

INQUIRY INTO THE CULTURAL CONSCIOUSNESS OF NURSING STUDENTS  
DURING A ONE-WEEK CULTURAL IMMERSION SERVICE LEARNING  
EXPERIENCE WITHIN AN AMERICAN INDIAN COMMUNITY

by

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DEDICATION

To nursing students past and present who have participated in the Cultural Immersion Service Learning Experience and the families and the children of the Northern Plains Indian Reservation: sources of constant inspiration.

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To Dr. Betsy Palmer, who inspired me to begin this journey and whose spirit has stayed with me, a pebble was tossed into the water in a far distant land, the ripples created by that pebble have travelled far and wide, thank you.

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## ABSTRACT

Cultural consciousness is a central element of purposeful and appropriate health care delivery that integrates knowledge, sensitivity and understanding (Korton & Sahtouris, 2001). The preponderance of research across a variety of disciplines suggests that cultural consciousness and awareness is strengthened through self-reflection (Axtell, Avery & Westra, 2010; Danielewicz, 2001; Furlong & Wright, 2011; Gay & Kirkland, 2003; Rew, 2014), dialogue about race (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2014), and experience within other cultures (Fredericks, 2006; Kozub, 2013; Peaz, Allen, Carson & Cooper, 2008; Stone, et.al., 2014).

The purpose of this study was to examine nursing students' perceptions of cultural consciousness pertaining to American Indian culture developed during a one-week cultural immersion service learning (CISL) experience. Specifically, The overarching research question central to the focus of this study was: How do nursing students at this university describe their CISL experience? Three sub questions were posed to inform the main research question.

An intrinsic single case study design bounded by the students' perceptions of a cultural immersion service learning experience within an American Indian community was used to answer the research questions. Thirty participants were selected from two cohorts of nursing students enrolled in Nursing Care of Children and Family, a required junior-level course participated in a one-week CISL experience. Data included instructor observations and two sets of student reflections. The data were analyzed using the constant-comparative method (Strauss, 1987).

Evidence from clinical reflections demonstrated most students wrestled a mismatch between their initial expectations and the reality of the situation, but several weeks afterward two-thirds of the students integrated the CISL experience into a coherent whole in which cultural consciousness emerged in their reflections. The findings from this study suggest that incorporating CISL experiences into undergraduate nursing curricula may facilitate the development of cultural consciousness and the skills needed for culturally competent care in student nurses. Also, there appeared to be a link between students' ability to recognize their societal privilege, the close proximity of healthcare disparities, and cultural consciousness. Additionally, recommendations were provided for developing a CISL experience within an undergraduate nursing program.

## CHAPTER ONE

## PURPOSE OF STUDY

Causative agents which interfere with the health of communities include health disparities. Health disparities exist across the globe (World Health Organization, 2008). These disparities are complex, multifaceted, and have multivariate causes. Among the many causes, one is cultural hegemony—specifically an incongruence of beliefs among people of different cultures that favors one set of cultural values over another. “Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health...historically linked to discrimination or exclusion...” (Centers for Disease Control and Prevention, 2014, p.1). Furthermore, often this incongruence is tacitly held and conveyed within the beliefs of the dominant group which further sequesters it from awareness, reflection, or discussion. This incongruence is captured by Moss (2016):

As Americans, we are presented with few opportunities to learn in depth about our Indigenous people. There is a cursory section or chapter in grade-school, and maybe again in high school and then nothing. The material when it is presented is always from the dominant culture’s point of view. (p.8)

Moss (2016), a member of the Lakota Nation, further wrote, “As a nurse and as an educator, I have found materials related to American Indian health and nursing to be nonexistent” (p.9).

Cultural consciousness is a central element of purposeful and appropriate health care delivery that integrates knowledge, sensitivity and understanding (Korton &

Sahtouris, 2001). Cultural consciousness amongst healthcare providers is an essential element in bridging an awareness gap inherent in cultural hegemony. Changes in the health care delivery system towards community based nursing require a re-emphasis in nursing education towards the mentoring and support of student learning for a more culturally conscious practice. Mentoring and student learning that facilitates cultural consciousness fits within the service-learning paradigm.

The profession of nursing has historically been and continues to be a provider of service and an advocate for quality care. In addition, nursing has sought to promote community and individual health. In briefly recounting the history of nursing education, Bartels et. al. (1998) reminded us that the expectations for humanistic learning in nursing education have long been espoused. The delivery of service within the context of a community is an integral part of the social contract of nursing education. In the last two decades, sweeping health care reform in the United States has begun to move away from institutionally delivered care to a focus on community health, “but nursing as a profession has not, until recently begun to embrace true service learning.” (Norbeck, Connolly & Koerner, 1998 p.1)

The National and Community Service Trust Act of 1993 defined service-learning as:

...a method under which students or participants learn and develop through active participation in thoughtfully organized service that is conducted in and meets the needs of a community, is integrated into and enhances the academic curriculum of the students program, and includes structured time for students and participants to reflect on the service experience. (as cited in Norbeck & Koerner, 1998, p 1 ).

Nursing students must be able to combine the art of caring with critical thinking skills which take into account the idiosyncratic nuances of the patients' cultural values and beliefs (Kardong-Edgren, et.al. 2010; Giger & Davidhazar, 1999). Such integration is essential to the development of cross-cultural health care. Without such integration, nursing students will not be able to assess and provide the kind of interventions that are culturally appropriate. Culturally diverse nursing care knowledge, skills and dispositions are required to ensure that all people have equal access to quality, culturally appropriate healthcare. Only nurses who recognize the value of culturally appropriate care can be effective care agents for diverse patient communities and contribute to the elimination of health care disparities.

The service learning model as part of nurse preparation is one approach which can be utilized to engage nursing students in situations which foster reflection and critical thinking about healthcare and social disparity amongst diverse people. As nursing students share and develop technical knowledge and skill, those benefitting from the technical knowledge share their culture, belief systems, perspective and worldview with the nursing students. Jean Watson (1987), a nursing theorist, stated: "To care for someone, I must know who I am. To care for someone I must know who the other is. To care for someone I must be able to bridge the gap between myself and the other" (p.7). Service learning through a cultural immersion experience may have the potential for creating a bridge that closes the gap between students and diverse people. Dr. Watson's seminal work serves as inspiration for this dissertation project.

Service learning is one method of engaging college students in local and community projects, both domestic and foreign and the benefits of service learning experiences are predominantly documented anecdotally by students and faculty in reflective journaling.(Pugsley & Clayton, 2003) However, immersion experiences remain difficult for individual faculty to develop within their course parameters. Gillis and McLellan (2010) reported in their review of the literature on service learning with vulnerable populations, barriers to successful service learning were noted in 25 of the articles reviewed. Barriers included insufficient time, heavy workloads, promotion and tenure responsibilities that are not measured equitably between research teaching and service. Thus, faculty who are designing and implementing service learning programs, courses and experiences can benefit from the insights of faculty who have developed service learning immersion experiences in their own courses.

### Background of the Study

Registered nurses (RNs) represent the largest sector of the health care industry in the United States numbering more than 2.8 million (Health Resources and Services Administration, 2013). In discussing the preparation of professional nurses Walsh & DeJoseph (2003) wrote, “Inclusion of cultural content in theory courses and clinical assignments in diverse settings are two ways to increase student nurses’ cultural competence” (p.266). Furthermore, facilitating cultural consciousness among nursing students as well as students in other healthcare professions has been incorporated into the educational standards for preparing nurses as well as the preparation standards for many

other professionals. Cultural consciousness is integral to professional practice (Theoharris, 2002). Yet, Moss, (2016) described her own professional nursing practice with the following bold statement “ the concepts I learned on the job, even as a Native American nurse, were never taught to me in any nursing program.” Thus, there is a clear need to establish effective instructional practices which develop the understanding of cultural consciousness of nursing students regarding American Indian communities and their members.

Lenninger (1988), a seminal author in transcultural nursing, wrote that “maintaining culturally congruent care is essential to satisfying meaningful and beneficial care for clients” (p.38). This philosophical perspective laid the groundwork for one of the essentials of baccalaureate nursing education—the inclusion of studies focused on the issues of diversity, cultural consciousness and social justice. Cultural consciousness has been incorporated into the preparation standards at the university providing the context for this study as an outcome for BSN graduates, and service learning became the major pedagogical approach used in teaching a Pediatric Nursing course required for a BSN degree at the campus.

An important key to a successful service learning experience is to involve the community in which the learning is to take place (Synder & Weyer, 2002). Pascarelli and Terenzini (1997) reported that “college and university students who are involved in community centered activities, especially activities with cultural and ethnic groups different from their own, show the greatest growth in advanced levels of moral reasoning.” (p 349).



In service learning, the primary objective continues to focus on academic goals but student learning needs are met through the provision of a service. According to Gillis and MacLellan (2010), traditional classroom learning tends to be structured, passive and compartmentalized. Service learning is reflective, active and integrative in ways that alter the worldview of the service learning participants. In regards to partnerships, traditional learning is collaborative but may be authoritarian and hegemonic; on the other hand service learning, tends to display genuine collaborative relationships with shared responsibility.

### The Problem

Service learning is a widely accepted tool used in the educational development of student nurses (Reams & Twale, 2007). Yet, little research has examined student perceptions of the insights developed during cultural immersion service learning experiences (Gillis & McLellan, 2010). Despite the acknowledged importance of service learning in the higher education classroom, there is a lack of understanding regarding how students perceive a cultural immersion service learning experience (Smith, Emmett & Woods, 2008). Although several studies have explored the outcomes of service learning with vulnerable populations in nursing education, Gillis and McLellan found only three studies published between 1999 and 2009 which described a cultural immersion service learning experience with vulnerable populations. These studies described international projects. None of their reviewed studies examined a service

learning approach in the context of an American Indian community. Furthermore, scant research exists on service learning within American Indian communities.

### Purpose

The purpose of this study was to examine nursing students' perceptions of cultural consciousness pertaining to American Indian culture developed during a one-week cultural immersion service learning (CISL) experience, embedded within an undergraduate nursing course and within an American Indian community. Such research will increase knowledge about students' perceptions of cultural consciousness gained through CISL experiences as well as inform the development of undergraduate nursing coursework focused on facilitating cultural consciousness of nursing practice within diverse communities. This knowledge may be of interest to nursing faculty shaping future curricular offerings that facilitate cross-cultural healthcare practices and work toward reducing health disparities.

### Research Questions

The overarching research question central to the focus of this study was:  
How do nursing students describe their CISL experience?

Three sub questions were posed to inform the main research question:

1: What CISL experiences do nursing students describe as important in developing their consciousness of American Indian culture within two of the Northern Plains Indian tribes?

- 2: How do nursing students describe the knowledge they acquire regarding the care of historically underserved populations during their one week CISL experience?
- 3: What do students describe as influential in their development of empathy in the complex link between poverty and health?

### Foundational Assumptions

The major assumptions that frame this study focus on learning and the importance of learning on societal change. Learning is a process of creating and recreating knowledge (Kolb, 1984). As human beings, we seek to make sense of the world and do this by organizing our experiences into systems of beliefs that we then impose upon the world to create structure and order. The process of ordering the world into patterns and structures is learning. Experiences markedly different from the patterns we now hold may, over time, cause us to change our patterns of thought and restructure our beliefs and actions.

A culture is defined by its beliefs, values and customs (Spring, 2004). We assimilate the beliefs of our cultural environment as we grow from childhood into adulthood, and while in that same environment, we have little reason to question the beliefs that order our world and wonder why others can hold different belief systems. As long as our beliefs are aligned to the predominant beliefs within our environment, we have little reason to question our beliefs. The issue of hegemony emerges when a majority holds one set of beliefs and a minority of people holds a different set, while both

groups live within the same environment. As a result, disparities emerge in societal institutions such as healthcare and education. In order to resolve the disparities, increased cultural consciousness is required. Individuals must question their beliefs to recreate existing knowledge patterns in order to accommodate a bicultural or multicultural view. Thus, within the context of this study, increased cultural consciousness by healthcare providers translates into culturally conscious healthcare for underserved and vulnerable populations.

Another essential assumption embedded in the design of this study is the reliance on truth in the self-reports participants make about their perceptions. The data collected and analyzed in this study relied on reports from individuals about their personal perceptions. Therefore, the logic of any conclusions about this study was based upon the premise that all participants truthfully and accurately reported their perceptions.

An essential assumption addressing the significance of this study was based on the idea that the information embedded in the case study may be generalized by the reader to situations important to the reader. For the reader to be able to successfully generalize the information in this case study, it must be sufficiently thick and rich enabling the reader to accurately translate the information from one context to another based upon similarities seen within the context of this case study and the situational context that the reader wishes to apply to the findings.

Theoretical and Conceptual  
Framework for this Study

Education can never be considered a neutral education process (Freire, 1970). As such, Experiential Learning Theory (Kolb, 1975) and cultural consciousness intersect through a dialectic process. In applying knowledge of nursing theories to the specifics of a given situation, students construct their understanding of how general knowledge applies in a specific context and the context is never neutral. Thus, it is essential that a dialectic process be a part of the educational process. As nursing students applied their knowledge of theory to a situation in order to construct a solution, their knowledge was transformed by the results of that solution. This transformation occurred through praxis—the reflective and deliberate action taking place through personal agency in a specific situation (Freire, 1970).

Experiential Learning Theory applied the pragmatic philosophy of Dewey (1938), with the self-directed humanistic psychology of Rogers (1969), and the notions of accommodation and assimilation from Piaget's (1963) cognitive development model into an organic continuous learning cycle whereby knowledge is created by transforming experience into meaningful frameworks that then change the way a person thinks and behaves (Kolb, 1984). Dewey (1938), Kolb (1984), Piaget (1963) and Rogers (1969) agreed on two basic tenets:

learning takes place as an individual changes their thinking based on an experience and most importantly, by reflecting on that experience learners revisit that thinking again and again as they experiment in new situations, modifying their thinking through the results of new experiences. (Menaker, Coleman, Collins, & Murawski, 2006, p 2)

Kolb (1984), in his seminal work, explained experiential learning as a process whereby knowledge is developed through the transformation of experiences in a four stage cycle. The process begins with concrete experience. In this study, nursing students acquired concrete experiences by interacting with others and practicing nursing skills within an American Indian community through a one-week CISL experience.

Within stage two of Kolb's (1984) cycle, through the process of describing their concrete experiences, students analyze and compare their experiences against prior knowledge and assumptions. During the CISL experience students participated in reflective discussions daily and were required to submit written reflections of the experience within two days of completing the CISL experience. The reflective process or reflective observation was essential to experiential learning (Carpenter, 1999). The in-situ reflections collected in this study sought to capture the nursing students' perceptions during this stage of the experiential learning process.

In stage three of Kolb's (1984) cycle, students attach personal meaning to the experience by beginning to generalize their experience and move towards developing conclusions based on studied principles. This study sought to capture nursing students' perceptions of this stage in an end of course reflection of their CISL experience.

Finally in the last stage of Kolb's (1984) process cycle, students develop ideas on how they can use their conclusions by making inferences which can then be generalized to other contexts. Within the conceptual framework of this study, this last stage of the experiential learning process may potentially increase cultural consciousness among the nursing students who participated in the CISL experience. Figure 1, Initial Conceptual

Model of the CISL Experience, graphically depicted Kolb’s experiential learning cycle as applied in designing the study of this university’s students’ descriptions of the CISL experience—an experience that sought to facilitate cultural consciousness among students.

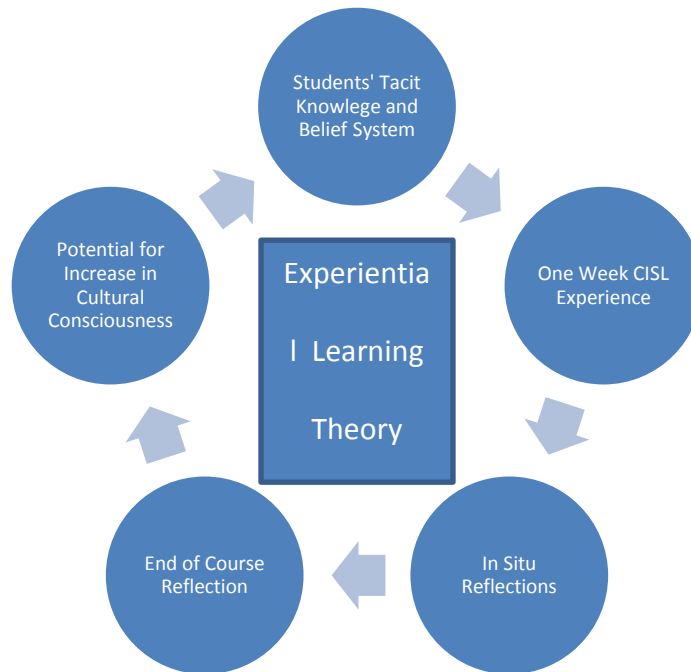


Figure 1. Initial Conceptual Model of the CISL Experience

In constructing a logic model of the study, Figure 2, Conceptual Framework of this Study, as shown below, depicted how the conceptual model for the CISL experience was evaluated.

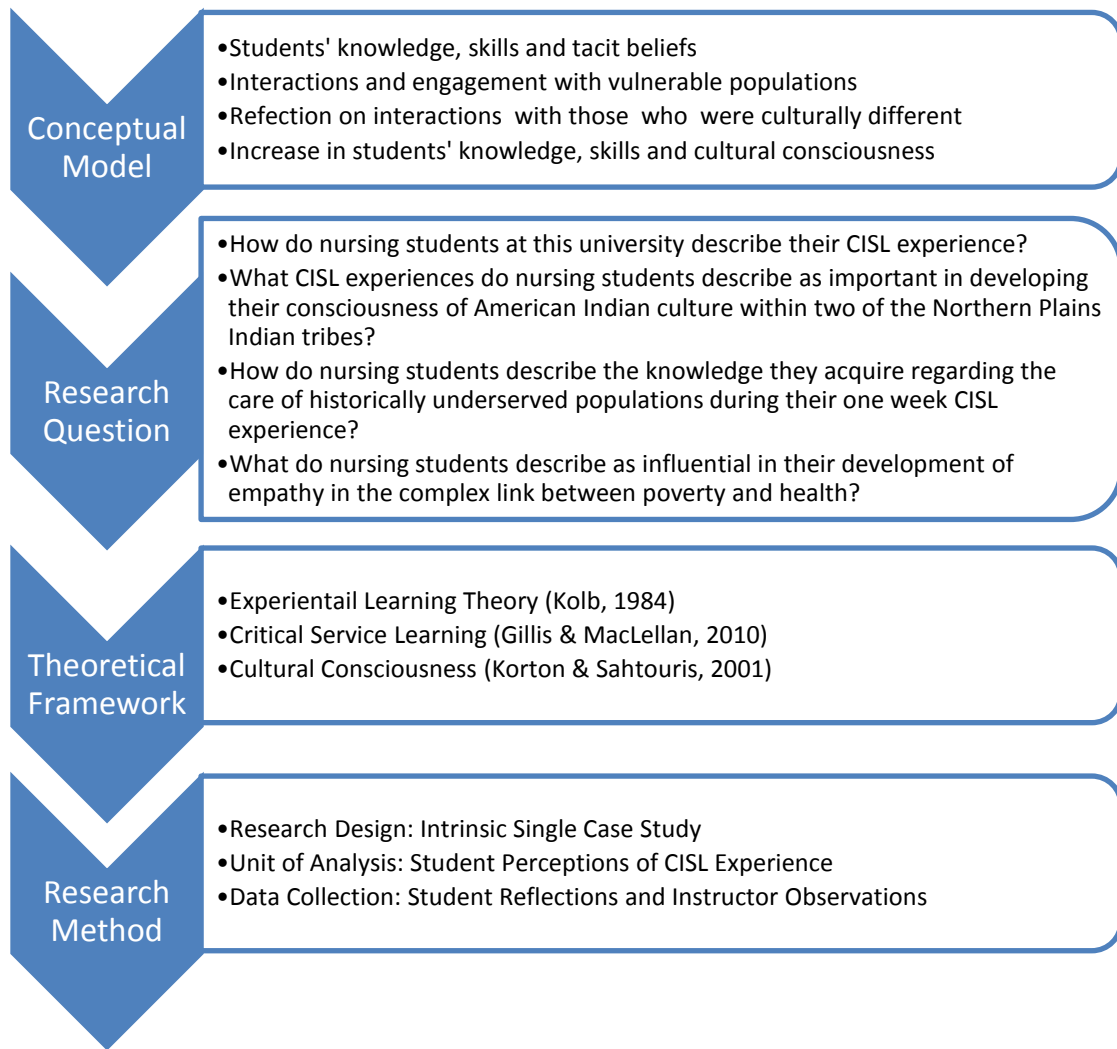


Figure 2. Conceptual Framework of the Study

Specifically, the conceptual model of the CISL Experience was based on the experiential learning process described by Kolb (1984). An overarching research question focused on how nursing students described their CISL experience in response to three research sub-questions that captured nursing student perceptions about the CISL experience and determine if evidence existed regarding the development of cultural consciousness. The theoretical framework used in constructing the methodology and interpreting the results



rested on three foundational pillars. The first pillar was Experiential Learning Theory (Kolb, 1984). The second pillar was a critical service learning model for working with vulnerable populations of patients described by Gillis and MacLellan (2010). The third pillar was the concept of cultural consciousness as defined by Kortton and Santouris (2001) and described by Gay and Kirkland (2003). This theoretical framework and the supporting research are fully explained in Chapter 2. Furthermore, the research methodology outlined below is fully described in Chapter 3.

### Outline of Research Methods

#### Context for the Study

Nursing students enrolled in Nursing Care of Children and Family at the university participated in a required week long CISL experience on an American Indian reservation. Appendix C outlined the development of the cultural immersion experience embedded in Nursing Care of Children and Family course. The goal of the service learning experience was designed to foster successful student learning in a clinical setting culturally different from the student's home campus. Thus, it provided a unique opportunity to further develop student nurses skills within the framework of cultural consciousness. Objectives related to the cultural immersion service learning experience included:

- Students will gain an understanding and appreciation of American Indian culture within two of the Northern Plains Indian tribes.

- Students will gain an understanding of historical trauma and its impact on healthy lifestyles, well-being and social justice.
- Students will gain insight into the complex link between poverty and health.
- Students will work together collaboratively to meet a desired need of their Native hosts.

### Synthesis of the Investigation

In order to effectively answer the research questions, this study used a single case study design and focused on student insights during a one week CISL experience embedded within a required undergraduate nursing course. A defining feature of a case study is a well-established boundary (Yin, 2009). The boundary of this study was delimited by nursing students' perceptions of cultural consciousness during a one-week CISL experience within an American Indian community. Student perceptions were gathered from reflections during the experience. The design of this study was deliberately constructed as an intrinsic single case study (Yin, 2009) using as its independent variable, the one week CISL experience, and as its dependent variable, the reflections and insights of nursing students. The qualitative evidence obtained from artifacts produced by the students while they participated in the one-week CISL experience.

The qualitative data were analyzed using the constant-comparative method. A detailed description of and rationale for the study's methodology is provided in Chapter 3, the above was intended to provide only an overview of the research approach used to answer the research question.

### Limitations of the Study

The limitations in the design of this study are that the study relied predominantly on student self-reports. Although approaches in gathering these self-reports were triangulated using multiple sources of data (artifacts) from multiple participants, the trustworthiness of the findings and conclusions relied on students being truthful when the data were collected.

### Definition of Key Terms

*Accelerated Nursing Program:* 14 month long program at the university, designed for returning students who have previously earned a bachelor's degree in a discipline other than Nursing.

*American Indian:* For purposes of this study, the term was used interchangeably with the term Native American to refer to Indigenous people living within the boundaries of the continental United States.

*Cultural Consciousness:* For purposes of this study, the term was used to express a conscious self-aware process, a relationship between an examination of long held world views and the social constructs that are approximations of complex realities especially when working with and amongst individuals who identify with a culture different from our own, improves communication amongst diverse groups of people (Korton & Sahtouris, 2001). Spector (2013) wrote, "The provision of health care across cultural boundaries and takes into account the context in which the patient lives, as well as the situations in which patients' health problems arise" (p.11).

*Experiential Learning:* A theoretical framework combining the conceptual models of Dewey, Lewin and Piaget to describe learning as “a process whereby knowledge is created through the transformation of experience. This framework emphasizes learning as (1) “a process of adaptation...”, (2) that “knowledge is a transformation process continually being created and recreated...” and (3) that “learning transforms experience in both objective and subjective forms” (Kolb, 1984, p.38).

*Health Care Disparity:* For the purposes of this study, the term was used as defined by the Office of Disease Prevention and Health Promotion, (2011) which stated:

... a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. They adversely affect groups of people who have systemically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (p.1)

*Health Care Equity:* For purposes of this study, the term was used as stated by the Office of Disease Prevention and Health Promotion (2011), the elimination “of disparities and improvement of the health of all groups” (p.2).

*Health Inequality:* In this study, the term referred to the “designation of differences and variations in health and risk factors among individuals and groups. It implies that there is a cause to be concerned about related to these differences.” (Raphael, 2012, p.292)

*Homogenous Group:* In this study, the term referred to “a group who share a single culture and this culture is typically the dominant culture within American society” (Spring, 2009, p. 21).

*Immersion Experience:* Throughout this study, the term referred to an experiential learning situation in which the students are surrounded or immersed into a culture that is not their own.

*Indian Reservation:* Sovereign territory within the United States granted by treaty to American Indian tribes.

*Preceptor:* A licensed professional practicing at the clinical site who provided on-site tutoring and mentoring support for nursing students.

*Rural Segregation:* Geographically isolated individuals and groups (Kawachi, Subramanian & Almeida-Filho, 2002).

*Social Determinants of Health:* “the conditions in which people are born, grow up, live work and age including their health. These circumstances are in turn shaped by a wider set of forces, economics, social policies and politics.” World Health Organization, (2010, p 1).

*Social Justice:* “Equitable sharing of both the common burdens and the common benefits or advantages in society... Social justice is a value central to the practice of Nursing. Community and Public Health Nursing” (Harkness and DiMarco, 2012, p 143).

*Traditional Nursing Program:* 4 year, Bachelors of Science Degree in Nursing at the university, designed for students entering directly from high school or working towards a first undergraduate degree in Nursing without prior college or university experience.

### Significance of the Study

Without knowledge and a clear understanding of student perceptions, many faculty members may not be encouraged to invest the time and energy associated with service learning experiences into their curricula. The significance of this research was that it sought to understand how students described their perceptions during a one week CISL experience within an American Indian community. Through the research of student perceptions during a one-week CISL experience, the contributions of this study may begin to develop a greater understanding of how to facilitate cultural consciousness in nursing students.

### Chapter Summary

Cultural consciousness among healthcare providers is an essential element in bridging an awareness gap inherent in cultural hegemony. Changes in the health care delivery system towards community based nursing, require a re-emphasis in nursing education towards the mentoring and support of student learning for a more culturally conscious practice. Despite the acknowledged importance of service learning in the higher education classroom, there is a lack of understanding about how students perceive a cultural immersion service learning experience. Furthermore, scant research exists on service learning within American Indian communities. The purpose of this study was to examine nursing students' descriptions of their perceptions of a one-week cultural immersion service learning (CISL) experience, embedded within an undergraduate nursing course and within an American Indian community. Through the research of

student descriptions of their perceptions during a one-week CISL experience, a greater understanding of how to facilitate cultural consciousness in nursing students may emerge.

## CHAPTER TWO

## LITERATURE REVIEW

There is an expanding recognition regarding the importance of cultural consciousness in providing healthcare to a diverse patient population. Kortton & Sahtouris (2001) defined *cultural consciousness* as a conscious self-awareness process, a relationship between an examination of long held world views and the social constructs that are approximations of complex realities, especially when working with and amongst individuals who identify with a culture different from their own. Through increased capacity for communication and shared understanding, inter-personal trust between clients and healthcare providers can improve access to equitable healthcare and improve health outcomes (Leininger, 1988). Cultural consciousness is the daily practice of keeping cultural awareness in the foreground and not letting the promise of openness and the honoring of cultural values, or assumptions different from one's own, fade to the background in daily activities (Rew, 2014).

To situate, understand and interpret the students' descriptions of their CISL experiences, this chapter reviewed existing literature pertaining to: (1) the importance of cultural consciousness or awareness for nursing students in reducing healthcare disparities. (2) Experiential Learning Theory as a means for acquiring and transmitting cultural consciousness; and (3) service learning as a set of instructional strategies to facilitate cultural consciousness and awareness of vulnerable populations.



Reducing Healthcare Disparities through  
Increased Cultural Consciousness

Health inequalities are defined as differences, variations and disparities in the health achievements and risk factors of individuals and groups (Center of Disease Control and Prevention, 2014; World Health Organization (WHO), 2008). Some health inequalities are related to genetically determined predispositions or related to accidents, and injuries as a result of personal choice, normal aging or unavoidable situational bad luck, but most health inequalities are a direct result of exposure to adverse living conditions and circumstances that threaten health and wellbeing, (Public Health Agency of Canada, 2007). These preventable and socially unjust differences in health are considered health disparities. According to the WHO (2008),

...disparities in health, avoidable health achievement variations, arise because of the circumstances in which people grow, live, work and age, and the system put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic force. (p.1)

These political, social and economic forces lead to differences in health outcomes among different groups of people, typically groups who have been historically oppressed (Center for Disease Control and Prevention, 2014). Health disparities are therefore largely preventable and the degree of disparity may grow or shrink based on public policy, community environment, and access to culturally competent healthcare.

For almost 70 years there have been international policies promoting healthcare equity and access to all people. For example, the United Nations General Assembly (1948) declared:

Everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” Article 25 (1)

The United Nations Human Rights Office (1989) specifically addressed the rights of children in stating “Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and ... shall strive to ensure that no child is deprived of his or her right of access to such health care services” Article 24 (1). More recently, the United Nations General Assembly (2007) agreed that “Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including: education, employment, vocational training and retraining, housing, sanitation, health and social security.” Article 21 (1)

#### Healthcare Disparities Among Vulnerable Populations

The United States stands alone in being the only wealthy, developed country without universal access to healthcare services (Bezruchka, 2012). In the last 50 years, there have been three major federal health policy initiatives directed at increasing healthcare access. Two federal programs were both enacted in 1966 and have remained politically controversial since their inception. Medicare provides access to basic healthcare for senior citizens. Medicaid provides support to state-level healthcare access for indigent people and varies widely from state to state. Furthermore, the passage of the Patient Protection and Affordable Care Act in 2010 extending a basic level of healthcare insurance to all Americans continues to be attacked by strong political forces. Each

decade since 1979, the U.S. Department of Health issued *Healthy People* reports identifying health and healthcare disparities as well as making policy recommendations to reduce and eliminate the disparities (CDC, 2010a). Causes of healthcare disparities include the more obvious issues of unequal access to affordable insurance coverage which directly relates to people not receiving needed healthcare and physical barriers such as geographic isolation or lack of transportation (Holtz, 2013). On the other hand, some issues are more tacit. For example, Hispanics and American Indians are less likely to participate in health insurance programs even when they are made available and affordable (Center for Disease Control, 2004). Minority groups are less likely than Caucasians to be given appropriate cardiac medicines, less likely to receive cardiac bypass surgery, renal dialysis, transplants or the best diagnostic tests or treatment for cancer, HIV/AIDS or a stroke (Sullivan Commission Report, 2004). African Americans are more likely than Caucasians to seek care from hospitals with fewer resources and more dated technology, and receive care from physicians with less training.

Language and cultural barriers underlie large disparities in infant mortality rates, life expectancy, cancer, diabetes, and stroke (CDC, 2010b). People with limited English language abilities are less likely to make medical care appointments or understand the urgency of care in some situations (Holtz, 2013). Furthermore, a lack of English skills inhibits the comprehension of healthcare advice or the understanding of basic healthcare information necessary for making appropriate healthy lifestyle decisions. Additionally, a lack of diversity among healthcare providers can also be a concern. Minority patients are less comfortable and less trusting of healthcare providers who are not like themselves and

do not understand the cultural nuances of their healthcare beliefs and practices (Sridhar, 2005). The Institute of Medicine (2003) reported:

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patient's insurance status and income are controlled...The study committee focused part of its analysis on the clinical encounter itself, and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment. (p. 162)

Despite a cacophony of policy statements supporting the health equity and universal access to care, healthcare disparity persists with the greatest disparities occurring among American Indians living on rural reservations (Indian Health Service, 2003). The 56,068 American Indian residents of Montana, living on or off of reservations face serious and persistent health problems as well as social and economic hardships. Many American Indian reservation communities, including the Northern Plains Indian Reservation, are impacted by high rates of unemployment, geographic isolation and geographic disparities in access to health care services. The Northern Plains Tribes Health Care Director stated, "Vast distances, lack of cars or enough gas money can make it difficult for rural tribal members to get to a clinic to access healthcare. Even if they do make it to town, there may not be enough providers available for them to be seen that day" (Personal communication, October 21, 2013). Furthermore, Schoen and Doty (2004) reported that health services provided in rural, geographically isolated communities in the U.S. "may be of less than optimal quality." The physician to patient ratio on the Northern Plains Indian Reservation was 1:4010

American Indian morbidity rates persist at far greater rates than the morbidity rates for non-Natives across a large number of healthcare concerns (Indian Health

Service, 2014). For example, alcohol related disease is six times as great among American Indians, diabetes is almost three times more prevalent. Injuries among American Indians occur two and a half times more often. Suicide is 1.8 times more prevalent, pneumonia is 1.3 times more prevalent and infant mortality is 1.2 times more prevalent (Sweeney, Karol & Nolan, 2011).

The failure to address these health disparities and their presence is unjust. Policies and programs are needed that systematically increase cultural consciousness of healthcare professionals working with members of these communities to reduce the healthcare disparity that exists among American Indian communities. (Moss 2016) stated “The culture of poverty that exists for [this state’s] American Indians is responsible for poorer health, higher disease rates, lower life expectancy, and greater difficulty obtaining health care” (p. 275). Moss goes on to report that this state has a higher poverty rate and burden of disease than is experienced by American Indians in neighboring states.

Despite their long and proud history, the two tribes of the Northern Plains Indian Reservation face a number of pressing economic and health concerns. Eighty percent of the American Indian population of the Northern Plains Indian Reservation lives below 200% of the federal poverty level. The median age of death at the Northern Plains Indian Reservation is 50 years for American Indian males and 60 years for American Indian females, compared to 75 years and 82 years respectively for state citizens as a whole. The primary causes of death for American Indians of the Northern Plains Indian Reservation are cardiovascular, kidney and lung disease as well as alcohol abuse. Forty-one percent of deaths among American Indians are attributable to drug or alcohol use, suicide, accidents

or violence. Finally, the Robert Wood Johnson Foundation (2014) named the Northern Plains Indian Reservation's primary county as the unhealthiest county in the state based on health outcomes.

Examining and understanding the socially unjust healthcare disparities that exist within a given community is essential to the efficacious treatment of each patient within the community. Yet, nursing students tend to focus on the clinical and technical aspects of patient assessment and care without examining systemic factors that exist at the community level. Educating students to develop culturally competent nursing skills requires critical examination of socially unjust health disparities, so that as healthcare providers, nursing students understand why vulnerable patient populations experience such different life circumstances and how public policy decisions and unexamined assumptions in healthcare practices shape the difference in life circumstances is critical. Incorporating a human rights approach to nursing education facilitates cultural consciousness by placing issues of health, health disparities and the sources of health disparities into a larger framework of human rights principles (Rioux, 2010).

#### Moderating Health Care Disparities through Cultural Consciousness

One approach in trying to alleviate socially unjust health care disparity is to prepare nurses who are culturally conscious (Leininger, 1988; Kortton & Sahtouris, 2001). Nursing education includes the incorporation of patient-centered care as outlined in the Patient Protection and Affordable Care Act (2010). Nurses who are not familiar with the culture with which each patient identifies will not be able to provide optimal care to those

patients. One's culture and ethnic background affects interpretation, sense-making, and value judgments; for healthcare providers the lack of cultural consciousness distorts diagnostic clarity (Campinha-Bacote (2007). Korton & Sahtouris (2001) suggested that increased cultural consciousness improves communication amongst diverse groups of people. It is through this improved communication that a shared understanding emerges which is essential in providing optimal nursing care.

Cultural consciousness includes multiple elements of cultural understanding and sensitivity. One element is the understanding of time and how the perception of time influences culture. Reynolds and Valentine (2003), described three cultural views on the perception of time, monochromatic (linear) and polychronic (flexible) and cyclical (circular, repetitive). Cultures who perceive time as linear prefer the management of one major activity at a time. Polychronic cultures prefer to work on several activities simultaneously and cultures where time is perceived in a circular fashion prefer to allow events to unfurl naturally.

Anglo Saxon and Germanic cultures, Northern European, Scandinavian and the United States are as cultures where time is task oriented (Reynolds & Valentine, 2003). Time is not to be wasted. Tasks are allocated a time to be completed, with rigid appointment scheduling and a focus on the future.

Native American, Inuit, South East Asian and African cultures believe that life controls time. Time is circular; these cultures perceive time in relation to connections and interrelations to people and events (Reynolds & Valentine, 2003; Wilson, 2005). Tasks are completed over a long period of actual time while considering contemplation and

reflection, time is focused on the past rather than the future. Cultural consciousness includes an understanding of cultural beliefs relating to the perception of time and thus the perception of task completion and orientation to what is perceived by one culture versus another as important. Without this understanding misperception or misunderstanding may occur which can contribute to a perpetuation of tacit bias.

Cohen and Goode (1999) identified reasons for developing cultural consciousness, and competence among healthcare providers which included, “eliminating long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds [and] improving the quality of services and outcomes” (p.10). Culturally competent care requires healthcare providers to act consciously to examine what they think, and how they act toward others (Hunt, 2001).

The preponderance of the research across a variety of disciplines suggests that cultural consciousness and awareness is strengthened through self-reflection (Axtell, Avery & Westra, 2010; Danielewicz, 2001; Furlong & Wright, 2011; Gay & Kirkland, 2003; Rew, 2014), dialogue about race (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2014), and experience within other cultures (Fredericks, 2006; Kozub, 2013; Peaz, Allen, Carson & Cooper, 2008; Stone, et.al., 2014). In addressing self-reflection for cultural consciousness, Gay and Kirkland wrote that “self-reflection and critical cultural consciousness are imperative to improving... opportunities and outcomes [for people] of color. They involve thoroughly analyzing and carefully monitoring both personal beliefs and [professional] behaviors about the value of cultural diversity...” (p.182). Danielewicz (2001) elaborated this idea stating:



Reflexivity is an act of self-conscious consideration that ...involves a person's active analysis of past situations, events, and products, with the inherent goals of critique and revision for the explicit purpose of achieving an understanding that can lead to change in thought and behavior. (p. 155-156)

### Models of Cultural Consciousness

Carpio and Majumbar (1993) discussed the importance of student's self-examination of their own beliefs, values and assumptions as part of a beginning to grasp an appreciation of others. Self-reflection leads to a desire to understand and to acquire knowledge making for effective and efficient care of patients from diverse cultures. This process is a developmental learning approach for adult learners (Knowles, 1980). The instructor facilitates student desire to learn and understand by providing the clinical practice opportunities for students to develop the skills necessary to provide culturally appropriate care. According to Carpio and Majunder's seven-stage process model for the development of multicultural awareness, students are initially ethnocentric (first stage), then through experience and reflection they begin to gain awareness (second stage). The third stage involves the acceptance or rejection of other values and belief systems followed by a fourth stage of appreciation and valuing. The fifth stage involves the selective adaptation of different values, assumptions and beliefs followed by a sixth stage of assimilation of the values, assumptions, and beliefs, and adaptation of views and practices through biculturalism toward multiculturalism. The seventh and final stage is the application of multiculturalism to professional practice.

Campinha-Bacote (2007) wrote that one's cultural consciousness lies on a continuum across four levels or stages. Unconscious Incompetence is being unaware of one's lack of cultural knowledge and not understanding the importance that such cultural knowledge plays in providing appropriate healthcare (Cambell-Jones, Campbell-Jones & Lindsey (2010); Purnell, 1998). In other words, the nurse is unaware that client holds different cultural assumptions. The next stage is conscious incompetence where one is aware that cultural differences exist and there is a lack of knowledge about the cultural group. Healthcare professionals know there is a difference but lack the know how to bridge the difference. The third stage involves deliberate cultural learning about the client's cultural assumptions by verifying generalizations, questioning one's own tacit assumptions, and providing interventions that are culturally relevant to the client. The final stage, unconscious competence, occurs when the healthcare provider has experienced many encounters with culturally diverse clients in which deliberate cultural learning was practiced, and automatically questions his or her tacit assumptions about a client as well as verified generalizations regarding the client's worldview.

Another developmental model of cultural consciousness and awareness was proposed by Tatum (1994) based on the work of Helms and Carter (1991) regarding attitudes of Caucasians toward racial identity (Helms, 2007). Tatum's model focuses specifically on the cultural awareness of Caucasian students in developing multicultural awareness. She explained that Caucasian students must often address their own feelings; knowledge and life experience and question their own misconceptions. Some students shut down or become confrontational and defensive. Students may experience feelings of

guilt and need to be taken through six stages of identity development. The first stage is *contact*: Caucasian students view themselves as normal, unaware of their own racial identity, and thus they are also unaware of institutional racism and systemic privileges afforded to them through race. The second stage is characterized by *disintegration*. According to Tatum, Caucasian students experience guilt and anger as they become aware of racism. They often will withdraw from experiences where race is made explicit, such as classes which address issues of racism. *Reintegration* is stage 3 and occurs as a result of the anger and guilt experienced in stage 2. The anger and guilt are transformed into hostility towards individuals of color. In stage 4, *pseudo independence*, students reject the idea of racial superiority and seek out persons of color with whom to participate in ways in which to end racism. In stage 5, *immersion/emersion*, Caucasian students question what it means to be Caucasian and actively seek out Caucasian role models who exemplify non-racist ideology. In the final stage, *autonomy*, Caucasian students complete their internalization of racial identity and seek out ways in which to be actively and meaningfully antiracist. Although the movement of students from one stage to the next is idiosyncratic, experience and reflection seem to facilitate movement.

Lister (1999) proposed taxonomy for developing cultural competence in nursing education addressing five levels: (1) awareness, (2) knowledge, (3) understanding, (4) sensitivity, and (5) competence. Unlike Tatum's model, the empirical evidence to support Lister's taxonomy was scant. Furthermore, the empirical foundation for Tatum's model, the validity of the White Racial Identity Attitude Scale (WRIAS) has been questioned

(Behrens, 1997; Leach, Behren & Lafleur, 2002), yet the validity of the instrument remains far from settled (Helms, 1997, 2006).

### Cultural Consciousness and Nursing Education

In its report on racial and ethnic healthcare disparities, the Institute of Medicine (2003) recommended that healthcare provider preparation programs “increase healthcare providers’ awareness of disparities” (Recommendation 2-2, p. 175) and “cross-cultural curricula should be integrated early into the training of future healthcare providers and practical, case-based, rigorously evaluated training should persist throughout education programs” (p. 170). One way nurse educators have responded to an expanding recognition of need for cultural consciousness, awareness and culturally congruent care was demonstrated by the Commission of Collegiate Nursing Education (CCNE, 2013) in the revision of Standards for Accreditation of Baccalaureate and Graduate Nursing Programs. Social justice, advocacy, and commitment to reducing healthcare disparities are now addressed through establishing standards for teaching the skills needed for culturally competent care. For example, the American Association of Colleges of Nursing (AACN) in *The Essentials of Baccalaureate Education for Professional Nursing Practice* stated:

The increasing diversity of this nation’s population mandates an attention to diversity in order to provide safe, humanistic high quality care. This includes cultural, spiritual, ethnic, gender and sexual orientation diversity. In addition, the increasing globalization of healthcare requires that professional nurses be prepared to practice in a multicultural environment and possess the skills needed to provide culturally competent care (2008, Essential IX)

The AACN, in collaboration with the Centers for Disease Control, also recommended that schools of nursing consider an “ecological model”, which focuses on social determinants of health, in the assessment, planning and intervention of care much of which has moved to the community (Robert Wood Johnson Foundation, 2014).

Furthermore, the report goes on to recommend that this be done through the “use of more immersive clinical experiences including apprenticeships and situated learning” (p.7).

Yet, there is scant research regarding the development and implementation of cultural immersion clinical experiences with vulnerable patient populations (Gillis & McClellan, 2010).

Caring through commitment of nursing to relationships and the human environment process has been a hallmark of the profession beginning with Florence Nightingale (Ray, 2010). This commitment to developing caring relationships within a cultural contextual approach is clearly advocated by key nursing theorists (Leininger, 1996; Watson, 2005). Organizations such as AACN recognize the importance of learning, teaching and practicing culturally competent care beginning with the development of cultural consciousness and awareness (Pacquiao, 2007). Leininger (1970), considered to be the mother of transcultural nursing, stated it best when she wrote:

The cultural context approach strives for specificity in the consideration of patient problems and for reducing ambiguity in nursing goals. ...Each cultural group...has its own life style, patterns of living, and its own special way of viewing the world about it. Its special view is the essential basis of a people’s modes of acting and thinking, and its world view serves as the basic framework for their unique cultural context of behavior. (p. 111)

For the majority of the 170,000 nursing students in the United States, nursing education remains steadfast to models used for decades (Robert Wood Johnson Foundation, 2014). Innovative programs of study, which include cultural immersion service learning experiences, are the exception, despite public policies, which have moved the largest part of patient care to community based settings, and nursing preparation policies seeking to facilitate the development of culturally competent care for vulnerable patient populations (Patient Protection and Affordable Care Act, 2010; AACN, 2008).

#### Nursing Program Models for Incorporating Cultural Consciousness

Three examples are provided below demonstrate how national policies facilitate the development of culturally conscious care for vulnerable patient populations enacted by nursing preparation programs. The first example comes from Baker University in Topeka, Kansas, a private, Christian-based university accredited by the Higher Learning Commission for the North Central Association of Schools and Colleges, which has been educating Bachelors' and Masters' prepared nurses for more than two decades. Baker University's espoused a commitment to diversity whereby students are "able to address the civic, social, health and environmental needs of our global community (Baker University School of Nursing, nd, para 3). Baker University's School of Nursing incorporates service learning throughout their curriculum. As stated on its website:

Service learning activities enhance your nursing skills as you progress through the program. Because learning takes place not only in the classroom but also in the community, service learning is an important part

of the nursing curriculum. Service learning promotes hands on learning by:

- Fulfilling community needs
- Promoting civic responsibility
- Actively reflecting and reinforcing classroom learning
- Developing strengths that last a lifetime (Baker University School of Nursing, nd, para 12)

The Baker University School of Nursing provides prospective students with examples aligned with each of the semester curriculum:

Level I students assist with a health fair at a local retirement home... Level II students may assist with assessments of babies at a local breast-feeding clinic... Level III students may assist with a wellness clinic at a local senior center or housing complex for the elderly or disabled. Level IV students are required to complete a minimum of three hours of service learning as part of their practicum course. (Baker University School of Nursing,nd, para 19)

Additionally, other opportunities for service learning were provided, such as assisting in the preparation of the state's nurses' association convention, a university wellness fair, and safe car seat installation at the county health department. Baker University's School of Nursing focus to assist the local community in the provision of safe and equitable health care is exemplified in schools and colleges of nursing across the nation, and yet cultural consciousness is not directly addressed.

In a different example, the university is a land-grant university recognized with a Community Engagement Classification from the Carnegie Foundation for the Advancement of Teaching, addressed cultural consciousness when referring to this CISL experience. "The health disparities experienced by children in reservation communities is

profound, and the services provided by our nursing students is greatly needed” (Cantrell, 2013, p.54). In discussing a university-community partnership, university’s President (2015, April 2) stated,

The [College of Nursing and Northern Plains Indian Reservation’s Health Promotion and Disease Prevention] partnership exemplifies our University’s land-grant mission and embodies the engagement goal in our strategic plan: Members of the [names university] community will be leaders, scholars and engaged citizens of their local, national and global communities, working together with community partners to exchange and apply knowledge and resources to improve the human prospect. (p.1).

Finally, in a third example, One student from Mount Royal University engaged in a four week cultural immersion experience wrote that about her experiences teaching health to Indigenous children and conducting a parent workshop in Hawaii. Mount Royal University in Alberta, Canada offered a global indigenous child health field course (NURS3124) for junior level nursing students. “This practicum is part of Mount Royal University’s School of Nursing program that offers experiential learning to connect local and global Indigenous children’s health. Students are learning how Indigenous ways of being and knowing inform their role to promote child health under the guidance of Elder Francine Dudoit, Director, Traditional Hawaiian Health at the Waikiki Health Center.” (Cardinal, 2015)

The mission, goals, and strategic plans of the College of Nursing align with the university’s commitment to community engagement and cultural awareness. Specifically the College of Nursing’s mission is” to enhance the health of the people of [this state], our nation, and the global community by providing leadership for professional nursing through excellence in education, research, practice and service” (CON Mission



Statement, 2012, p.1). Embedded within this mission is an understanding as to the work nursing education entails. *Nursing education* “intentionally fosters the use of multiple fields of study, the use of wide-ranging knowledge of science, cultures, and society; high level intellectual and practical skills; an active commitment to personal and social responsibility, demonstrated ability to apply learning to complex problems and challenges, and personal engagement as a responsible citizen in a global society.”

(Association of American Colleges and Universities, 2007, p.4). The College of Nursing and Northern Plains Indian Reservation Health Promotion Disease Prevention Program partnership exemplifies this by aligning pediatric nursing course objectives to foster learning and professional development in a cross-cultural setting. The strategic planning document for the College of Nursing established two goals to support the development of partnerships with underserved communities (CON, Strategic Direction 5c, 2012) and support faculty in providing international/intercultural health care experiences for students (CON Strategic Direction 3-3.1b, 2012). Through this partnership, nursing students gain an understanding of the culture of two Northern Plains Native American tribes; historical trauma and its impact on health, lifestyle, well-being and social justice; the complex link between poverty and health; while working collaboratively to meet an identified need of a host community in a cross-cultural setting.

#### Acquisition of Cultural Consciousness through Experiential Learning Theory

Pedersen (1988) suggested eight techniques to stimulate cultural consciousness and awareness. Among these techniques, most involved experiential learning, such as

role plays, role reversals, simulations, field trips, interviews with experts and community members, and bicultural observations. Through these activities, students are able to compare and contrast their cultural assumptions with the cultural assumptions held by others with a different worldview and through reflection on these experiences gain insight into their personal bias and privilege (Friere, 2005). Yount, (2001) defined experiential learning as “active participation of learners in events or activities which leads to the accumulation of knowledge or skill” (p 276). Simply put experiential learning is learning by doing. Cantor (1995) described two essential elements of experiential learning—(1) engaging the learners directly in the phenomenon related to their studies, and (2) requiring the students to reflect on their experience, analyze it and learn from the experience. Expressed differently, experiential learning places the emphasis on the students’ subjective experiences and the meaning derived from reflection on those experiences (Hedin, 2010). Experiential learning differs from other types of learning processes because “experiential learning is an intentional process of experiences and reflection about the experience in order to develop new knowledge or skills” (Lewis & Williams, 1994, p.185). In applying concepts of experiential learning to nursing education, preparing nursing students by providing them with nursing theory is not enough. Nursing students must also be educated in the application of theories and principles to correctly provide nursing care to specific patients in a specific context. This is done through providing students the opportunity to apply their knowledge in ways that will develop their skills and experience.

Theoretical Foundations for  
Facilitating Cultural Consciousness

Education can never be considered a neutral education process (Freire, 1970). As such Experiential Learning Theory and cultural consciousness intersect through a dialectic process (Kolb, 1975). In his introduction to Paulo Freire's, seminal work *Pedagogy of the Oppressed*, Schall stated, "there is no such thing as a neutral educational process. Education is the means by which men and women deal critically and creatively with reality to discover how to participate in the transformation of their world." (p. 16). In applying knowledge of nursing theories to the specifics of a given situation, the nursing students construct their understanding of how this knowledge applies in a specific context and the context is never neutral. Thus, it is essential that a dialectic process be a part of the educational process. As nursing students apply their knowledge of theory to a situation to construct a solution, their knowledge is transformed by the results of that solution. This transformation occurs through praxis—the reflective and deliberate action taking place in a specific situation (Freire, 1970). Authentic learning takes place in praxis and deepens an attitude of awareness. Therefore experiential learning is a dialectic awaking of committed consciousness. Freire argued this best in the following passage:

Human beings *are* because they *are* in a situation. And they will be more the more they not only critically reflect upon their existence but critically act upon it. Reflection upon situationality is reflection about the very condition of existence: critical thinking by means of which people discover each other to be "in a situation." Only as this situation ceases to present itself as a dense, enveloping reality or a tormenting blind alley, and they can come to perceive it as an objective-problematic situation—only then can commitment exist. Humankind emerge from their submersion and acquire the ability to intervene in reality as it is unveiled. Intervention is reality—historical awareness itself—thus represents a step forward from emergence, and results from conscientizacao [critical

consciousness] of the situation. Conscientizacao is the deepening of the attitude of awareness characteristic of all emergence. (p. 90)

Experiential learning borrows from cognitive and humanistic theories. It applies the pragmatic educational philosophy of Dewey (1938) with the self-directed humanistic psychology of Rogers (1969) and the notions of accommodation and assimilation from Piaget's cognitive development model into an organic continuous learning cycle where knowledge is created by transforming experience into meaningful frameworks that then change the way a person thinks and behaves (Kolb, 1984). John Dewey (1938) argued in *Experience in Education* that "amid all uncertainties there is one permanent frame of reference: namely, the organic connection between education and personal experience"(p. 34). Dewey (1938), Kolb (1984), Piaget (1963) and Rogers (1969) agree on two basic tenets "that learning takes place as an individual changes their thinking based on an experience and most importantly, by reflecting on that experience learners revisit that thinking again and again as they experiment in new situations, modifying their thinking through the results of new experiences" (Menaker, Coleman, Collins, & Murawski, 2006, p 2). Some theorists believe the steps learners take occur spontaneously, others believe that authentic experiences build on each other to create greater understanding and meaning making for students.

Key to Dewey's (1938) pragmatism is that learning occurs within a social environment. "The principle that development of experience comes about through interaction means that education is essentially a social process" (Dewey, 1938, p. 58). Beginning with knowledge, the faculty facilitates student experiences while keeping in mind student readiness. The social environment Dewey referred to involves contact and

communication. He argued that traditional education relies heavily on rules, schedules and procedures which inhibit student learning. He advocated for increased social interaction within schools, and he believed that the education of students is the responsibility of the entire social system. Experiential learning is reciprocal in nature and involves a community where the learning is taking place. In the higher education system, the community is the group of learners and their faculty, their college, university, and the community where the experiential learning is taking place.

In traditional education, knowledge is acquired through methods such as reading, memorization and participation in lectures. Knowledge is acquired from the outside in. Dewey (1938) described knowledge attained through progressive education or experiential learning as occurring when students learn from their experiences. He argued that educational control is found within the experience of students rather than defined and organized by others. Dewey was highly critical of content organization and argued that content is organized into isolated subjects, which creates difficulties for students to integrate their knowledge into real life situations. Furthermore, placing students into real life situations within the context of experiential learning, allows students to learn from their experiences which they can then apply as knowledge to future situations. The role of the teacher, or educator, is to facilitate student engagement. In experiential learning, “the teacher loses the position of external boss or dictator but takes on that of leader of group activities” (Dewey, 1938, p.59).

Dewey (1938) asserted that the key to the success of experiential learning is that the teacher must be responsible for both knowledge acquisition of the subject matter and

knowledge of the student learner. Not only must the experience planned be within each student's capabilities, but the student must also be prepared to learn. Student readiness varies widely, which makes planning for experiential learning more complex and difficult. The planning includes four elements that must all be addressed equally. Selection of appropriate experiences for student learners, intimate knowledge of the student learner, collaboration with the community where the learning is taking place, and knowledge of the content or material to be studied. Experiential education often involves the faculty's ability to shift the experience in order to achieve desired outcomes.

To summarize Dewey's contribution to experiential learning, Roberts (2003) wrote:

Dewey asserts that experience is the foundation for everything in life. Accordingly, he proposes that civilized people learn from their experiences, which allow them to shape future experiences. Experiences also influence the condition under which future experiences are had. Thus the prior experiences of a student are directly related to their future capacity to learn. (p. 7)

Some theorists argue that experiential learning is not so much a theory of learning but rather a "broad perspective on learning that focuses on authentic learning experiences as the necessary basis for meaningful skill acquisition and human development" (Lewis & Williams, 1994, p 22). Despite differing views, experiential learning does hold forth its own propositions regarding how students learn and ways in which faculty can enhance student learning in authentic experiences, which must include intentional learning processed through deep and thoughtful reflection towards the construction of meaning. Colleges of Nursing and other allied health professions must consider new learning strategies to facilitate active learning that promotes cultural consciousness as a means to

develop the professional attributes needed by the increasingly complex role of the professional nurse if changes are to occur in reducing healthcare disparities in the United States.

#### Process of Experiential Learning for Cultural Consciousness

The process of reflection is essential in experiential learning. “Reflection is a metacognitive state where we analyze and direct our thinking” (Lee, 2014, p. 332). Rogers (1986) coined this metacognitive state as *emancipatory learning*. Emancipatory learning takes place in different contexts and for different reasons but “requires self-understanding, [contextual] awareness and transformation of the cultural and personal suppositions that are always with us and affect the way we act” (Lee, 2014 p. 334). Emancipatory learning occurs through experiential learning.

Kolb (1984) in his seminal work explained the process of experiential learning as based on an assumption that learning is a process whereby knowledge is developed through the transformation of experiences in a four stage cycle. He argued that the learning process begins with concrete experience. The reflective process or reflective observation is essential to experiential learning. Faculty facilitate student learning by using reflective writing or verbalization of the concrete experience. Students are prompted to describe what happened, what they saw, felt, and heard. Within stage two, through the process of describing their concrete experiences, students begin to analyze and compare their experiences against prior knowledge and assumptions. In stage three, students attach personal meaning to the experience by beginning to generalize their experience and move towards developing conclusions based on studied principles.

Finally, in the last stage, students develop ideas on how they can use their conclusions by making inferences which can then be generalized to other contexts.

Abby, Hunt and Weisner (1985) further developed Kolb's work to describe the taxonomy of students who were non-adaptive learners in Kolb's four stage theory. They labelled the non-adaptive students as Northerners, Easterners, Southerners and Westerners. Students who did not adapt to one of the four stages were placed in one of the four compass directions.

Northerners have difficulty making meaning of the experience through abstract conceptualization. These learners have difficulty synthesizing all the information provided to them through lectures, experiences and the development of a framework for the information. Frustrated by the inability to make meaning from the information, they react emotionally and intuitively. What they require is specific and concrete examples to move them forward.

Easterners have difficulty moving from an abstract idea to developing the skills needed to apply the idea within a specific context. They prefer to sit back, to think and to reflect rather than to act. They may in fact feel that they do not have the skills to act; this learner needs experiences that draw on his/her abilities and encouragement to develop efficacy.

The southerner approaches the experience in a mechanical and sterile way. This learner can memorize effectively and accurately needed information and data but cannot apply the information memorized. This learner has an especially difficult time establishing a rapport with their patients. They are uncomfortable in unstructured



situations and are the least comfortable in in active learning situations and experiences (Junt, 1992).

The Westerner is self-directed and active, they are doers, they move from conceptualization to action without stopping for reflection. This student learner needs faculty assistance to help them to take the time necessary to reflect and to plan.

Experiential education is best displayed in higher education as service learning (Elyer & Giles, 1999). Putting this issue bluntly, they wrote, “a real person facing real difficulties in authentic context forces students to a level of understanding that is sometimes not obtained when they read and glibly summarize what they have read about a complex social issue” (Elyer & Giles, 1999, p.9)

### Service Learning and Cultural Consciousness

In describing cultural consciousness instruction Gay and Kirkland (2003) wrote that faculty need to:

...provide frequent and genuine opportunities for students to practice being multiculturally reflective and critically conscious. Design projects that allow students to bring to consciousness cultural values and beliefs embedded in U.S. schools and society that are taken for granted, or assumed to be universal; to understand how cultural hegemony and racism are manifested in school programs and practices; and to [modify professional practices so they are] more responsive to ethnic and cultural diversity. (pp. 185-186)

Service learning pedagogies that combine the use of self-reflection, dialogue, and experiential learning in developing student knowledge, skills and dispositions appear to provide an instructional strategy for achieving cultural consciousness.

According to Mintz and Liu (1994), service learning is a method and philosophy of experiential learning, a core element of which is structured educational components which challenge participants to think critically about and learn from their experiences. Service learning is a multisensory process which evolves out of experience (NEA Higher Education Advocate 2014). Carpenter (1999) wrote, “The concept of service learning in education is a teaching pedagogy that combines several aspects of experiential education, critical thinking, ways of knowing, and civic and personal responsibility” (p 2.).

Current literature on the importance of service learning in higher education is abundant. In the past 5 years (2011-2016), the PsychInfo database contains 7187 articles related to service learning published in peer reviewed journals. Needless to say delimitation of the research literature is in order. This section will focus on service learning research as applied to the healthcare of vulnerable populations and to the perceptions of nursing students about service learning experiences.

Pascarelli and Terenzini (1997) report that “college and university students who are involved in community centered activities, especially activities with cultural and ethnic groups different from their own, show the greatest growth in advanced levels of moral reasoning.” (p.349). Synder & Weyer (2009) argued that an important element to a successful service-learning experience is to involve the community in which the learning is to take place. The community members and or representatives should be encouraged to share equally in the goals and mission of the service-learning experience whereby both students and community members are equally benefited (Walsh & DeJosech, 2003).

Leininger (1988) stated that “maintaining culturally congruent care is essential to satisfying meaningful and beneficial care for clients”(p.46). This philosophical perspective, laid the groundwork for one of the essentials of baccalaureate nursing education—the inclusion of studies focused on the issues of diversity, cultural awareness and social justice. The use of service learning course work is a widely accepted tool used to enhance the transformative learning of students (Goldberg and Caulal, 2009). Service learning can be of particular value when teaching students who are attending colleges and universities in predominantly homogenous regions of the country (Elyer & Giles, 1999). Yet, scant empirical research exists addressing the issues of how service learning impacts a student’s understanding of vulnerable populations or the relationship between service learning and student cultural consciousness. Service learning differs from traditional learning in that the objective is to assist nursing students to understand the complex social contexts which determine health. Students who understand social determinants of health are better equipped to appreciate factors that contribute to and sustain health disparities for vulnerable populations (Gillis & MacLellen, 2010). Elyer (2002) suggests that it is by thinking about and analyzing complex health issues through critical reflection, and using experience to suggest further questions for exploration, that service is transformed into service learning.

The University of Michigan School of Nursing (2008) reported that student challenges for incorporating alternative clinical sites into their education were hampered by students’ lack of knowledge and discomfort. Opportunities exposed students to situations in a safe environment putting a real-world face on vulnerable populations

(Villarreal, Bigelow, Alvarez, & Carmen, 2008). Service learning can heighten student anxiety as students attempt to develop psychomotor skills and transfer knowledge acquisition into critical thinking (Hutchinson & Goodin, 2013). Heightened student anxiety diminishes the student's ability to learn, because anxiety inhibits higher order thinking. This hampered cognitive state then interferes with positive outcomes for both the students and their patients.

Faculty who are viewed as caring and respectful, by students, along with student self-care abilities lessen the negative impact of student anxiety (Cook, 2005).

Furthermore, faculty can utilize student reflection activities as a means to guiding students as well as a means of demonstrating care and respect (McLeis 2007; Wade & Kasper, 2006; Watson, 2012). Watson's (2012) concept of caring is a central focus of nursing. In her words:

The goal of nursing is to promote human dignity and to respond to the human being as it manifests itself. Student anxiety is a type of being. The caring transaction between a faculty member and student is a dialogue that allows the faculty member to protect and affirm the dignity of the student, assist the student to find meaning in the anxiety, and enhance learning outcomes. (p. 12)

The essence of a healthy democratic society is open discussion and debate about issues of public concern, including the discussion of controversial social, economic, and healthcare policies (McLeis, 2007). A controversial issues discussion is defined as reflective dialogue among students, or between students and teachers about an issue on which there is disagreement (Stradling 1984). Service Learning espouses the commitment of educators to use reflective discussions and writing as integral components of the experiential learning environment. Typically, a discussion is sparked by a question

or assertion made either by a student or teacher faced with authentic and concrete situations through interaction with vulnerable populations. The ensuing dialogue then allows for the presentation of supportive evidence, comments and the expression of differing points of view. Discussion is therefore, by nature, an dialectic endeavor, and reflective dialogue engenders listening and responding to ideas as expressed by one's peers. Such discussions within the framework of service learning: (1) prepare students for their roles as citizens in a pluralistic society, (2) develop critical thinking skills such as constructing hypothesis and collecting and evaluating evidence, (3) improve interpersonal skills, such as listening carefully, responding empathetically, speaking persuasively and cooperating with others in a group, and (4) improve students attitude toward self and school (Celio, Durlak & Dymnicki, 2011).

#### Definitions for Service Learning that Integrate Cultural Consciousness

Definitions of service learning in the literature are diverse and the majority of studies are descriptions of individual service learning projects, however very little is written providing a framework for service learning across a variety of contexts. One potential framework centers on the engagement of students in situations which foster reflection and critical thinking about health care and social disparity amongst diverse people. For example, there is a reciprocity where students share and develop technical knowledge and skill and those benefitting from the technical knowledge share their culture, belief systems, perspective and world view with students (Sigmon, 1979). Sigmon emphasized that “service-learning occurs only when both the provider and the

recipients of service benefit from the activities” (p 5). However, despite its acknowledged importance, there is a lack of a unified agreement as to its reciprocal nature, what constitutes service learning in the higher education classroom, or how advocates effectively assess if students have been in any way affected by the opportunity to learn in this way (Smith, Emmett & Woods, 2008).

Although reciprocal learning is a necessary element for critical service learning, it is not the definitive element. Gillis and MacLellan (2010) clarified the differences among traditional learning, service learning, and critical service learning along four dimensions—objective, learner, learning, and partnerships. The primary objective in traditional classroom learning is for the student to learn the content. In service learning, the primary objective continues to focus on academic goals but student learning needs are met through the provision of a service. In critical service learning, the objective shifts to balance the service needs of the client, and the achievement of the academic goals with “an examination of root causes that contribute to the service need” (p.2). The learner in traditional learning is the student. In service learning, the learners are the students and community partners, whereas in critical service learning the students, community members, and faculty are reciprocal learners as well as agents for social change. Learning, according to Gillis and MacLellan (2010), in traditional classrooms tends to be structured, passive and compartmentalized. Service learning is reflective, active and integrative in ways that alter the worldview of the service learning partners. Learning within a critical service learning framework is also reflective, active and integrative with “a focus on social responsibility [which] combines reflection and active problem solving

to address systemic inequalities” (p.2). Finally in regard to partnerships, traditional learning is collaborative but may be authoritarian and hegemonic; on the other hand service learning, both in its traditional and critical forms, tends to display genuine collaborative relationships with shared responsibility. In summary, Gillis and MacLellan (2010) wrote:

A critical approach is one that combines the provision of service with reflection on the systems of injustice that create the need for the service. This is in contrast to traditional service learning where the focus is the provision of service without specific attention to the sources of injustice. Through a critical service learning approach nurse educators can re-create new roles for students, faculty, and community partners. All partners work together to re-distribute power among participants, develop authentic relationships, and adopt a social change perspective (Mitchell, 2008). A critical approach enables students to see themselves as agents of change and excites within them a passion to use their experience of service and respond to injustices in their communities, particularly when dealing with vulnerable populations. (p.3).

It is the balance between the service provided to the client and the academic needs of the student that is the defining characteristic difference between traditional learning and critical service learning.

#### Students' Perceptions of Service Learning with Vulnerable Populations

The perceptions of students about service learning are best reflected by Eyer and Giles (1999) through their findings of data collected from service learning students through surveys and interviews.

- A majority of service-learning students report that they learn more and are motivated to work harder in a service-learning class than in regular classes.

- A majority report that a deeper understanding of subject matter, understanding the complexity of social issues, and being able to apply material they learn in class to real problems are among the important benefits of service-learning.
- Application of subject matter and experience, as well as opportunities for structured reflection through writing and discussion, is associated with reports of increased learning.
- High-quality community placements where students have real responsibilities and interesting and challenging work resulted in student reports of increased learning and the learning of specific skills.
- Students in classes where service and learning are well integrated through classroom focus and reflection are more likely to demonstrate greater issue knowledge, have a more realistic and detailed personal political strategy, and give a more complex analysis of causes of and solutions to the problem at the conclusion of their experience than those in classes where the service was less well integrated into the course or service was not done.
- Quality of the service-learning experience is a predictor of most of the learning outcomes that we explored. (p.80-81)

As inferred from the last three findings, and supported by the literature on service learning with vulnerable populations (Celio, Durlak & Dymnicki, 2011; Gillis & McClellan, 2010; Voss, Mathews, Fossen, Scott, & Schaefer, 2015), there is a continuum of service engagement and integration of service in service learning ranging from volunteerism to immersion. Volunteerism is where students select a local community



project and participate in that project for a given set of hours throughout the semester which are usually logged and reflected upon. In volunteerism, the service is loosely connected to the objectives of the service learning course. On the other end of the continuum is an immersion service learning experience where the student is immersed full time into a community, dissimilar to the campus community, for a period of days or weeks. The immersion service learning experience is well integrated into the course objectives and often the course is built around the immersion experience.

#### CISL Experiences in Promoting Cultural Consciousness

An immersion experience, as described by the AACN (2008), provides nursing students with opportunities for building clinical reasoning, management and evaluation skills. Such opportunities increase the student's self-efficacy and sense of belonging which in turn facilitates the transition of the nursing student into a competent and confident nurse. "Immersion experiences allow students to integrate previous learning and more fully develop the roles of the baccalaureate generalist nurse. ...The immersion experience provides faculty opportunities to observe student performance over time and more effectively evaluate the students professional development" (AACN, 2008, p.3)

Recommended outcomes for baccalaureate nursing programs contained the provision that clinical experiences for students include, in part, access to patients from diverse backgrounds, cultures, and differing religious and spiritual practices. In geographical regions that have a homogenous demography, providing clinical experiences for nursing students that facilitate engagement with culturally diverse patients is challenging as

clinical experiences predominantly occur within the community where the nursing school campus is located. Patient diversity reflects the cultural diversity of the community. When the community is demographically homogeneous, then the range of cultural diversity is narrow. A potential way to overcome this challenge is to provide nursing students from culturally homogeneous communities with access to patients from diverse backgrounds through CISL experiences.

Leininger (1988) developed a theoretical model of Cultural Care Diversity and Universality. In that model, she posited that culturally congruent care is essential to satisfying, meaningful and beneficial care to clients. Building on Leininger's work, an increasing number of researchers have reported finding that international experiences lead to improved communication skills, expanded worldviews, greater openness to cultural differences, personal and professional growth leading to a more culturally focused nursing practice. (Callister & Cox, 2006; Evanston & Zust, 2004; Ryan, Twibell, Brigham & Bennett, 2000; and Walsh & DeJoseph, 2002).

#### Cultural Immersion Experiences in International Projects

Most cultural immersion service learning experiences are international projects. A representative example is seen in a 5-year nursing international exchange program involving 6 North American universities (Kuehn, Chircop, Downe-Wamboldt, Sheppard-LeMoine, Wittstock, Herbert, Benavides-Torres, Murnaghan, & Critchley (2011). The program consisted of an online course followed by an immersion experience (undefined length) and was evaluated using the Adapted Multicultural Attitude Assessment (Balicu,

Grieg & Rivers, 1998) in a pre-test / post-test design to measure student cultural awareness during an orientation course. Some significant change was noted in attitude during the course—changes focused on increased awareness of cultural diversity, to include extending nursing process to include family members, encouragement of cultural pride, placing more emphasis on multicultural awareness and understanding that increased diversity does not mean increased conflict. Measures of student attitudes were not taken during the clinical encounters due to the short length of the immersion experience; however, students demonstrated acquired knowledge, skills, and culturally competent abilities through participation demonstrated by qualitative student self-reports and evaluation feedback. Key components of the exchange included: creating partnerships, an orientation course and a student exchange experience among U.S., Canadian and Mexican students. Mexican students did not respond to immersion experience evaluations. Preparation for the critical service learning experience included a preparatory lecture, guest speakers representing the host community, detailed handouts of expectations including expected conduct guidelines, group dynamics and team building exercises, as well as lists of what to bring, what is needed to be comfortable in the host environment and an introductory tour of the host community upon arrival. The preparatory activities were developed over time and were enhanced as the faculty became aware of student needs, especially those regarding the alleviation of anxiety.

Green, Comer, Elliott and Neurbrander (2010) replicated and extended the work of Schim, Doorembos, Benkert and Miller (2007) using a Culturally Congruent Care Model through a cultural immersion experience for graduate and undergraduate nursing

students and medical students in Honduras. The authors purported that healthcare providers must be prepared to care for a growing diverse population in the United States. Specifically, students must have the skills necessary to overcome differences in language, culture, beliefs, values and customs. Culturally competent healthcare entails the development of four elements of cultural congruence: (1) cultural diversity-attained by exposure to people of different cultures, (2) cultural awareness-cognitive knowledge of different cultures, (3) cultural consciousness-a deeper understanding that results in a change in attitude about oneself and others, an openness to cultural learning and a desire to engage in cross-cultural experiences, and (4) cultural competence-melds cultural diversity, awareness and consciousness together as demonstrated in clinical practice. Green, et. al. (2010) found an increase in student cultural competence behaviors in all four of the cultural congruence elements following the international service-learning experience.

Shoulder to Shoulder is a model of healthcare cultural immersion which includes both medical students, nursing students and other health care disciplines from the United States, providing care to remote and rural communities in Honduras, Ecuador and Tanzania since 1990. This program has been highly successful in both facilitating international service learning experiences for students, while working with local host communities to meet healthcare needs. One of the key elements in the Shoulder to Shoulder model is to empower local communities through partnership. Communities work with healthcare volunteers from the U.S. to develop active health committees which define the work of the projects to be done. Shoulder to Shoulder has seven non-profit

partners with a shared vision for sustainable development along with a comprehensive view of health. The partners share resources, personnel infrastructure, experience and vision (see [www.shouldertoshoulder.org](http://www.shouldertoshoulder.org)). More than 1,400 healthcare student volunteers between 1990 and 2007 provided care to over 6,000 patients each year, totaling over 50,000 patients in several hundred small and remote villages. The sustainable model has led to improved health outcomes to vulnerable populations in Latin America in conjunction with service learning experiences for U.S. students. Although the program is somewhat unique in synthesizing the community voice in establishing its goals, community member perceptions of service learning were not studied.

Caffrey, Neander, Markle and Stewart (2005) used the Caffrey's Cultural Competence in Healthcare Scale to compare baccalaureate students who had participated in an international learning experience with classmates who had not participated in a similar experience. The findings demonstrated that participating students had significantly higher perceived cultural competence. Evanston and Züst (2006) replicated this study two years later, confirming the long-term benefits of an international learning experience on nursing students. Students who participated in an international service learning experience incorporated the cultural consciousness gained from the experience into their professional practice. Smith, Emmett & Woods, (2008) studied the perceptions of nursing students regarding their authentic learning experiences in a rural setting in Australia. They found that "providing rural and remote student practicum experiences enhances the learning outcomes of the student and the health outcomes of the community.

It encouraged the consideration of rural and remote community based nursing practice as a viable professional option for graduates” (p. 1-2).

Service learning in combination with didactic learning “encourages students to reflect on social justice issues” (Green et. al.,2010; Rodman & Clark, 2002). More specifically, healthcare students participating in an international service learning experience were able to conceptualize global social-justice, foster respect for other cultures and understand the goals of health equity and the reduction of health disparities (Parsi & List, 2008). On the other hand, students and health care providers working with patients from a culture different from their own may experience culture shock. “Lack of knowledge of differences in diseases, cultural practices, beliefs, and values can result in feelings of helplessness, frustration, and inadequacy for everyone involved in the helping relationship” Dunn, 2004, p.39). Dunn recommends faculty leading immersion experiences must prepare themselves and their students before the immersion experience and support students during the experience. Preparation about the cultural group to be served as well as the recognition of the signs and symptoms of culture shock should occur before embarking on the experience.

#### Cultural Immersion Service Learning Experiences within the U.S.

One of the few domestic cultural immersion service learning experiences described in the literature was described as a 3-day field trip (Rone, 2008). Rone’s findings support the effectiveness of cultural immersion service learning experiences by enhancing didactic content received in the classroom. Her findings support those of other

researchers as a more effective teaching tool than readings, video or audio recordings. Rone recommended relationship building with community members. Working with community members to develop a plan for reciprocity was essential “to help students to understand the continuum between theory, practice and policy” (p. 224). Rone’s recommendations as well as the findings from the other cultural immersion service learning studies reviewed, together with the precepts of experiential learning theory and research findings regarding service learning among vulnerable populations as discussed above were synthesized and contextualized into the development of the Northern Plains cultural immersion service learning experience embedded into a pediatric nursing course offered by this university.

### Chapter Summary

The literature, as described in Chapter Two, demonstrates that there are healthcare disparities in the United States (Institute of Medicine, 2003) and within American Indian communities. Healthcare disparities decrease life expectancy and life quality (Indian Health Service, 2003; Robert Wood Johnson Foundation, 2014; Schoen & Doty, 2004; Sweeney, Karol & Nolan, 2011). The failure to address these health disparities and their continued presence is unjust (Institute of Medicine, 2003; Moss, 2016; United Nations General Assembly, 1948; United Nations Population Fund, 2011). There is substantial evidence that stereotyping, biases, and uncertainty on the part of healthcare providers may contribute to unequal treatment of patients from minority racial and ethnic cultures (Institute of Medicine 2003). Cultural consciousness and awareness of healthcare

providers is necessary for reducing the unequal treatment of patients and decreasing healthcare disparities (Institute of Medicine, 2003; Kortton & Sahtouris, 2001; Rioux, 2010). As a result, the nursing standards of practice and educational standards facilitate the development of cultural consciousness, awareness and cultural competency (AACN, 2008; Leininger, 1988; CON Goals, 2014). A set of service learning pedagogies grounded in experiential learning theory (Dewey, 1943; Kolb, 1975) have been used to facilitate cultural consciousness (Gillis & McLellen, 2010; Kortton & Sahtouris, 2001; Rioux, 2010). However, less than two dozen studies have documented the impact of service learning on cultural consciousness and awareness of vulnerable populations (Gillis & McLellen, 2010). Furthermore, CISL methods in combination with reflection activities seems to offer an effective method for facilitating cultural consciousness in healthcare students. Yet, empirical evidence on facilitating the cultural consciousness of nursing students using CISL experiences within the United States remains sparse (Kuehn, et.al., 2011).

This study seeks to contribute to the literature by examining the overarching research question, “How do nursing students at this university describe their CISL experience?” By examining this overarching research question, perhaps a better understanding of how nursing students’ perceptions of cultural consciousness are developed can be gleaned from such research. The next chapter addresses the methodology of this study in answering the overarching research question by focusing on the following research sub questions: (1) What cultural immersion service learning experiences do nursing students describe as important in developing their consciousness



of American Indian culture within two of the Northern Plains Indian tribes? (2) How do nursing students describe the knowledge they acquire regarding the care of vulnerable populations during their one-week cultural immersion service learning experience? and (3) What do students describe as influential in their understanding of others in the complex link between poverty and health?

## CHAPTER THREE

## RESEARCH METHODS

Facilitating cultural consciousness among nursing students has been incorporated into the Standards for Accreditation of Baccalaureate and Graduate Nursing Programs (CCNE, 2013). Yet, Moss, (2016) described her own professional nursing practice with the following bold statement “the concepts I learned on the job, even as a Native American nurse, were never taught to me in any nursing program.” Thus, there is a clear need to establish effective instructional practices which develop the understanding of cultural consciousness of nursing students regarding American Indian communities and their members.

Service learning is a widely accepted tool used in the educational development of student nurses (Reams & Twale, 2007). Yet, little research has examined student perceptions of their insights developed during cultural immersion service learning (CISL) experiences (Gillis & McLellan, 2010). Although several studies have explored the outcomes of nursing student service learning with vulnerable populations, Gillis and McLellan found only three studies published between 1999 and 2009 which described a CISL experience with vulnerable populations. These studies described international projects. None of their reviewed studies examined a service learning approach in the context of a American Indian community. Furthermore, scant research exists on service learning within American Indian communities. Thus, the purpose of this study was to examine nursing students’ perceptions of cultural consciousness pertaining to American

Indian culture developed during a one-week cultural immersion service learning (CISL) experience, embedded within an undergraduate nursing course and within an American Indian community.

This chapter describes and explains the rationale for the methods used in examining nursing students' perceptions of cultural consciousness pertaining to American Indian culture developed during a one-week cultural immersion service learning (CISL) experience within an American Indian community. The overarching research question explored was "How do nursing students describe their CISL experience?" by designing and implementing methods designed to address the following research questions: (1) What CISL experiences do nursing students describe as important in developing their consciousness of American Indian culture within two of the Northern Plains Indian tribes? (2) How do nursing students describe the knowledge they acquire regarding the care of vulnerable populations during their one week CISL experience? (3) What do students describe as influential in their understanding the complex link between poverty and health?

### Research Design

This study used an intrinsic single case study design to answer the research questions posed for this study. Creswell (2013) described an intrinsic case study as a design "in which the focus is on the case itself...because the case presents an unusual or unique situation" (p.100). Including a one-week CISL experience within a geographically isolated Northern Plains American Indian community into a pediatrics course required for

a Bachelor's of Science in Nursing degree is unique. Of the 25 articles reviewed by Gillis and MacLellan (2010) on critical service learning with vulnerable population, only three involved an immersion experience and these published reports only discussed international projects and none of the projects involved coursework required for student graduation. In addition to focusing on a cultural immersion service learning experience, there were several unique aspects of this study. First, the CISL experience was embedded into a unique required Bachelors of Science in Nursing course. Second, the level of cultural homogeneity on the campus was high; located in the Northern Rocky Mountain region of the United States, a majority of students were from rural areas where there is little racial or cultural diversity. Third, during the immersion experience students were engaged in clinical work developing their nursing skills within the American Indian community context during the day and in the evening they engaged in traditional American Indian activities with tribal Elders. Each of these unique aspects of the situation provides sufficient justification for an intrinsic case. Taken as a whole, the situation presented a compelling opportunity to explore the nature of CISL, its impact on student understanding of cultural consciousness, healthcare equity among vulnerable populations, and the complex relationship between poverty and health. In summary, the situation established as a case study provided a unique opportunity to answer the overarching research question, how do nursing students describe their CISL experience? as well as the three research questions posed above.

### Boundaries of the Case Study

Defining features of a case study design is that it is bounded and seeks to provide an in-depth understanding of phenomena under study (Creswell, 2013). This single case study design was bounded by the students' descriptions of a one-week CISL experience within an American Indian community taking a required pediatric nursing course. The context of both the community and the course were important in providing the reader with a rich understanding of the study. Yin (2009) described case studies as being of two types—holistic and embedded. This case study design used the holistic type because there was a single unit of analysis—the students' descriptions of their CISL experience. To address the overarching research question and each of the research questions, the single case study design focused on the reflections of students during and shortly after the CISL experience. Thus, the one-week CISL experience and the students' descriptions of the experience portrayed in their reflections occupied the heart of the case study design.

### Purposeful Selection of the Case

The selection and demarcation of this case study was purposeful and based on the rationale that this case offered a unique perspective in evaluating the outcomes of a CISL experience. The rationale for uniqueness was based on four points. First, this cultural immersion service learning experience immersed students in a rurally-isolated American Indian cultural environment. Second, the CISL experience was embedded in a required course for a Bachelor of Science in Nursing degree. Third, tribal Elders and community representatives actively engaged with the nursing students to facilitate an understanding of cultural values, routines and ways of knowing. Finally, the ethnic and racial

demographics of nursing students attending the university was generally homogeneous chiefly comprised (over 95%) of non-Hispanic, Caucasian students.

### Context of the CISL Experience

The CISL experience was an intervention to facilitate cultural consciousness among undergraduate nursing students. The one-week CISL experience began in 2011 as an instructor-initiated partnership between the College of Nursing at a land-grant university and a Northern Plains American Indian tribe's Health Promotion Disease Prevention (HPDP) Program. Students enrolled in Nursing Care of Children and Family, a required junior-level course for students in a Bachelor of Science in Nursing degree program, participated in a one-week CISL experience. Students traveled seven hours from the campus to the Northern Plains Indian Reservation on Sunday and returned to the campus on the following Saturday. Monday through Friday, the nursing students provided healthcare screenings and health education at six public school sites on the Northern Plains Indian Reservation during school hours. Each evening students participated in cultural activities and met with the tribal Elders and representatives of the community. The Elders described their culture, its history, customs and ways of knowing. Taking students outside of the classroom and traditional clinical or practicum environment for an extended experience beyond the local campus community challenged the students to consider the complexities of health inequalities, cultural awareness in healthcare delivery and the impact of limited healthcare experienced by American Indian children and families.

To fully describe this experience, development of the CISL experience is explained first. The context of the community is explained next, followed by an explanation of the university's context and an overview of the course in which the CISL experience is embedded. Finally, a detailed description of the experience in terms of its goals, activities, assignments, and assessments are provided.

### Context of the Community

The Northern Plains Indian Reservation (a pseudonym) is one of seven reservations in the state and is the most remote geographically and in relation to services. It is home to two tribes. The reservation has over 2 million acres of land that stretches 110 miles long and 40 miles wide across semiarid grasslands, generally flat with rolling hills. Winters are severe with hot, dry summers. Most of the 10,321 people on the Northern Plains Indian Reservation live along its southern boundary in four communities (U.S. Census, 2010). A U.S. Highway and a cross-continental railroad line link these communities.

Prior to 1888, the Northern Plains community was one of three Indian agencies serving a land reservation created by the Fort Laramie Treaty of 1868 that extended from the eastern border of the Montana Territory west to the continental divide and north from the Missouri River to the Canadian border. In 1888, the Sweetgrass Hills Treaty established the Northern Plains Indian Reservation as well as two other Indian Reservations in return for promises of annuities and government rations. Over the following two decades, disease and malnutrition decreased the population of the two tribes to 1651 people. Bryan (1994) wrote:

With such a small group of people and more than 2 million acres of land, the pressure to allot reservation lands became insurmountable. Thousands of non-Indians who had arrived via the Great Northern Railroad wanted to homestead here. As a result, the first [Northern Plains] Allotment Act was passed in May 1908...and the reservation was opened to homesteading in 1913. ...About 1.3 million acres were opened up to settlement by the 12,000 applicants who drew land shares. ...Most of the best agricultural land was taken out of Indian hands, having been lost in the surplus-land sales. (p.46)

Currently, the economy of the Northern Plains Indian Reservation is based in agriculture and ranching with tribal members producing hay, wheat, barley, cereal grains and owning approximately 9000 head of cattle and a herd of bison. Resources such as oil and natural gas are fairly abundant and there are substantial reserves of lignite found on the reservation. A tribally-owned manufacturing firm which flourished during the 1990s has since declined.

The geographic isolation and lack of economic opportunity often result in unaffordable or inaccessible healthcare. Native American children in the Northern Plains community experience significant health disparities compared to other children in the state, creating a need for primary health services provided by the nursing students. Poverty, geographic isolation, and high healthcare provider turnover contribute to limited health care access, extreme health disparities on the reservation result in a median age of death 22-25 years earlier than white residents of the state. Youth suffer from a high incidence of preventable illness, including diabetes, obesity and tooth decay; unhealthy lifestyles such as smoking, alcohol and drug abuse are rampant. Suicide has reached epidemic levels.



Despite their long and proud history, the tribes of the Northern Plains Indian Reservation face a number of pressing economic and health concerns. Almost 60% of the American Indian population on the Northern Plains Indian Reservation lives below 200% of the federal poverty level. The median age of death on this Indian Reservation is 50 years for American Indian males and 60 years for American Indian females, compared to 75 years and 82 years for residents of the state as a whole. The primary causes of death for American Indians on the Northern Plains Indian Reservation are cardiovascular, kidney and lung diseases as well as alcohol abuse. Forty-one percent of deaths among American Indians are attributable to drug or alcohol use, suicide, accidents or violence. The physician to patient ratio on the Northern Plains Indian Reservation is 1:4010. Indian Health Service clinics experience staffing shortages, lack of funding, and have long waiting lists. Furthermore, private clinics, of which there are few, often will not accept Medicaid, nor uninsured patients, and the nearest federally qualified, primary care facility is more than 100 miles distant, or a two and a half hour drive from the reservation.

The governance of most American Indian nations in the United States was dictated by the Reorganization Act of 1934; however, the Northern Plains tribes are an exception, their governance was retained in the tribal constitution adopted in 1927 (Bryan, 1994). In addition to specifying the duties of the governing board members, and the tribal executives, it formed 8 standing committees and each tribal council member serves on three committees. Two committees meet each day. One of these standing committees focuses on health, education and welfare. In 2000, this committee established the HPDP program. The mission of the HPDP program is to “restore the traditional

values of the [two] tribes, and to help our communities return to a healthier lifestyle. ... bringing back the heart of the tribe by improving our health, one child and one beat at a time.” (HPDP, 2011, p. 1). In 2006, the HPDP program developed school-based health clinics for the purpose of helping “students do better in school by working to solve physical and mental health problems, preventing serious illness, and promoting healthy lifestyles, all while respecting and instilling a strong sense of culture and tradition.”(HPDP 2011, p. 2). The HPDP Program’s school-based health clinics provide the clinical sites for the one-week CISL experience for the nursing students.

#### Context of the University and College of Nursing

The University is committed to community engagement, evidenced by a Community Engagement Classification from the Carnegie Foundation for the Advancement of Teaching. The University’s College of Nursing partnership with the Northern Plains Reservation’s Health Promotion and Disease Prevention program is an exemplar for community engagement. Student nurses practice pediatric clinical nursing skills while learning how to work collaboratively in a cross cultural setting, beginning to appreciate the complex link between poverty and health. “The health disparities experienced by children in reservation communities is profound, and the services provided by our nursing students is greatly needed.” (Dean of the College of Nursing, quoted in Cantrell, 2013, p.54). The University President (2015, April 2) wrote,

The partnership exemplifies the University’s land-grant mission and embodies the engagement goal in our strategic plan: Members of the [university] community will be

leaders, scholars and engaged citizens of their local, national and global communities, working together with community partners to exchange and apply knowledge and resources to improve the human prospect (p.1).

Furthermore, in addressing the need for graduates with the cultural skills needed for a global community, the university President (2014) stated:

Global trends are transforming society, and at [our university] we are preparing our graduates for the “borderless careers” they will enter. Among numerous benefits, international initiatives and experiences expand our horizons, enrich our breadth of appreciation of different cultures and help all of us become well rounded citizens.

The mission, goals, and strategic plans of the College of Nursing align with the university’s commitment to community engagement and cultural awareness. Specifically the College of Nursing’s mission is” to enhance the health of the people of [our state], our nation , and the global community by providing leadership for professional nursing through excellence in education, research, practice and service” (CON Mission Statement, 2012, p.1). Similarly, the vision of the College of Nursing is to be internationally recognized for innovation, discovery, excellence and leadership in education, research and practice. Four specific goals are stated to accomplish this vision.

- 1) To inspire baccalaureate and graduate students within a diverse, challenging and engaging learning environment, to become leaders in the practice of professional nursing.
- 2) To create an interactive environment in which faculty and students discover, learn and integrate knowledge into nursing practice.

- 3) To serve as leaders in nursing by generating, translating and disseminating knowledge through research and scholarly activities.
- 4) To promote health and wellness through professional practice, collaboration, consultation, civic engagement, education and leadership.

In understanding these goals and the underlying organizational philosophy of the College of Nursing five constructs are defined (College of Nursing, 2012)—person, environment, health, nursing and nursing education. The *person* is described as “any individual, family, group, community or population” (p.1). The *environment* includes “all factors influencing a person’s health perceptions, behaviors and responses. The human experience is contextually defined by the interrelationship of spiritual, cultural, developmental, physical, psycho-social, political and economic subsystems. The appropriate arena for nursing action extends beyond the person and includes promotion of healthy environments and social action” (p.1). Health is described as

a state of physical, mental, social and spiritual well-being defined by the person. *Health* is multi factorial and is influenced by many factors such as behaviors, environments, genetics and resources. There are diverse cultural definitions of health (p.1).

*Nursing*—Nurses generate a unique body of knowledge to meet the complex needs of persons in a variety of health care settings from rural to urban (p.1).

*Nursing education*—intentionally fosters use of multiple fields of study, use of wide-ranging knowledge of science, cultures, and society; high level intellectual and practical skills; an active commitment to personal and social responsibility, demonstrated ability to apply learning to complex problems and challenges, and personal engagement as a responsible citizen in a global society (Association of American Colleges and Universities, College Learning for the New Global Century, 2007, p.4).

Finally, the strategic planning document for the College of Nursing established two goals to support the development of partnerships with underserved communities (CON, Strategic Direction 5c, 2012) and support faculty in providing international/intercultural health care experiences for students (CON Strategic Direction 3-3.1b, 2012). Furthermore, CON Policy A-3 (May, 2011) supports the intent of this work to sustain and deepen the partnership with the Northern Plains reservation community. The College of Nursing believes that students enrolled in other courses within the college and the university, could contribute significantly to the needs of the residents of the reservation while expanding their own learning in a social justice , service oriented framework. Expanding this model of learning to other reservations across the state is a long-term goal.

In summary, the Director of the Northern Plains Tribes' HPDP program (2015, March 25) stated:

Thankfully through partnerships like the [university] College of Nursing, we are able to provide all students in three tribal schools with preventative assessments and treatments, regardless of insurance status or ability. We are always seeking committed, ongoing, mutually beneficial relationships that will help to sustain this initiative into the next generation, and the commitment of [names professor] and her students is an excellent example of such a partnership. We believe this partnership to be an excellent example of how University systems should be partnering in Indian Country to address the significant health disparities facing our people. (p.1)

The [university] College of Nursing/Northern Plains Tribes HPDP program partnership is consistent with [university's] land grant mission and strategic plan, as well as with the vision of the HPDP program. The HPDP Program Director and faculty member worked closely to plan and implement the first student visit to the reservation,

and the collaboration has deepened as the partnership has progressed. The framework for this CISL experience is based on a framework that emphasizes the need for cultural sensitivity and understanding as integral components of service learning experiences, as well as personal self-reflection, especially in a culture where social and health disparities abound.

Although the policies and leadership of the campus are evident to students in terms of campus climate, the following is a concrete description of the physical environment of the campus summarizing field notes recorded during the spring semester of 2016.

The College of Nursing building is a non-descript 1960-1970's era brick building with large windows which capture a majestic view of the western landscape and a comfortable student lounge which has computer stations, work tables, a refrigerator, microwave and electric kettle and armchairs for relaxation. Undergraduate and graduate students gather in the common area, sharing school and life experiences. By the end of the first week, students have settled in. By the second year of the nursing program, students were generally a collegial supportive group. It is these junior students who participated in this study.

Clinical reflections were completed on a student's own time, not in the classroom setting, however exams are provided in a classroom setting. Reflections written during the CISL experience occurred in the evenings while at the Reservation, following the clinical day. The evenings were set aside so that students can relax with each other, change out of their uniforms and into their usual clothing, cook a meal for themselves and begin the process of debriefing with each other their clinical day. The students resided in a house on the reservation, a husband and wife, on the premises, serve as hosts. The home is a 1970's era ranch, comfortably decorated, with couches, arm chairs, computer access and individual beds for each student in shared bedrooms. A large kitchen with all of the basic amenities and one full bathroom with shower. Laundry facilities are also available in the home. The house is situated five miles outside of the nearest town with uninterrupted views of the landscape to the West and to the East. Students often remark on the beautiful sunrises and sunsets

which are viewed by many to be healing at the end of long and often difficult days.

Instructor field note, April 4, 2016)

### Course Description and Objectives

Nursing Care of Children and Family is a five credit pediatric nursing course focusing on the health promotion, disease prevention, illness management, and pediatric nursing care within the family context. Two credits of this course are designated as lecture and the remaining three credits are clinical labs in which students spend a minimum of 135 clock hours at various clinical sites directly supervised by a licensed Registered Nurse (RN) preceptor or clinical instructor. To clarify, a clinical preceptor is an on-site healthcare provider and the clinical instructor is an employee of the university; both facilitate the nursing students' practical knowledge and specific nursing skills within specific clinical contexts. Typical clinical sites include the hospital pediatric floor, surgery, primary care pediatrician offices, a pediatric dental office, therapeutic settings and public schools located in and around the local campus community. The students spend 60 clinical hours on the Northern Plains Indian Reservation. Typically, clinical courses, such as Nursing Care of Children and Family are not service learning courses; however, this course has been designated by the university as a service learning course, based on the structure and clinical student activities that occur on the Northern Plains Indian Reservation.

The course syllabus is contained in Appendix A. The students were required to demonstrate six course objectives: (1) Using evidence-based nursing practices to assist children and families with the promotion, maintenance and restoration of health; (2)

Providing culturally sensitive and competent nursing care to children and families; (3) Using knowledge of growth and development to provide safe nursing care to children and families; (4) Using community-based nursing concepts in caring for children and their families; (5) Demonstrating responsibility and accountability reflecting professional values; and (6) Demonstrating the ability to communicate effectively with children, families, and professionals. All of these objectives were addressed during the cultural immersion service learning experience on the Northern Plains Indian Reservation, but objectives two, four and five were emphasized.

During the lecture portion of the course which meets once per week for 3 hours, students engaged in lessons designed to prepare them for the immersion experience during the first ten weeks of a 15-week semester in addition to subject specific content. Topics began with the guidelines written specifically for the CISL experience, a lecture provided by the tribal host, team building exercises, guest lecturers who provided information on cultural sensitivity and the steps necessary to becoming culturally sensitive, discussion of basic human rights to health were intertwined with more traditional pediatric nursing care topics such as childhood obesity and diabetes, environmental air quality and asthma. Each of the pediatric care subjects were lectured from the perspective of the general pediatric population and also from the population specific to Native American culture. For example, if a particular disease process is more prevalent in the Native American population, this detail was addressed within the content of the course specific to each disease or condition process. Students engaged in an exercise which developed group norms for the immersion experience. Students agreed to



the group norms, wrote up a document outlining the group norms and signed the document which functioned as a contract to assist with alleviating moments of potential group strife within the CISL experience.

Students were exposed to the concept of human rights as related to health by first understanding how the United Nations Population Fund (2011) defines the principles such as universality and inalienability, indivisibility and dignity, equality and non-discrimination, and reducing vulnerability to ill health through the adherence of human rights. Specifically:

Everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” (Universal Declaration of Human Rights, 1948 Article 25 (1))

The Northern Plains/CON partnership aligned with the university’s pediatric nursing course objectives and fostered learning and professional development in a cross-cultural setting. Nursing students gain an understanding of the culture of two American Indian tribes, and the tribes’ cultures’ impact on health, lifestyle, well-being, social justice, and the complex link between poverty and health; while working collaboratively to meet an identified need of a host community in a cross-cultural setting.

#### Description of the CISL Experience

The purpose of the CISL experience on the Northern Plains Indian Reservation was to facilitate a process of inquiry among students into identifying health inequalities between American Indian communities and dominant-culture communities within the

state so that they may begin to explore the causes of health inequality that exists in the United States at large. Students must formulate the basis upon which health inequalities are defined and explore the causes of the identified health inequalities. Students must then ask why vulnerable populations experience such different life circumstances and how these different life circumstances become translated into health inequalities. This approach to health promotion, maintenance and restoration was designed in part to deconstruct technical processes of health and illness to demonstrate the social impact of healthcare on considerations of living circumstances and the public policy decisions that shape these circumstances (Watson, 2008).

Each clinical site had specific learning objectives explicitly stated and provided to students with the course syllabus. The learning objectives for the CISL experience at the Northern Plains Indian Reservation are as follows:

To foster student learning and professional development in a clinical setting that is culturally different from the student's home campus.

1. Students will gain an understanding and appreciation of Native American culture within two of the Northern Plains Indian tribes.
2. Students will gain an understanding of historical trauma and its impact on healthy lifestyles, well-being and social justice.
3. Students will gain insight into the complex link between poverty and health.
4. Students will work collaboratively to meet a desired need of their Native hosts.

Additionally, the following dispositions are also explicitly stated with the learning objectives for the CISL experience: flexibility, communication, team work, leadership, and professionalism.

Each academic year up to 32 junior nursing students traveled in groups of eight with their instructor 868 miles, round trip, to the Northern Plains Indian Reservation, where they lived and worked for one week. Students stayed together in a multi-room house provided by the tribal council, and were responsible for preparing their own meals. The state's Area Health Education Center (AHEC) supported transportation reimbursement for students. During each week day, students delivered primary and preventative health care to American Indian children being served through tribally-operated, locally-controlled school-based health clinics.

#### Pre- Experience Activities

At the beginning of the semester, students were provided with a document that outlined the clinical objectives, cultural expectations, logistic concerns, and other information specific to the one-week CISL experience entitled Guidelines for the [Northern Plains] Experience (see Appendix B). This document is thoroughly reviewed by the instructor and discussed with the students on the first day of class along with the syllabus and other key course materials to convey a clear set of expectations.

In the weeks leading up to the CISL experience, the students and the instructor worked together to develop group norm agreements. Students developed the group norm agreements with the instructor to prevent any unnecessary tension when a group of students was residing in a common space that is not their own. Students mutually agreed

on a set of behaviors, attitudes and conduct expectations during the one-week CISL experience. This document was then typed, signed by each student and the instructor, and each student was provided with a copy. This document was especially useful when there were participating students of different genders, backgrounds and personal needs. Group norm agreements were used to express needs for privacy, private time, prayer, dress preferences (modesty), special dietary needs and any other student concerns. Preferences and concerns were discussed in the classroom setting and agreed upon as a group.

The HPDP (Health Promotions and Disease Prevention) Director for the Northern Plains Tribes visited the students on their campus for an orientation lecture. Other guest speakers with experience in American Indian culture, such as a faculty member from the university's Center for Bilingual and Multicultural Education, were brought in to speak with students. Students were provided with healthcare education topics and were expected to teach classroom lessons to children while at the Northern Plains Indian Reservation. Prior to departure, the students were responsible for researching the needs of the children in this community and for developing health and self-esteem-related teaching materials to implement these lessons.

### On-site Activities

Eight nursing students departed the campus at approximately nine AM on Sunday morning in two cars, and arrived at the Northern Plains Indian Reservation community between 4 and 6 PM. As the course was capped at 16 students, two groups of eight students are scheduled for the CISL experience sequentially. The instructor drove to the Northern Plains Indian Reservation with the first group of students and drove back to

campus with the second group of students. Sunday evening, students prepared and ate dinner, received school clinic assignments, and received a community orientation from the HPDP Director or member of his staff. Nursing students were immersed in the Northern Plains tribal cultures for 12-14 hours per day providing care to children in six tribal schools and participating in cultural events. Throughout the school day, nursing students provided healthcare for children in Pre-Kindergarten classrooms (including Head Start Inc. classrooms with 3-year old children) through 12<sup>th</sup> grade classrooms by performing health screenings, physical exams, healthcare education and tending to minor injuries and acute illness as needed during the school day. In the evenings, nursing students participated in cultural events offered by the tribe, including discussions with Elders and other community members, beading, arrow making, archery, horseback riding, and meal sharing. Through these evening activities, students were encouraged to see the strengths of the community. Friday evening, students were honored with traditional dancing exhibitions in which children and community hosts teach the nursing students traditional dances. Students were permitted to leave at dawn Saturday morning.

Each day, all nursing students and the instructor participated in a clinical reflective post-conference. The conference was conducted in a neutral setting, away from children, their families and members of the community. This relaxed informal atmosphere allowed students to reflect on children they have seen, their conditions and the social and cultural framework impacting the nursing students' care, their feelings, experiences, and possible misconceptions. The daily group reflection was non-confrontational, not graded, and sought to leverage the student group as a whole to help

each individual student in processing his/her day. A reflection guide (see Appendix D), provided to the students as part of their orientation, facilitated students' reflections during these daily sessions and discouraged negative dialogue (complaining). Late evenings were reserved for student study, reflection and rest.

### Post-Experience Activities

Students were required to complete a clinical reflection due on the day following their return from the CISL experience. Another reflection, about the CISL experience, was incorporated as a bonus question in their end of course examination. In addition to the reflective writing exercises, students received a midterm and a final clinical evaluation from the instructor. Each of these evaluations was conducted individually, and was completed within 20-30 minutes. The final clinical evaluation provided the student with direct feedback from the instructor on their performance during the one-week CISL experience within the context of the student's overall clinical performance for the semester. All College of Nursing students are provided with detailed feedback verbally then provided a written summary of their performance during each clinical evaluation session.

### Perspective on the CISL Experience

Adjustments to the CISL experience occurred every semester regarding student preparation (Appendix 1). Adjustments were identified based on two prominent factors: (1) previous student performance during the CISL experience, and (2) previous student feedback during and after the CISL experience. The week-long CISL experience has

evolved over five years to show address clarity in student nurse development. The following is a description of the one week CISL experience from the perspective of the instructor. It depicts the activities and events that took place as the first group of eight traditional nursing students completed the experience in Spring 2016.

Day One: The first day of the experience was set aside for travel to the reservation and for settling in once arrived. The students and the faculty met early in the morning in a central location in the town where the university is located. Cars were loaded with everything the students may need for one week away from home.

Two brief stretch stops and one lunch break later, we arrived at our destination, 450 miles away and after eight hours of driving. As we entered into the community, student nurses immediately the condition of extreme poverty. The homes are small and Spartan. We stopped at the local grocery store on the reservation to purchase a few perishable goods. The students seemed reluctant to enter the store, but they followed me. The reason for this stop was an introduction to the community beyond the windshield tour. The students gathered grocery items, paid and we departed. Thirty one miles later we arrived at the host home. Students were introduced to the staff and began settling in.

Day Two: The day began with more introductions to team members, staff, and community. I drove the students around town, showing them where the key facilities are: the library, schools, head start, hospital, clinics and pharmacy. Along the way I greeted people in the community that I know and introduced my students. The nursing students

received their clinical assignments for the week and spent the afternoon working on their health education projects together as a team.

Day Three: Clinical began at 7:00 AM, the students needed to be out and driving themselves up to 45 miles to their clinical assignments in school-based health centers across the reservation. The weather was not as harsh as it sometimes is. For this spring semester group, the wind was gusting, but there wasn't much snow and the temperature was in the 20s that morning. Once at the school clinic, children lined up to be seen steadily throughout the day, sometimes accompanied by family members or teachers but often on their own. The children's concerns ranged from headaches, stomach aches, ear aches, falls, bruises, bullying, and depression. The nursing students began to put together the art of forming a relationship with their patients, establishing relationships and sensitively interviewing their patients about: "Who takes care of you when you are at home? Where do you like to sleep at night? Did you have your breakfast at school this morning? Do you have a friend at school? What do you like to do after school?" Prior to participating in the CISL experience, the nursing students were taught to look beyond the presenting symptoms. On-site, the interviews were modeled by the faculty initially which entailed a head to toe pediatric assessment interspersed with compliments throughout. For example, a younger child may be complimented for her long beautiful braid, whereas an older child may receive a compliment on his height advantage in sports activities. The nursing students learned that one reason for the clinic visit became more apparent: hunger, sleep deprivation, worry, bullying.



Day Four: Day four was the hardest day of the week because by this time into the CISL experience, the nursing students were becoming tired, they missed home and they were questioning their own beliefs, assumptions and skills. One student stated” I began to seriously question if I was cut out to be a nurse.” The nursing students have witnessed first-hand children and family situations that were often difficult to understand, they were beginning to understand the true meaning of the concept of privilege, vulnerable populations, social justice, poverty, and disparity.

Day Five: This day came as a relief, the nursing students made it through the hardest part of the week, and they have found a rhythm in their work as well as in the cohort relationships. They seemed to have settled into their experience as confidence in their technical skills has increased, students were able to recognize their own abilities, and they were beginning to realize that they can make a difference.

Day Six: The last clinical day was marked by evening celebrations with the nursing students hosted a potluck dinner for the community. Storytelling was shared as Elders talked of the reservation life when they were young, they recounted stories of their parents, the hardships and the joys and their connection to the land and their culture. Many nursing students became emotionally touched by hearing from the community members how much the students’ contributions were appreciated, the difference the students made in the lives of children and families, and how valuable the cultural exchange is for community members. Our American Indian hosts shared that they were

delighted to have the opportunity to share their home, their culture and their children, their most valuable assets, with the nursing students.

Day Seven: Nursing students are required to stay on site until after sunrise. This is primarily for safety reasons as the roads may be icy and harder to negotiate before dawn. This last day at Northern Plains Indian Reservation came too soon for some and not soon enough for others. One student remarked, “it is both wonderful and horrible all at the same time.” At 6:05 AM, the students started their eight hour trip home. (summary of field notes dated April 3-9, 2016).

#### Development of the CISL Experience

In the fall of 2010, the Course Coordinator for the Nursing Care of Children and Family course contacted tribal officials on the Northern Plains Indian Reservation with an aim to establishing a relationship between the university and the tribes of the Northern Plains Indian Reservation for a new approach in teaching the class—an approach that incorporated the mission of the university while providing students with opportunities for learning outside of the typical hospital or community clinic setting. The community surrounding the university has approximately 95,000 residents with good access to health care, education and social services and an above average median household income and educational level. Children in this area are largely healthy and disease free, they are rarely hospitalized, and if hospitalized, the hospital stay is for only short periods of time. The local community was viewed as atypical in terms of state-wide pediatric healthcare. On the other hand, the HPDP Director described the health care needs of the children on

the reservation as profound, especially as compared to non-Indian children and stated the “health care is often reactionary rather than preventative” [Personal conversation with, Director of the HPDP Program for the Northern Plains Tribes, September 18, 2010]. The identified need for children’s healthcare services on the Northern Plains Indian Reservation opened the door for clinical opportunities that were not available in the university community. In March of 2011, the first two groups of six students travelled with their instructor the 480 miles by car to spend one week of intensive collaborative learning with members of the tribe, health care providers, school officials and, of course, children and their families. The inaugural experience was not mandatory, nursing students were offered the opportunity to participate, of the sixteen students enrolled in the course, 12 students chose to participate. Health care provided by the nursing students focused on lifestyle, diet, exercise and self-esteem development: issues having the potential to change health outcomes of the children on the reservation.

Many lessons were learned after the initial experience in 2011, the Course Coordinator realized that adult learners require much more planning and organization than initially understood. This initial experience focus was on the development of additional hands-on, rich clinical experiences for the student nurses. It was during this initial experience that the instructor realized that the inclusion of culturally consciousness materials was essential in order for the student nurses to be able provide the care that had been requested by the community in a sensitive and culturally respectful way. A timeline of key events outlining the development of the one-week CISL experience is contained in Appendix C. A significant challenge to the success of the one-week CISL experience was

an initial rejection by some students during, and immediately following the experience. Yet, many of the students who initially rejected the experience later became advocates for continuing the experience. To address this issue, much more American Indian cultural exposure was provided to students prior to the one-week CISL experience. For example, the Health Promotion and Disease Prevention (HPDP) Director now travels to the campus to meet with the students prior to their arrival on the reservation, speaking about life on the reservation and cultural practices. He brings with him the materials to create and bead a medicine pouch, and students are provided time in class to complete their traditional craft while asking questions about their upcoming experience. Other strategies such as additional guest speakers with expertise in American Indian culture, values clarification exercises, and pre-experience reflection writing now occur prior to visiting the reservation. A second lesson learned during an early visit to the reservation was the need for separate housing for students and faculty. Both the students and faculty reported a need for time away from each other to process and to unwind.

In addition to the changes noted above, other key features of the one-week CISL experience have developed to clarify expectations, improve logistic efficiency, and course effectiveness. These include: (1) developing a video/power point with photographs of the reservation and the places to be visited, (2) establishing written guidelines that are very specific in detail to include maps, telephone numbers, details about housing, recreation, internet access, and behavioral expectations aligned with the host's standards and the university's conduct guidelines, (3) initiating written agreements developed by the students establishing common expectations, (4) providing students with

guidelines and more structure for reflective writing exercises, and (5) developing emergency plans for student illness, travel back to the campus in case of family emergency and procedures to follow through on student conduct issues. An example of the student reflection guide is contained at Appendix D. After each experience, the Course Coordinator and Instructor completed a written report on what worked well and what needs improvement. These notes are used to formulate continuous changes and improvements of experience.

Preparing students participating in this study for the CISL experience began before the semester started. Nursing students heard about the experience from their peers in the class ahead of them, and they sometimes visit with the instructor in the weeks and months before taking the course to better anticipate the kinds of things they may get to do and to see. On the first day of the semester and every week leading up to the experience, activities and materials in preparation for the CISL experience occurred. One of the highlights was a visit by a representative of tribe who oriented the nursing students to the tribe, their history and the work performed by the students. This presentation used the Native American approach to teaching through storytelling. Deer hide, beads and needles were brought to the classroom, and students created a medicine pouch to take with them on their CISL experience. Table 1 below outlines all of the preparation activities by week.

Table 1. List of Preparation Activities

<b>Week</b>	<b>Activity</b>
1	Students receive course syllabus
1	Fort Peck Guidelines
1	PowerPoint on CISL with pictures
1	CISL Behavior Contract
2	Guest Lecture on Non-verbal cues
3	Guest Lecture from Northern Plains Indian Reservation Elder
4	Guest Lecture on Cultural Awareness
5	Review Packing List and Complete Travel Documents
6	Develop Peer Behavioral Norms

### Role of the Researcher

Participant-observation has long been associated with case study methodology (Yin, 2009). Similar to other qualitative research methods, emic (researcher-based) and etic (empirically-based) perspectives are combined to provide a rich description of the researched story ending in assertions (Stake, 1995). All good research, both qualitative and quantitative, ends in making assertions that the reader must critique before generalizing the findings to specific contexts, ideas, or applications. To establish a sound critique, the point of view of the author or researcher must be established. In quantitative research, the researcher's role is assumed to be that of an objective observer of the phenomena being studied (Creswell, 2013). In qualitative research, there is no such

assumption; and therefore, describing the role of the researcher in the context of the phenomena being studied is an important aspect of establishing trustworthiness.

Furthermore, since case study research is highly contextualized, the role of the researcher as well as the researcher's proximity to the case is important to establish at the beginning of the research story. Throughout this study, I assumed multiple roles—researcher, instructor, and nurse practitioner.

I am a Pediatric Nurse Practitioner with 28 years of experience in pediatric nursing. My experiences throughout my career have focused on the healthcare of children in vulnerable populations in a wide variety of contexts ranging from a specialty unit in the National Children's Medical Center, to being the direct health care provider in an inner-city clinic for children with special needs, to being, more recently, the school nurse in a rural Kindergarten through Eighth grade rural school. In 2009, I was hired as a nurse educator at a land-grant university to teach Nursing Care of Children and Family, a required course for undergraduates seeking as a Bachelor of Science in Nursing degree.

My motivation for this research evolved naturally and over time. New to this state, I was invited to teach a pediatric course at the College of Nursing when an opening became available. Although I had never imagined myself as an academic, it was the right time in my life to accept a new challenge. Simultaneously, I was admitted to the Adult and Higher Education Doctor of Education (Ed.D.) program at the same institution. Surrounded for the first time in my professional career by researchers, I slowly began to gain an interest in understanding more thoroughly the work I was doing and I wanted to learn how best to provide for the learning needs of my students. Through course work

and the mentorship of my own faculty and colleagues, I learned to critically analyze the work I was doing in the field and to purposefully improve the CISL experience based on my own trial and error but supported by educational theory espoused within the framework of experiential learning theory and the work of Dewey (1938) and Friere (1970).

As an undergraduate nursing student at the Catholic University of America, I was fortunate to receive an education which was grounded in service, then as a graduate student at the University of Texas Health Sciences Center in San Antonio, Texas, I was very fortunate to not only experience an education rich in cultural diversity awareness but to participate in service learning with diverse rural communities. Beginning my teaching experience in this state, I became quickly aware that many of my students experienced a different cultural perspective that was rich in a rural western view but was also largely homogenized. The field of transcultural nursing reminds all nurses that our patients come from many backgrounds, cultures and belief systems, and to care for our patient's best, we must strive as health care providers to understand the lives of those different from ourselves to the maximum extent possible. In the field of nursing, the theorist most widely recognized for her work in transcultural nursing is Jean Watson. Her work inspired my motivation to provide my own nursing students, attending a university that is predominantly ethnically homogenous, with a course designed to challenge and to enhance the student nurses' individual world views.

In alignment with the university's land-grant mission to serve the population of the state, I chose to focus on the American Indian population residing within the state's



boundaries. American Indians are considered to be a vulnerable population according to the United Nations, as are certain other cultural, ethnic and minority groups across the nation. I felt that it was important to not only support the American Indian population with in our home state, but that it was also important for my students to understand the complex link between underserved vulnerable populations, poverty and health outcomes. I have discovered that for many students the impact of seeing firsthand the disparity of available services within one's own home state is a most profound experience—an experience which cannot be fully attained through readings and /or case studies.

Service learning for students in American colleges and universities is well espoused. However, service learning experiences often involve working with communities of vulnerable populations in foreign countries. Although a very worthy practice, focusing on the needs of communities in countries other than our own does not illustrate the needs of American communities to American nursing students, nor are these valuable learning experiences accessible to all nursing students due to the cost of international travel experiences. The CISL experience developed and implemented within the Nursing Care of Children and Family course at this university is available to all enrolled nursing students on one of five of the College of Nursing's campuses at no personal cost to themselves.

The students in the nursing undergraduate program were predominantly female, Caucasian, and come from rural, middle-class backgrounds. Many of the students have had limited opportunities to interact with people who hold different cultural beliefs or have diverse identities. Yet, a course competency for the Nursing Care of Children and

Family course is to identify issues of cultural proficiency as well as develop pediatric nursing knowledge and skills. To expand clinical opportunity as well as increase student contact with members of a different community, I contacted the Tribal Health Officer at an American Indian Reservation within the state, and with the support of College of the Nursing administrators, a one-week CISL experience was developed as a service learning component allowing nursing students to experience healthcare on the Northern Plains Indian Reservation. The following year, the course was designated by the university as a service learning course.

During the initial experience in 2011 which focused on expanding the opportunities for clinical experiences, I was surprised at the lack of cultural awareness among my students. It was from this experience that my tacit assumptions shifted from facilitating the development of nursing skills to facilitating cultural consciousness among my students through the development of nursing skills. Interestingly upon reflection, I saw that my own understanding was changed through the experiential learning model which frames this dissertation. Specifically, I went into this experience with set of beliefs assuming that my students had more of an understanding and awareness of cultural competency. Within the experience of taking students to develop their nursing skills in an American Indian community, the contrast between my initial assumptions about student cultural awareness and their observed cultural awareness was strikingly different. Through reflection, the emphasis of the course changed to more purposefully promote cultural awareness and cultural consciousness while ensuring the development of pediatric nursing knowledge and skills.

It is this one-week CISL experience embedded in a junior-level nursing course, the Nursing Care of Children and Family, that is the subject of this dissertation. This study was developed to provide me with an understanding of how using the pedagogy of a one-week CISL experience impacted the cultural consciousness of students, who are predominantly Caucasian, female, and from middle class, rural backgrounds. Then, enable me to share what I have learned with others who are interested. The most beneficial experience that I extracted from several years in accompanying students who participate in the CISL experience has been to watch students embrace the importance of making cultural connections with members of the Northern Plains Indian Reservation community.

#### Selection of Participants

Participants for this study were selected from two cohorts of nursing students. One group of 14 participants was enrolled in this university's Accelerated Bachelors of Science in Nursing program. The Accelerated Bachelors of Science in Nursing program is for nursing students who have previously earned a Bachelor's degree in another discipline. The other group of 16 participants was enrolled in the Traditional Bachelors of Science in Nursing program at this university earning their initial degree. Data were collected in the fall semester 2015 from the accelerated program nursing students and in the spring 2016 from the traditional program nursing students.

The written reflections of 30 CISL participants were examined during the 2015-16 academic year while all participants were enrolled in an undergraduate nursing course,

Nursing Care of Children and Family, at a university in the western United States. One group of 14 participants took the course with an embedded one-week CISL component during the fall semester, the other group of 16 participants took the course during the spring semester. Student participants in the fall term were in an accelerated nursing program where the nursing education curriculum is condensed to a 15-month timeframe, students in this program have previously earned a degree in another discipline.

Participants enrolled in the spring semester were junior-level students in a traditional four-year undergraduate nursing program, although not all of these students were of traditional age.

The student participants were almost exclusively women (28), with two men. Similarly, almost all student participants (27) were Caucasian with one Asian participant and two American Indian participants. Neither of the American Indian participants were members of the community visited during the CISL experience. With respect to age, most student participants were 20-29 years old (21). Eight student participants were 30-39 and one person was over 50. While nearly all of the student participants were residents of a state in the western United States (28), only half of these student participants (14) were state residents of the rural state in which the university is located, 15 students were residents of other states and one student was a U.S. citizen by marriage and raised in a foreign country. Two student participants were raised outside of the United States, one in Asia and the other in eastern Europe. Similarly, most student participants (19) were raised in a suburban community with many of the remaining student participants (10) being raised in rural communities. One student participant was raised in an urban

neighborhood. The diversity of the student participants was reflective of the cultural and racial make-up of the rural western state where the university is located. Table 2 below disaggregates the demographic information to individuals identified by a pseudonym.

Table 2. Demographic Information for Each Participant

<b>Name</b>	<b>Term Enrolled</b>	<b>Race</b>	<b>Age</b>	<b>Community</b>	<b>International Travel</b>
Angus	Fall	Caucasian	Over 50	Suburban	yes
Beth	Fall	Caucasian	30-39	Suburban	yes
Cecelia	Fall	Asian	30-39	Urban	yes
Debra	Fall	Caucasian	20-29	Rural	yes
Erica	Fall	Caucasian	20-29	Suburban	no
Felix	Spring	Caucasian	20-29	Suburban	no
Gail	Spring	Caucasian	20-29	Rural	no
Hillary	Spring	Caucasian	30-39	Suburban	no
Ivy	Spring	Caucasian	20-29	Suburban	no
Jane	Spring	Am Indian	30-39	Rural	no
Kasey	Fall	Am Indian	30-39	Rural	no
Linda	Fall	Caucasian	20-29	Suburban	no
Mary	Spring	Caucasian	20-29	Suburban	no
Nancy	Spring	Caucasian	20-29	Rural	no
Orla	Spring	Caucasian	20-29	Suburban	no
Penny	Spring	Caucasian	20-29	Rural	no

Table 2. Demographic Information for Each Participant, continued

<b>Name</b>	<b>Term Enrolled</b>	<b>Race</b>	<b>Age</b>	<b>Community</b>	<b>International Travel</b>
Quinn	Spring	Caucasian	20-29	Rural	no
Robin	Spring	Caucasian	20-29	Suburban	no
Susan	Spring	Caucasian	20-29	Suburban	yes
Terri	Spring	Caucasian	30-39	Suburban	no
Ursula	Spring	Caucasian	20-29	Suburban	yes
Valerie	Spring	Caucasian	20-29	Suburban	no
Xena	Spring	Caucasian	30-39	Suburban	no
Yvonne	Fall	Caucasian	20-29	Suburban	no
Zera	Fall	Caucasian	20-29	Suburban	no
Anna	Fall	Caucasian	20-29	Rural	no
Marie					
Beth Ann	Fall	Caucasian	20-29	Rural	no
Carrie Sue	Fall	Caucasian	30-39	Rural	no
Danelle	Fall	Caucasian	20-29	Suburban	no
Lynn					
Ellen Jo	Fall	Caucasian	20-29	Suburban	yes

### Data Collection Procedures

These research questions were explored through written student reflections in situ and again at the end of the semester based course. Thirty students participated in the

reflective writings regarding their CISL experience and all agreed to allow their reflective writing to be a part of this research project. Each student's reflective writing was prompted by a set of open-ended questions addressing course objective two, "Providing culturally sensitive and competent nursing care to children and families, which allowed the student to articulate in writing their own thoughts regarding the CISL experience both in situ and several weeks after the conclusion of the experience at the end of the semester. All of the participants were asked the same questions in the same format. Some students answered the pre-set questions in more detail than others. The purpose of the reflective questions was to draw upon the immediate and post experience thoughts of the participating students. Each student participant is a unique individual who brings with them their own life experiences. These experiences help to shape the way in which each student engaged in the CISL experience and what elements of that experience stood out for each participant.

The author-developed clinical self-evaluation tool, used for clinical assignments throughout the Nursing Care of Children and Family course, was used to gather participants' in-situ reflective writing. The rationale for using the same self-evaluation tool used in all clinical experiences not just the CISL experience, was to normalize the experience within a curriculum, to facilitate the authentic responses of the student participants and reduce the possibility of biasing student responses by begging the issues. A copy of the clinical self-evaluation tool is located in Appendix B. The written student reflections gathered at the end of the semester were prompted by a five-point bonus question on the final course examination. All students in the two cohorts participating in

the CISL experience completed the bonus question and all received full credit for their responses. Students processed the CISL experience over a duration of time and the written responses to this question sought to capture how the students discussed the CISL experience and a few weeks to reflect upon it. The bonus question read:

Vulnerable populations include the underserved. Please discuss three key concepts you learned during the cultural immersion service learning experience on the [Northern Plains] Indian Reservation, making sure to discuss how you feel this experience will or will not impact your practice as a professional nurse. Please feel free to be honest.

This question was designed to elicit responses that reached beyond a student's possible perception of right or wrong in capturing the nature of disparity, cultural consciousness and poverty.

Qualitative data were collected from participants within each of two cohorts. The qualitative data collected included: (1) instructor observations of students during the cultural immersion service learning experience, (2) initial student reflections immediately after participating in the cultural immersion service learning experience, and (3) follow-up student reflections written approximately 2 - 3 weeks after participating in the cultural immersion service learning experience. Instructor observations recorded throughout the week were focused on student interactions with children and adults that demonstrated the degree of cultural consciousness and environmental awareness as well as the performance of specific nursing skills. Table 3 summarizes the types of data collected and provides a brief rationale for the collection of the data.



Table 3. Summary of Data Collected and Rationale

Data Collection	Rationale
Instructor Observations	<ul style="list-style-type: none"> <li>Provides a means to anchor students' self-reports and perceptions to behavioral observations of students' responses and interactions during the cultural immersion service learning experience</li> </ul>
Student Initial Reflections	<ul style="list-style-type: none"> <li>Provides students' initial perceptions and dispositions regarding the cultural immersion service learning experience immediately following the experience</li> </ul>
Student Follow-up Reflections	<ul style="list-style-type: none"> <li>Provides students' end of course perceptions and dispositions regarding the cultural immersion service learning experience 2-3 weeks following the experience</li> </ul>

Observations considered how the student applied clinical judgment in addressing context specific healthcare and provided evidence about the students' acquisition of knowledge about vulnerable populations throughout the CISL experience. The instructor observations sought to provide triangulation of events discussed in student reflections including physical descriptions of behaviors observed in specific settings, and the reconstruction of dialogue (Gall, Gall & Borg, 2007).

The initial reflections by students were in response to using the clinical self-evaluation form that the students' complete for each clinical experience. The form is attached at Appendix B. In completing this reflection, the nursing student described her or his goals for the CISL experience and how the goals were met, the student's thoughts regarding what went well and what challenges were encountered, and the student's self-assessment about their communication skills, the therapeutic interventions enacted, and her or his critical thinking processes. Although the instructor's expectation was for students to complete the goals prior to clinical experience, some students may have completed the entire the self-evaluation, including the goals portion, immediately

following the experience. The process of the students' describing their concrete experiences facilitated students' analysis and comparison of the experiences against prior knowledge and assumptions (Kolb, 1975). The benefits of using the same clinical self-evaluation form as all other clinical experiences in the course are two-fold. First, it was a form that the nursing students were familiar with and therefore its use did not create undue anxiety for the students. Second, the generic nature of the form prevented the introduction of leading questions and thus decreased the potential for bias results. A potential challenge to the use of the generic clinical self-evaluation was that student reflections might not contain sufficient responses to answer the specific research questions of this study. Although this challenge was a possibility, the use of the clinical self-assessment form by previous cohorts of students (over 100 students) demonstrated that the level of responses by students without being prompted were sufficient to answer the research questions. The clinical self-assessment was completed and turned in to the instructor two days after completing the CISL experience.

The follow-up reflection by students was in response to the following prompt:

Vulnerable populations include the underserved. Please discuss three key concepts you learned during the cultural immersion service learning experience on the [Northern Plains] Indian reservation, making sure to discuss how you feel this experience will or will not impact your practice as a professional nurse. *Please feel free to be honest.*

Students completed the follow-up reflection on the last day of the course. For the first rotation of students this reflection was completed 3 weeks following the CISL experience, and for those nursing students in the second rotation, the reflection was completed 2 weeks following the CISL experience. The timing of the follow-up

reflection sought to take advantage of the students' preparation for the course final examination so to facilitate the incorporation of the CISL experience into a more generalized schema. Experiential Learning Theory predicts that students attach personal meaning to the experience as they incorporate the generalized meaning of the experience and move towards developing conclusions based on studied principles and understanding of how they can use their conclusions (Kolb, 1975).

### Data Analysis

As part of the qualitative study design, student reflections from both the clinical self-evaluation tool and the final examination bonus question were reviewed by two readers. Both analysts were Caucasian faculty members (one from the College of Nursing and the other from the Department of Education) with five and ten years of experience, respectively. Each had worked with Northern Plains Indian Reservation community members, and were experienced in performing qualitative research. Both analysts reviewed the student responses and field notes sentence by sentence, codes were developed by first recording the code and recording a quote from the students' reflections to be used to define the code for further use across all reflections. These quotes included sentences and phrases as written by the students. The two analysts then compared codes each derived from the review of the student written reflections. The list of codes was discussed between the two analysts resulting in a consolidated list of codes and definitions. Reflections were read again to ensure that all the applicable phrases and sentences in the students' reflections were consistently coded. The codes were then

analyzed to develop themes using the constant-comparison method (Strauss, 1987). The identified themes were used to describe the student's reflective thoughts during and after the CISL experience. Analytic memos recording different possible interpretations of the data were used to create a careful and detailed examination of the student's reflective writing. Initial memos were used to identify axial codes and create an initial thematic structure. Successive memos developed thematic structures which were repeatedly compared with the coded data over a period of four weeks to develop a framework of themes and subthemes that accounted for and explained all of the data contained in students' reflections and instructor observations from field notes.

Both sets of student reflections were analyzed for each nursing student participant using discourse analysis. "Discourse analysis is the study of language-in-use. ...It is about saying, doing, and being, and gains its meaning from the ...practice it is part of and enacts-" (Gee, 2011, p.11). Qualitative determination of cultural consciousness required a critical method of analysis that captured both what was stated and what remains unstated. Gee noted that language conveys meaning across seven dimensions, it signals: (1) significance, (2) recognition of engagement or enactment, (3) identity of self and others, (4) relationships, (5) politics, defined as distribution of social goods, (6) connection, or disconnection, and (7) the privilege or de-privilege of beliefs and knowledge systems. Discourse analysis revealed the meaning contained in language across these seven dimensions. Furthermore, such an analysis was essential to understanding cultural consciousness reflected in the writings of the nursing students.

Once the meaning of the language used by the nursing students was analyzed, the results of the analysis were paired with the observations of the students. These initial results were then analyzed using the constant-comparative method (Strauss, 1994). Specifically, reflection and observation notes for each nursing student were assembled into distinct units to allow a meaningful analysis. Each of these distinct units formed a unit of analysis. Furthermore, each unit of analysis was read by two people to determine emergent themes within the content. Each reflection and observation, or unit of analysis, was read multiple times to identify key points, common aspects and distinct features to create preliminary codes. Emergent themes were developed from these codes into operational definitions which formed the major themes and subthemes. These operational definitions facilitated data management in a systematic way (Lincoln & Guba, 1985).

After codes were established, the materials were re-read to verify the accuracy of the codes and to confirm that all of the examples of the themes and subthemes were captured and to detect any necessary adjustments needed to the themes. This process was reiterative and reciprocal (Gall, Gall & Borg, 2007). The codes and coding of each unit of analysis was compared between readers sentence by sentence to ensure agreement. When codes differed, the working definition of a code was applied and discussed until a consensus was reached by both readers or a new code was created and defined.

The themes established and agreed upon by each of the readers for each unit of analysis were then used to compare the similarities and differences that exist among the different students. Additionally, the established themes and subthemes were further compared to the Caucasian cultural consciousness and racial awareness development

theory espoused by Helm (2007) and applied to healthcare providers by Tatum (1994). Such comparisons were referred to as *memos* by Strauss (1984)—“the provisional linkages between the *discovered*, or created, concepts [embedded in the qualitative data] and other discovered concepts or with concepts based upon established theories” (p. 17).

Finally, the themes, subthemes and comparisons to stages of cultural consciousness development were synthesized into categories to ensure that they accurately encompassed the complexity of meaning portrayed by the data. Categories were organized by research question. Then, examples were selected from the data for each code and each category.

Once the themes, subthemes and categories were assembled into a cohesive narrative grounded by the data, the narrative was challenged by seeking contradictory information that did not fit into the constructed narrative. Finally, the themes and constructed narrative were validated by the participants. Interviews with participants from the Traditional BSN program cohort and a focus group with the participants from the Accelerated BSN program cohort were conducted. Participants were first asked to concretely describe examples from the inductively created categories. These examples were then compared with the themes and subthemes to insure alignment. Finally the participants were provided with the grounded narrative and asked where any adjustments needed to be made. All participants agreed that the grounded narrative accurately conveyed their perceptions of the CISL experience.

### Trustworthiness

Trustworthiness in qualitative research is a process by which procedures are designed and utilized to improve the credibility, dependability, confirmability, and transferability of a study (Creswell, 2013). The procedures utilized in this case study to improve trustworthiness included: clarifying the researcher's positionality in relation to the research; triangulation of data sources, participant groups, and different analysts; providing a thick and rich description of the context; and member checking. These procedures and their relation to the study's trustworthiness are described in detail below.

#### Key Concepts of Trustworthiness

The qualitative researcher must address his/her individual positionality in order to contribute to the credibility of the findings (Lincoln & Guba, 1985). All good research, both qualitative and quantitative, ends in making assertions that the reader must critique before generalizing the findings to specific contexts, ideas, or applications. To establish a sound critique, the point of view of the author or researcher must be established. In quantitative research, the researcher's role is assumed to be that of an objective observer of the phenomena being studied (Creswell, 2013). In qualitative research, there is no assumption and therefore the role of the researcher in the context of the phenomena being studied is an important aspect of establishing trustworthiness. Furthermore, since case study research is highly contextualized, the role of the researcher as well as the researcher's proximity to the case is important to establish at the beginning of the research story. My proximity to this study is emic; I was a participant observer. This fact and information regarding my background were described in the above section entitled,

Role of the Researcher, to provide the reader with the understanding needed to evaluate the evidence and assertions presented in this case study.

Yin (2009) described the necessity of triangulation in case study in order to develop separate lines of inquiry that converged. This case study triangulated different sources of data—observations and reflections, different participants from two distinct cohorts, and used two different readers in analyzing the data. “Triangulated techniques are helpful for cross-checking and used to provide confirmation and completeness, which brings ‘balance’ between two or more different types of research” (Yeasmin & Rahman, 2012, p. 157). Combining multiple methods in data collection in this study served to corroborate the findings from the same individuals on the same topic (Janesick, 2002). Therefore, triangulated methods used in case study research helped to increase the dependability and confirmability of the results by overcoming some of the potential weaknesses or biases associated with a single-construct, single-observer methodology (Stake, 2002). Due to the fact that multiple methods of inquiry contribute to overcoming potential weakness and biases, triangulated techniques also add to the overall credibility of the study (Denzin & Lincoln, 2002).

By providing a rich description of the setting and participants, case study researchers can decide if the findings could be transferred to other similar cases (Creswell, 2013) Whenever possible, the researcher used descriptive language to convey the context of the course in which the CISL experience was embedded as well as to describe the activities and the American Indian community where the CISL took place. Maintaining the confidentiality of the participants was the number one priority; however,



whenever practical, the researcher attempted to accurately describe the participants, their background, behaviors, and their interactions.

Member checking involves soliciting participants' perspectives on the credibility of the research findings (Creswell, 2013). All participants were contacted and participants were either interviewed or participated in a focus group to confirm the themes, subthemes, categories and accuracy of the grounded narrative. This procedure added to the richness of the study by corroborating the essential findings and validating the interpretations presented in the evidence (Yin, 2009). Clarifications from the focus group and interviews were included in the results.

#### Applying Concepts of Trustworthiness in this Case Study

The trustworthiness of this case study was supported by triangulation of data sources—students' clinical self-evaluations, students' end of course reflections, and instructor field notes; triangulation of perspective—instructor and student perspectives; triangulation of two different student cohorts— 16 junior level student nurses from the traditional program and 14 junior level student nurses from the accelerated program; and triangulation of four different one week CISL experiences—a maximum of eight students participated in each one week period. Students were divided alphabetically into two groups each semester, the first eight students in the alphabet, based on the first letter of their last name and the second eight students in the alphabet.

Additionally, a focus group was conducted with all 14 of the participants from the accelerated program cohort; the students validated the case study themes. Time and

student schedule constraints made conducting a focus group with all participants from the traditional program cohort impossible and interviews were conducted with seven participants from the traditional program who were on-campus and available. During the focus group discussion and interviews, the participants were provided the themes and asked to provide examples (*exempli gratia* (e.g.) to member check the theme of recognition of privilege, students were asked, “Please describe your initial thoughts and feelings when you arrived at [Northern Plains Indian Reservation]? All participating students answered all of the questions posed. The examples provided by the participants matched the codes incorporated into the sub-themes and themes across all cases. For example, “What were your initial goals for the CISL experience? What were your thoughts after you arrived at the Northern Plains Reservation? What were your initial responses upon arrival? Did these initial responses persist? How did they change? What impact did the CISL experience have (for you and the community)? What story is formed by these themes? Participants provided with an overview of the findings (The information was presented under the heading, Emerging Themes from Student Reflections, the leader then asked; How does this narrative align with your experiences at the Northern Plains Indian Reservation? Of the 30 students participating in the study, nine were unavailable to participate in the member check process due to scheduling conflicts prior to the end of the semester and their departure from the campus after completing their final examinations. Thus, 21 of the 30 students participated in the member check process which led to the formulation of a trustworthy determination regarding the perceptions of nursing students who had participated in a cultural

immersion service learning experience embedded within a required undergraduate nursing course at a university in a rural western state.

### Assumptions and Limitations of the Study

The major assumptions that frame this study focus on learning and the importance of learning on societal change. Learning is a process of creating and recreating knowledge (Kolb, 1984). As human beings, we seek to make sense of the world and do this by organizing our experiences into systems of beliefs that we then impose upon the world to create structure and order. The process of ordering the world into patterns and structures is learning. Experience markedly different from the patterns we now hold, may over time, cause us to change our patterns of thought and restructure our beliefs and actions.

A culture is defined by its beliefs, values and customs (Spring, 2004). We assimilate the beliefs of our cultural environment as we grow from childhood into adulthood, and while in that same environment, we have little reason to question the beliefs that order our world and wonder why others can hold different belief systems. As long as our beliefs are aligned to the predominant beliefs within our environment, we have little reason to question our beliefs. The issue of hegemony emerges when a majority holds one set of beliefs and a minority of people holds a different set while both groups live within the same environment. Disparities emerge in societal institutions such as healthcare and education. To resolve the disparities increased cultural awareness is needed. Individuals must question their beliefs to recreate existing knowledge patterns in

order to accommodate a bicultural or multicultural view. Thus, within the context of this study, increased cultural awareness by healthcare providers will translate into culturally responsive healthcare for underserved and vulnerable populations. Embedded within the assumption that increased cultural awareness will translate to culturally responsive healthcare for underserve and vulnerable populations is the assumption that (1) cultural consciousness can be taught to students, and (2) that the CISL experience may facilitate progress toward the development of cultural consciousness.

Another essential assumption embedded in the design of this study is the reliance on truth in self-reports participants make about their perceptions. The data collected and analyzed in this study relies upon reports from individuals both students and community members about their personal perceptions. Therefore, the logic of any conclusions about this study is based upon the premise that all participants will truthfully and accurately report their perceptions.

An essential assumption addressing the significance of this study is based on the idea that the information embedded in the case study may be generalized by the reader to situations important to the reader. For the reader to be able to successfully generalize the information in this case study, it must be sufficiently rich enabling the reader to accurately translate the information from one context to another based upon similarities seen within the context of this case study and the situational context that the reader wishes to apply the findings.

Finally, there are two limitations in the design of this study. First, the study relies predominantly on student self-reports. Although approaches in gathering these self-

reports are triangulated with instructor/ preceptor observations made during the cultural immersion service learning experience, the trustworthiness of the findings and conclusions relies on students being truthful in their reflections. Second, this study is bounded and constrained by time. Experiential learning as well as cultural awareness occur in stages developed over time (Kolb,1985; Tatum, 1994). The limited amount of time between when students participate in the cultural service learning experience and their follow-up reflections at the end of the course may not fully reveal the extent any impact that the cultural immersion service learning experience on the cultural consciousness of student nurses.

### Chapter Summary

This chapter described and explained the rationale for the methods used in examining the overarching research question, “How do nursing students at this university describe their CISL experience?” through three research sub questions. The research design was an intrinsic case study which bounded the students’ reflections of an intervention, a one-week CISL experience, regarding issues of cultural consciousness. The case study was developed from instructor observations of the nursing students during the CISL experience, from nursing student reflections collected immediately following the CISL experience, and from nursing student reflections collected at the end of the course, 2 to 3 weeks following the CISL experience. The reflections were analyzed using discourse analysis methods (Gee, 2011) then combined with the observation notes, by student, to perform a constant-comparison analysis (Strauss, 1994) to determine themes,

subthemes and memos as appropriate. This chapter also described the role of the researcher, the context and activities of the one-week CISL experience, and the assumptions and limitations inherent in the research methods.

## CHAPTER 4

## FINDINGS

The purpose of this study was to examine nursing students' perceptions of cultural consciousness pertaining to American Indian culture developed during a one-week cultural immersion service learning (CISL) experience, embedded within an undergraduate nursing course and within an American Indian community. This chapter presents the themes and subthemes resulting from the analysis of the collected data as described in Chapter 3, Research Methodology, and the evidence upon which the themes and subthemes were built. The chapter begins with an overview of the emergent themes followed by a description of each theme, its subthemes and the supporting evidence.

Emergent Themes

This section provides an overview of the themes and subthemes that emerged from student reflections and observations to answer the overarching research question, "How do (MSU) CISL students describe their CISL experiences? An indepth interpretation of each them is presented in the next section. The five major themes identified from the analysis were Student Goals for CISL, Recognition of Priviledge , Responses, Actions, and Impact. These themes and their underlying subthemes are found in Table 4.

Table 4. Organization of Categories and Themes

<b>Themes</b>					
	<b>Student Goals for CISL</b>	<b>Recognition of Privilege</b>	<b>Student Responses</b>	<b>Student Actions</b>	<b>Student Impact</b>
<b>Subthemes</b>	Skill Development	Communities Compared	Uncertainty	Bonding	
	Make a Difference		Feeling Overwhelmed	Projecting Tacit Assumptions	Providing Help
		See Disparities with Greater Clarity		Reframing the situation	Feeling Increased Responsibility
	Cultural Engagement		Suspending Judgment	Respecting and Engaging Culture	
				-Forming Connection	Cultural Consciousness
				-Paying Deeper Attention	

The “Student Goals for CISL” theme was comprised of subthemes where students expressed the importance of skill development in becoming proficient at nursing, Making a Difference in terms of reducing health care disparities and engaging in the cultural to better understand unique health care needs. Twenty-nine of the thirty students listed two or three goals for the week. The primary goal was skill development and all students noted skill development as a goal except one. The one exception was a student



who only listed cultural engagement as a goal. Making a difference was always listed as the second or third goal

The subthemes named, Communities Compared, and Disparities with Greater Clarity formed the Recognition of Privilege theme. Once at the reservation, the students compared the reservation community with the community encompassing the university campus and saw disparity as complex and concrete, which in turn facilitates the recognition of privilege. Twenty-four of the students responded to this recognition with reflections indicating being overwhelmed and uncertain. Eight students responded to this recognition by initially suspending judgment. Results from student reflections and interviews indicated that they felt privileged to have quality health care as compared to the Native Americans in the community where they were engaged in their CISL experience.

The theme, Student Responses, emerged based on subtheme concepts related to Uncertainty, Feeling Overwhelmed and Suspending Judgment. Students expressed that their CISL experience although scheduled for the week was not structured like a typical nursing course. There were many times when they did not know what to expect during their CISL experience or from interactions with their clients creating feelings of uncertainty related to their roles and interactions with the predominant culture. Their CISL experience taught them that they could learn from uncertainty of activities or interactions with others and suspend judgment based solely on previously held beliefs and experiences.

The most complex theme, Student Actions, was comprised of six subthemes identified as Bonding, Projecting Tacit Assumptions, Reframing the Situation, Respecting and Engaging in Culture, Forming Connections and Paying Deeper Attention. Results from reflections found that students bonding with each other helped to resolve overwhelming feelings and uncertainty in their roles as health care providers. The connections that they also formed with their patients helped them to understand and respect the cultural practices of the Native Americans that they were engaged with during their CISL experience. The connections they formed with their patients helped them to better understand cultural practices. Students learned to reframe perceptions of their CISL experiences and interpret them through the lens of the Native American community they were involved with. The subthemes identified as Providing Help, Feeling Increased Responsibility and Cultural Consciousness were combined to form the theme interpreted as Student Impact. In the clinical observation reflections, 28 of the 30 students described their experience in terms denoting themes of helping or making a difference. Six students discussed a need for increased responsibility for the quality of their help directly addressing the disparity in healthcare access. One student provided evidence of cultural consciousness in her clinical observation reflections. Several weeks later in their end of course reflections, evidence of cultural consciousness was demonstrated by 21 additional students in statements linking concrete nursing skills, such as head to toe assessments, to the culture of the Northern Plains Indian tribes. Although, students felt an increased responsibility to provide help to vulnerable populations with health care needs, they also

emphasized that cultural consciousness was important in treating the whole persons when providing quality health care.

The interpretation of the subthemes identified as “Skill Development” , “Make a Difference”, and “Cultural Engagement” as well as the overall theme “Student Goals for CISL” provided evidence to answer the first sub question, “What CISL experiences do nursing students describe as important in developing their cultural consciousness of American Indian culture within two of the Northern Plains Indian tribes” The second sub question, “How do nursing students describe the knowledge they acquire regarding the care of vulnerable populations during their one week CISL experience?” was also answered by two of the subthemes comprising “Students Goals for CISL, “Skill Development” and “Make a Difference”. “The theme, “Recognition of Privilege “and the subtheme “make a difference” offered insights to answer the third sub question, “What do students describe as influential in their understanding of others in the complex link between poverty and health?”

Looking across time, most students seemed to have formed an initial set of expectations based upon class discussions about what to expect colored by tacit assumptions formed by middle-class, dominant cultural experiences. Concrete examples of this were found in the student statements coded as Recognition of Privilege detailed later in this chapter. The reality of the situations they encountered in the one-week CISL experience did not match these expectations. For most students, the week was spent learning technical nursing skills (such as pediatric head to toe assessments) and responding to urgent and immediate patient/child needs. Over the course of several

weeks, most students were able to integrate the CISL experience into a coherent whole in which cultural consciousness emerged in their reflections as seen in the number of students demonstrating evidence of cultural consciousness during the interval between their reflections immediately following the CISL experience and their reflections at the end of the course several weeks later. Specifically, only one student demonstrated cultural consciousness immediately following the CISL experience and 21 additional students demonstrated cultural consciousness in their end of course reflections.

### Students' Stated Goals for CISL

Students stated their individual goals for the week. These stated goals emerged around three themes—skill development, make a difference, and cultural engagement. Most students listed two or three goals for the week. The primary goal was skill development and all students noted skill development as a goal except one. The one exception was a student who only listed cultural engagement as her goal. Making a difference was referred to by all students as the second or third goal.

### Skill Development

Nursing students are acculturated in their programs of study to show proficiency in a variety of clinical settings. In the clinical setting it is often the demonstration of accomplishment in the required skill sets that determines clinical satisfactory or unsatisfactory performance. Naturally, students wish to do well and are therefore often very focused on practicing and completing required clinical skills to demonstrate proficiency. Students participating in the CISL experience routinely discussed their ability to practice

and to improve their physical assessments of the pediatric patient with improved confidence as their primary objective or goal of the experience. Students explained skill development in ways that both established skill development as a goal as well as in terms of how the goal was met.

Students discussed skill development in reference to technical skills such as performing head to toe assessments, developing therapeutic relationships, or teaching health and wellbeing topics. For example, Beth wrote, "...to develop therapeutic relationships with my clients" as a secondary goal for the CISL experience. Another student provided another example in writing, "During my time at [Northern Plains Indian Reservation] I hope to become proficient at doing pediatric assessments on a range of children from Kindergarten through high school."

Students also discussed skill development as a process of acquiring a skill, gaining proficiency, and gaining confidence in performing a given skill. As an example of skill acquisition, Penny wrote, "From this experience, I learned how important reading body language is with children. The way they act can give more information than what they say, and it is crucial to be able to pick up on these signals." An example of gaining proficiency was provided by Nancy:

I gained many new clinical skills from perfecting my head-to-toe assessment, to learning to chart thoroughly on paper, and incorporating education into assessments. For example, during a head-to-toe assessment of a 10-year old female, I competently performed physical assessment while also assessing the child's psychosocial situation in a conversational manner that both established a therapeutic relationship and elicited a wealth of information.

Another student provided an example of confidence in performing nursing skills in writing, “It felt like I was a school nurse attending to different kinds of patients with cases ranging from viral URTI, sprain, head lice, headache, bruises and sports assessments.” Susan provided another example nuancing performance confidence as comfort in stating, “By Wednesday, I felt comfortable with interacting with children and young teens, and I was well versed in head-to-toe assessments.”

### Make a Difference

Yvonne, compared her goal to complete a number of head to toe assessments with a realization that she was able to provide care but in a less obvious way. The art of nursing and its nuances came through in her reflection, “I was not able to do as many head to toe assessments as would have liked; however, I got experience in many ways that I wasn’t expecting to. I feel so great that we were able to help in the ways that we were.” Yvonne recognized that her patients’ goals and her own as a student may be very different, and that patients are not in our care only for our own benefit and practice.

Another student, Susan, conveyed the idea of making a difference by repeatedly starting her paragraphs with “I was able to help.” She concluded her clinical reflection by writing, “I had a great experience. I received exposure to lice and how to treat it, sores that appeared infectious, and sores of an unknown origin. It was so rewarding to be able to help the kids and to see their gratitude.”

Another student’s report paralleled this sentiment,

I was honored by the patient’s request that I return to help with the next treatment of her hair. I was moved by this request and happy that I was able to create an atraumatic care environment for this child so much so

that she requested that my classmate and I care for her again. This was a very touching experience-one that I will never forget.

It is well accepted that nursing is a “helping” profession. Making a difference was one of the themes identified in the analysis of student reflections that illustrated clearly the student nurses desire to help.

### Cultural Engagement

Cultural engagement emerged as a theme where students synthesized the concepts of cultural awareness and appreciation through interactions with people at the Northern Plains Indian Reservation. The follow student’s clinical reflection provided a good example:

In my experience, I learned more than I ever thought I would regarding the importance of cultural understanding in healthcare. I learned to appreciate the culture of the population the involvement of extended family, complimentary therapies (sweat lodges), etc. My cultural awareness for this population greatly increased, and by showing cultural sensitivity, I feel as though my care improved.

Carrie Sue wrote, “I also realized that though there is a great need, there is also an aspect of the culture that is so beautiful and amazing. They really have so much to offer and to share with others.”

These students seemed to be able to see beyond the disparity and poverty to appreciate the culture of this particular Native American community demonstrating an ability to recognize health care concerns while also recognizing community and cultural strengths.

Recognition of Privilege

When teaching a course that incorporates the concepts of poverty, vulnerable populations and disparity in relationship to access to health care and wellbeing, the concept of privilege emerged repeatedly as an idea in the classroom but that idea seemed to acquire increased meaning for the students during the CISL experience. For example, one student wrote, “I worked hard to go to school and to pay for college etc. however I realize that I have been given opportunities for health and education that these children will never have.”

A student who had some peripheral experience with vulnerable populations, stated:

For every patient interaction, I had that required some teaching, I had to really get information on their family background and what resources they had at school and at home to be able to adjust the information I gave for it to be practical and useful for them.

Although the concept of privilege was addressed directly by two students this represents a small portion of the nursing students. For most nursing student’s participating in this study, the primary focus was on skill acquisition. Debra articulated her thoughts by stating, “I focus more on what I am doing wrong rather than what I am doing right, which distracts me from what is important and inhibits my learning experience.” Later in her clinical reflection she wrote, “I tend to hold back and may not give as much information as I should. I dislike talking in front of a group of people and may become forgetful in these situations.”



### Communities Compared

Recognizing privilege was also described through a comparison of the community in which the nursing students study and the reservation community. One student who was attending a clinical rotation at a private pediatric dentist's office in her home community stated, "I found that overall, the children whose teeth we cared for today truly had very good oral health in comparison to the children on the reservation...It made me grateful for the resources we have available in our community." Another student wrote:

...several children we assessed at head start seemed to have traumatic experiences with previous health care, I am excited about the day with the dentist after seeing the extent of the dental decay on the reservation. ...Based on my experience on the reservation, I am very interested to see how a resource such as this (refers to a clinical agency) can be so valuable to the [University] community and taking that knowledge and seeing how the reservation lacks many resources such as this, and what a difference it could make if the reservation had it.

The participants' community comparisons seemed intertwined with recognition of privilege as well as a closer proximity of existing disparities as reflected by this participant's statement "It definitely opened my eyes to the problems we can have so close to home." Perhaps, it was a new awareness of the proximity of disparities that provided students with greater clarity in seeing the disparities.

#### See Disparity with Greater Clarity

The recognition of disparity and experiencing its impacts improved nursing students understanding about what healthcare disparity means and its complexity in concrete ways. For example, one student wrote:

I learned that adequate access to care is crucial; especially in rural areas...There is a huge chance that care will not be provided in time, so having adequate access is detrimental to the health of everyone. ...After

the experience, I was able to see just how much poverty there is on the reservation and that it does affect the health and wellbeing of children...Poverty impacts so many aspects of the health and wellbeing of children in physical, psychosocial and emotional forms...I learned that vulnerable populations need more time and focused care.

Another student linked access directly to the health of the community in writing, "The health of children in a community can only be adequate when access to care is adequate." Continuing with this theme, a third student stated, "I did not realize how much harder it is for the children of the reservation to access health care."

In addition to comments about healthcare access, 18 students wrote in their clinical reflections about adequacy of resources. For example, one student wrote, "Through this experience you see that these children are vulnerable in so many ways and experience health disparity results due to their situations. It was a very eye-opening experience to see the lack of resources available to this population." Another student wrote:

Seeing children that did not have the resources to see providers regularly was unfathomable to me....If you don't know that something is abnormal, then what choice do you have but to accept it. It is heartbreaking to see kids stuck with pain and burdens they shouldn't have to carry.

Felix discussed the lack of available exercise facilities as a connection to access by stating, "The biggest resource that was lacking on the reservation was, in my opinion, a facility for activity and exercise." Similar comments were made by a few other students as well. Gail extended the view of wellbeing as an integral part of healthcare by focusing on health food and health choices. She wrote "Poverty limits their access to healthy foods and healthy choices." Similarly, another student carried on this theme nuanced with the

idea of resource adequacy in writing, “Obesity is common and not everyone has the resources to buy healthy foods.”

While many students discussed physical health and wellbeing in their reflections about the disparities they saw, some focused on mental and psychological wellbeing. For example, one student in her end of course reflection wrote “The most important thing I found was that in an underserved population often times patients just need someone to talk to because they are lacking that as well. In my opinion, many illnesses stem from poor mental health.”

Ivy’s statement provided an apt conclusion regarding the theme seen in students’ reflections about recognizing privilege. “I learned that there is a huge need on the ...reservation. If you do not have access to care then health declines; this was very difficult to see.” Another student conveyed the emotional difficulty more tacitly in how she referred to the overall CISL experience. She wrote, “I was educated to see healthcare disparities and embraced the culture of the [Northern Plains] Indian Reservation community. Grasping the complexity of disparity and recognizing the impact of disparity on communities has implications.”

Twelve other students seemed to recognize the implications depicted in the following student’s end of course reflection:

I realized how detrimental health care is in discovering abuse, and hopefully stopping it. Although I learned a lot regarding the impact of poverty on the health and wellbeing of children, I learned more regarding the social injustices present in this community

### Student Responses to the Complexity of Disparity

Building on the demonstrated theme of recognizing the complexities and implications of disparity, students differed in how they responded to disparity. These responses seemed to cluster into three themes—uncertainty, being overwhelmed, and by suspending judgment.

#### Uncertainty

Beth provided an example of uncertainty in summarizing her thoughts most succinctly, “I had no idea what to expect prior to going there.” Undergraduate nursing students find comfort in knowing what is expected. They anticipate a course syllabus which outlines in detail what the course requirements are and how to attain the best grade possible

Instruction on the university campus is typically organized in a linear pattern; however, part of the learning experience is to recognize that an American Indian community does not function in a linear pattern but rather a circular one. Below are quotes from students which highlight their feelings regarding their anxiety in the lack of coordination and a need for flexibility.

For example one student wrote:

There was a lack of coordination on the part of the school to let the teachers know about the schedule and so we didn't really get to do exactly what we wanted to impart on the children. We still managed to do the best we can to adjust accordingly and make things happen.

Another student wrote about anxiety.

Tuesday was the first day the clinic had been opened at ...which lent a certain amount of chaos to the day which exacerbated my anxiety, confusion and disorganization. By the end of the day, I was seriously questioning whether I should be in this program, my goal for the next clinical experience is to try to be more flexible in dealing with unexpected situations.

Mary reflected more positively on the need for flexibility by stating, “The entire week went fantastically. I think it went well because we had all been well prepped to be flexible.” Yvonne noted” It was a little unorganized at times, but that was expected and did not bother me.” Yvonne went on to describe the ability to work with an uncertain schedule in reflecting:

The entire week took a lot of critical thinking skills for many reasons. The first was that we often didn’t know what we were doing for the next day until the night before, and it required quick planning and utilizing the resources we had available in the best way.

Debra reported, “I went with the flow and learned to be adaptable, which is an important characteristic to have as a nurse.”

From these reflections we can see that uncertainty with clinical, daily and schedule expectations were more difficult for some students than others. Some students found uncertainty so discomfoting that they questioned their choice of profession. Other students perceived the experiences as disorganized on the part of the community, they did not recognize that a non-linear but rather circular perspective was preferred by this Native American community among others.

Most nursing students were able to connect the pre-experience preparation emphasizing the need for flexibility and adaptation. One student articulated this by stating, “I felt as though I came to [Northern Plains] with an open slate and was willing to

apply myself to any environment. I was aware that plans could change at any time, so I felt comfortable when something unexpected came up.”

### Feeling Overwhelmed

Continuing with the themes of uncertainty and flexibility, students described a sense of being overwhelmed. Again planning and organization were important to the nursing students but when the plans did not go as expected, some students described being overwhelmed. These students were not prepared for the less than ideal. One student wrote:

I did meet my clinical goals because I was flexible and open to whatever situation presented. I don't think I met my goal for the third day because during the maturation class I felt like I was overwhelmed and we lost their attention (referring to the middle school students she was teaching). This was one area where I struggled because I didn't prepare myself for this type of situation and I didn't foresee the class going in that direction. I feel if I had thought about the different scenarios and how I could control them I would have been able to respond better.

Another student wrote that “planning our days and what we were going to do was challenging.” The nursing students must critically think to balance the need for flexibility with the need for organization in an environment that to them seems chaotic.

Seeking to balance the need for flexibility with the need for organization and structure seemed to be overwhelming for some students. For example, Susan, a student who had a particularly difficult time leaving her family to participate in the required CISL experience, wrote “I like a more structured environment and a clear outline of what to do.” ... “It was much harder to get them [middle school students] to engage and to open up, which I can understand since they didn't know or trust me.”

### Suspending Judgment

Nancy wrote in her end of course reflection, “One of the biggest things I learned is that if you don’t understand the culture your patients are from, there is a tendency to be judgmental.” Another student demonstrated an understanding of the implications of not suspending judgment in writing, “It showed me how it must feel to come into a deprived community and tell everybody how you sympathize with their plight and want to help them change and improve.”

Patient education with an emphasis on healthy lifestyles is an integral part of the nursing profession, but in practice such lifestyles may not necessarily be attainable for all patient populations because of existing disparities. For example, as one student explained in her end of course reflection:

We talk about how important getting adequate meals and nutrition is, but these kids have no control over what type of food is provided for them. It doesn’t matter how many toothbrushes or toothpaste tubes we give children, if they don’t have running water at home, there is no point.

Another example is seen from a nursing student who was teaching elementary schools about the hazards of cigarette smoking, this student wrote:

We were educating them [elementary school students] on the harmful effects of second hand smoke. When thinking about the second hand smoke, it made me feel bad for the children who are placed in this situation...if whomever they live with smokes, they really have no choice in the matter.

Twenty-three of the 30 students eluded to a despair due to the lack of control over their environment that many children and members of vulnerable populations face.

Phrases such as “there is no point” and “it made me feel bad,” respectively denoted this despair.

Students seemed to act in ways that reduced their uncertainty, reduced their feelings of being overwhelmed and reduced the despair in the implications of their recognition of the reality of the disparities.

### Student Actions to Resolve Uncertainty and Feeling Overwhelmed

#### Bonding

Students travelled and lived together in close proximity for one week, they experienced the highs and lows of their work together, they worked, ate, rested and relaxed as a group sharing their triumphs and concerns. One student reflected, “I also loved our group. We had an awesome dynamic and all got along so well. It was a really great time to bond and work together.” Hillary, who is a self-admitted extrovert, was initially concerned about how she would be received by her cohort of introverts. She wrote, “The whole experience was incredible, I got along well with all of my classmates.” She goes on to state, “Yvonne and I communicated well throughout the week since we were together every day.” Susan reported, “I learned more in one week than I have all semester. Our group had plenty of time to bond with each other. It was so much fun!” Susan’s statement is positive and illustrated the hard work and a sense of accomplishment.

Cultural norms and perceptions vary widely across cultures; what is perceived by one group of individuals as acceptable may be the exact opposite for another group. Study guides and textbooks that deal with transcultural groups and even travel guides offer some insight into common difference (Watson, 2005). The CISL experience



included information on generalities regarding customs and norms. The instructor may need to intervene to assist participating students to understand what they are seeing in the moment. Students in this study seemed to project tacit assumptions on to CISL experiences. Tacit assumptions in this study referred to inherent beliefs and values or prior knowledge.

### Projecting Tacit Assumptions

One example of this occurred when:

The nursing students questioned me as to why damaged and burned building are not cleared away, why were they left? Initially, the students attributed what they were seeing to community members not caring about the community, laziness or other negative statements. These questions provided an opportunity for me to discuss other thoughts for example the cost of removal, who bears the cost, the home owner or the community. Some Native American communities may believe that all things return to the earth in their natural form (Field notes from April 4, 2016).

Yvonne's clinical reflection showed that she was questioning her assumptions and understanding of a different perspective that she may not have previously had.

When [the instructor] talked about the American Indian view regarding partially destroyed buildings and how they need to return to the Earth. I would like to believe I would not have judged a house left in disrepair, but I am sure I would have wondered. Knowing this little fact helped me in looking beyond appearances. It was useful for both [the Northern Plains Indian Reservation] community and the rest of my life.

Another student discussed her questioning of assumptions in writing about a different example.

It is so important to never make any assumptions about your patients. The conversation we had about cutting of hair really demonstrated this. I did not know that sometimes Native Americans cut their hair when a loved one passes away. This really showed me how easy it would be to assume this child cut her hair due to lice or simply to change their hairstyle. I

would be mortified if I told someone their “haircut looked great, and I love getting my haircut” only to find out they did so because someone passed away. So in the future, I will remind myself how easy assumptions are to make.

Orla commented on a healthcare provider’s interaction with a child in the clinic which the nursing student felt was culturally disrespectful, she wrote, “This experience has taught me to really put time and effort into every patient that I see regardless of culture and social status & to set aside any biases I may have in order to give the best care to each of my patients.”

### Reframing the Situation

Six students expressed how they resolved their suspended judgment by reframing the situation. Beth wrote:

Taking the chance to learn and experience different cultures helps us shift from a “what is wrong with you” way of thinking to a how can I best help you as an individual succeed and thrive in the best way that I am capable of doing.

Yvonne took a broader perspective in her end of course reflection in writing:

Personally, I learned that experiences like this are all about attitude. It is what you decide to make it. You see the good and some bad, and the way you decide to frame it is how you will experience your environment. I’ve had this philosophy in general, and wanted to see if I could apply it on the reservation. It worked great, and I consider it as one of my goals that were met.

### Student Actions to Resolve the Suspended of Judgment

As noted above some students responded to the complexity and realities of the disparities that they saw by suspending judgment. Several of the comments about the

need for suspending judgment also contained indicators of despair. Student actions to resolve the despair involved embracing a respect for the Native American culture, forming connections with the community members, reframing the situation, and paying closer attention to the situation.

### Respecting and Embracing Culture

Learning about a culture or community is interpreted by community members at the Northern Plains Indian Reservation as a form of respect. Orla demonstrated her understanding of respecting and embracing culture in her clinical reflection writing:

I have learned that in locations such as [the Northern Plains Indian Reservation], it is much harder to recruit nurses and other medical staff that are truly passionate about the population and the culture. Locums that are placed on the reservation do not have the time invested in the community, I believe they do not demonstrate the appropriate care [cultural competence] about providing the absolute best care to those in need.

On the other hand, the desire to embrace the culture was mixed with degrees of uncertainty as expressed in student reflections such as “ I fear that I might say something silly because I may not know enough about a particular culture.” Another student offered a suggestion regarding cultural understanding. She wrote:

Looking up local statistics is an exercise that can be accomplished in preparation for the experience while still on the home campus, students can be asked to collect information on areas such as the local weather extremes, number of grocery stores, unemployment rate, mortality and morbidity rates, graduation rates. On this particular reservation, it is not unusual for homes to house several generations of family members without adequate food, heating and sometimes running water.

Another student remarked about her use of critical thinking throughout the entire week.

When caring for children with head lice, I couldn't assume that the family had hot water, a washer and dryer, a shower, money to pay for the shampoo, and a vacuum cleaner. I had to think of other ways to help.

Anna Marie acknowledged firsthand a minority perspective.

Moving to the United States made me feel "left out" or "different" in the beginning because of my skin color and the way I do things. That feeling made me more sensitive to my approach to people, especially those considered to belong to a minority group.

Unlike this student who has traveled outside the United States, many students

participating in the CISL experience at [University] were immersed in a different culture

for the first

On Tuesday...the first day at the [school] clinic lent a certain amount of chaos to the day which exacerbated my anxiety, confusion, and disorganization. By the end of the day I was seriously questioning whether I should really be in this program. ...By Thursday, I felt much more comfortable and efficient...I felt very comfortable with the kids.

### Forming Connections

Nursing students described an essential element of their work in terms of establishing a rapport or forming a connection with their patients, one student stated,

"The activities that we prepared were age-appropriate...", she went on to say:

This is still something that I'm continuously working on because it really does take a lot of practice to be more effective in making a connection with a pediatric patient. I would usually sit at eye level, give them a compliment here and there to get them to warm up and make them feel good about themselves even for the little bit of time I spent with each of them.

The nursing student who questioned whether or not they had chosen the right profession, wrote "I feel very comfortable with the kids for the most part." This student's hesitancy and doubt is readily apparent as he went on to say:

I feel I am able to communicate with the children fairly well generally make them feel comfortable. I was fairly proud of the fact that by carefully questioning the teenage girl that came in complaining of dehydration I was able to ascertain that in fact she was suffering from anxiety, depression and was possibly suicidal.

Another student wrote:

While also assessing the child's psychosocial situation in a conversational manner, I established a therapeutic relationship and elicited a wealth of information. Based on the information I gathered from the student I was able to tailor patient education to her areas of need and curiosity appropriate oral care, "good" versus "bad medicines", and allowed her to auscultate her own heart sounds with my stethoscope. I felt this was a very successful experience in integrating all of the assessment, communication and education techniques I have learned thus far in nursing school.

Reflecting on relationships another student wrote:

I was able to do a lot of communicating with these kids, which was really rewarding because they are so receptive to us, and fun to teach them about healthier ways of living. Although I wasn't expecting the children to be so open to talking to us, many of the kids seem to need someone to just talk to, and I saw a number of them that appeared to be reaching out for help because they don't have anyone who cares about them at home.

### Paying Deeper Attention

Four nursing students' reflections included the themes of gathering information and paying deeper attention. Nancy expressed the need to pay deeper attention by asking questions in her clinical reflection writing:

There was one girl that came in because she hurt a foot. Upon taking her history I was able to learn that she wasn't sleeping well because of less than ideal circumstances at home and that she hadn't eaten anything. This just illustrates that it is important to be observant and ask the right questions.

Another student's clinical reflection built on this theme. She wrote, "I think it is also important to ask questions, to validate a child's need for help, even when the reason they

approach you is not a real issue, sometimes they need attention and to have someone listen to them.”

Susan reflected on non-verbal cues as part of gathering information and paying deeper attention. Susan incorporated the information on reading children’s non-verbal cues that she had learned prior to the CISL experience and wrote, “Always read non-verbal cues of the patient! I will always try to be aware of my patients cues.”

Paying deeper attention also meant looking critically at the context of the situation. Susan’s end of course reflection stated:

I learned that no one health or social condition exists on its own; it is often intricately interwoven together with other issues. As a nurse, I will remember that things are often more complicated or involved with other issues than they may initially seem.

Paying deeper attention to the situation and observing the details of a child’s demeanor, such as facial expressions can make a big difference.

### Student Perceptions of Their Impact

Most students (29 of 30) expressed seeking to make a difference as an explicitly stated goal in their clinical reflections. Overall, the students who participated in this study perceived that their CISL experience provided help and in providing help a sense of increased responsibility seemed to evolve.

### Providing Help

One student shared the following reflection.

I grew up in the 60’s with the push towards ethnic and gender equality and became fairly sensitive to cultural differences and ways not to offend and

patronize while interacting with different groups. I want to help eliminate issues that cause deep cultural unhappiness while not changing the culture.

Another student also referred to helping in abstract terms, this student referred to vulnerable populations in her end of course reflection. “If we don’t administer effective care to vulnerable populations such as minorities and children, we will not be able to improve the health of our society as a whole.” In these reflections, the theme of providing help seemed more idealistic and philosophical—more of a social responsibility than a practice.

Several of the nursing students bridged the gap between helping groups and helping individuals. For example, Terri wrote:

Vulnerable populations...need advocates and help with getting the care that they need. ...As nurses, we can be that advocate and/or provide the care, teaching, or referrals needed. For example, one little boy at Northern Plains Indian Reservation had [scars that were concerning]. We reported him as potentially being in an abusive situation. We acted as his advocate even if he is no longer in an abusive situation.

Yvonne’s clinical reflection is an example of encouragement and support. She wrote:

I didn’t realize how hard life is for most of these kids. I though our biggest role during the week was just listening to what the kids had to say, and providing support and advice when it was needed.

### Feeling Increased Responsibility

Increased responsibility speaks to an acknowledgement that all of us have a responsibility in ensuring that all individuals receive high quality care. Nursing students participating in the CISL experience demonstrated this understanding in their reflective writing. For example in anticipation of the CISL experience, one student wrote, “Up to

this date, I have not done anything concrete to help someone from another culture.

Another student, Valerie, wrote, “I respond superficially, and have not reached a point where I am knowledgeable of other cultures.” Several weeks after completing the CISL experience, the same student wrote:

Vulnerable populations, such as children and economically deprived individuals & communities are dependent on others to care for them. This power inequality makes this population especially vulnerable to neglect and abuse. It is important as nurses to provide care to these individuals in a way that provides choice and enables the individual to care for his or herself as much as possible.

Her end of course reflection expressed increased responsibility along with help and respect.

This sense of increased responsibility was expressed by Quinn more pragmatically in writing, “I realized how important our assessments were to these kids that may be the only time they get seen for their health for the whole year.” Another student wrote in her end of course reflection:

I didn’t understand previously how society turned a blind eye to vulnerable populations and attributed those populations’ ailments to just being “characteristic” or “stereotypical” of that population. How can anything get better with these vulnerable populations if we ignore issues instead of lending a helping hand?

With recognition of increased responsibility came a new awareness among more than a third of the students. One student captured this when he wrote, “the main thing I learned is that I only have to go 500 miles to find a place that needs my help.”

### Developing Cultural Consciousness

One goal of the CISL experience was to define and emphasize the difference between service learning and other worthwhile projects such as volunteerism. There was



evidence that this goal was met for more than a few students. As an example, one student wrote in her reflection, “I observed the importance of culturally sensitive care and how a community’s culture can both augment and impede the development of a community health program.” Another student wrote:

What lies on the surface, especially with teens, may not be the only reason they are seeking treatment. It may be what brings them to the clinic but may not be what they really need addressed. There are many missed opportunities in health care if caregivers are simply treating what is on the surface.

This was echoed by Yvonne who wrote, “From this experience I will implement practices that allow me to slow down and look at the whole person instead of just checking things off of a list.” Susan confirmed these thoughts when she stated, “Cultural understanding enables a nurse to be self-aware and deliver sensitive and specific care.”

Student nurses responses varied in depth. Debra’s end of course reflection expressed the importance of seeing each patient as an individual person.

This experience has taught me to really put time and effort into every patient that I see regardless of culture and social status, and to set aside any bias I may have in order to give the best possible care to each of my patients.

Another student wrote:

I think that the “treat others as you want to be treated” has been a lesson I strive to live by, so I may treat people in a way I am comfortable with, but this is not congruent with all cultures because not all cultures share the same ideas...

The perceived impact of the CISL experience on nursing students’ ability to integrate culture and patient care is best evidenced by Susan in her end of course reflection. She wrote:

Cultural understanding is imperative in health care, and I think that by being immersed in a culture that I was not familiar with, I appreciate more the need to incorporate it in all patient care and interactions. If we don't show cultural understanding, we have failed to fully assess a patient and have lost the chance to connect and make a positive difference in their care and health.

### Chapter Summary

In spite of gender, ethnicity and differences in chronological age and life experience, the 30 students who participated in the CISL experience expressed various examples of important issues facing Native Americans and the complexities of life situations on the reservation which directly and indirectly affect health and wellbeing. One student stated, "I learned so much more than I could have ever expected. This experience has already started to shape my career in nursing." When considering the guiding research question, "How Do (MSU) Students Describe their CISL experience?", I found that many students initially struggled with their emotions when confronting the disparity of citizens within the same state where they were attending university. In addition they described feelings of uncertainty and being overwhelmed, moving towards new and enhanced skill development including flexibility, organization, teamwork, cultural respect, idealistic hope for the future and for change, inspiration for career enhancement and finally cultural consciousness.

Several students expressed confirmation that cultural immersion service learning experiences must be learned in situ, although preparation for such an experience is key, including selected readings, exercises and presentations. One student's final reflection summed up the experiences of the group best when she wrote, "Who knew that a bunch

of sweet kiddos who live 480 miles away from me would teach me some of the hardest and most valuable lessons during my college career?”

## CHAPTER FIVE

## DISCUSSION

Summary of Previous Chapters

The examination of nursing students' perceptions of a one-week cultural immersion service learning (CISL) experience will increase nursing faculty's knowledge of students' perceptions of cultural consciousness gained through CISL experiences as well as inform the development of undergraduate nursing coursework focused on facilitating cultural consciousness of nursing practice within diverse communities. Cultural consciousness is a central element of purposeful and appropriate health care delivery that integrates knowledge, sensitivity and understanding (Korton & Sahtouris, 2001). It is an essential element in bridging an awareness gap inherent in cultural hegemony, and requires a re-emphasis in nursing education towards the mentoring and support of student learning toward a more culturally conscious practice.

This knowledge may be of interest to nursing faculty shaping future curricular offerings that facilitate cross-cultural healthcare practices and work toward reducing health disparities. Yet, very few empirical studies have been published on cultural immersion service learning (CISL) experiences and their impact on cultural consciousness. The purpose of this study was to examine nursing students' perceptions of cultural consciousness pertaining to American Indian culture developed during a one-week cultural immersion service learning (CISL) experience, embedded within an

undergraduate nursing course and within an American Indian community. Specifically, the overarching research question central to the focus of this study was:

How do nursing students at this university describe their CISL experience?

Three sub questions were posed to inform the main research question: (1) What CISL experiences do nursing students describe as important in developing their consciousness of American Indian culture within two of the Northern Plains Indian tribes? (2) How do nursing students describe the knowledge they acquire regarding the care of vulnerable populations during their one week CISL experience? (3) What do students describe as influential in their understanding of others in the complex link between poverty and health? Through the research of student perceptions during a one-week CISL experience, we may begin to develop a greater understanding of how to facilitate cultural consciousness in nursing students.

American Indian morbidity rates persist at far greater rates than the morbidity rates for non-Natives across a large number of healthcare concerns (Indian Health Service, 2014). For example, alcohol related disease is six times as great among American Indians, diabetes is almost three times more prevalent. Injuries among American Indians occur two and a half times more often. Suicide is 1.8 times more prevalent, pneumonia is 1.3 times more prevalent and infant mortality is 1.2 times more prevalent (Sweeney, Karol & Nolan, 2011).

One approach in trying to alleviate health care disparity is to prepare nurses who are culturally conscious (Leininger, 1988; Korton & Sahtouris, 2001). Cultural consciousness attunes the nurse to nuances which exist in a trans-cultural environment

enabling the nursing students to provide patient-centered healthcare to culturally different patients. Nursing education includes the incorporation of patient-centered care as outlined in the Patient Protection and Affordable Care Act (2010). Nurses who are not familiar with the culture with which each patient identifies will not be able to provide optimal care to those patients. One's culture and ethnic background affects interpretation, sense-making, and value judgments; for healthcare providers the lack of cultural consciousness distorts diagnostic clarity (Campinha-Bacote (2007). Korton & Sahtouris (2001) suggested that increased cultural consciousness improves communication amongst diverse groups of people. It is through this improved communication that a shared understanding emerges which is essential in providing optimal nursing care. Cohen and Goode (1999) identified reasons for developing cultural consciousness, and competence among healthcare providers which included, "eliminating long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds [and] improving the quality of services and outcomes" (p.10). Culturally competent care requires healthcare providers to act consciously to examine what we think, and how we act toward others (Hunt, 2001).

The preponderance of research across a variety of disciplines suggests that cultural consciousness and awareness is strengthened through self-reflection (Axtell, Avery & Westra, 2010; Danielewicz, 2001; Furlong & Wright, 2011; Gay & Kirkland, 2003; Rew, 2014), dialogue about race (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2014), and experience within other cultures (Fredericks, 2006; Kozub, 2013; Peaz, Allen, Carson & Cooper, 2008; Stone, et.al., 2014). In addressing self-reflection for

cultural consciousness, Gay and Kirkland wrote that “self-reflection and cultural critical consciousness are imperative to improving... opportunities and outcomes [for people] of color. They involve thoroughly analyzing and carefully monitoring both personal beliefs and [professional] behaviors about the value of cultural diversity...” (p.182). Self-reflection leads to a desire to understand and to acquire knowledge making for effective and efficient care of patients from diverse cultures. This process is a developmental learning approach for adult learners (Knowles, 1980).

The American Association of Colleges of Nursing (AACN), in collaboration with the Centers for Disease Control, also recommended that schools of nursing consider an “ecological model”, which focuses on social determinants of health, in the assessment, planning and intervention of care much of which has moved to the community (Robert Wood Johnson Foundation, 2014). Furthermore, the report goes on to recommend that this be done through the “use of more immersive clinical experiences including apprenticeships and situated learning” (p.7). Yet, there is scant research regarding the development and implementation of CISL experiences with vulnerable patient populations (Gillis & McClellan, 2011).

Caring through commitment of nursing to relationships and the human environment process has been a hallmark of the nursing profession beginning with Florence Nightingale (Ray, 2010). This commitment to developing caring relationships within a cultural contextual approach is clearly advocated by key nursing theorists (Leininger, 1996; Watson, 2005). Organizations such as AACN recognize the importance

of learning, teaching and practicing culturally competent care beginning with the development of cultural consciousness and awareness (Pacquiao, 2007).

Pedersen (1988) suggested eight techniques to stimulate cultural consciousness and awareness, most involved experiential learning. Simply put experiential learning is learning by doing. Cantor (1995) described two essential elements of experiential learning—(1) engaging the learners directly in the phenomenon related to their studies, and (2) requiring the students to reflect on their experience, analyze it and learn from the experience. In applying these concepts to nursing education, providing students with theory is not enough. Nursing students must be educated in the application of theories and principles to correctly provide nursing care to specific patients in a specific context. Experiential learning is essential. Leininger (1988) developed a theoretical model, Cultural Care Diversity and Universality. In that model, she posited that culturally congruent care is essential to satisfying, meaningful and beneficial care to clients. Building on Leininger's work, researchers have reported that international experiences leads to improved communication skills, expanded worldviews, greater openness to cultural differences, personal and professional growth leading to a more culturally focused nursing practice. (Callister & Cox, 2006; Evanston & Zust, 2004; Ryan, Twibell, Brigham & Bennett, 2000; and Walsh & DeJoseph, 2002).

### Summary of Methods

An intrinsic single case study design bounded by the students' perceptions of a cultural immersion service learning experience within an American Indian community was used to collect data to answer the research questions. Participants for this study were



selected from two cohorts of nursing students. One group of 14 participants were enrolled in an accelerated BSN program and had previously earned a Bachelor's degree in another discipline. The other group of 16 participants was enrolled in a traditional BSN program earning their initial degree. The one-week CISL experience began in 2011 as an instructor-initiated partnership between the College of Nursing at a land-grant university and the Health Promotion Disease Prevention (HPDP) Program of a Northern Plains Indian tribe. Students enrolled in Nursing Care of Children and Family, a required junior-level course for students in a Bachelor of Science in Nursing degree program, participated in a one-week CISL experience. During the week, nursing students provide healthcare screenings and education at six public school sites on the Northern Plains Indian Reservation during public school hours, then each evening students participate in cultural activities and meet with the elders of the community who share their culture, customs and ways of knowing held by the tribal members.

The qualitative data collected from each group included: (1) instructor and preceptor observations of students during the cultural immersion service learning experience, (2) initial student reflections immediately after participating in the cultural immersion service learning experience, and (3) follow-up student reflections written approximately 2 - 3 weeks after participation in the cultural immersion service learning experience. The reflection data derived from the discourse analysis and observation data were analyzed using the constant-comparative method (Strauss, 1987). Each reflection and observation, or unit of analysis, was read multiple times to identify key points, common aspects and distinct features to create preliminary codes. Once codes were

established, the materials were re-read to verify the accuracy of the codes and to detect any necessary adjustments needed to the codes. Finally, the themes were synthesized into categories and a grounded theory was developed. This process was reiterative and reciprocal (Gall, Gall & Borg, 2007). A Focus group and interviews with participants were held as member checks to ensure that the themes and grounded theory accurately encompassed the complexity of meaning portrayed by the data. These procedures contributed to the trustworthiness of the conclusions by: clarifying the researcher's positionality in relation to the research, triangulation, providing a thick and rich description of the context, and member checking.

### Summary of Findings

The overarching research question, how do nursing students describe their CISL experience was investigated by the narrative story formed from the emerging themes found in interpreting student reflections about their one-week CISL experience. As students prepared for their CISL experience, they stated their individual goals for the week. These stated goals emerged around three themes—skill development, make a difference, and cultural engagement. Most students listed two or three goals for the week. The primary goal was skill development and all but one student noted skill development as a goal.

Once at the reservation, the nursing students compared the campus community and the reservation community, and saw disparity as complex and concrete, which in turn facilitates the recognition of privilege. Many of the nursing students responded to this recognition by being overwhelmed and uncertain. Some responded to this recognition by

suspending judgement. Actions in response to feelings of uncertainty were discussed in themes about flexibility, organization (creating order), and teamwork. Actions in response to feelings of being overwhelmed were discussed in a theme of projected tacit assumptions. Actions in response to suspending judgement were discussed in themes about paying attention more deeply, reframing the situation, forming connections, and cultural respect.

In the clinical observation reflections, most students discussed results in themes of helping and making a difference. A few students discussed results in terms of a need for increased responsibility for the quality of their help because of the disparity in healthcare access. One student provided evidence of cultural consciousness in her clinical observation reflections. For example, she indicated that she learned to slow down and “look at the whole person instead of checking things off of a list.” Several weeks later in their end of course reflections, evidence of cultural consciousness were demonstrated by 20 of the 30 students. As demonstrated above in chapter four the students’ responses varied, but in general, they reiterated the need to set aside bias, look at the whole person, look beyond the presenting problem, and connect with the patient.

Looking back across time as I reflected on the class discussions and lectures as part of the preparation for the CISL experience, many students seemed to have formed an initial set of expectations regarding what to expect in the CISL experience, expectations which were colored by tacit assumptions formed by middle-class, dominant cultural experiences. The reality of the situations they encountered in the one-week CISL experience did not match these expectations. For most students, the week was spent

wrestling with their response to this mismatch, learning technical nursing skills (such as pediatric head to toe assessments), and acting upon the immediate situation. Over the course of several weeks, most students were able to integrate the CISL experience into a coherent whole in which cultural consciousness emerged in their reflections.

Furthermore, from the perspective of the community, the CISL experience is a success.

Evidence of the community' perspective is demonstrated in a letter written in August 2016 in which the HPDP Director wrote:

We are always seeking committed, ongoing, mutually beneficial relationships that will help us sustain this initiative [providing school districts with preventative assessments and treatments of children] into the future generations, and the commitment of [university] CON students is an excellent example of such a partnership.

### Interpretation of Findings

The evidence from 20 of the 30 students' end of course reflections demonstrated the existence of cultural consciousness in their reflective descriptions. The interpretation of this evidence, and other findings in this study, is organized below by addressing and interpreting the findings for each research question which collectively served to answer the overarching question, "How do nursing students describe their CISL experience?"

Figure 3 below provides a graphic representation of the revised conceptual framework by applying the constructs of experiential learning (Kolb, 1984) with the findings of this study. In comparing the revised conceptual model shown in Figure 3 to the initial conceptual model (see Figure 1 discussed in Chapter 1) used in designing the CISL experience, the connection between Kolb's (1984) key constructs and the students'

perceptions was demonstrated to be far less linear than suggested in the initial model. Furthermore, the pattern of student perceptions seemed to indicate multiple pathways to evidence of students' perceptions of cultural consciousness. Thus, from an initial conceptual design of a cycle, where elements have a linear connection, the revised conceptual framework was more spiraled with multiple pathways which could or could not lead to the center of the labyrinth where cultural consciousness and nursing skill intersect in facilitating help for vulnerable populations.

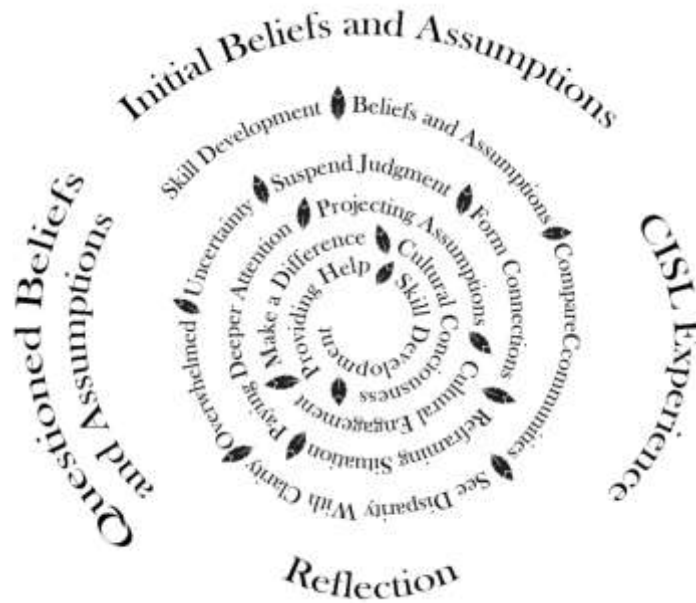


Figure 3. Revised Conceptual Model

Research Sub Question One

The first research question asked: What CISL experiences do nursing students describe as important in developing their consciousness of American Indian culture within two of the Northern Plains Indian tribes? Through the preponderance of evidence

presented in the findings, nursing students at this university described having an intentional goal of cultural engagement, realizing that disparities are complex phenomena, needing to suspend judgment and be flexible, pay deeper attention, form connections with community members, and finally being respectful of the culture as important in developing consciousness of American Indian culture. These influences on students' development of cultural consciousness were clearly represented by Susan, who reflected "Although I learned a lot regarding the impact of poverty on the health and wellbeing of children, I learned more regarding the social injustices present in this community...." This student went on to say:

I learned more than I ever thought I would [about] cultural understanding in healthcare. I learned to appreciate the culture of the population-the involvement of extended family, complementary therapies (sweat lodges), etc. My cultural awareness of this population greatly increased, and by showing cultural sensitivity, I feel as though my nursing care improved.

In another example, one nursing student wrote in her reflection:

Cultural understanding enables a nurse to be self-aware and deliver sensitive and specific care. Because of my experience on the [Northern Plains Indian Reservation] I understand that resources such as shampoo may not be in a household, the caregiver of a child may be a relative other than a parent, and many Native American families like [as many varieties of interventions] as possible.

This student's reflection provides support that the CISL experience facilitates the opportunity for students to begin to grapple with the perspectives of members of a cultural group different from their own. This cannot be accomplished to the same degree and with same impact from textbooks, lectures, videos or scenarios. Carpio and Majumbar (1993) wrote about the importance of student's self-examination of their own beliefs, values, and assumptions as part of a developmental process of acquiring

multicultural awareness. This self-examination requires both experience and reflection. In the weeks leading up to the CISL experience, students engaged in readings, presentations, and discussions about the culture of the tribes on the Northern Plains Indian Reservation. Yet, the majority of student clinical reflections revealed that the self-examination in questioning previously held assumptions occurred during the CISL experience and not before.

Finally, the development of cultural awareness that most students described as an important outcome of their CISL experience is aligned to the taxonomy for developing cultural competence in nursing education proposed by Lister (1999). Her model outlined five levels beginning with the development of (1) awareness, (2) knowledge, (3) understanding, (4) sensitivity and (5) competence. The nursing students in this study experienced the realization that disparities are complex. This realization marked an increased awareness leading to a genuine knowledge. Themes of suspension of judgment, being flexible and paying deeper attention provide evidence that students used their newly acquired knowledge to better understand the culture in which they were immersed. Additionally, themes of forming connections with community members and cultural respect provided evidence of sensitivity and cultural competence.

#### Research Sub Question Two

The second research question asked: How do nursing students describe the knowledge they acquire regarding the care of historically underserved populations during their one week CISL experience? The nursing students described a more complex understanding of the disparity through themes of differences between two communities in

the same state, the campus community and the reservation community. Furthermore, the descriptions found in the nursing students' reflections elaborated the implications of this disparity. For example in comparing differences in the two communities, one student wrote, "Through this experience I learned that access to healthcare is not as readily available to others as it is in [named the university community], nearly seven hours away from [names the reservation]". She elaborated the implications of this difference in reflecting:

I remember learning about health disparities in vulnerable populations in the beginning of the semester and not necessarily knowing what it was. However, you see it first hand at [named the reservation]. Due to the poverty and cultural/historical trauma, this population is at risk for higher rates of obesity, abuse, drug and alcohol use and mental health issues. Unfortunately, due to the poverty and lack of resources, these children do not have the means to be supported through these life issues which in turn leads to higher rates of illness and decreased health and wellbeing.

In addition to descriptions of the disparities and a cycle of poverty that perpetuates healthcare disparities, the nursing students described the institutional bias that contributes to the disparities seen in underserved populations. Jane captured this best in writing, "I didn't understand previously how society turned a blind eye to vulnerable populations and attribute those populations' ailments to just being, "characteristic" or "stereotypic" of that population." She reflected:

It is easy to turn a blind eye, build up a wall and treat everyone like they are made from the same cookie-cutter mold, but living this way is unrealistic. Taking the chance to learn and experience different cultures helps us to shift from "what is wrong with your way of thinking" to a "how can I best help you.

The existence of healthcare disparities that are complex, multifaceted and have multivariate causes is well known (World Health Organization, 2008). Furthermore, that



these healthcare disparities negatively and systemically have a greater impact on underserved populations historically linked to discrimination or exclusion is also well established (Centers for Disease Control and Prevention, 2014). In describing the knowledge they acquired regarding the care of historically underserved populations, the nursing students participating in the CISL experience provided evidence of a better understanding of the implications of what the words, *healthcare disparity* and *underserved populations* mean and how it applies in providing cultural conscious nursing care.

### Research Sub Question Three

The third research question asked: What do students describe as influential in their development of empathy in the complex link between poverty and health? Through the preponderance of evidence presented in the findings, nursing students described an emerging awareness of their own privilege as influential in their development of empathy in the complex link between poverty and health. For example, one student stated in her reflection “I did not realize how much harder it is for the children on the Northern Plains Indian reservation (names the reservation) to access healthcare.” Although the impact of poverty on healthcare begins through lecture and reading exercises in the weeks leading up to the CISL experience, as students enter the Northern Plains Indian Reservation community they immediately see the stark contrast between life on the reservation and the pastoral beauty of the rolling plains during the journey to the reservation. Immediate visual signs of poverty are everywhere. The chain-link fence that surrounds the community cemetery collects blowing garbage. Houses are small, wooden and often have

boarded up windows, and some emotionally and chemically affected community members are outside in small groups on street corners, and in alleyways. This narrative is not unique to the Native American population; however, the community does provide an experience for students to explore the many complex layers of the link between poverty and healthcare disparity, particularly for these students who have not had the opportunity previously to consider these complex issues. One student wrote, “I did not understand how many barriers there are to achieving health and wellbeing in an area with so much poverty before visiting [named the reservation]. Her further remarks exemplified the process that students undertake the exploration of their thoughts, and previous conceptions about Native Americans. She wrote, “I worked hard to go to school, and pay for college, however, I realize that I have been given the opportunity for health and education that these children will never have.”

Examining and understanding the healthcare disparities that exist within a given community is essential to the efficacious treatment of each patient within the community. Initially, all but one nursing student set explicit goals focused on the clinical and technical aspects of patient assessment without examining systematic factors that exist at the community level. Yet, during and immediately following the CISL experience, the nursing students in this study demonstrated in their clinical and end of course reflections an understanding as to why vulnerable populations experience such different life circumstances and how public policy decisions and unexamined assumptions in nursing practices can shape the outcomes.

Recognition of their own privilege, and the understanding of why vulnerable populations experience life differently, emerged at different rates among different nursing students in this study. This was not unusual given that many of the nursing students in this study were middle class students from homogenous communities grappling to make sense of new experiences, situations, and concepts they may have never before considered. Some students recognized their privilege and the need to adjust their interactions to meet patient's needs early in the week. On the other hand, other nursing students in this study, while not directly addressing privilege, wrote about their recognition of having a hard time putting patients' needs before their own; their desire to do well interrupt their clinical ability to establish authentic relationships with patients. This was captured in Debra's statement, "I focus more on what I am doing wrong rather than what I am doing right, which distracts me from what is important and inhibits my learning experience." Later in her clinical reflection she wrote, "I tend to hold back and may not give as much information as I should. I dislike talking in front of a group of people and may become forgetful in these situations."

These findings are similar to those of Tatum (1994) as well as others (Helms, 2007; Helms & Carter, 1991) who found that some Caucasian students shut down or may experience feelings of guilt when dealing with issues related to cultural awareness. Results from this research found that students who seemed to shut down or focus more on themselves and their actions during the CISL experience were less likely to demonstrate evidence of cultural consciousness in their end of course reflections. On the other hand, nursing students who seemed to engage in actively constructing relationships with their

patients and community members also demonstrated evidence of cultural consciousness in their end of course reflections. One example of active engagement in close proximity to existing disparities was taken from a student's clinical reflection in which community comparisons were intertwined with recognition of privilege. She wrote, "It definitely opened my eyes to the problems we can have so close to home." This student was able to formulate and articulate reflective thoughts that encompassed access to care in relationship to geographical setting, poverty, and vulnerable populations, physical, psychological and emotional needs. From the evidence of student reflections, it seems that there must be a willingness by the student to actively engage notions of privilege in the close proximity to existing disparities for greater clarity in seeing the disparities to occur; simply being in close proximity seemed insufficient.

#### Recommendations for Incorporating CISL Experiences into Nursing Programs

The implementation of a cultural immersion service learning experience imbedded within an undergraduate nursing course for the purpose of providing clinical experiences to assist in the development of cultural consciousness in student nurses should be considered from two perspectives. First, students who deliberately engage in service learning are most likely to do so through the selection of a course through reputation and through course catalogue offerings. These students purposefully select and plan for engagement in a service learning experience either domestically or internationally. These students have a commitment to the experience financially and emotionally. Although it is possible that they may not be satisfied with the offering as in

any course selection, they are more likely to be accepting and may even be enthusiastic about the challenging aspects of the experience. Travel time, personal comfort, privacy and dietary offerings are just a few examples of student concerns that could be mollified by student self-selection. Conversely, students who participate in a service learning experience that is imbedded within a required course and within a curriculum are not self-selecting the service learning experience. The instructor is challenged to not only organize the service learning experience but to also convince the students that the experience is worthwhile to them; this can be particularly challenging for adult learners who may have other important responsibilities in their lives such as work and parenting, or who may have ideas, thoughts and conceptions and biases about the community participants that are not in alignment with faculty perspectives.

Healthy debate and the sharing of ideas in the college classroom is an expected and welcomed activity, exploring one's own thoughts is part of the work involved in a CISL experience. However it is also the responsibility of the faculty to ensure that this debate is respectful to not only the other students in the course but most importantly to the partnering community. In the development of this CISL experience, this was addressed in two ways after an initial experience when it became evident that more planning and leadership was needed.

#### Framing the CISL Experience for Nursing Students

The instructor developed a CISL experience behavioral contract with the support of the campus director and the College Dean. Specific guidelines were put in writing,

along with written consequences. These guidelines were written to align with the university's code of conduct while addressing issues specific to the location of the CISL experience and the community being served. All students received this contract, signed and dated the contract on the first day of the course, having reviewed the contract with the instructor in detail during class time. One question that was routinely expressed by students: "Is it possible to fail the service-learning experience?" The response to this question must address the responsibility of the instructor for clearly explaining and articulating the difference between service learning and informal volunteerism, the CISL experience's place in the curriculum and how one interprets professional standards. In this course, the answer was "yes." Specifically, a student's conduct that is culturally offensive and unsafe behaviors may warrant a clinical experience failure. Helping students to understand the difference between a field trip, volunteering, and service with the partnering community is solely the responsibility of the course instructor.

#### The Importance of Developing Peer-mediated Group Norms

Students spent part of a class period in preparation for the CISL experience by developing their own peer-mediated group norms. Students explored their perceptions of peer respect, including how they planned to resolve conflict within the group. Spending a week learning and living together can be stressful, and impact the value of the experience on the learner. Instructors are encouraged to develop similar documents with their students, which alleviates the faculty from negotiating issues that are not relevant to course content and student competency. The student learners take control of those issues

that may be of most importance to their own feelings of security and comfort. Examples such as music style, loudness, quiet time, lights out, privacy, food choices, sleeping arrangements, shower schedules, bathroom time etc. Without the group norms in place, some students may be more likely to be distracted from engaging in the CISL experience and community environment, or to complain about the experience as a whole when the actual concerns are related to their peers, deflecting criticism to those receiving the service. For example in the first year of this experience one student wrote about the CISL in the course evaluation by stating “The week was very disorganized, I need to have more time to myself,” Although CISL involves collaboration with a community partner, thereby requiring flexibility in changing schedules and plans, the commentary may have been in part due to a student’s need to feel more ownership of the experience. Through the implementation of peer mediated group norms, students were provided with increased ownership of the experience.

The behavioral contract and the group norms contract are utilized to assist students who may be struggling to explore new ideas with professionalism and cultural responsiveness. An example of this occurred in the first experience. One student who had spent the day completing well child exams, reflected in post conference with her peers, “Why don’t they just brush their teeth?” This question was a natural and important question for the student learner to express when trying to understand a level of tooth decay that had not been experienced by this student in her previous experiences in life and in the classroom; however, when the same reflection is made in a disrespectful tone while adding, “Why are they so lazy?” The powerless are blamed for the conditions in

which they survive. The behavioral contract and the group norms contracts can be utilized if necessary to assist a student who is not willing to perform in a professional and culturally responsive manner. The instructor must be prepared for difficult moments such as these. Helping the student to understand the layers of social and policy issues that contribute to tooth decay such as the prenatal health of the mother, intrauterine health of the fetus, access to healthy foods, access to dental care services, access to tooth brushes and toothpaste, access to running water and cultural expectations of healthy teeth. One of the important outcomes of the CISL experience was the learning that occurs in situ which cannot be attained to the same degree without the personal experience. The impact of common and severe tooth decay and disease is hard to deliver didactically. This study illustrates that face to face experiences are more likely to have an impact on student learning. As a result cognitive dissonance is decreased and cultural competency is improved. In the case illustrated above, the student peer group took up the discussion posed and assisted their peer to consider the possibility of other factors which may contribute to the severity and the frequency of severe tooth decay in the population being served. The group norms document prepared in advance of the experience facilitated student expectations of these types of situations. As a group, students decide how they would like to best move forward in awkward moments and in a supportive manner. The instructor is then free to encourage healthy and respectful discourse while avoiding over correction or embarrassing a student learner. This is an important point, because the CISL experience does not allow for the same degree of privacy in the learning environment as is the norm within the home campus setting. All members of the student team, including



the instructor must live together in harmony for the duration of the experience and for the benefit of the group and the community. A student who feels embarrassed, that they were singled out, treated unfairly or overly criticized may impact the groups thinking and their willingness to share and to explore difficult topics during the remainder of the experience.

The group norms document does not have to be oriented towards the possibility of those issues that may cause strife; students can also be encouraged to develop a document that has a positive framework. One example from students who have participated in the CISL experience over the years is reflected in the dinner meal experience. Students discuss food preferences, grocery supplies, eating family style or not, making group meals or make your own. One group had a classmate who was strictly vegetarian, as a means of supporting their peer, the entire cohort elected to assume a vegetarian diet for the week. Another group had a cooking competition, each classmate cooked a meal for the group on one evening, At the end of the week, the group decided on a winner. Another group cooked and ate as a family and at the end of the week they typed up and shared their recipes with each other and with their host community. Sharing a meal is an integral part of sharing culture; this sharing can be used to assist participating students to build shared bonds and group cohesion.

#### Aligning Course Design to Course Objectives

Individual course objectives are the cornerstone for course design and the assessment of student progress. In the Nursing Care of Children and Family course

although all 6 of the course objectives could be attained during the CISL experience, one course objective “Provide culturally sensitive and competent nursing care to children and their families”, was most pertinent to the CISL experience. This course objective required the instructor to provide students with information, readings, activities, assignments and remediation to facilitate competence of the course objective, while working within the parameters of available resources.

As a new instructor who was trained in an urban setting, I realized early on in my teaching career that I would need to provide a creative mechanism for my students to meet this course objective, since opportunities to care for patients from cultures different from their own was not immediately available at the local hospital and clinics near the university, the usual site for much of the clinical training and experiences. Ideas for accomplishing this objective could include, scenarios, vignettes, simulation laboratory’s, readings, video and conferencing with other student groups or patient groups in more diverse settings. Another alternative, the one adopted, was to design and implement a CISL experience with a community and cultural group different from the university community where the course was offered.

Another course objective stated “Utilize-evidence-based nursing practice to assist children and their families with the promotion, maintenance and restoration of health: disease prevention and management; and death with dignity". This course objective could have been readily met within the parameters of the learning experiences available to all of the nursing students in the local community; however, well documented health care needs

of the children and families of the Northern Plains American Indian community provided opportunities for hands-on learning that would not otherwise be available.

Faculty members considering the implementation of a CISL experience imbedded within a required course are encouraged to consider that students enrolled in the course will not have the same level of interest for the service experience. As a result, achieving the goals of the service learning experience may be more difficult to attain with some students than with others. Course objectives should be utilized to support the goals of the CISL experience. In the first group of students to participant in the CISL experience, prior to this study, there were two individuals who I remember as being particularly resistant to the experience. Many of their reflections both verbally and in writing emphasized what they had given up in order to participate in an experience that they did not feel was optional. Dialogue was heavily referenced to their perceived inconvenience. At the end of the experience, these students referred to their volunteerism and were self-congratulating of their own achievements. As a result of the disconnect between the course goals and those perceived by some of the participants, the initial CISL experience was much more difficult for me as the instructor, but also affected the experience of the students, peers and community members. A great deal of thought and planning was put into effect before considering a second experience. I had to ask myself some difficult questions: (1) How could the experience be improved? (2) How was the curriculum lacking in terms of preparing the students both emotionally and in skill development for the CISL experience? (3) Is cultural respect a skill? And if so, How do you teach cultural respect? (4) What does cultural consciousness look like in nursing students and how

should it be assessed? (5) What student needs must be addressed before initiating another CISL experience? Another set of critical questions emerged from the question—should the CISL experience be required for all students?

(1) If not all students choose to participate in the CISL experience, what aspects of the course objectives would need to be met through a different format?

(2) If the experience were optional, would the student most likely to develop cultural consciousness be the least likely to self-select the experience?

(3) How would I, as the instructor, assess the learning outcomes of students who were meeting the course objectives through different and incommensurable activities?

(4) How would I ensure equality and fairness in course grades between the two groups?

A service-learning experience incorporating elements of social justice can be especially challenging for faculty working with students who may not have the same level of interest as the faculty and or their classmates. Public institutions of higher learning are charged with challenging students to learn, while also providing a learning environment that is emotionally safe for all students.

### Conclusions

The American Association of Colleges of Nursing (2008) makes it clear that the preparation of professional nurses must include practice in a multicultural environment and that professional nurses possess the skills needed to provide culturally competent care are essential elements in nursing education. Furthermore, the commitment to

developing caring relationships within a cultural contextual approach is clearly advocated by key nursing theorists (Leininger, 1996; Watson, 2005). Yet, for the majority of the 170,000 nursing students in the United States, nursing education remains steadfast to models used for decades (Robert Wood Johnson Foundation, 2014). The findings from this study suggest that incorporating CISL experiences into undergraduate nursing curricula may facilitate a means for including student nurses in multicultural practice environments as well as developing cultural consciousness and the skills needed for culturally competent care. Incorporating CISL experiences and critical service learning experiences provides students with an integrative, active and reflective framework facilitating student problem solving to address systemic inequalities (Gillis & MacLellan, 2010). Such experiential learning approaches develop authentic relationships which allow nursing students to adopt social change perspectives. It enables students to see themselves as agents of change and excites a passion to use their experience of service (Mitchell, 2008).

From the qualitative descriptive findings of this study, there appeared to be a link between students' ability to recognize their societal privilege, the close proximity of healthcare disparities, and cultural consciousness. Specifically, the CISL experience placed nursing students participating in this study in close proximity to many concrete examples of healthcare disparity. The nursing students participating in the CISL experience who were able to recognize and who seemed to accept their societal privilege articulated seeing these disparities with greater clarity. Furthermore, 20 of the 30 nursing students in this study who articulated seeing these disparities with greater clarity also

demonstrated evidence of cultural consciousness in their end of course reflections. Further research must be done to determine if the relationship between these phenomena is valid and reliable and to determine if the relationship is casual. Nevertheless, should this link be validated, it would be an important link. Such a link suggests that the development of cultural consciousness and the skills needed for culturally competent nursing care would be very difficult to achieve in a classroom environment. Furthermore, such a link suggests that cultural consciousness and the skills needed for culturally competent nursing care occurs best in an experiential environment supporting communities of underserved or vulnerable populations.

Finally, the results of this study support the possibility that transformational learning of cultural consciousness may occur in students participating in a well-designed CISL experience. Interested faculty may find that a similar experience could benefit their own student learning communities, especially at university communities with limited diversity. On the other hand, creating a CISL experience is time and resource intensive. Faculty members who are working on their own research projects, or are participating in the arduous process of promotion and tenure, may find that the implementation of a service learning experience may require an effort and time commitment that is not practical.

The results of this study support the premise that a CISL experience may facilitate the development of cultural consciousness in student nurses, particularly in those student nurses who are learning within a homogenous learning environment. Interested faculty members who have the support of their college or university, their Dean, their colleagues

and the collaborative interest of a partnering community are highly encouraged to develop their own CISL experiences. The opportunity to be instrumental in opening doors for students who are just beginning the process of discovering other ways of thinking and its impact on their future patients is empowering, and speaks most highly to the privilege of teaching.

### Recommendations for Further Research

This study qualitatively demonstrated that 30 students from two cohorts perceived the CISL experience in ways that show a developmental process consolidating around five themes—goal identification, recognition of privilege, varied responses to a culturally different community, varied strategies to work with an underserved population of children, and impact of efforts.

One line of research could replicate the methods of this study with nursing students working in different multicultural environments in different clinical areas for different durations of clinical exposure to see how these themes develop and reoccur over time. In this study, there was evidence in 20 of the 30 students' written perceptions that cultural consciousness was achieved by the conclusion of the course. Although the development of cultural consciousness seemed related to the CISL in terms of time, there is no discernable proof regarding the true efficacy of the CISL experience in facilitating cultural consciousness because there was no control group established. Another line of inquiry emerging from this study could test the efficacy of the CISL experience. Given that the College of Nursing operates on several different campuses, it would be possible

to establish a quasi-experimental study to test the efficacy. A true experimental study would be difficult in that students are not randomly assigned to campuses.

Recommendations for further research also include replication of the study with faculty who do not have an ongoing practice in a non-dominant cultural environment. Finally, evidence of sustained cultural consciousness over time has not been gathered in this study but is recommended for further study.

### Chapter Summary

The development and implementation of a CISL experience specifically designed for students whose colleges and universities are located in a predominantly homogenous community provided a successful and meaningful approach to meeting course objectives that cannot be attained in a student's local learning community. Specifically, The course objective—"Provide culturally sensitive and competent nursing care to children and families," was met through the CISL experience required for all students graduating from this specific university campus for the degree of a Bachelor's of Science in Nursing. The CISL experience as described supported the mission of the university and the College of Nursing by preparing students for "borderless careers", expanding horizons and enriching their appreciation of different cultures. The CISL experience's success in developing the cultural consciousness of most nursing students was due in part to the College of Nursing's commitment to community engagement and cultural awareness, and its mission to "enhance the health of the people of [our state], our nation and the global community by providing excellence in education, research, practice and service. (CON



mission statement, 2012, p1). Reciprocally, as noted by Butin (2010) “Service-learning is a cross-disciplinary, real-world, and consequential practice that fosters meaningful connections between colleges and their communities” (p.153).

This CISL experience was one clinical experience imbedded within one course within a curriculum designed to provide engaged scholarship for all students enrolled in a required course for graduation with a Bachelor’s of Science Degree in Nursing. Providing the opportunity for students to engage in a rigorous and challenging experience and guiding their reflection of critical issues impacting the health of an underserved and vulnerable population facilitated clarity and a better understanding of the health disparities that exist within their own state. Furthermore, most nursing students participating in the CISL experience were able to develop cultural consciousness and the skills needed for culturally competent nursing care. Additional research is needed to determine if this is an improved method of developing cultural consciousness in nursing students through comparative research. The evidence of this study supported the conclusion that using CISL experiences embedded in a required nursing course seemed to be an effective way of developing cultural consciousness for most nursing students at this university participating in the study.

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APPENDICES

APPENDIX A

COURSE SYLLABUS

[University Campus]  
**COLLEGE OF NURSING**  
**NRSG 348: Nursing Care of Children and Family**



**FACULTY:** Julie H. Alexander-Ruff, MSN, RN, CPNP-PC  
 Assistant Teaching Professor/ Course Coordinator  
 Cell: 599-xxxx  
 E-mail: julie.ruff@montana.edu  
 Office hours by appointment

**TIME:** Lecture: Mondays 9-12am, (Please refer to the course calendar for specific dates and times of lectures and exams). Room 106/107 Sherrick Hall

**LAB:** Clinical dates vary for each student in the course. Please refer to the clinical course calendar for specific clinical lab assignments.

Credits: 5 credits (2 lecture, 3 clinical lab)

Prerequisites: NRSG 258, NRSG 336, NRSG 341, and NRSG 352.

**COURSE DESCRIPTION:**

The focus of this course is health promotion, disease prevention, illness management, and nursing care of children within the family context in a variety of settings. This course builds upon and integrates knowledge gained from, sciences and the humanities.

**COURSE OBJECTIVES:** The student will:

1. Utilize evidence-based nursing practice to assist children and their families with the promotion, maintenance and restoration of health: disease prevention and management; and death with dignity. (T2, 3, 5-7, 13)
2. Provide culturally sensitive and competent nursing care to children and their families.(T2,3,5-7,9,12,13)
3. Utilize knowledge of growth and development to provide for safe nursing care of children and their families. (T2-5, 10, 13)
4. Utilize community based nursing concepts in caring for children and their families. (T1-7, 12, 13)
5. Demonstrate responsibility and accountability reflecting professional values. (T6-10, 13)
6. Demonstrate the ability to communicate effectively with children, families and professionals. (T2-4,6,7,9,10)

**REQUIRED TEXT:**

Rudd, K. & Kocisko, D. (2014). *Pediatric nursing: The critical Components of nursing care*. Philadelphia: F.A. Davis Co

**RECOMMENDED TEXT:** Any current NCLEX review book

**TEACHING/LEARNING STRATEGIES:**

This course uses a variety of teaching and learning strategies to enhance the application of theoretical content and performance in caring for children and their families. Lecture, presentation, small group discussions, cooperative group work, questions, modeling, role play, computer assisted instruction, D2L, and simulation lab experiences may be utilized. The student is provided clinical experiences in a variety of pediatric settings.

**STUDENT CONDUCT:** Students are expected to adhere to the student expectations outlined in the Undergraduate Student Handbook. You can also refer to the student academic and conduct guidelines as well as grievance procedures at <http://www2.state.edu/policy/studentconduct>. Additionally, all students will demonstrate behaviors that are congruent with **Code of Conduct, CON Student Handbook** and the ANA Code of Ethics, Scope and Standards of Practice and Social Policy Statements in all class related interactions.

**STUDENT DISABILITIES:** If a student has a documented disability for which he/she may be requesting an accommodation(s), he/she must notify the instructor and have documentation from Disabled Student Services.

**STUDENT EVALUATION:**

Evaluation of student assignments will be based on universal intellectual standards:

- Clarity: the ability to illustrate an idea
- Accuracy: Is it valid?
- Precision: Is it specific and detailed?
- Relevance: Is it relevant to the problem?
- Depth: Are the complex issues explored?
- Logic: Does it make sense and flow together?
- Significance: Is the focus on the most important issue?

Adapted from the Foundation for Critical Thinking. Critical thinking: Basic Theory and Instructional Structures. Sonoma, California: 1998 <http://www.sonoma.edu/cthink/>

**COURSE EVALUATION:**

The final course grade will be determined by combining the scores from the following:

Quizzes—8 quizzes will be administered that cover lecture material and required readings (5 points each, or 40 points total) (40% of grade)

Quizzes will be multiple choice, essay and fill in the blank questions. The questions will be derived from lectures, class discussions, guest speakers, and assigned readings.

Comprehensive Final Exam – 33 points

Exam questions will be multiple choice, essay and fill in the blank questions. The questions will be derived from lectures, class discussions, guest speakers, and assigned readings.



Review of Quizzes and Exams: Students will have the opportunity to review their quiz in class and exam score by appointment. Students will have ONE WEEK to dispute any quiz or test items.

Make up Quizzes and Exams: There will be NO MAKE UP Quizzes or exams unless the student is ill or has an emergency verified by the Dean of Students, and notifies the instructor prior to class/examination. Each student will get one opportunity to have a make-up quiz. The make-up quiz will be scheduled at the convenience of the instructor and considered on an individual basis. Any student who does not take a make-up quiz will receive a zero for that quiz.

Patient Care Presentation-15 Points

Details regarding Patient Care Presentations will be posted in the content area of D2L.

Participation—12 Points

Students must be present, active in the classroom, engaged in discussions and prepared for lecture and clinics having completed the required readings prior to class and/or clinical.

Total possible points=100

In order to receive a passing grade for NRS 348, each student must: (1) attend all lectures or have any absence excused by the instructor, (2) the course average must be at least 70%, and (3) the student must earn a satisfactory grade for each clinical performance (see clinical guidelines for further guidance).

Course Grading Ranges:

A = 90 – 100%

B = 80 –89%

C = 70 – 79%

D = 60 – 69%

F = < 60%

A final grade of D or F in the course will result in a requirement to repeat the course. A student is expected to schedule an appointment with the faculty for advisement when earning less than a grade of C on any given assignment.

#### **EVALUATION OF CLASSROOM PERFORMANCE:**

**Exams:** There will be a final comprehensive exam only. The exams may be a combination of multiple-choice, short answer, True/False, matching, and case study, test material will be derived from lecture/power points, group work and assigned readings. Following the exam, students will have an opportunity to review their exam by appointment. Students who wish to dispute a question may make an appointment with the instructor individually to discuss their view. Exam grades will be determined by adding test grades (to the nearest 100th point) with **NO** rounding of grades. For example, an 89.96 is a “B” (not an “A”).

**Participation:** Students are expected to participate in lectures and in labs in a scholarly and respectful fashion, with their peers, faculty and preceptors. Students are encouraged to engage in asking questions and in sharing relevant experiences with the class.

**Clinical Labs:**

Clinical labs will be held in both inpatient and outpatient settings and classroom settings. Details of each setting, the location, hours, contact information and dress requirements will be supplied on the first day of orientation.

**In-depth Field Experience:**

Students will participate in an intensive week long field experience on the Northern Plains Indian Reservation, providing direct care to Native children and their families in school based clinics and in homes. Students will receive 60 hours of clinical time as well as service learning credit upon successful completion of this experience. Students are expected to cover their own costs for transportation to and from Northern Plains Indian Reservation as well as for their own meals. The instructor will attempt to secure limited funding to assist with transportation costs, but this is not guaranteed. There are no known additional costs associated with this experience beyond a thank you card, along with a small token of appreciation to each of the preceptors, and hosting a pot luck dinner the last evening at Northern Plains Indian Reservation.

**EVALUATION OF CLINICAL LAB PERFORMANCE:**

Clinical performance is seen as having such significance that satisfactory performance is required to pass the course. **Unsatisfactory clinical performance will result in a course grade of F, regardless of grades attained in the classroom.** Therefore, satisfactory rating in all parts of each laboratory assignment (including written materials) is necessary to pass the course. Students will be expected to self-evaluate themselves and clinical faculty will evaluate the students on a weekly basis.

**Satisfactory** performance is attainment of objectives for the learning experience. The student uses learning opportunities to achieve objectives. While he/she may experience difficulty with some new experiences, he/she is at ease with tasks encountered previously. The student identifies learning and/or supervisory needs reliably with only occasional assistance from instructors. A satisfactory performance is characterized by the level of nursing behavior and the attitude of inquiry required for professional nursing.

**Unsatisfactory** performance is failure to attain objectives for the experience. Given the opportunity to learn, the student fails to engage in learning activities which lead him/her to attainment of the objective(s) or the student may continue to have marked difficulty with commonly encountered nursing problems not just new ones, or the student may consistently require a level of supervision unusual for his/her level as a learner, or the student's performance may be so inconsistent that he/she is considered unsafe.

\* Failure to arrive for a clinical experience prepared, on-time and professionally attired will result in an unsatisfactory clinical grade. The faculty will determine if the student will stay to complete the clinical day.

\* Failure to complete a clinical day and/or leaving a clinical site early will result in an unsatisfactory clinical grade.

**STUDENT RESPONSIBILITIES AND GENERAL INFORMATION**

**Academic Expectations:** Students are expected to adhere to the university campus' Student Academic and Conduct Guidelines.

**[University] Conduct Guidelines** (Section 310.00 ) states that students must:

1 Be prompt and regular in attending classes; remain for the allotted class and clinical time.

- 2 Be well prepared for classes; including having completed the reading assignments.
- 3 Submit required assignments in a timely manner;
- 4 Actively participate in class and in clinical
- 5 Discuss issues of concern with the faculty in a respectful manner
- 6 Act in a respectful manner toward other students and the instructor and in a way that does not detract from the learning experience while maintaining professional behavior at all times.
- 7 Check for announcements in D2L
- 8 Make and keep appointments when necessary to meet with the instructor.

**Attendance:** Attendance in class is expected. Attendance at clinical conference, clinical skills lab and assigned clinical area is required. The student is expected to be prepared and to participate in class and clinical conference discussions.

**Communication:** Communication with course faculty outside of class is best done through the listed email addresses posted on page 1 of this syllabus. It is the expectation that students and faculty will check email at least once daily Monday through Friday. Please do not call cell phone between the hours of 8 pm and 6 am. Students are expected to adhere to the Student Expectations outlined in the Undergraduate Student Handbook. You can also refer to the Student Academic and Conduct guidelines and Grievance Procedures at <http://ww2.state.edu/policy/student> conduct, the use of another student's work, or the incorporation of work not one's own, without proper credit will result in failure of this course.

#### **INTEGRATION OF TECHNOLOGY**

This course is supported by the Desire to Learn (D2L) Web-based platform. D2L is used to enhance this course by:

- Communicating course information and announcements
- Providing lecture outlines (see Lectures under Content)
- Providing links to relevant web sites (see Web Sites under Content)
- Sharing information amongst class members and instructors (mailbox)
- Submitting assignments (Dropbox).

Clinical assignments can change frequently and with little notice due to changes at the clinical site and/or preceptor availability. Students should be checking D2L on a regular basis for the duration of the course to insure they have the most up to date information.

APPENDIX B

CLINICAL EVALUATION FORM

(Student Reflection Template)

Name \_\_\_\_\_, Date \_\_\_\_\_

**Weekly Clinical Self-Evaluation:** Directions: prior to the beginning of each pediatric (N348) clinical week, complete the first part of the goals section. Complete the remainder of the document after finishing the clinical week. You only need one document for each clinical week; therefore you may include several different clinical experiences on each document. Turn the completed document in to the faculty, Julie Ruff during class on Tuesday mornings. Completion of this document in a thorough manner will go towards class participation points. Late documents will not be accepted.

**GOALS:**

WHAT IS YOUR GOAL FOR EACH CLINICAL DAY SCHEDULED THIS WEEK?

DESCRIBE HOW YOU DID OR DID NOT MEET EACH CLINICAL DAYS GOALS

BASED ON THIS WEEKS EXPERIENCE, WHAT IS YOUR GOAL FOR THE NEXT CLINICAL WEEK?

**THOUGHTS ABOUT YOUR OVERALL EXPERIENCE THIS WEEK:**

WHAT WENT WELL? WHY?

WHAT DID NOT GO WELL? WHY?

**ASSESS YOURSELF IN THE FOLLOWING AREAS:**

COMMUNICATION SKILLS. GIVE AN EXAMPLE

THERAPEUTIC INTERVENTIONS (fundamental skills, nursing care plan etc.) GIVE AN EXAMPLE

CRITICAL THINKING

APPENDIX C

DEVELOPMENTAL TIMELINE OF THE CISL EXPERIENCE

## Developmental Timeline of the CISL Experience

YEAR	EVENTS
2010	<ul style="list-style-type: none"> <li>• Inception of idea for cultural immersion service learning experience</li> <li>• Establishing partnership with Health Promotion and Disease Prevention Program at Northern Plains Indian Reservation</li> <li>• Initial planning and coordination of cultural immersion service learning experience</li> </ul>
2011	<ul style="list-style-type: none"> <li>• Cultural immersion service learning experience is incorporated into NRS 348, Nursing Care of Children and Family.</li> <li>• First group of 14 students participate in the cultural immersion service learning experience in March</li> <li>• Instructor shared housing accommodations with students</li> </ul>
2012	<ul style="list-style-type: none"> <li>• Second group of 14 students participate in the cultural immersion service learning experience in March</li> <li>• Third group of 16 students participate in the cultural immersion service learning experience in October. This was the first group of students from the accelerated BSN program.</li> <li>• Instructor and students housed separately—tribe provided housing for students</li> <li>• Guidelines for the Northern Plains Indian Reservation Experience handout is developed and provided to students along with course materials</li> </ul>

## Developmental Timeline of the CISL Experience

YEAR	EVENTS
2013	<ul style="list-style-type: none"> <li>• Fourth group of 15 students participate in the cultural immersion service learning experience in March</li> <li>• Fifth group of 16 students participate in the cultural immersion service learning experience in October</li> <li>• Guest speakers discuss the Native American community and cultural issues in class to prepare students for the cultural immersion service learning experience</li> </ul>
2014	<ul style="list-style-type: none"> <li>• Sixth group of 15 students participate in the cultural immersion service learning experience in March</li> <li>• Five previous participants of the cultural immersion service learning experience petitioned to do their community health class project at Northern Plains Indian Reservation during summer term</li> <li>• Seventh group of 14 students participate in the cultural immersion service learning experience in October</li> <li>• Group norms for the service learning experience are first developed by student consensus</li> </ul>



## Developmental Timeline of the CISL Experience

YEAR	EVENTS
2015	<ul style="list-style-type: none"> <li data-bbox="500 415 1425 598">• Cultural Immersion Service Learning experience recognized as a service learning model program receiving the university President's Award for Service Learning</li> <li data-bbox="500 640 1425 745">• School of Nursing requires student participation in the cultural immersion service experience</li> <li data-bbox="500 787 1425 892">• Eighth group of 14 students participate in the cultural immersion service learning experience in March</li> <li data-bbox="500 934 1425 1186">• Two previous participants of the cultural immersion service learning experience organized a 5-day trip for 6 secondary students from the Northern Plains Indian Reservation to visit the university's town as a community health class project</li> <li data-bbox="500 1228 1425 1337">• Ninth group of 14 students participated in the cultural immersion service learning experience in November</li> </ul>

APPENDIX D

STUDENT REFLECTION GUIDE

## Student Reflection Guide

Describe the people you met during your clinical experience.

Name three things that stuck in your mind about t your clinical experience.

Describe some of your interactions.

Why do you think (an activity described in a previous question) happened?

How are you different compared to when you started?

What did the body language of the people tell you?

How did people's responses make you feel?

How did the environment make you feel? (as compared to other identifiable places)

Are "strangers" welcome at your clinical site? Why or why not?

How are you similar/different than the other care-givers?

In what ways did being different help/hinder the group?

What have you learned about yourself?

If you were one of the people receiving services, what would you think of yourself?

How does this experience compare to others that you have had?

What connections do you see between this experience and what you've learned in your classes?

How has your clinical experience contributed to your growth in any of these areas: civic responsibility, political consciousness, professional development, spiritual fulfillment, social understanding, intellectual pursuit?

What have you learned about a particular community or societal issue?

How did this experience challenge your assumptions and stereotypes?

Do you think these people (or situations) are unique? Why or why not?

What public policies are involved and what are their implications?

How can public policy be improved?

Who determines what is best for the community?

Describe what a typical day might be like for someone who uses the services of the organization you worked with?

How would you do this differently if you were in charge?

What was the best/worst/most challenging thing that happened?

Did you feel like a part of the community you were working in?

How do you define community?

How might communities work differently and why?

Describe an internal or external conflict that has surfaced for you during your clinical work.

Explain the factors that contribute to it and how you might resolve or cope with the conflict.

Discuss a social problem that you have come in contact with during your service work.

What do you think are the root causes of this problem?

Explain how your help could make it more of an upstream focus.

Where do you go from here?

What is the next step?