficult, especially when the client makes choices that are opposite those the nurse would make. One participant told of a client she cared for who was a substance abuser. When the parents were not in the room the teen "strait up tells me she's going to continue just to ruin her body. I just told her 'While you're under my care, I'm going to try and give you the best possible care and help you get better to get home. What you do after that, even though I don't agree, is completely your decision.' You just have to hold your tongue sometimes. I had to just think before I said anything [to that client]." (B)

Participants mentioned specific actions they now take to ensure improved interactions and achieve optimal healthcare for their clients. They mention becoming more aware, a significant part of the definition of cultural sensitivity mentioned previously. This increased awareness impacts their interactions with clients from cultures other than their own. The participants feel better able to interact with clients and meet their needs, as demonstrated by the following comments.

> I have "empathy and understanding for whatever circumstances they come from…focus on the strengths [of my clients and try to] understand where they're coming from." (B)

> I am "more perceptive to peoples' reactions towards me as a health care provider and see those reactions as an indicator of how well I am caring for that client. [I have] stopped judging people at all. I'm more flexible…more patient." (F)

> I am "more aware and more accepting. It's helped with interacting with the parents. I imagine myself in their shoes and see things more from their point of view." (C)

Two participants discussed the need to take a broader look at the health care they provide. Sometimes health problems cannot be solved simply by interaction with individuals. They recognized that culture, community or global action may be needed to address some health issues.

> I'm looking into "finding ways to contribute to solving some of these big societal issues that specifically really impact our underserved kind of minority populations." (D)

> Sometimes when working with clients "it helps to know common problems in the community… It's a partnership. It's not about me knowing what's best for you always. But it's about me having some knowledge that I can give to you and some skills that I can use to help. But it's also about …understanding where you want to take your care and be a partner in your care… You have to ask questions" (E)

The hoped for outcome following a cultural immersion experience in baccalaureate studies, is to find that participants are able to integrate the cultural competency skills learned into professional practice. Every participant in this study (n=13) was able to clearly enunciate skills learned during the immersion experience that have been applicable to their current practice situation. Empathy and awareness of needs for clients of cultures other than their own was the most commonly mentioned skill (n = 10). Other important skills included focus on teaching/learning issues (n = 5) and being an advocate for clients (n = 4). Two participants mentioned increased awareness of healthcare concerns that would affect larger groups of diverse at-risk clients. Every participant indicated the immersion experience has impacted their professional practice.

Phenenomenological Dimensions

The purpose of the phenomenological question under consideration was to explore and comprehend the lived experiences of graduated baccalaureate prepared nurses who had participated in a cultural immersion experience in the Navajo Nation during their final year of nursing education. Based on the themes that emerged from the thirteen registered nurses who were interviewed, nurses stated that a cultural immersion experience impacted their practice.

All nurses were able to discuss specific areas of cultural understanding that now influence their interactions with clients. Interviewed nurses held a common shared belief that a cultural immersion experience during undergraduate education benefits nurses as they work with clients from cultures other than their own. Overall, the nurses found meaning in participating in a process

they felt improved their skills in cultural competency and result in better outcomes for the clients they work with.

Five themes emerged from the interviews with graduated nurses who had experienced a 24-day immersion experience to the Navajo Nation during their senior year of baccalaureate studies in nursing. The nurses felt they had an increased awareness of health disparities and healthcare barriers that impact the Navajo people and minority groups in general. Most participants recognized the distrust of outsiders evidenced among the Navajo and understood the historical reasons behind it. Participants found value in the family and tribal hierarchy found in the Navajo nation. A preference for Native Medicine practices and practitioners was seen by the participants; they appreciated the reasons for the preference. All participants discussed at length how the immersion experience promoted development of cultural skills both on a personal level and for their professional practice. The nurses found the immersion experience had impact on their nursing practice in the workplace.

In Chapter 4 conclusions derived from five themes and two sub-themes were presented. The information derived from the literature in Chapter 2 and the research methods presented in Chapter 3 supported the analysis and findings of the study. The themes represent the insights described by the nurses, painting a picture of how they synthesized and found meaning from their immersion experience that could be applied to nursing practice at the bedside. The themes represent the qualities that make the phenomenon what it is (van Manen, 1990). The extracted themes reveal the significance of an undergraduate 24-day immersion experience to the Navajo Nation for nurses who have been in practice as registered nurses for 1-3 years.

CHAPTER V

DISCUSSION

Chapter 5 will present a summary of the findings of the study and discuss connections to the literature. Themes derived within this study will be discussed, showing how literature supports and validates findings, and also how some findings are unique and need to be further investigated. The themes support that cultural immersion, even in a domestic setting, is a preferred method of teaching cultural concepts (Levine, 2009; Frenk, et al., 2010; Lipson & Desantis, 2007). More important is the overall outcome, that their professional care delivery has improved giving care to a diverse population one to three years after entering practice as a registered nurse. All the participants relate this improved care delivery to the cultural immersion experience to the Navajo Nation.

The second part of the chapter will contain the implications of findings and recommendations for further research. Nursing education is an area that is rich with possibilities for research investigation that can potentially validate the findings of this study. The methods of teaching cultural content in baccalaureate nursing education need to be scrutinized to ensure that higher education is presenting cultural content effectively. The role of healthcare institutions striving to provide culturally competent providers for clients will also be addressed.

Limitations of the study will be presented. Participant selection processes always create potential bias in findings. Strict selection criteria can offset that limitation. Additionally, the qualitative process has the inherent limitation of being a subjective process.

Concluding sections will summarize. Personal reflections highlight the strongest learning moments for this author and briefly discuss areas where the impactful insights occurred. A summary follows.

Findings and Interpretation

The purpose of this phenomenological study was to explore the lived experience of baccalaureate-prepared registered nurses who had been in practice for one to three years after participating in an immersion experience to the Navajo Nation during the senior year of their nursing studies. Numerous nursing education and professional practice organizations have stressed the importance of learning and practicing cultural skills. A review of the literature revealed that although a plethora of studies examined the impact of cultural immersion education experiences during the undergraduate educational process, there is little information on the impact after nurses enter professional practice.

This study is a first step in filling a glaring lack of research examining the impact of cultural education, especially cultural immersion experiences, on registered nurses in practice. A study (n=23), conducted in Australia, showed that an immersion experience enhanced overall cultural competence in nursing students when measured one year later in their educational process (Gower, Duggan, Dantas, & Bokly, 2019). Another study in the US reassessed students one year following a one week immersion experience (n=15), but again the participants were not actually in professional practice at the time of the study (Roller & Ballestas, 2017). This gap is troubling, as there is no research showing that the gains noted in cultural competency following immersion experiences in nursing school persist into practice.

Themes

As presented in Chapter IV, literature supports definitions used in this study. The definitions of cultural sensitivity, cultural humility and cultural competence support the findings and relate to each of the identified themes. Two themes identified in this study titled “Valued family and tribal traditions” and “Appreciated Navajo preference for Native medicine versus

Western medicine" are supported by similar themes found in studies done previously investigating immersion experiences during nursing baccalaureate education. Three other themes identified in this study "Increased Awareness of health disparities," "Recognized distrust of white people, others, outsiders," and "Promoted development of cultural skills" are not found in previous immersion literature.

Supported Themes

There were two themes found in this study that the literatures supported as occurring with immersion experiences. Participants in this study valued family and tribal traditions (Theme 3) they observed during their experience in the Navajo Nation. This finding demonstrates that participants in this study possess criteria for both cultural sensitivity and cultural humility. Cultural sensitivity indicates an awareness of differences and similarities between cultures and how that awareness can impact behaviors within the culture (Robinson, Bowman, Ewing, Hanna & Lopez-DeFede, 1997). A portion of the definition of cultural humility embraces the idea that there is a willingness to recognize and value strengths in other cultures (Isaacson, 2014). Participants were able to voice how they have learned to recognize and value the strengths they found within the Navajo culture. This influenced their professional practice as they reported looking for strengths and values in patients' cultures that are different from their own during their current nursing practice. The participant nurses state that they recognize that every culture has strengths and some explained how they try to find ways to identify and capitalize on those strengths as they care for clients. The nurses' immersion experience influenced their professional practice as they became more aware of how culture can influence health behaviors (Robinson, Bowman, Ewing, Hanna & Lopez-DeFede, 1997).

The fourth theme identified in this research, "Appreciated Navajo preference for Native Medicine versus Western Medicine" also demonstrates cultural sensitivity and humility (Robinson, Bowman, Ewing, Hanna & Lopez-DeFede, 1997; Isaacson, 2014). As participants learned about the more holistic approach the Navajo people take to identifying and treating health issues, they commented on how impactful the medicine men/women were on their Navajo clients. Medicine men/women are as likely to visit a client in their home as to meet them in a designated clinic or hospital setting. A variety of practices to address the spiritual, psycho-emotional, as well as physical concerns are employed in treatment in the Navajo Nation traditional practices. The relationship between the medicine women/ men and their clients is close and trusting. Every participant recognized the Navajo preference for native healers, especially among the older population and commented on the value of the holistic approach. Some participants were able to apply this information to the interactions they have had with clients from cultures other than their own. This led them to believe that holistic approaches taken by many other cultures would be a valuable perspective for health systems in the United States to adopt. However, other research participants did not make that connection and expressed concern that the practices of traditional healers within the Navajo culture overlooked what some participants saw as essentially physical issues. This bias toward Western Medicine practices demonstrated by some of the participants failed to recognize the different definitions of health and wellness from the Navajo perspective. So, the participants voiced opinions were not always congruent. This dichotomoy of practice belief is problematic because it ignores the ethical right of self-determination for clients within the Navajo culture. Cultural beliefs have value to health and are especially significant in cultures that have a holistic view of health and wellness, as the Navajo do. The Navajo perception of health includes spiritual, emotional, and physical

components, as well as a connection to nature, making the purely physical view of Western medicine practice incongruent to their belief system.

In general, these findings concur with previous studies. Small studies within the milieu of baccalaureate nursing education show that students value traditions and strengths found in cultures other than their own during immersion experiences. Evanson & Zust (2004) report that students immersed in a rural, economically challenged area of Guatamala appreciated the lives and values displayed by the Guatemalan people they worked with. Likewise, Levine (2009) reported that students investigated in her study found value in the strengths of the cultures they were immersed in. Wallace (2007) stated that nursing students immersed in the Korean culture found value in both the Korean cultural traditions, and also recognized the importance Koreans found in their traditional Oriental healthcare practices. Mentioned studies support the short-term value of an immersion experience to assist students to become culturally sensitive and develop cultural humility. However, the results from this study take research to the next level of inquiry. Ingulli et al. (2014) state the purpose of an immersion experience during undergraduate studies is to help nurses contextualize culture and apply learned concepts and skills to their professional practice. This study demonstrates that the immersion experience has long-term value for practice.

Unique Themes

There were three themes found in this study that were congruent with literature definitions for cultural sensitivity, cultural humility, and cultural competence. However, the literature that supported these definitions were not part of immersion experience research. Therefore, these findings add to the scholarship on cultural competency education by highlighting how the immersion experience can facilitate the acquisition of cultural sensitivity, cultural humility and cultural competence. The themes give direction to future research activity

on the topic of impact of cultural immersion experiences in the population of registered nurses in practice. As before stated, because this study queried registered nurses in practice, it was possible to identify specific cultural skills that were gained by the participants who shared this 24-day immersion experience to the Navajo Nation and had been in practice for 1 to 3 years as registered nurses.

Increased awareness of health disparities and healthcare barriers. Participants in this study were very aware of health disparities experienced by the Navajos. Awareness is a key component of acquiring cultural sensitivity (Robinson, Bowman, Ewing, Hanna, & Lopez-DeFede, 1997). Chronic diseases including diabetes mellitus Type 2, renal disease, and chronic liver diseases are higher than the United States national averages; acute illnesses including respiratory infections and septicemia are also significantly higher (Indian Health Services, 2010). Suicide rates are more than quadrupled, compared to all other age groups and races in the United States (Devi, 2011). Victims of motor vehicle accidents, assault, and sexually transmitted diseases, as well as teen pregnancies were also reported to be problematic by study participants. Participants identified environmental and social factors in the Navajo Nation that they believed were barriers to the Navajo people having access to things they perceived as essential for health. The very rural setting, lack of electricity and running water to homes, and inaccessibility of a varied diet contributed to the health disparities participants identified.

Participants cited the isolation of many homes, transportation issues, and lack of access to communications technology as evidence of healthcare barriers. However, participants also identified the preference of some of the Navajo people for living close to nature in more isolated homes, rejection of cell phones, and preferences for horses over other modes of transportation. Health People 2020 (2010) identifies healthcare barriers as things that prevent access to health

care services and negatively impact physical, social and mental health status, and quality of life. The more holistic view of health taken by the Navajo people might make it more appropriate to differentiate between barriers and differences in lifestyle choices. Choosing to live in a remote, rural area may make it more difficult to travel to a hospital when injured, but living in a more populated area may have a negative impact on the mental health or spiritual wellbeing of some people. In this case, a cultural difference, not a barrier exists. Other Navajo tribal members may wish to live closer to healthcare, even temporarily as in the case of pregnancy, but are unable to do so because of financial or other reasons, in which case it can be said a barrier to healthcare exists. It is evident that one to three years after the immersion experience participants are aware of factors that impact health and access to healthcare. However, they are not totally culturally competent, as they allow their own previous experiences and bias to Western medicine color their views of the choices made by the Navajo and perhaps current clients in their nursing practice.

Awareness of disparities and healthcare barriers is a theme not identified in immersion literature but is a critical factor for the practicing nurse to understand when acting in the professional role (Orgera & Artiga, 2018). It is known that at-risk groups who are disproportionally affected by disparities and barriers to accessing healthcare are not the only groups who suffer. Orgera & Artiga (2018) also found that ignoring disparity limits advancement in quality of care for the entire population and is one unnecessary reason for increasing healthcare costs. The Healthy People 2020 position paper notes that when clients are seen by a trusted care provider they are more likely to enter the healthcare system at the appropriate level of care (HealthyPeople.gov, 2010). An application of this information is that the culturally competent nurse will refer a client with a non-critical healthcare issue to an urgent care or

clinical setting, rather than a trauma center emergency room, thus saving significant costs to the individual client and the healthcare system. This Navajo immersion study indicates that a cultural immersion experience helped participants to be more aware of disparities and barriers to healthcare. As they moved into practice, participants were able to enlarge this skill. They now assess for, identify, and act to intervene with clients who are affected by disparities and healthcare barriers. Nursing educators can make use of this information, as they provide cultural training to their students. Rather than being an incidental finding, educators can plan for this outcome with case studies and by drawing disparity and healthcare barriers to the attention of students prior to and during an immersion experience. Educators can also help students differentiate between healthcare barriers that actually impede access to desired healthcare services and cultural differences that have value to the members of a cultural group.

Participants in this study were aware of disparities and in some cases correctly interpreted their experiences to identify barriers to healthcare access and differences in culture that led the Navajo to make holistic choices that impacted their spiritual, emotional, and physical health. These findings make it appear that these concepts are difficult to acquire during baccalaureate education and also to apply in practice. Isaacson (2014) also found that during undergraduate cultural immersion studies, some students had persistent negative stereotypical views. All participants in this study stated they felt less judgmental as a result of the immersion experience. It is reassuring that some participants were able to differentiate between healthcare barriers and cultural differences and have applied that skill to their current professional practice. This skill is valuable when nurses work with clients from a culture other than their own because it makes it more likely that collaboration between the nurse and client occurs. The client will feel their view of health and wellness is recognized, validated, and supported in the care process.

Recognized distrust of outsiders. The participants of this study identified distrust of outsiders by a cultural group as a factor they first recognized during their Navajo cultural immersion experience. This awareness is again, a symptom of cultural sensitivity (Robinson, Bowman, Ewing, Hanna& Lopez-DeFede, 1997). Most participants related stories of practice situations where they have taken this sensitivity to the next level of practicing cultural humility. Participant comments recognized the distrust and have moved to take responsibility for interacting with clients responsibly, to counteract that distrust. As practicing nurses, they have developed skills to overcome distrust by learning basic greetings in the languages of cultures they currently work with and also by having personal stories to share that are congruent with the culture of the client. The nurses recognize that these practices improve the collaborative relationship between the nurse and their clients from cultures other than their own.

This finding has significant implications in the practice setting. Recognition of distrust for outsiders is often missed by practicing nurses, but is crucial when looking at compliance to treatment. Schim, Doorenbos, Benkert, & Miller (2007) indicated that compliance is likely improved when the provider's caring behaviors and communications are congruent with the client's culture. Nurses are often unaware of how culture history influences trust. Two examples in United States history include the relocation of Native Americans to reservation lands and the Tuskegee syphilis experiment that affected Black Americans, both of which have seriously impacted trust in the United States healthcare system by those minority populations (Sotero, 2006; Kennedy, Mathis, & Woods, 2007). Trust is an important motivator for treatment compliance (Daniels & West, 2018).

Persistent evidence of cultural skills. Participants of this study have report decreased anxiety working with clients of a different culture in their nursing practice since their immersion

experience. The immersion experience exposed them to advocacy and furthered their understanding of cultural differences. They have carried that into practice, where it had matured into a strong desire to work with diverse clients. The desire to work with clients from other cultures has persisted one to three years into practice for these participants.

The literature review for this study has only mentioned this desire in research conducted using student nurse participants. Self-efficacy surveys administered to undergraduates and investigating the impact of immersion experiences in baccalaureate nursing programs indicate that students report decreased anxiety when interacting with clients from other cultures, whether in domestic settings or internationally (Evanson & Zust, 2004). As a result, students become more open to and desire to work with clients from cultures other than their own (Amerson, 2010; Evanson & Zust, 2004; Koller & Ailinger, 2002). Ingulli, Doutrich, Allen, and Dekker (2014) also reported the immersion experience led the student participants to report a desire for continued opportunities to impact cultures outside their own through involvement with non-governmental organizations (NGOs) during their schooling.

Nurse participants in this study reported they have implemented the cultural competency skills, learned in an undergraduate immersion experience, into their current nursing practice and into their personal lives. Several participants have deliberately chosen to work with culturally diverse clients in their practice, stating they felt impelled to make good use of the cultural skills gained. These participants are practicing beginning cultural competency skills as defined by some researchers. Campinha-Bacote (1999) noted that the ability to effectively work within a culture other than one's own is a key outcome on the continuum in cultural competence while other researchers state individualizing client care to meet cultural, social, and linguistic needs is evidence of cultural competence (Bettencourt, Green & Carillo, 2002).

The significant findings of this study indicate that not only do participants gain the skills to effectively work within a culture other than their own, but have also developed a strong desire to do so. And the skills and desire have continued to influence life and career choices for one to three years after entering into their careers as registered nurses. This is a significant finding beyond what has been found previously in research involving undergraduate nursing students. The cultural diversity within the nursing profession lags well behind national diversity representations, impacting the provision of healthcare services to minorities (Villarruel, Washington, Lecher, & Carver, 2015). Culturally competent nurses who desire to work with underserved populations can help bridge this deficit as the profession works to increase diversity within their ranks.

Four participants stated that they chose jobs, practice settings, or engaged in volunteer work that capitalized on their cultural competency as a direct result of their experiences and what they learned through the cultural immersion experience they had in their undergraduate nursing studies.

1. Participant D has been employed in middle management in a health care clinic system in Minnesota. He recently was offered a job to manage a clinic. Although he was offered several options, D chose to manage a clinic serving Somali refugees in an inner city setting.
2. Participant F is continuing his education to become a primary care provider to high-risk groups of Native American and Hispanic populations.
3. Participant I has participated in four international healthcare service trips to various places outside the US: Ecuador, Tanzania, Indonesia, and Mexico. She has honed her

fluency in Spanish and currently practices in Hawaii with a variety of Pacific Islander minority populations.

4. Participant J works in community health services among the Native American Inuit population in arctic Alaska. She has recently applied to graduate school and is hoping to become a Nurse Practitioner and continue working with the same populations.

Summary of Impact on Care Delivery

Each of the five themes, "Increased awareness of health disparities and healthcare barriers," "Recognized distrust of white people, others, outsiders," "Valued family and tribal leadership influences," "Appreciated Navajo preference for Native Medicine versus Western Medicine," "Promoted development of cultural skills," from the data point to participants increased awareness of the needs of clients of a culture different than the registered nurse. Research participants' remarks support their ability to provide care addressing cultural preferences of clients. For example, some participants described incidents of clients sharing information with them that were not shared with other healthcare providers. One nurse participant stated that a client requested to have the same nurse (her) after she cared for that patient in the hospital. They attributed these indications of patient satisfaction to their cultural competence. Participants felt clients had increased trust and confidence in care provided by them. This is significant, as the ability to work effectively within a culture other than one's own is the desired outcome on the continuum in cultural competence (Campinha-Bacote, 1999).

The findings in this research study also supported some themes found in in previous studies investigating immersion experiences. One, "Promoted development of cultural skills," is commonly mentioned by student participants in self-efficacy studies investigating the effects of cultural immersion either during or immediately after the immersion experience. Although no

tool was used to evaluate self-efficacy in this study, participants felt their cultural competence had improved through this immersion experience to the Navajo Nation. A perception of improved cultural competency is common among students who have experienced cultural immersion (Allen, Smart, Odom-Maryon & Swain, 2013; Larsen & Reif, 2011; Caffrey, Neander, Markle & Stewart, 2005). Every participant in this study indicated they felt the experience was worthwhile and immersion experiences should be made available to nursing students, which is also a common finding in previous studies (Isaacson, 2014; Larsen & Leif, 2011; Smith-Miller, Leak, Harlan, Dieckmann and Sherwood, 2010). So, although the lens of the participants differed in that the mentioned studies had student participants and this study investigated practicing nurses, some findings were consistent. It is significant to note that every participant supported all of the themes that emerged from this study.

Participant nurses stated that they became more accepting and understanding of cultural differences during their cultural immersion experience. Although there are a few indications of incongruence in the data, the nurses report that as their bias and judgement decreased their ability to empathize and find ways to include culturally appropriate interventions increased. Participants identified how particular insights and lessons learned in the cultural immersion experience continues to influence the ways in which they successfully interact with clients of cultures other than their own. They are better able to identify needs and provide care that addresses the cultural preferences of their clients. Patient care delivery improves when care providers deliver services that are respectful of clients' cultural health beliefs and practices (National Institutes of Health (2016). Improved care delivery not only included improved health outcomes for clients, but increased client satisfaction. A systematic literature review by Govere & Govere (2016) also found evidence that cultural competence training of healthcare providers is associated with

increased patient satisfaction. Daniels & West (2018) describe how behaviors by care providers communicate to clients they are respected, leading to improved compliance with care and increased patient satisfaction with the healthcare experience.

Cultural Immersion

This study is unique in that the setting was within the United States, only a six-hour drive from the university attended by the participants. The participants in this study were able to experience living in a very different culture, exposure to the challenges of working with clients who may not speak English, nursing practice within the Indian Health Service, and a culture with different perceptions about what health and wellness mean within a short distance from where they lived at a considerably reduced financial cost compared to an international immersion experience. Previous studies investigating the outcomes of undergraduate immersion experiences, as reported in literature, typically look at programs that take students out of the geographical boundaries of the United States (Cruellar, 2016; Ingulli, Doutrich, Allen, & Dekker, 2014; Adamshick & August-Brady, 2012; Delpech, 2013; Amerson, 2010; Caffrey, Neander, Markle, & Stewart, 2005; Evanson & Zust, 2004). The cost of international immersion programs is considerable in terms of logistics, including advance travel by faculty to survey and prepare the site for students, development of relationships at the immersion site to support the experience, time away from work and home, and securing safe housing, transportation, and food, among other concerns (Delpech, 2013). This study showed the impact of an immersion experience in the United States can be similar to an immersion experience spent in another country.

The participants in this study reported that they felt the cultural experience to the Navajo Nation delivered the educational components of learning about a different healthcare delivery

model, allowing them to experience nursing practice within a different culture than their own, and to learn of a different cultural perspective on health and wellness. None of the participants had any experience with the Native American Healthcare Services system prior to the immersion experience. They reported that learning another healthcare system, even though technically in the United States, made them more aware that diverse and international clients they now work with often have had a very different healthcare experience in their countries of origin. The nurses who participated in the Navajo immersion experience, were now more likely to ask about the clients' previous healthcare experiences to gain perspective as they developed teaching and healthcare delivery plans for diverse clients. This study correlates well with literature supporting cultural immersion as a preferred method of teaching cultural competence to nurses (Levine, 2009; Frenk, et al., 2010; Silvestri-Elmore, Alpert, Kawi & Feng, 2017). Cultural immersion experiences during undergraduate studies allow student nurses to learn about a variety of healthcare delivery models, experience nursing practice from the perspective of a different culture than their own, and to gain a global perspective on health and wellness (Kent-Wilkinson, Leurer, Luimes, Ferguson, and Murray, 2015). Silvestri-Elmore and colleagues research (2010) support immersion over classroom techniques of teaching cultural competence, finding statistically significant evidence that participants perceived they had a higher level of cultural competence following a cultural immersion experience.

Implications and Recommendations

Nursing Education & Research

This study provided data showing cultural competency skills learned in undergraduate nursing cultural immersion experiences can be retained and influence registered nurses after entry into practice. Every participant reported their immersion experience was worthwhile and

had a positive impact on them. The themes clearly revealed specific areas of cultural awareness and competence gained.

A first recommendation is to conduct another phenomenological study with practicing nurses who had an immersion experience in another culture. The themes found in this study have relevance to providing culturally competent nursing care in the increasingly diverse population of the United States. The themes may or may not be replicated in immersion experiences to other international cultural venues. Although this study's findings have aspects that are unique, the information gained could potentially be transferred, lending further support to the efficacy of immersion as a preferred method of teaching cultural competence.

A second recommendation would be to conduct a focus group study to determine if registered nurse participants can identify learning experiences or teaching techniques used by the instructor that were instrumental in helping them to develop specific skills, like recognizing disparity. This could lead to an intervention study to investigate if a particular activity or lecture can assist in the development of the specific cultural skills that educators desire to be carried forward into professional nursing practice. These types of studies would be beneficial in guiding nursing educators to develop best practice guidelines in teaching cultural competence.

A third recommendation is to initiate a study comparing cultural immersion experiences and cultural encounters. Few studies have been done looking at the outcomes of cultural encounters in nursing education. Some universities do not have the means to prepare for or execute immersion experiences. It is unknown if arranging interactions between students and members of other cultures, in healthcare settings, community settings, and student exchange programs leads to increased cultural competence that continues into practice. The only article on cultural encounters in nursing education found was focused on the interaction between nursing

students from Norway interacting with nursing students from Tanzania (Torsvik & Hedlund, 2008). A few interdisciplinary articles are available on the topic which may or may not be directly relevant or transferable to nursing practice (Christiansen, Galal, & Hvenegard-Lassen, 2018; Wirth, Langewilz, Reiter-Theil, & Schuster, 2018).

A fourth recommendation is for nursing education to facilitate students gaining cultural competence more aggressively. The literature revealed that most nursing schools rely on a single course or teaching modality to teach cultural competency skills to students (Mesler, 2014). Opportunities to introduce and reinforce cultural skills can be integrated into most nursing coursework. These methods are unlikely to have as powerful an impact on students as an immersion experience, but course work can help prepare students for immersion experiences earlier in their education. In the event immersion experiences are not an option, course work may be a weaker substitute for presenting cultural competency content. Each of the teaching modalities mentioned in the literature review may have a place in supporting the end goal of placing nurses with strong cultural competence skills into the workforce.

Immersion is, of necessity a stand-alone course, but classroom techniques and cultural encounters enhancing lecture and laboratory experiences are often easily inserted into current educational practices. Students can be assigned to work with minority nurses and clients in clinical settings. Students should be encouraged to recognize that minorities include not only race, but also groups that are identified by language, ethnic origin, religion, and sexual orientation, among others. Case studies and other written course-work might include a cultural component for students to consider. These actions may also serve to decrease cultural bias felt by minority faculty members and students.

Nursing Practice

Participant Nurses were able to demonstrate how they have applied the knowledge gained through the cultural immersion experience to their professional lives. Participants specifically mentioned insights gained from their cultural immersion experience have caused them to demonstrate more respect and understanding for their clients. They now tend to be less judgmental and are more tolerant and accepting of differences between their way of thinking and the thinking patterns of their clients from cultures other than their own. They recognize that other cultures define health differently. For instance, the Navajo have a more holistic view, incorporating spiritual and social/family elements with the physical symptoms. They feel they are more empathetic to their clients, more aware of what is important to the clients, rather than focusing on what is important to them as they provide care.

The US Bureau of labor anticipates 1.1 million additional nurses will be needed be meet needs in the US by 2022, a growth rate of greater than 15% through 2026 (Haddad & Toney-Butler, 2019). While currently the US population is 76% white according to US census bureau (2018), according to William H Frey (2018) of the Metropolitan Policy Program at Brookings, minority populations will continue to increase, with whites becoming less than 50% of the population before 2050. The demand for nurses prepared to care for a culturally diverse population in the United States is anticipated to grow for the foreseeable future. While the burden of preparing culturally competent nurses is primarily a responsibility of nursing education, maintaining and supporting nurses in culturally competent practice is a responsibility of practice settings.

Evidence of cultural training can be a strong consideration during hiring processes, especially as the United States population continues to diversify. A recommendation for practice

settings would include actively seeking qualified potential employees with a history of cultural training and who can verbalize or demonstrate cultural skills. Further, hiring managers should be educated to be culturally neutral in the hiring process. Diversity in the workforce increases the likelihood that every client will have a care provider whom they can feel more comfortable with.

Limitations

As with all research, there are limitations related to this study. The recruitment process presented one set of limitations. Additionally, the choice of the Navajo Nation as the specific cultural setting shared by the participants may not be representative of cultural immersion experiences in other cultures. Since the participants are discussing events that happened several years ago and how they have processed information from those events, perfect recall of events is not likely. The limitation of non-objective reporting is inherent to qualitative research.

The participant selection process presented several limitations related to bias. The nurse who would volunteer to participate in a study may differ greatly from a peer who would not care to be involved in research or discuss the immersion experience they shared in undergraduate studies. The participant pool was from a private religion-based university in the Mountain West area of the United States. Most participants may have shared a specific faith culture, although membership and activity in that faith is not a prerequisite for attending the university. All participants attended school and lived in the Mountain West during their undergraduate studies. Coming from a similar geographical setting and climate to the Navajo Nation may have had an effect on the participants' learning as they experienced the physical environment on the reservation. It is possible that nurses who had cultural immersion in other regions of the United States or in other countries would have a different experience. The familiarity and comfort of the instructor with the immersion culture may have impact on the immersion experience of their

students as well. Although I did not know any of the participants well, I had met several of them prior to their immersion experience in the Navajo Nation. I was familiar with Mountain West geography, climate, and the faith culture of the University. Bracketing of my personal opinion was done to prevent bias. During interviews, I compartmentalized my own experience and was engaged in the stories of the participants. I was very conscious of the need to bracket as the data analysis process unfolded.

Strict inclusion criteria assisted in recruitment of participants for this study, but may also have been a limitation to the research analysis and interpretation (Cresswell, 2008). The Navajo Nation experience is only one of ten immersion experience options available to nursing students at the university. Participants who are either more similar or less similar to the members of the immersion culture in terms of race, language, economic status, and education may have different experiences. The primary instructor for the immersion experience was a member of the immersion culture and very experienced sharing her culture with students. Her familiarity with the culture and many members of the community in the Navajo Nation may also have made this experience very different from those students who went to a setting where the instructor was an outsider, did not speak the language, or was uncomfortable.

Strict, objective accuracy and factual reporting is not a characteristic of interviewing processes used in qualitative research. Personal interpretation of events is a common characteristic of autobiographical storytelling. Phenomenological research seeks the essence of the lived experiences as individuals perceive it (Creswell, 2014). Consequently, generalizability to other groups and experiences is not an outcome for phenomenological studies. The credibility of the information can be verified by checking back with the participants to ensure the researcher's interpretation of information coincides with the participant's intent (Guba &

Lincoln, 1994). The information participants share is the most accurate source of their own experiences and interpretation. Further support from an expert qualitative researcher on my dissertation committee, who reviewed participant comments and theme descriptions, validated findings.

Personal Reflections

My interest in this topic has been fueled by my own experiences as a member of a large multi-racial family. I had many interfaces with nurses and other healthcare professionals that were less than satisfying. It was gratifying to learn about the participants' integration of cultural skills, learned in undergraduate nursing studies, into their practice at the bedside. Each participant spoke of specific interactions with people of other cultures that were positive and gratifying. They evidenced a strong commitment to providing culturally competent care to their clients. Also, they saw opportunities in their personal lives to reach out to help or learn from people who were different from them; they were not afraid to reach out of their comfort zone for those experiences. They have become the kind of nurses I would want to have care for those I love.

Critical Need for Minority Nurses

Although this is not a theme for all participants, the minority participants in this study had similar insights that made this topic jump out. The three minority participants in this study had experiences and gained insights from the cultural immersion experience that were not shared by their white counterparts. In general, they felt accepted by the Navajo people. One reported that he was sometimes mistaken for being Navajo while in Chinle. All three felt they had better relationships with the Navajo health care providers, were more welcome in homes during community health visits, and were given more information by the native healers and during

client encounters than other students. There were distinct differences in the way minority participants responded to the immersion experience compared to their white peers. Minority participants recognized they were better able to successfully respond to cultural cues that some of their Caucasian counterparts missed. They felt able to empathize with the Navajo people. Because of their own experiences of being a minority in both healthcare and educational settings, they often quickly identified cultural differences that were seen as barriers to the Caucasian participants. For instance, one English-as-a-second-language participant spoke of quickly making use of an interpreter instead of making the mistake of speaking louder and slower. He noted that in the past when people thought speaking louder or slower would better make him understand, he often felt it was a manifestation of bias, questioned his intellect, and was disrespectful. Participant comments support the finding of Whitman (2018), who stated that diversity in nursing breaks down stereotypes and helps in the development of inclusive environments for both nurses and clients in healthcare settings.

Current literature recommends that both nursing and medical care providers need to be more diverse to meet the needs of the increasingly multicultural client base in the United States. The Institute of Medicine put forth a landmark report in 2010 calling for more racial, ethnic, and gender diversity in the nursing workforce. They deemed this essential to reduce health disparities and improve healthcare quality. Cooper et al. (2003) stated that increasing ethnic diversity among care providers may be one of the easiest and most direct ways to provide satisfying and effective health care experiences to an ethnically diverse clientele. The makeup of nurses in the United States does not reflect the diversity of the general population (Villarruel, Washington, Lecher, & Carver, 2015) and probably has consequences to the care of ethnic minorities.

Based on census information, the aging population data, and projected healthcare needs in the next few decades, the nursing profession will require more nurses. The nursing profession needs to better represent the populations it serves. Minority students as well as male students should be actively recruited into the profession. Education of both practicing RNs and student nurses must support cultural competence to meet the needs of the clients. A representative population of nurses with strong cultural competency skills are the profession's best chance at successfully meeting the healthcare needs of an increasingly diverse population successfully.

Nurses practicing in the United States must be educated and confident as they work with clients from cultures other than their own. The continued changing demographics of the populations nurses will provide care for demands a culturally competent workforce. Faculty should engage all students in an ongoing discussion about how to meet the needs of every client. This means that students should be exposed to as many cultural populations as is feasible during the educational process. Faculty should be prepared to be role models in the process.

Communication

A number of participants in this study commented they focus on good communication as a key component of implementing cultural competence in their practice as registered nurses. Adapting to client communication patterns during information gathering, teaching, nursing care, and the effective use of interpreters were areas that participants in this study identified as components necessary for effective care when working with diverse populations. Ryan, Twibell, Brigham & Bennett (2000) also identified communication as a skill that improved during undergraduate immersion experiences, further stating that students may have opportunity to practice foreign language skills during immersion experiences. Participants in this study stated that being immersed in a culture with a different language compounded communication

difficulties, but they gained the confidence to overcome these problems with the use of medical interpreters. Though many participants in this Navajo immersion experience were not able to communicate in the Navajo language, nevertheless felt the immersion experience gave them additional practice in dealing with language barriers they continue to face in their current nursing practice.

This study supports research and literature addressing communication with clients from cultures other than that of the healthcare providers. Patient care delivery improves when care providers deliver services that are responsive to client communication needs (NIH 2016). Responsiveness to client communication needs is important because racial and ethnic minorities who are deficient in English language skills are more likely to encounter health care disparities (AHRQ, 2011). A number of studies conducted found that cultural immersion experiences serve to strengthen communication skills (Ryan, Twibell, Brigham & Bennett, 2000; AHRQ, 2011; Smith-Miller, Leak, Dieckmann, & Sherwood, 2010; Schim, Doorenbos, Benkert, & Miller, 2007). Smith-Miller and colleagues (2010) showed that stronger communication skills carry beyond the educational immersion experience into practice.

Identification of Specific Competency Areas

Some parts of the data collected in this study were surprising. Although I believed that cultural immersion experiences were a good way to teach cultural competency skills, I did not anticipate that these nurses would so clearly identify specific areas of competence so early in their careers. And I also was not convinced that they would tie that competence directly to their immersion experience. I had supposed they would be able to point to other life experiences that could have influenced them. As I have traveled extensively, it did not occur to me that so many

of the participants would have such a culturally limited life. The immersion experience in the Navajo Nation truly was a unique, life-changing event for many of these nurses.

Outcomes for Educators

As previously discussed, there is a gap between the requirement to provide cultural competency training for nurses and clear outcomes to guide the profession as we strive to achieve the requirement. This research brought to light four outcomes that I believe are essential for an immersion experience.

1. Cultural training should assist students in understanding cultural differences. Educators should be prepared to guide learners in identifying cultural factors that impact their choices, beliefs, and practices. Instructors must facilitate development of an appreciation of cultural understanding in practice. This process might include study of historical, governmental, physical and social environments, significant events observations (birth, coming-of-age, marriage, and death rituals), availability of adequate nutrition, educational opportunity, and other factors within immersion cultures. One participant in this study noted that there are reasons behind the choices people make, not only in healthcare, but in their lives in general. Nurses should be prepared to investigate the reasons so they can better help clients make choices that are congruent with their belief systems.
2. Cultural training should promote a collaborative attitude toward the client. Too often in healthcare, I believe, providers take the stance that our scientific education makes us somehow superior to our clients. Clients may be labeled as non-compliant when, in fact, their cultural belief system makes it impossible for them to adhere to a specific course of treatment. A collaborative attitude would welcome the client into the

decision-making process. Every client can be compliant to a healthcare pathway that they understand and embraces the beliefs and goals they value.

3. Advocacy is a key component of successful culturally competent nursing practice. This goes hand-in-hand with a collaborative attitude. Many times clients from cultures other than that of the nurse are also hindered in other ways from voicing their needs and desires in regards to their healthcare. Language barriers, cultural practices that prevent direct confrontation, gender issues, and educational differences are examples of reasons a client cannot advocate for themselves. Culturally competent nurses champion the cause of their clients.
4. Immersion experiences can prepare nurses to practice active leadership. Nurses should recognize situations where clients need an advocate and step in as needed. Active leadership behaviors should be considered an option in interactions with peers, the physicians and healthcare systems at any time a client is unable to advocate strongly in their own behalf. One participant in this study spoke of a client situation where a patient was placed on hospice care against his wishes. Because of oral and written language differences, he was rushed through signing a pile of papers that he did not understand. On the shift prior to his discharge home, this nurse obtained proficient translator services to investigate the situation. She championed the cause of her client to the physician and social worker, resulting in a change in direction for the patient's care that coincided with his desires and cultural belief system. Although some peers chastised her for the "trouble" she caused, she was adamant in her support for her client.

Clear outcomes, such as those mentioned above, should guide nursing education in the pursuit of preparing professionals with a firm grasp on cultural humility at graduation and in pursuit of cultural competency in their careers.

Summary

This phenomenological qualitative study surveyed 13 nurses who had been in a cultural immersion experience to the Navajo Nation during their senior year of baccalaureate education. Study criteria stipulated that participants had been in practice for one to three years as a registered nurse. Participants were recruited from the alumni of a private, faith-based university in the Mountain West region of the United States. The five themes that emerged presented a better understanding of how registered nurses retain and interpret cultural education gained during undergraduate nursing education.

This study adds to the body of knowledge on cultural immersion experiences as an effective educational modality to teach cultural competence. Based on the findings of this study, the immersion experience to the Navajo Nation had an impact on the cultural competence of nurses after being in practice for between one to three years. They verbalized becoming more aware of disparities and barriers faced by clients from minority cultures. They were better able to appreciate the strengths and attitudes of their clients from cultures other than their own. Additionally, participants were able to demonstrate how the knowledge gained from their immersion experience has impacted both their nursing practice and personal lives. Although much more research is needed on this topic, nurse educators can have more confidence that immersion experiences will prepare their students to be culturally competent professionals in the workforce.

APPENDICES

Appendix A

IRB Approval Letter

Appendix B

Recruitment Letter

Appendix C

Informed Consent

Appendix D

Demographic Survey

Appendix E

Semi-structured Interview Guide

Appendix A
IRB Approval Letter

UNLV Biomedical IRB - Exempt Review
Exempt Notice

DATE:	November 28, 2017
TO:	Michele Clark, PhD
FROM:	Office of Research Integrity - Human Subjects
PROTOCOL TITLE:	[1125600-3] Assessing the Long-term Effects of a Cultural Immersion Experience on Nursing Practice
ACTION:	DETERMINATION OF EXEMPT STATUS
EXEMPT DATE:	November 28, 2017
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of Revision materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

The following document will need to be modified prior to using it on the study:

Informed Consent Form:

1. Please include the PI and the PI's contact information in the sentence "For questions or concerns about the study, you may contact Karen de la Cruz..."
2. Participant Section: Please include the exclusion criteria as listed in section 7.3 of the Protocol Proposal Form into this section of the consent form.
3. Please be sure to review and modify formatting, grammar, and spelling. For instance, the grammar in the second sentence in the Purpose of the Study section should be modified from "The purpose of *these* study ..." to "The purpose of *this* study.." Also, in the Cost/Compensation section please remove the ICF template language *"minutes/hours/days*."

PLEASE NOTE:

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials.

If your project involves paying research participants, it is recommended to contact Carisa Shaffer, ORI Program Coordinator at (702) 895-2794 to ensure compliance with the Policy for Incentives for Human Research Subjects.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

Office of Research Integrity - Human Subjects
4505 Maryland Parkway . Box 451047 . Las Vegas, Nevada 89154-1047 (702) 895-2794 . FAX: (702) 895-0805 . IRB@unlv.edu

Appendix B
Recruitment Letter

School of Nursing

Date:

Dear _____,

You are invited to participate in a research study on the effect of cultural immersion experiences during baccalaureate nursing coursework. In particular, we are interested in your perceptions of how the 24-day cultural immersion experience in the Navajo Nation has influenced your current nursing practice. The Principal Investigator for this study is Dr. Michele Clark, with Karen de la Cruz as the Student Investigator.

Nurses who participated in the *Nursing 390R Independent Study in Nursing Culture Class – Navajo Nation* and *Nursing 404 Clinical Practicum Public and Global Health* course and graduated between December 2012 and May 2015 are needed for the research study. The researcher, a doctoral graduate student at the University of Nevada Las Vegas, School of Nursing, will be conducting the interviews. Interviews will be audio-recorded and conducted in English. You may be contacted after the initial interview to clarify information.

There are no anticipated risks associated with the study. Several procedures are in place to safeguard your anonymity. Information will remain confidential, and your name will never be used. Although the interviews will be recorded, the recordings will be destroyed after transcription is completed. The typed interviews will have your name removed and will be kept in a locked cabinet in the office of the researcher. Only the two researchers and a research assistant sworn to confidentiality will have access to the interviews. All information will be destroyed after 4 years.

Your participation is voluntary. If you decide to participate, you will receive a $10 gift card for your time and trouble. However, you may withdraw from the study at any time. If you do this, all information from you will be destroyed.

The study will begin in October 2017 and conclude in March 2018. Face-to-face interviews will be conducted at a mutually agreed upon neutral site, at a time that is convenient for you.

If you are interested, please contact Karen de la Cruz at karen-delacruz@byu.edu or by cell phone at (719)251-1078 for more information. A copy of the *Research Consent* form is available upon request and will be reviewed with you prior to the beginning of the study. This study has been reviewed and received approval from the Institutional Review Board at the University of Nevada Las Vegas.

Thank you for this consideration.

Sincerely,

Karen de la Cruz

University of Nevada Las Vegas, School of Nursing

Appendix C
Informed Consent

INFORMED CONSENT
Department of School of Nursing

TITLE OF STUDY: Assessing Nurse Perceptions on the Long-term Effects of an Immersion Experience on Nursing Practice

INVESTIGATOR(S): Primary Investigator: Dr. Michele Clark;
Student Investegator: Karen de la Cruz;
Research Assistant: Daniel Smith

For questions or concerns about the study, you may contact Karen de la Cruz at **DELACK1@unlv.nevada.edu or at 719-251-1078** or Dr. Michele Clark at **michele.clark@unlv.edu. at 409–599- 5165 or 702–895-3360**

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study
You are invited to participate in a research study. The purpose of this study is to learn about nurses' perceptions of the long-term effects of their cultural immersion experience on nursing practice.

Participants
You are being asked to participate in the study because you fit this criteria:

Inclusion Criteria

1. The participant recruits will have participated in a 24-day immersion experience to the Navajo Nation during the Spring term of the final year of their baccalaureate education at the selected private faith-based university.
2. The participants' first undergraduate degree will be a Baccalaureate degree with a major in Nursing (BSN).
3. Participants will have the equivalent of one to three years (1800 to 5400 hours) of direct patient care.

Exclusion Criteria

1. Participant recruits who have a BSN but have not worked.
2. Participant recruits who have less than the equivalent of one year (1800 hours) or more than the equivalent of three years (5400 hours) work experience.
3. Participant recruits who are Native Americans.
4. Participant recruits who are conversant in the Navajo language.
5. Participant recruits raised on Navajo Nation lands.

Procedures

If you volunteer to participate in this study, you will be asked to do the following:
1. Participate in one interview lasting 60-90 minutes with the researcher and/or research assistant asking questions regarding the immersion experience in the Navajo Nation and perceived impact on your current nursing practice. A face-to-face interview will be scheduled at a time and place convenient to you. Semi-structured interview questions will be asked for the purpose of learning more about a particular topic. The interviews will be recorded by the researcher or research assistant A 15-30 minute follow-up interview may be asked of you to clarify or seek further information within 60 days of the first interview.

Benefits of Participation

There may not be direct benefits to you as a participant in this study. However, we hope to learn new information obtained that may improve the practice of nursing and enhance patient outcomes for those receiving nursing care.

Risks of Participation

There are risks involved in all research studies. Risks in this study are expected to be minimal and comparable to what a person would experience in every-day life. For instance, you may feel uncomfortable answering some questions. However, you may choose to not answer a question if you feel uncomfortable. This study and the researchers are anticipated to have no impact on social, educational, or employment decisions that may affect any participant.

Cost /Compensation

There may not be financial cost to you to participate in this study. The study will take 60 to 120 minutes of your time in one or two interviews. You will be compensated for your time.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for 4 years after completion of the study. After the storage time the information gathered will be destroyed.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

_____ _____

Signature of Participant Date

_____

Participant Name (Please Print)

Audio/Video Taping:

I agree to be audio taped for the purpose of this research study.

_____ _____

Signature of Participant Date

_____

Participant Name (Please Print)

Appendix D
Demographic & International Education Survey

Please complete each of the following items by placing a "√" next to your choice or by providing the information requested.

I. Demographic Data

A. Age: _____ years old.

B. Age at time of international education: _____ years old.

C. Month/Year of graduation: _____.

D. Gender: _____ Female

_____ Male

E. Current employment position:

_____ Staff nurse in an acute care setting

_____ Staff nurse in long-term care

_____ Nursing Supervisor/Charge Nurse

_____ Community/public health staff nurse

_____ School nurse

_____ Physician's office/clinic

_____ Nurse Educator, Community based

_____ Nurse Educator, Facility based

_____ Nurse Educator, Academia

_____ Occupational health nurse

_____ Advanced nursing practice (practitioner, CNS, anesthetist)

_____ Other (please specify) _____

F. In months, how long have you been employed as an RN? _____

G. Race: _____ Black

_____ Hispanic

_____ Caucasian

_____ Native American

_____ Asian

_____ Other (please specify) _____

H. What is the highest level of education you have completed?

_____ Baccalaureate in nursing

_____ Masters in nursing

_____ Doctoral degree (please specify)_____

_____ Other (please specify) _____

I. Before entering college, did you visit or live in another country? (please specify which country and for how long)_____

J. Have you been in a long-term relationship or married to someone from another culture? (please specify what culture and for how long)_____

K. Do you speak any language other than English? (please specify) _____

L. Since graduation, have you traveled to a foreign country? (please specify where and for how long)_____

Appendix E
Semi-structured Interview Guide

Proposed questions:

1. Tell the story of your global health immersion experience in the Navajo Nation.

2. What kind of specific experiences do you recall?

3. Describe an incident that happened during your immersion experience that was meaningful to you. Why was it meaningful? Is it still meaningful to you and can you explain how?

4. What do you think you learned from the cultural immersion experience in the Navajo Nation?

5. How has the immersion experience influenced your practice as a nurse at the bedside? Please give examples.

6. How do you perceive those experiences as influencing your nursing identity?

The following questions will be implemented to refocus on the purpose of this study or bring the interview to closure.

7. How do you deal/interact with people who are different from you?

8. Has your immersion experience in the Navajo nation influenced how you interact with people who are different from you? In what ways?

9. In a global way, how do you feel the cultural immersion experience impacted you?

10. Help me to understand better how your cultural immersion experience has influenced your bedside practice as a nurse.

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CURRICULUM VITAE
Karen H. de la Cruz

TITLE: Assistant Professor

EMAIL: karen-delacruz@byu.edu

1. Educational Preparation

INSTITUTION AND LOCATION	DEGREE	MM/YYYY	FIELD OF STUDY
Colorado State University, Pueblo, CO	Post-Masters Certificate	05/2007	Family Nurse Practitioner
Colorado State University, Pueblo, CO	Post-Masters Certificate	05/2005	Acute Care Nurse Practitioner
Colorado State University, Pueblo, CO	Post-Masters Certificate	05/2005	Nurse Educator
University of Phoenix Colorado Springs, CO	Master of Science	04/2001	Nursing
California State University Hayward, CA	Bachelor of Science	03/1987	Nursing

1.a. Certifications and Licensure

INSTITUTION/ORGANIZATION	CERTIFICATE	MM/YYYY
State of Utah, Division of Occupational & Professional Licensing	Registered Nurse License	09/2009 – Present
Transcultural Nursing Association	Certificate of Transcultural Nursing – Advanced (CTN-A)	07/2016 – Present
American Heart Association	Basic Life Support Provider	01/2016 – Present
State of Colorado Board of Nursing	License: Advanced Practice RN, Nurse Practitioner	04/2005 – 09/2010

2. Professional Experience

Academic Positions

INSTITUTION AND LOCATION	TITLE	YEARS OF SERVICE
Brigham Young University Provo, UT	Assistant Professor	2011 – Present
Brigham Young University Provo, Utah	Visiting Assistant Professor	2009 – 2011
Colorado State University Pueblo, CO	Assistant Professor	2006 – 2009

Professional Positions

INSTITUTION AND LOCATION	SPECIALTY/ROLE	YEARS OF SERVICE
Southern Colorado Family Medicine Clinic, Pueblo, CO	Nurse Practitioner	2007 – 2009
St. Mary Corwin Medical Center Pueblo, CO	Nurse Practitioner Education Coordinator Clinical Educator PICC Team Critical Care RN Psychiatric Liaison	2005 – 2006 2005 2001 – 2005 1999 – 2001 1997 – 2001 1997 – 2000
Acute Care Treatment Services Denver, CO	Emergent Intervention Psychiatric Evaluator	1996 – 1997
"C" Street Counseling Center Pueblo, CO	Founding Board Member	1996 – 2003
Parkview Episcopal Medical Center Pueblo, CO	Certified Neonatal Nurse	1995 – 1997
Doctor's Medical Center Modesto, CA	Registered Nurse, Neonatology	1991 – 1995
Lucille Salter Packard Children's Hospital, Stanford, CA	Registered Nurse, Pediatric Oncology	1987 – 1991

3. Citizenship Experience

INSTITUTION	TITLE/ROLE	YEARS OF SERVICE
Professional Citizenship		
Transcultural Nursing Society	Conference Planning Committee	2016 – Present
Western Institute of Nursing	Member	2016 – Present
Tonga Nurses Association	Affiliate Member	2015 – Present
Phi Kappa Phi Honor Society	Member	2014 – Present
Transcultural Nursing Society	Member	2013 – Present
Utah Nurses Association	Treasurer	2012 – Present
Student Nurses Association	Faculty Member	2010 – Present
National League of Nursing	Member	2009 – Present
Sigma Theta Tau, Iota Iota Chapter	Secretary	2009 – Present
Faculty Women's Association	Member	2009 – Present
American Association of Nurse Practitioners	Member	2005 – 2012
Southern Colorado Nurse Practitioner Physician's Assist Alliance	Member	2006 – 2010
Sigma Theta Tau, Iota Pi Chapter	Secretary	2006 – 2009
Community Institutional Review Board Pueblo, CO	Board Member	2005 – 2006
Sigma Theta Tau Iota Pi Chapter	Member	2003 – 2009
"C" Street Counseling Center Pueblo, CO	Founding Board Member	1996 – 2003
Volunteer Coordinators of Pueblo	Member	1997 – 2002

University Citizenship		
Kennedy Center Inquiry Conference	Invited panel discussion moderator	2014
College Citizenship		
Faculty Development Council	Chair	2016 – Present
Undergraduate Academic Council	Member	2016 – Present
Public & Global Health Council	Member	2013 – Present
Faculty Development Council	Member	2013 – 2016
College Assembly Council	Member	2009 – Present
Undergraduate Academic Council	Member	2011 – 2013
International Affairs Council	Member	2009 – 2012

Community Service

INSTITUTION	TITLE/ROLE	YEARS OF SERVICE
Boy Scouts of America	Merit Badge counselor	1982 – Present

4. **Teaching**

A. Brigham Young University

UNDERGRADUATE COURSES TAUGHT	YEARS
NURS390R Independent Study in Nursing Care of the Refugee Patient	2018 – Present
NURS404 Public & Global Health Nursing Refugee	2018 – Present
NURS390R Independent Study in Nursing Testing Strategies	2015 – Present
NURS333/SOC333 End-of-Life Care	2015 – Present
NURS390R Independent Study in Nursing Care of the Ghanaian Patient NURS404 Public & Global Health Nursing Ghana (Previously NURS 390R and NURS404 were combined as NURS402 Global Health and Human Diversity)	2016 – 2018, 2010 – 2014 2016 – 2018, 2010 – 2014

NURS390R Independent Study in Nursing Care of the Tongan Patient	2015
NURS404 Public & Global Health Nursing Tonga	2015
NURS292 Nursing Care of the Older Adult Clinical Practicum	2010 – 2014
NURS341 Nursing Care of Adults with Acute and Chronic Illnesses	2009 – Present
NURS342 Clinical Practicum for Nursing Care for Adults with Acute & Chronic Illness (Previously NURS341 & NURS342 were combined as NURS330 Nursing Care of Adults with Acute and Chronic Illnesses)	2009 – Present

B. Student Mentoring

UNDERGRADUATE STUDENT MENTORING

Year	Honors Thesis, ORCA, MEG	Outcome/Presentation
2016	ORCA	Emma Brague Robinson, Poster Co-presenter, Western Institute of Nursing Conference *Coping Strategies of Hospice Nurses: A Qualitative Evaluation*
2015	Honors Thesis	Sarah Skriloff, Presenter, Student Global Health Initiative Conference, University of Utah *Exploring Opportunities for User-Centered Design in the Advance Directive System*
2015	Unfunded	Kaeli Flinders Thomas, Podium Co-presenter, Transcultural Nursing Society Conference *Interventional Study: Pediatric Anemia in Rural Ghana*
2014	Unfunded	9 students, Anemia Research in Rural Ghana
2014	Unfunded	Sarah Leggett, Undergraduate Inquiry Conference, BYU *Creating a Culturally Competent Nurse: Community Assessment and Root Cause Analysis in Ghana*
2013	Unfunded	Emily Louder, Podium Co-presenter, Transcultural Nursing Society Conference *Cultural Considerations for Research in Rural Ghana*

2012	Unfunded	Sarah Leggett, Undergraduate Inquiry Conference, BYU *The experience of Gaining Cultural Humility*
2012	ORCA	*Effective Leadership Qualities in Nursing Clinical Instructors*

GRADUATE STUDENT MENTORING

Year	Mentoring Opportunity	Publication/Presentation
2017 – Present	Graduate Thesis	Daniel Smith *Minority Nurse Perceptions of an Immersion Experience in the Navajo Nation on Professional Practice*
2014 – 2016	Graduate Thesis	Megan Zitting *Comparison of Albendazole Versus an Iron Supplement on Hemoglobin Levels of Kindergarten-aged Children in Abomosu Sub-district of the Atiwa District of Ghana, West Africa.* (Content Expert).
2013	Graduate Studies Mentoring Assistantship Grant	Kim Thompson Mentoring of a Graduate Student Who Will Mentor Undergraduate Nursing Students in a Global Health and Human Diversity Clinical Experience in Ghana
2012	Graduate Studies Mentoring Assistantship Grant	Jennifer Jenkinson Mentoring of Undergraduate Students in a Global Health and Human Diversity Clinical Experience in Ghana
2011	Graduate Mentoring in Applied Setting	Jann Stacey Pickens Mentoring of Undergraduate Students in a Global Health and Human Diversity Clinical Experience in Ghana

5. Contribution to the Discipline

Defined Focus or Foci: Cultural Issues in Healthcare, Nursing Education

A. Presentations (*Undergraduate Student, ** Graduate Student)

1. Peer-Reviewed, Blinded Podium Presentations.

International Podium Presentations

Wing, D., **de la Cruz, K.,** & Ray, G. (2016). "Interpreting Unexpected Results: Pediatric Anemia Research in Rural West Africa." Transcultural Nursing Society 42nd Annual Conference, Cincinnati, OH.

Palmer, S. & **de la Cruz, K.** (2015). "Nursing Students Serving, Transforming and Leading within 5 Miles to 3000 Miles." Sigma Theta Tau International Conference, Las Vegas, NV.

de la Cruz, K., **Zitting, M., & *Thomas, K. (2015). "Forming Collaborative Connections: A West African Healthcare Investigative Experience." Transcultural Nursing Society Conference, Portland, OR.

de la Cruz, K. & *Louder, E. (2014). "Cultural Considerations in a Clinical Interventions Study in Rural Ghana: Interface with Formal & Informal Local Community Leaders" Transcultural Nursing Society Conference, Charleston, SC.

de la Cruz, K. (2013). "Partnership in Rural Africa: Improving community Health Care" Transcultural Nursing Society Conference, Albuquerque, NM.

de la Cruz, K. (2011). "Transitioning from Clinician to Clinical Educator" Sigma Theta Tau International Conference, Grapevine, TX.

National Podium Presentations

Wing, D., **de la Cruz, K.**, Corbett, C., & Reed, S. (2012). "The World is Our Campus", National League of Nursing Summit, Anaheim, CA

Regional Podium Presentations

de la Cruz, K. (2010). "Transitioning the New Clinical Educator: You Can Fly" Nurse Educator's Conference in the Rockies, Breckenridge, CO.

2. Non-Peer Reviewed Podium Presentations.
Local Podium Presentations

*Thomas, K. F. & **de la Cruz, K.** (2016). "Anemia Research in Africa: Interpreting Unexpected Findings." 2016 Utah Conference of Undergraduate Research, Salt Lake City, UT

de la Cruz, K. & *Thomas, K. F. (2015). "Surprising Findings: Investigation of Pediatric Anemia in Rural Ghana Implementing Two Interventional Techniques." 2015 Scholarly Works Research Conference, Brigham Young University, Provo, UT.

3. Invited Presentations.
Local Presentations

de la Cruz, K. (2014). Keynote Presentation: "Proof in the Passion", Science, Technology, Engineering, and Math (STEM) Conference, Utah Valley University, Orem Utah.

de la Cruz, K. (2012). "Mini NCLEX Review", Utah Student Nurses' Association 60th Convention, Utah Valley University, Orem, UT.

de la Cruz, K. (2011). "NCLEX Testing Strategy" Utah Student Nurses' Association Conference, Salt Lake Community College, West Jordan, UT.

de la Cruz, K. (2010). "NCLEX Testing Strategy" Utah Student Nurses Association Conference College, Ephraim, UT.

4. Peer-Reviewed, Blinded Poster Presentations.
International

de la Cruz, K. & Smith, P. (2014). "Smith-de la Cruz Theory of Critical Culture Recognition in Nursing (S-dTCCRN)" Transcultural Nursing Society Conference, Charleston, SC.

Regional Poster Presentations

de la Cruz, K. (2016). "IRB Cultural Considerations: A Clinical Intervention Study in Rural Ghana." Western Institute of Nursing Communicating Nursing Research Conference, Anaheim, CA.

de la Cruz, K., Coram, C., Galloway, A. (2007). "**C**urricular Framework Education: From Dull to Dynamic" Eighteenth Annual International Nurse Educators Conference in the Rockies, Breckenridge, CO.

Glabensklee, C. & **de la Cruz, K.** (2007). "**S**ynchronized Master's Level Interdisciplinary Hybrid Courses" Eighteenth Annual International Nurse Educators Conference in the Rockies, Breckenridge, CO.

5. Non-Peer Reviewed Poster Presentations.
Local Poster Presentations

*Skriloff, S., Howell, B, **de la Cruz, K.,** Rush, J. (2016). "Exploring Opportunities for User-Centered Design in the Advance Directive System." 2016 Student Global Health Initiative Conference, Salt Lake City, UT

B. Publications

1. Peer-Reviewed Blinded Articles.

Palmer, S., Wing, D., Miles, L., Heaston, S., **de la Cruz, K.** (2013). Study abroad programs: Using alumni and graduate students as affiliate faculty. *Nurse Educator, 38* (5). 198-201.

2. Published abstracts of peer reviewed presentations/posters.

de la Cruz, K. & Smith, D. (2018). Assessing the Long-term Effects of an Immersion Experience on Nursing Practice: *Transcultural Nursing Society 44th Annual Conference Book of Abstracts:* Livonia, MI: p.__ (Podium).

de la Cruz, K., Wing, D. & Ruda, P. (2017). "The Culture of Karen: Educational Strategy to Promote Cultural Understanding in Students Preparing to Provide Healthcare to Ghanaian Populations" *Transcultural Nursing Society 43rd Annual Conference Book of Abstracts:* Livonia, MI: Transcultural Nursing Society, p. 47. (podium).

Wing, D., **de la Cruz, K.,** & Ray, G., (2016). Interpreting Unexpected Results: Pediatric Anemia Research in Rural West Africa: *Transcultural Nursing Society 42nd Annual Conference Book of Abstracts:* Livonia, MI: Transcultural Nursing Society, p. 52. (podium)

de la Cruz, K. & *Robinson, E., & Heise, B. (2016). Coping strategies of hospice nurses: A qualitative evaluation. *Communicating Nursing Research Conference Proceedings*; 49, Anaheim, CA: Western Institute of Nursing.

3. Manuscripts currently at various state of preparation.

de la Cruz, K. & Smith, P. S., Candela, L. "Smith-de la Cruz theory of critical culture recognition in nursing"

de la Cruz, K. & Wing, D. "Cultural disconnect in the ER: Tiffany's story"

C. Professional Review
Manuscript/Book/Grant Reviewing

Van Leeuwen Lab & Diagnostic Tests Textbook 1e Chapter 27, F.A. Davis Company, October, 2012.

D. Other Contributions to the Discipline

1. Research Grants Submitted and Funded

FUNDING SOURCE	AUTHORS	YEAR/AMOUNT	GRANT TITLE/DESCRITPION
External			
Utah Nurses Association	de la Cruz, K.	2015 / $1,000	Anemia Study and Intervention in Rural Ghana Pediatric Population
Internal			
Mentoring Experience Grant	de la Cruz, K.	2017 / $20,000	Long-term Effects of Undergraduate Immersion Experience on Practice
College of Nursing Research Grant	de la Cruz, K.	2015 / $5,000	Pediatric Anemia Studies in Rural Ghana
Myrtie Fulton Mentoring Grant	de la Cruz, K.	2014 / $10,500	Anemia Study and Intervention in Rural Ghana Pediatric Population
College of Nursing Grant	de la Cruz, K.	2014 / $5,000	Pediatric Anemia Studies in Rural Ghana Populations
Graduate Studies Mentoring Assistantship	de la Cruz, K.	2013/ $5,000	Anemia Research in a Non-domestic Setting: Rural Ghana
Graduate Mentoring in Applied Setting	de la Cruz, K.	2011 / $4,000	Mentoring of Undergraduate Students in a Global Health and Human Diversity Clinical Experience in Ghana

2. Honors and Awards

HONOR/AWARD SOURCE	YEAR	HONOR OR AWARD
Utah Nurses Association	2015	Grant-in-Aid Scholarship $1,000
Phi Kappa Phi Honor Society	2014	Induction
Sigma Theta Tau Honor Society	2005	Induction

3. Conferences, workshops and other classes attended

A. International Professional Conferences (Taught and Attended)

October, 2018	44th Annual Conference of the Transcultural Nursing Society, San Antonio, TX
October, 2017	43rd Annual Conference of the Transcultural Nursing Society, New Orleans, LA
October, 2016	42nd Annual Conference of the Transcultural Nursing Society, Cincinnati, OH
November, 2015	43rd Biennial Convention, Sigma Theta Tau International Honor Society of Nursing, Las Vegas, NV
October, 2015	41st Annual Conference of the Transcultural Nursing Society, Portland, OR
October, 2014	40th Annual Conference of the Transcultural Nursing Society, Charleston, SC
October, 2013	39th Annual Conference of the Transcultural Nursing Society, Albuquerque, NM
November, 2011	41st Biennial Convention, Sigma Theta Tau International Honor Society of Nursing, Grapevine, TX

B. National Professional Conferences (Taught and Attended)

April, 2016	49th Annual Communicating Nursing Research Conference, Western Institute of Nursing, Anaheim, CA
April, 2012	2012 National League of Nursing Summit, National League of Nursing, Anaheim, CA
June, 2011	Boot Camp for Nurse Educators, National Nurse Educator Conference, Albuquerque, NM

C. Regional Professional Conferences (Taught and Attended)

November, 2016	End-of-Life Nursing Education Consortium Conference on Advancing Palliative Care, Boise, ID
July, 2010	Nurse Educators Conference in the Rockies, Breckenridge, CO
July, 2007	Nurse Educators Conference in the Rockies, Breckenridge, CO

D. Local Professional Conferences (Taught and Attended)

October, 2018	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
March, 2018	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
October, 2017	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
March, 2017	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
October, 2016	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
March, 2016	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
March, 2016	2016 Student Global Health Initiative Conference, University of Utah, Salt Lake City, UT
October, 2015	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
March, 2015	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
October, 2014	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
July, 2014	Science, Technology, Engineering, and Math Conference, Utah Valley University, Orem Utah
March, 2014	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
March, 2014	Kennedy International Center, 16th Annual Inquiry Conference Brigham Young University, Provo, UT
October, 2013	College of Nursing Scholarly Works and Contribution to the Discipline Conference, Brigham Young University, Provo, UT
March, 2013	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT

October, 2012	2012 Utah Student Nurses Association Conference, Utah Valley University, Orem Utah
October, 2012	College of Nursing Research Conference, Brigham Young University, Provo, UT
March, 2012	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
October, 2011	2011 Utah Student Nurses Association Conference, Salt Lake Community College, West Jordan, UT
March, 2011	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT
October, 2010	2010 Utah Student Nurses Association Conference, Salt Lake Community College, West Jordan, UT
October, 2010	College of Nursing Research Conference, Brigham Young University, Provo, UT
March, 2010	College of Nursing Annual Professionalism Conference, Brigham Young University, Provo, UT