AN INTERPRETIVE QUALITATIVE STUDY OF BACCALAUREATE NURSING STUDENTS FOLLOWING AN EIGHT-DAY INTERNATIONAL CULTURAL EXPERIENCE IN TANZANIA

A dissertation submitted to the
Kent State University College of Education, Health, and Human Services
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy

by

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May 2013
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Intercultural competence through study abroad is widely recognized as a preferred teaching approach for the development of globally competent health care practitioners. Colleges and universities are looking for multiple ways to encourage students to study abroad because of the noteworthy effects that these experiential opportunities have on students. Sparse research has been conducted to determine if short-term study abroad trips of less than two weeks are achieving these same outcomes.

The purpose of this basic interpretative qualitative study was to describe the nature and meanings of a short-term international cultural experience for nursing students, and whether or how their understanding of the role of the professional nurse was changed. A group of baccalaureate nursing students traveled to Tanzania and took part in professional and social opportunities over an 8-day period. All participants were required to complete a nursing course with global objectives prior to the trip and pre-immersion seminars. Data were collected from reflective journals during the study abroad experience, focus group discussions one month after returning home, and personal interviews 6 months later. The results indicated that the participants experienced culture shock, but they also gained in self-awareness, cultural empathy, leadership skills, a desire to learn more, and a new perspective of the role of the professional nurse. Langer’s
theory of Mindfulness, Bennett’s Developmental Model of Sensitivity and Campinha-
Bacote’s Process of Cultural Competence provided the theoretical framework for this
study.
ACKNOWLEDGMENTS

My passion to expand my knowledge in order to improve patient and student outcomes has led me to pursue my Doctor of Philosophy, at the ripe old age of 60. I would like to express my gratitude to my dissertation chairs Dr. Teresa Rishel and Dr. Kenneth Cushner. I thank you for your patience, support, and invaluable insight. I am so grateful that you ignored the fact that I was probably the oldest Ph.D. student in the program. Without your support and knowledge, I would not have made it through this long and arduous process. Thanks to Dr. Rishel for her endless editing and to Dr. Cushner (the culture guru) for sharing his wealth of knowledge with me. I want to extend a special thanks to Dr. Tricia Niesz, one of the finest educators that I have had the pleasure of knowing and a member of my dissertation committee. She began this journey with me long ago while I was a student in her Qualitative Research class. It was with Dr. Niesz that I developed my research questions and methodology, and I will forever be grateful. A special thanks to my extraordinary friends Lorene, Karen, Celeste and Debbie; I do not know how I would have managed without your friendship, editing and advice.

To my Salem campus colleagues who cheered me on . . . thank you for your support. For the nursing students at the Salem campus . . . thanks for stopping by and asking, “how is it going?” You are the reason for this dissertation.

For my family and close friends, thanks for the good times and the distractions (and the wine) it helped! A very special thank you to my children Michael, Vanessa, and Alysse . . . this is for you. I could not have done this without your steadfast support and
your belief in me. You bring so much passion and joy to my life; you have always made
me so proud! To my “other” children, Mauris, Khalten, and Michael, thanks for your
“humor” and patience . . . you made me laugh at myself on many occasions, which
helped through this process. To my twin grandbabies, Isla and Oliver . . . I know that you
thought that the computer was an extension of my body, but it is not. Now we can play!!!

Finally, to my friends from Tanzania . . . you will always hold a special place in
my heart. I hope that we will meet again soon!
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGMENTS</th>
<th>iv</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>x</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. INTRODUCTION

- Growing Body of Evidence Supporting International Study .................................................. 4
- Problem Statement ...................................................................................................................... 7
- Purpose of Inquiry ...................................................................................................................... 8
- Research Questions ................................................................................................................... 9
- Research Methods ..................................................................................................................... 9
- The Epistemology of the Constructionist .................................................................................. 10
- The Ontological Framework of This Study ............................................................................... 11
- The Constructivist Paradigm and the Ontology of Holism ...................................................... 12
- Theoretical Framework of This Study ...................................................................................... 14
- Langer’s Theory of Mindfulness ............................................................................................... 14
- Bennett’s Developmental Model of Intercultural Sensitivity (DMIS) ..................................... 15
- Definitions of Terms ................................................................................................................ 17
  - Cultural Awareness and Cultural Sensitivity ........................................................................ 17
  - International Cultural Experiences Defined ......................................................................... 20
- Limitations and Delimitations ................................................................................................. 20
  - Limitations .......................................................................................................................... 20
  - Delimitations ....................................................................................................................... 20
  - Assumptions ......................................................................................................................... 21
- Contribution to the Knowledge Base as a Result of This Research ..................................... 21
- Dissertation Outline ................................................................................................................. 22

### II. LITERATURE REVIEW

- Introduction .............................................................................................................................. 25
- The Impact of Culturally Incompetent Practitioners on Health Care Outcomes .................... 25
  - Teaching of Intercultural and Transcultural Content ........................................................... 27
  - Current Approaches to Intercultural and Transcultural Learning in Nursing .................... 28
  - International Study Abroad Programs as Pedagogy ............................................................... 32
  - Outcomes of International Cultural Experiences ................................................................. 32
  - The Benefits of Long-Term Study Abroad Programs ............................................................ 34
Is a Long-Term International Experience Necessary? ........................................ 36
Alternative Experiential Learning Opportunities ........................................ 39
Deterrents to Study Abroad or Immersion Programs ...................................... 42
Challenges in Study Abroad ........................................................................... 44
Effective Pedagogy in Study Abroad ............................................................. 47
The Use of Reflection and Short-Term Immersion Experiences ...................... 48
The Need for Short-Term International Programs .......................................... 51
Cultural Humility and Experiential Learning ................................................ 55
Contribution of This Study to the Body of Research ...................................... 56
Summary of the Literature Review .................................................................. 59

III. METHODOLOGY ......................................................................................... 61
Qualitative Methodologies .............................................................................. 61
The Interpretive Qualitative Approach ............................................................ 64
Theoretical Framework .................................................................................... 65
Langer and Mindfulness .................................................................................. 66
Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare ........................................................................................................... 69
Bennett’s Developmental Model of Intercultural Sensitivity (DMIS) .............. 72
Summary of Theoretical Frameworks ............................................................... 76
The Setting for This Experiential Learning Program ......................................... 77
Participant Preparation for the International Cultural Experience ................. 78
Study Design .................................................................................................... 88
Participant Selection and Gaining Access ....................................................... 88
Participant Demographics ............................................................................. 89
Benefits for the Participants ........................................................................... 93
Ethical Considerations .................................................................................... 94
Issues Related to Risk and Consent ................................................................. 94
On-Site International Experiences in Tanzania ................................................. 95
Health Care Facilities .................................................................................... 95
Social Opportunities ....................................................................................... 96
Daily Reflection and Debriefing ....................................................................... 96
Data Collection ............................................................................................... 97
Data Collection Methods ............................................................................... 97
Self-Reflective Journaling ............................................................................... 99
Focus Groups .................................................................................................. 100
Participant Interviews ................................................................................... 101
Data Analysis and Interpretation .................................................................... 103
Recognition: Dividing the Data Into Units and Coding ................................ 104
Looking for Concepts and Themes in the Literature ..................................... 106
Trustworthiness ............................................................................................... 108
The Role of the Qualitative Researcher .......................................................... 110
Summary ......................................................................................................... 112
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Process of Cultural Competence in the Delivery of Healthcare Model</td>
<td>72</td>
</tr>
<tr>
<td>2. Participant Demographic Characteristics</td>
<td>90</td>
</tr>
<tr>
<td>3. Data Collection Methods</td>
<td>98</td>
</tr>
<tr>
<td>4. An Example of Organization of Data for the Concept of Shock</td>
<td>107</td>
</tr>
<tr>
<td>5. An Example of Organization of Data for the Concept of Self-Awareness</td>
<td>108</td>
</tr>
<tr>
<td>6. How Do the Participants Describe Their Experience of a One-Week International Cultural Experience in the Short Term and Six Months After Returning Home?</td>
<td>117</td>
</tr>
<tr>
<td>7. How do the Participants Re-Conceptualize Their Role as a Nurse Six Months After Returning Home?</td>
<td>170</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

“In the context of a rapidly changing and complex world, the need to educate students to participate in, and contribute to a global knowledge-based society, while maintaining appreciation and respect for difference, has never been greater” (Kinsella, Bossers, & Ferreira, 2008, p. 79). This is particularly apparent in the United States, where racial, ethnic, and socioeconomic status disparities in health care persist at unacceptably high levels (U.S. Department of Health and Human Services [USDHHS], 2010). Blacks, Asians, American Indians, Alaska Natives, and Hispanics receive poorer quality care than Whites and have limited access to care when compared to Whites within the United States, according to the 2010 National Healthcare Quality Report and National Healthcare Disparities Report issued by the USDHHS Agency for Healthcare Research and Quality (AHRQ). In addition, all people from lower socioeconomic groups had significantly worse quality and access to care.

Higher disproportionate rates of infant mortality, obesity, diabetes, cardiovascular diseases, and HIV infection are found in minority populations when compared to Whites in the United States. Also troubling are the lower numbers of breast and cervical cancer screenings as well as deficits in child or adult immunization rates for minorities (Centers for Disease Control [CDC], 2010). For example, the death rate for African Americans is higher than that of Whites for 12 of the 15 leading causes of death, according to the CDC (2010).
These disparities result in part from the lack of intercultural understanding and competence among medical staff (Chevarley, 2011). According to AHRQ’s Statistical Brief #312, communication between minority patients and health care professionals remains problematic. Health care professionals often lack the necessary skills required to meet the diverse needs of their patients (Chevarley, 2011). For example, Hispanic and Black individuals are more likely than non-Hispanic White adults to report communication problems with health care providers in three key communication categories (Chevarley, 2011). Hispanic and Black respondents said that their providers fail to listen carefully, fail to explain things in an understandable way, and fail to show respect for what the patients had to say (Chevarley, 2011, p. 1). Minority patients’ perception of a lack of caring, compassion, and respect for them as individuals hinders the delivery of adequate and effective care.

In *The Practice of Nursing*, Bertha Harmer and Henderson (1939) spoke to the importance of a “democratic spirit which leaves color, race and prejudice behind . . . It is the aim to give the same kind of care to men, women, and children, to all colors and creeds, rich and poor, enemies and friends” (p. 8). The American Association of Colleges of Nursing (AACN) recognizes that the environments in which professional nurses practice have become more “diverse and more global in nature,” and mandates “attention to diversity in order to provide safe, high quality care” (AACN, 2012, p. 6).

Cultural competency development is an “active progression of learning and practicing, which evolves over time requiring a lifelong commitment” (AACN, 2008, p. 9). Faculty often struggle with the best way to prepare nurses for our complex and
diverse society both on a national and global level. The challenge for nurse educators is to determine how to effectively incorporate cultural content into the curriculum and to translate classroom knowledge into nursing practice with a focus on cultural needs. There is a great need for the development of cultural and intercultural competence in the nursing profession to provide culturally effective and congruent nursing care to all patients.

Intercultural competence is defined as “complex abilities that are required to perform effectively and appropriately when interacting with others who are linguistically and culturally different from oneself” (Fantini, 1985, p. 458). We now recognize that changes in people’s attitudes toward cultures result from continuous and personal contact with people from different cultures (Cushner, McClelland, & Safford, 2003). Incorporating cultural content into curricula, translating knowledge into nursing practice, and participating in international cultural experiences, can help nursing graduates become more aware of the interconnectedness of the world’s regions, as they consider the impact of global perspectives on education, socioeconomics, government, and politics on health care (Banks, 1994). Moreover, their awareness and knowledge will help them communicate and effectively care for all diverse patients in their own communities.

Intercultural competence is the foundation for the practice of transcultural nursing, which recognizes the uniqueness of each individual and encourages the nurse to respect and protect the worth, dignity and rights of individuals, families, groups and communities. Transcultural nursing theory strives to guide the nurse in providing thoughtful, safe, effective, and competent care to all people, both of diverse and similar
cultures. The goal of transcultural nursing is to assess appropriately and accurately the cultural needs of patients, and to integrate skillfully the values, beliefs, and life-ways of individual cultures for health and well-being (Transcultural Nursing Society, 2011).

Transcultural nursing is the humanistic and scientific area of formal study and practice that focuses on differences and similarities among cultures with respect to human care, health (or well-being), and illness (Leininger, 1988). In transcultural nursing, people with different cultural backgrounds are not separated into “cultural” groups; rather, the nurse locates common needs and common experiences. The basis for transcultural nursing care lies in the nurse learning about the language, the worldview, the symbols, social structure, values and meanings about care of a certain culture (Leininger, 1988).

One way to develop culturally responsive nurses is to provide authentic ways for them to develop the transcultural nursing skills. International cultural experiences have been shown to be a highly effective pedagogical choice for enhancing and developing effective intercultural communications skills and transcultural competence.

**Growing Body of Evidence Supporting International Study**

Over the past decade the role of international study in the development of intercultural competence has been more widely noted in the literature (Caffrey, Neander, Markle, & Stewart, 2005; Campbell-Heider, Rejman, Austin-Ketch, Sackett, Feeley, & Wilk, 2006; Deardorff, 2006; Walsh & De Joseph, 2003). Numerous studies have found that these experiences contribute to students’ overall maturation, growth, self-confidence, intellectual development and general understanding of the international community
(Button, Green, Tengnah, Johansson, & Baker, 2005; Smith-Miller, Leak, Harlan, Dieckmann, & Sherwood, 2010). Additional studies found that immersion experiences or international cultural programs are effective teaching strategies that increase consciousness-raising and cross-cultural learning and help to diminish ethnocentricity (Crampton, Dowell, Parkin, & Thompson, 2003; Mixer, 2008). Similar studies link international cultural experience programs with positive learner outcomes such as cognitive development (Moseley, Reeder, & Armstrong, 2008; Ruddock & Turner, 2007) and changes in worldview (Larson, Ott, & Miles, 2010; Wright & Clarke, 2010).

Colleges and universities are searching for a variety of ways to encourage students to participate in international cultural experiences because of the measurable positive outcomes that these experiences have on students. As a result, international cultural experiences in all disciplines have increased in popularity in recent years, according to the Institute of International Education’s (IIE), *Open Doors Report* (2011). In the academic year 2008-2009, the number of Americans who studied abroad for academic credit was 260,327; in the academic year 2009-2010, the number was 270,604 (IIE, 2011). In addition, the number of U.S. students studying abroad has tripled over the past 20 years. However, this still represents just over one percent of all U.S. students enrolled in higher education, a very small proportion of the 20 million U.S. college students (IIE, 2011) and an even smaller percentage of nursing students. Whereas there are many reasons that prohibit students from studying abroad, including lack of finances, programs not conducive with their schedules, lack of faculty and parental support, the benefits of an international cultural experience program has been well-documented in the
literature (Salisbury, Umbach, Paulsen, & Pascarella, 2009). The decision to partake in an international cultural experience is based on parental support, curriculum flexibility, and affordability (Salisbury et al., 2009). A short-term option can help to address financial concerns and curricular challenges.

The benefits of long-term international cultural experiences are fairly well studied and documented (Bosworth et al., 2006; Inglis, Rolls, & Kristy, 2000; Zorn, 1996; Zorn, Ponick, & Peck, 1995). However, longer international cultural experiences are often difficult to arrange in rigorous programs such as nursing, which are bound by the rules and regulations of accrediting agencies. These accrediting agencies require in-hospital and other clinical experiences on a weekly basis, limiting the amount of time students can travel abroad. If a student chooses a semester of travel, the graduation date is often delayed for a semester or an entire year, since nursing courses follow a specific sequence. A summer option exists for some; however, many students choose to work over the summer months to supplement their income.

University faculty, especially nursing faculty, must confront the challenges that inhibit international cultural experiences. Short-term programs have played a significant role in providing increased opportunities for students to participate in international cultural experiences by offering flexible international study opportunities for those who might otherwise be unable to participate in traditional programs (IIE, 2012).

Studies identifying significant student outcomes through short-term international experiences report that students who participated in these short-term programs of less than one month were transformed by the experience (Caffrey et al., 2005; Maltby &
Abrams, 2009). They were able to demonstrate flexibility (Wood & Atkins, 2006),
greater self-awareness (Wallace, 2007), gains in understanding their professional role,
(Caffrey et al., 2005; Ter Maten & Garcia-Maas, 2009), an increase in intercultural
sensitivity (Anderson, Lawton, Rexeisen, & Hubbard, 2006; Caffrey et al., 2005), cultural
adaptation and adjustment (Inglis et al., 2000), and an increase in understanding global
interdependence (Chieffo & Griffiths, 2004). Research has shown that in short-term
programs faculty were often more engaged with the students and exerted more control
over the experience and a highly structured short-term program resulted in rich and
effective learning outcomes (Donnelly-Smith, 2009).

Obviously, the shorter the international cultural experience, the less expensive and
more accessible it is for students and faculty, but the question is whether these short
experiences reap positive outcomes. The research on international cultural experiences of
less than two weeks, whether quantitative or qualitative, is sparse. Most short-term
experiences that have been studied were at least three to six weeks long and reported
positive outcomes (Button et al., 2005; Caffrey et al., 2005; Maltby & Abrams, 2009; P.
J. Pedersen, 2009; Smith-Miller et al., 2010).

**Problem Statement**

International cultural experiences, also known as cultural immersion or study
abroad programs, have been shown to increase intercultural and transcultural competence
(Cordero & Rodriguez, 2009; Fennell, 2009; Greatrex-White, 2008; Inglis et al., 2000;
Johns & Thompson, 2010; Kitsantas, 2004; Koskinen & Tossavainen, 2004; Larson et al.,
2010; Moseley et al., 2008; Ruddock & Turner, 2007; Smith-Miller et al., 2010; Walsh &
DeJoseph, 2003; Wright & Clarke, 2010). For a nurse, intercultural and transcultural competence is essential when caring for patients, whether those patients live within the borders of the United States or are visiting from another nation. Although culture content is integrated throughout most nursing curriculum or taught in specific culture courses, there is still a void of cultural knowledge, awareness, sensitivity, humility, and competence among nursing graduates (Reeves & Fogg, 2006). Research by Reeves and Fogg found that only 50% of nursing graduates felt that they were adequately prepared and said they were not comfortable providing care to individuals who were different from their own ethnic or cultural backgrounds. Short-term international immersion programs may be one possible solution to enabling greater international cultural competence among nursing graduates, but there is a huge gap in the literature evaluating their efficacy. This dissertation seeks to address that gap by exploring the ways in which nursing participants created meaning from a short-term international immersion experience.

**Purpose of Inquiry**

The purpose of this interpretative qualitative study was to describe how participants (nursing students) created meaning from a short-term international cultural experience of eight days in Tanzania in the short term and after six months. Also examined within the study was how, or if, this one week international experience influenced the participants’ concept of the professional role of the nurse.

This research was uniquely different from previous research studies in that it examined the impact and outcomes of a short-term international cultural experience of eight days instead of a longer experience. Prior research on short-term experiences is
scarce and only two articles covering one-week programs were found: a program of one-week duration from the discipline of occupational therapy (Mu, Coppard, Bracciano, Doll, & Matthews, 2012) and a qualitative study by Evanson and Zust (2006) that examined the benefits of a short-term experience for six nursing graduates who spent one week in Guatemala.

**Research Questions**

The research questions that guided this study were:

1. How do participants (nursing students) make meaning from an 8-day international cultural experience in the short term and six months after returning home?

2. How do the participants re-conceptualize their role as a nurse six months after returning home?

**Research Methods**

I utilized an interpretive qualitative approach informed by theories from the fields of curriculum studies, cross-cultural psychology (intercultural communication), and transcultural nursing. Langer’s theory of Mindfulness, from curriculum studies, guided the pedagogical approaches used for this research. Bennett’s Developmental Model of Intercultural Sensitivity (DMIS) from intercultural communication, Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare, from the nursing discipline, and Langer’s theory of Mindfulness provided the framework for interpretation and analysis of the data.
Merriam (2002) described interpretative qualitative research as the construction of meaning. According to Merriam, symbolic interactionism informs this type of research. Symbolic interactionism focuses on the interpretation of human beings within a certain context of the larger society as the individual interacts with other people. Symbolic interactionism emphasizes seeing the world through the other person’s perspective and placing ourselves in the other person’s situation (Merriam, 2002). Likewise, interpretive qualitative research emphasizes subjectivity of people’s behaviors and realizes that people’s interpretations are based on everyday experiences that have meaning for them. Thus, meanings are not discovered as if they had a prior existence; instead human beings construct meanings as they engage in and make sense of their world (Merriam, 2002). The constructionist approach was selected to structure this learning environment in order to understand the participants’ different representations and interpretations during and following the immersion experience.

**The Epistemology of the Constructionist**

My research reflected a constructionist learning approach, which is positioned within the larger constructivist epistemology (Harel, 1991; Lincoln & Guba, 1985). Constructionists are concerned with the lens that people look through, the common interpretations of what is seen and what is experienced (Harel, 1991). They pay attention to shared meanings within a cultural context and how these meanings are interpreted. They understand that meaning and values can differ for every individual.

Constructivist research is an inductive process that assimilates information in order to develop a description that will clarify the phenomenon under investigation.
However, it is important to remember that this approach has several limitations. Humans as information gathering instruments are fallible, and the subjectivity that enriches this method can produce trivial and insignificant findings (Polit & Beck, 2008). As an interpretive researcher, I tried to remain cognizant and alert to my own biases and assumptions. There was no need to ignore assumptions, but I was cautious and aware of these assumptions and how it could misconstrue the data. This required me to first recognize and then suspend my cultural assumptions long enough to understand the perspective of the participants (H. J. Rubin & Rubin, 2005).

**The Ontological Framework of This Study**

The ontological perspective of this study was as important as its epistemological stance. Ontology is the philosophical study of the nature of being or of living and is a stance toward the nature of reality. It asks the principal questions *what is truth, what is the meaning of truth, and what is the nature of the reality* (Creswell, 2007). Ontology typically refers to statements about humanity (Pesut, 2010). As with epistemology, there are also several different ontological views. An ontological assumption is that reality is multiple, subjective, and constructed (Polit & Beck, 2008).

An ontological orientation focuses on people, experiences, and action. The ontological perspective illuminates the manner in which knowledge and knowing are related to subjectivity and context. Nursing’s ontology has been shaped by a philosophic view of the meta-paradigm concepts of the person, the nurse, health, and the environment (Pesut, 2010). Most nursing theories are constructed looking at the interplay between these concepts with the goal of optimal delivery of health care. The meta-paradigms
explore what it means to be human, how health is defined for the individual, how the nurse provides care for the client, and how the environment is defined. These concepts vary depending on the nursing theory that informs them. Health can be viewed as a continuum of wellness or illness. Life can be seen as the end of the continuum or a transition to a new and different dimension of existence (Rogers, 1970). The environment can be a concrete concept such as a physical place, or the more abstract concept of an energy field (Rogers, 1970).

The central unifying focus of nursing is the ontology of holism. The term holism means that organisms are united and indivisible; the parts are interdependent and interrelated (Owen & Holmes, 1993). In fact, early nurse theorists resisted reductionist thinking by emphasizing people as holistic beings interacting within a social context (Pesut, 2010). Holism is manifested in nursing’s worldviews, conceptual models, and theories, which are necessary to address the multiple ways that people differ on the basis, culture, race, gender, ethnicity, sexual orientation, religion, life experiences, geopolitical influences, and socioeconomic status (Pesut, 2010).

**The Constructivist Paradigm and the Ontology of Holism**

Holism is consistent with a systems approach and has evolved from the philosophical concept of Jan Christian Smuts in 1926 (Doheny, Stopper, & Cook, 1992). It is the integration of the mind, body, and spirit for the person; the focus is on the individual, not the disease. It emphasizes the whole person in health promotion and the treatment of illness. Holistic nursing sees each person as a unique whole being who seeks meaning within his or her lived experiences (Ray, 2010). Holism is both the way in
which nursing views the person and the way in which nurses give care. The person as a bio-psycho-social being is in constant interaction with a changing environment. The person functions in totality and any adaptive behavior is the behavior of the whole person (Ham-Ying, 1993).

The American Holistic Nurses’ Association (2012) stated that the practice of holistic nursing is grounded in nursing theory. The holistic nurse is an instrument of healing and a facilitator in the healing process. The constructivist epistemology is also consistent with holistic nursing and transcultural nursing, which asks the nurses to honor the individual’s subjective experience about health traditions, health experiences, health beliefs, and values. Holistic nursing requires nurses to use self-reflection when providing care for their patients.

The concern is for the “whole” person: body, mind, spirit, and environment. Thus, the ontological framework for my study values multiple realities and respects and cherishes the uniqueness and diversity of all people. The ontology of holism supports culturally competent, culturally sensitive, and culturally aware nursing care. The ontological perspective for nursing means that knowing is always situated within a personal, social, historical, and cultural setting, and thus transforms from cognitive understanding to a way of being (Pesut, 2010). The focus of the educational experiences for both students and teacher becomes that of enhancing and evolving students’ ways of being so they become culturally responsive, knowledgeable, ethical, and competent nurses (Pesut, 2010).
Theoretical Framework of This Study

The following theories were selected to provide the theoretical framework for this research, to provide a foundation for the design of the study (including the pedagogical choice), and to guide the analysis and interpretation of data. All of the theories selected have similarities and commonalities between them, yet each theory offers an expanded way to look at intercultural/transcultural competence and effective pedagogy. A more in-depth discussion of the theoretical framework, methodology, and procedures undertaken in this specific study are provided in Chapter 3.

Langer’s Theory of Mindfulness

The theory of Mindfulness was selected because of the components of reflexivity, multiple perspectives, analytical empathy, and intentional creativity (Vande Berg & Paige, 2009), all of which are necessary traits of the transcultural nurse. Constructionists/constructivists see mindfulness as an ongoing process of evaluation, cognitive framing or re-framing, in order to grasp a better understanding of the cultural context.

Mindfulness is a skill that supports intercultural capabilities and competence. It guides us to be aware of our own personal communication approach while reflecting on the effect that these interactions have on patient care. In the context of intercultural communication, mindfulness means attending to internal assumptions, cognitions, and affective behavior at the same time remaining acutely aware of opposing communication assumptions, cognition, and emotions (Ting-Toomey, 1999). This requires the individual to see other behaviors and traditions from multiple cultural angles (Langer, 1989). An
important aspect of mindfulness is the realization of how our worldview may influence others or social issues; mindfulness suggests a different approach to combating prejudice (Langer, 1992). The rationale for selecting Langer’s theory of Mindfulness is to help participants reflect, and thus encourage openness to new information as they care for individuals from diverse and unique cultures.

According to Pike (2008), Langer’s (1989, 1997) theory of Mindfulness has the potential of becoming a unifying framework for psychology and its subfields. Langer’s theory of Mindfulness, in a more practical manner, offers guidance for conceptualizing and remedying educational, health care, social, and cultural issues (Pike, 2008). Langer’s theory provides novel interventions for educational and nursing practice, including how material is taught and how it is understood (Pike, 2008).

**Bennett’s Developmental Model of Intercultural Sensitivity (DMIS)**

The Developmental Model of Intercultural Sensitivity (DMIS), also a constructivist model, evolved from observations obtained from grounded theory (Cushner et al., 2003). The constructivist approach and affective dimensions of the DMIS can help us to understand the meanings and complexities of an international cultural experience. The DMIS describes people’s reactions to cultural differences from an ethnocentric to an ethnorelative frame of reference. The basic assumption of the model is that as intercultural challenges occur, our experiences of cultural difference become more complex, and our competence in intercultural relations increases. M. J. Bennett’s (1993) DMIS connects the field of intercultural communication with the fields of human development and curriculum studies (Endicott, Bock, & Narvaez, 2003).
The DMIS supported the interpretation of data through participant interviews, discussions, and reflective journals. The categories of intercultural sensitivity described in the DMIS provided a basis for analyzing the journals. Bennett’s DMIS identifies six stages for developing intercultural competence, moving from ethnocentrism to ethnorelativism. These changes move the person from a position of cultural superiority, as seen with ethnocentrism, to accepting equality across cultures, or ethnorelativism. As people move through these stages, their worldview becomes more sophisticated and thoughtful. However, Cushner et al. (2003) cautioned us to consider that if we try to move too quickly, culture shock may be too great. A gradual, more thoughtful approach may be the best method. The first three stages in the process are ethnocentric: Denial, Defense, and Minimization; the last three stages are ethno relative: Acceptance, Adaptation, and Integration (M. J. Bennett, 1993; Cushner et al., 2003). The ethnocentric period focuses mainly on the self and a frame of reference that reflects our own culture. The ethnorelative phase is identified by a desire to learn more about other cultures and by an interest in meaningful interactions (Munoz, DoBroka & Mohammad, 2009). This desire to learn about other cultures is an important concept that is consistent with Campinha-Bacote’s model, the Process of Cultural Competence in the Delivery of Healthcare (1999).

**Caminha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare**

The Process of Cultural Competence in the Delivery of Healthcare Services is a model for delivering culturally competent health care developed by Campinha-Bacote. This model describes cultural competence as an ongoing process in which the health care
provider continuously strives to achieve the ability to work effectively within the cultural context of the client the client’s family and or the client’s community (Campinha-Bacote, 2002). The expectation of this model is that health care providers will view themselves as continuing along the process of becoming culturally competent rather than being culturally competent. This process entails the incorporation of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire: “a genuine passion to be open and flexible with others, to accept differences built on similarities, and to be willing to learn from others as cultural informants” (Campinha-Bacote, 2002, p. 183).

This model was also selected because it introduces the concept of cultural humility. When individuals acquire cultural humility, they begin to recognize and understand the extent and harm of health disparities. Cultural humility serves as the basis for good moral education toward optimal healthcare and culturally competent and effective nursing care.

**Definitions of Terms**

Two sets of terms were fundamental to this study. First terms that were crucial to understanding cultural awareness and sensitivity and how they apply to the practice of nursing were presented. Second, terms that described the conditions and nature of international and cross-cultural education experiences were discussed.

**Cultural Awareness and Cultural Sensitivity**

Cultural sensitivity means that we are cognizant of our personal attitudes and we strive to keep in check those behaviors and actions that may be offensive to another
cultural group (Purnell & Paulanka, 2008). Cultural awareness is the process that we undergo to learn respectful, appreciative, and sensitive behaviors when working with clients’ cultural values, beliefs, practices and problem-solving strategies (Campinha-Bacote, 2001). This can support the nurse’s understanding of the cultural interpretations of illness, pain, and other important factors that must be addressed for effective holistic care (Campinha-Bacote, 2001). Cultural awareness and sensitivity in the nursing environment are further defined as follows:

**Culturally appropriate care.** Culturally appropriate care is care attuned to patients that respects and honors different cultural beliefs, different ways of relating to people, different attitudes, and different behaviors, including adapting the delivery of care to meet the patients’ social, cultural, and linguistic needs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Unless the health care provider is cognizant of what is culturally congruent for the patient, the health care provider may be ineffective in delivering culturally competent care, which is the main ingredient for closing the disparities gap in health care (USDHHS, 2010).

**Cultural competence.** For the purpose of this research, I defined cultural competence as a “dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care-delivery strategies based on the knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they render care” (Giger & Davidhizar, 1999, p. 8). Cultural competence asks the nurse to understand and attend to the total context of the patient, utilizing a complex combination of knowledge, attitudes, and skills drawing from the ontology of holism.
**Cultural humility.** The important and distinct feature of cultural humility is that there is no endpoint. Cultural humility recognizes that growth toward intercultural competence requires a lifelong journey of learning about and experiencing other cultures (Tervalon & Murray-Garcia, 1998). Cultural humility asks the individual to self-critique and re-evaluate their commitment to redressing power imbalances in the patient health care provider relationship (Campinha-Bacote, 2007).

**Intercultural competence.** Intercultural competence is defined as “complex abilities that are required to perform effectively and appropriately when interacting with others who are linguistically and culturally different from oneself” (Fantini, 1985, p. 458). Intercultural competence for health care providers is defined as the ability to deliver effective, respectful, plausible and considerate care that is provided in a manner compatible with the patient’s health beliefs and practices (USDHHS, 2010).

**Transcultural nursing.** Transcultural nursing is the interactive relationship between all cultures (Leininger, 1988). The term transcultural implies a concept that goes beyond cultural boundaries and are common to all cultures (Murphy, 2006). Transcultural nursing is the combination of education and experience needed to provide knowledgeable, effective, competent, and safe care to all people.

The term transcultural nursing is often used interchangeably within the nursing literature as cross-cultural, intercultural or multicultural nursing. As the name implies, transcultural nursing crosses cultural boundaries, striving to find the essence of nursing, (Leininger, 1988).
International Cultural Experiences Defined

Long-term international cultural experiences. A long-term international cultural program is defined as a minimum of nine weeks in length, and often is a semester or a yearlong program.

Short-term international experiences. A short-term international cultural exchange program is defined as a program eight weeks or fewer in length.

Limitations and Delimitations

Limitations

One concern is that the participants who choose this immersion experience may have possessed a greater interest and sensitivity to cultural issues than those who declined to participate. The participants may have already developed a greater desire to interact with diverse people and cultures and this may have influenced their participation in this experience and research study. A further concern is that the participants also may have had difficulty overcoming preconceived biases and this 8-day experience may have reinforced these biases, rather than reduced them. For some potential participants, financial issues may have prevented them from participating in this international experience, artificially distorting the results.

Delimitations

The participants of this study were a homogenous group of students from the third poorest county in the State of Ohio, which is part of the Appalachian region. This study examined participants’ thoughts, perceptions, and feelings during the international cultural experience two months later and finally six months after returning home; the
long-term lasting effects of this experience were not studied. Also not examined in-depth was the motivation of students participating in this experience.

**Assumptions**

For the purpose of this research, I identified the following assumptions: The participants responded to questions honestly and without duress; the participants’ reflective journals were completed willingly and accurately reflect each participant’s thoughts, feelings, and perceptions; the participants understood the terms, concepts, and vocabulary used during the research study; the data, consisting of reflective journals, focus group discussions, and individual interviews, provided sufficient evidence to support the findings of this study; and finally, the data interpretation accurately reflected the perceptions, feelings, and thoughts of the participants.

**Contribution to the Knowledge Base as a Result of This Research**

It is important to recognize that intercultural competence can be realized only through repeated and well planned exposure to intercultural experiences that will serve to “nudge an individual to increasingly complex levels” (Cushner, 2004, p. 59). Past research supports an increase in students’ global understanding and cross-cultural knowledge for traditional long-term international cultural experiences and even for some well-planned shorter programs, most of which were at least one month long. This study sought to describe the experiences and meanings from a short-term cultural experience of eight days in Tanzania. Also examined within the study was how, or if, this one week international experience influenced the participants’ concept of the professional role of
the nurse. This study is uniquely different in that it used guided pedagogy while abroad through reflective journaling looking at immediate and intermediate results.

**Dissertation Outline**

The dissertation is presented in five chapters, including this introduction. The second chapter reviews relevant literature, including a discussion of international cultural experiences that comprise immersion, study abroad, and tourist-based programs. Chapter 2 also examines the international programs as a form of pedagogy and reports on research outcomes from international cultural experiences for all college students as well as those with a health care focus such as nursing. Chapter 2 explores the link between program duration and lasting impact. Also included is a critical analysis of the existing literature that both supports and disputes the value of short-term international cultural experiences. Difficulties with international cultural experiences, study abroad or immersion programs, including lack of faculty preparedness, difficulties with language, financial constraints, and cultural dissonance, were identified as obstacles to successful international experiences.

Chapter 3, methodology, explains why the basic interpretative qualitative approach was the most useful for this study. This chapter describes three theories used to frame this study, which included Langer’s concept of “Mindfulness” (1999), Campinha-Bacote’s model, The Process of Cultural Competence in the Delivery of Healthcare (1999), and Bennett’s Developmental Model of Intercultural Sensitivity (1993). This chapter provides an in-depth description of each theory and how each theory was used to support this study. Several qualitative research approaches were contrasted and
compared and I provide a rationale for selecting the interpretive qualitative approach. Data collection methods of reflective journaling, focus group discussions, and individual interviews are explained. The procedure and steps used for data analysis and interpretation are provided. Last, I examined my role as the researcher, discussed ethical considerations, and described the efforts utilized to maintain trustworthiness and credibility for this study.

Chapter 4 presents the results of this study. Inductive reasoning was used to analyze the reflective journals, focus group discussions, and personal interviews. Each question was answered through the development of themes that reflected both positive and negative consequences of this short and intense cultural experience. I provide rich descriptions to support the themes. I also examined the immediate impact and compared these results with data gathered six months after returning home. Both research questions were answered based on multiple coding techniques to organize and reduce the data and to establish the themes and subthemes. Detailed narratives are provided to ensure transparency. The theories of Langer, Bennett, and Campinha-Bacote as well as pertinent research studies are provided to support data interpretation and analysis.

Chapter 5 discusses the results of this dissertation and unexpected findings. In this chapter I answer the two questions that guided this research and discuss issues raised by this study, including implications for practice. The limitations of this study are reviewed as well as suggestions for further research. Some worrisome results of this 8-day international cultural experiences, as well as benefits, are presented. A special emphasis was given to the impact of culture shock. This chapter also summarizes the
CHAPTER II

LITERATURE REVIEW

Introduction

This chapter explores the literature on international cultural experiences and the relevancy of such to intercultural and transcultural competence for the nursing student. I review different teaching approaches from a historical perspective, ending with current pedagogical choices. I also investigate the differing lengths and approaches to international cultural experiences as well as the difficulties and deterrents to study abroad.

The Impact of Culturally Incompetent Practitioners on Health Care Outcomes

Owing to shifting demographic patterns in the United States, worldwide cultural competence and cultural sensitivity has become a critical skill for all health care providers. Cultural competence in health care refers to “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations” (Betancourt et al., 2003, p. 297).

Despite increased awareness for a multicultural approach to health care delivery, health care providers often disregard or are insensitive to patients’ cultural norms. Stereotyping, discrimination, bias, racism, and prejudice act as barriers to culturally effective care. This insensitivity for the cultural needs of the patient breaks down
communication and precipitates mistrust between minority patients and their health care providers (N. Langer, 1999).

The Transcultural Nursing Society (2012) has found that the nurse and other health care providers frequently are reluctant to or incapable of providing meaningful care to people who are different from their own cultural backgrounds. Rather, blatant cultural clashes and practices that are ineffective or harmful are imposed on the diverse patient, ignoring the cultural needs of the individual. Often, low-income minorities refrain from seeking help in traditional health care settings due to the mistrust that many feel toward health care providers because of historical maltreatment. LaVeist, Diala, and Jarrete (2000) found that 43% of African Americans and 28% of Latinos, in comparison with 5% of Caucasians, felt that a health care provider treated them poorly because of their race or ethnic background. In addition, LaVeist et al. reported that mistrust toward health care professionals and others in positions of authority is common among immigrants and refugees.

The 2011 U.S. Census reported that almost 36% of the population belongs to an ethnic or racial minority group. There are continuing disparities of illness and death experienced by minority populations when compared to the White population in the United States. According to the CDC (2012), minorities experience a disproportionate burden of preventable disease and are dying at appreciably higher rates compared with whites. The Office of Minority Health & Health Equity (CDC, 2012) reported that the 2007 age-adjusted death rate from diabetes for African Americans and Blacks is about double the rate for Whites and 1.5 times higher for American Indians and Alaskan
Natives when compared to the White population. It was also noted that Hispanic and Black patients were significantly more likely than non-Hispanic Whites to report poor communication with health providers (Chevarley, 2011).

**Teaching of Intercultural and Transcultural Content**

Studies related to intercultural competence, intercultural learning, and intercultural adaptation date back to the 1960s; however, there was no standard or widely accepted model for the education and evaluation of intercultural competence (Berry, Poortinga, Segall, & Dasen, 2008). During this era, various government agencies and intercultural scholars began the development of several educational models in which to advance intercultural education. The University Model, a purely didactic approach, emphasized a cognitive learning style that was lecture based (M. Paige & Martin, 1996). The Human Relations Sensitivity Model (M. Paige & Martin, 1996) emerged next and shifted to an experiential and participative learning approach—opposite of the University Model. Individuals were taught that what appears logical and rational in one culture, may have the opposite meaning, or may be viewed as unimportant, irrational, and contradictory in another culture (M. Paige & Martin, 1996). The problem with the Human Relations Sensitivity Model was that the researchers jumped from a solely didactic learning model to one that was entirely experiential. There was a void in a sound conceptual framework for the trainees. The Integrated Alternative Model, whereby integration of theory and practice was the goal, became the dominant model of the 1980s. This model combined conceptual, experiential, and skill acquisition (M. Paige & Martin, 1996).
Today the current training or educational model is that of an integrated approach incorporating both didactic and experiential learning (M. Paige & Martin, 1996). In addition, the interest has shifted somewhat to issues of power imbalances. As the field grew, resources were committed to a particular focus of study for a period of time examining learning styles, sophistication of techniques, and conceptual understanding or the design of a program. Pusch (2004) stated that this “constant reinvention does bring a certain eclectic creativity to the field, but it could be argued that it hinders in-depth new research on constructs and training techniques” (p. 30). Intercultural training toward a multicultural perspective asks the learner to develop a new worldview; it is the ability to function in multiple cultures and integrate those cultures into one’s identity (Pusch, 2004).

**Current Approaches to Intercultural and Transcultural Learning in Nursing**

There is a growing global focus on developing interculturally competent students, professionals, and citizens, and yet didactic education in cultural knowledge remains the primary pedagogical method for teaching intercultural competence. Unfortunately, didactic education does not necessarily equate with intercultural competence (J. M. Bennett & Salonen, 2007). Duffy (2001) cautioned us that while cultural care is taught in a traditional format in most nursing education programs, there is little evidence that this enhances health care, and in fact, the existing evidence suggests that traditional courses may narrow the students’ perspective of individual cultural groups. Campesino (2008) has identified significant limitations in the process of cultural education and transcultural theory, particularly the lack of dialogue and analysis across perspectives.
Transcultural nursing education began in the 1950s with Leininger and was later further refined by Campinha-Bacote (1995), Purnell and Paulanka (2008), and Spector (2009). All have promoted and contributed to the insertion of culture into nursing curriculum both at the graduate and undergraduate level, but no concrete recommendations for experiential programs were included (Ryan & Twibell, 2002). The basis for transcultural nursing care lies in the nurse learning about the meanings, language, worldview, symbols, and social structure for care of individuals from diverse cultural groups. According to Leininger (1988), different cultures respond to nurses in different ways and have different expectations of nursing care; “People are born, live, become ill, and die within a cultural belief and practice system, but are dependent upon human care for growth and survival” (p. 155). Cultural competence requires the nurse to alter his or her way of thinking. Rather than expecting the patient to adapt to the health care system, the health care system should be flexible enough to adapt to the patient’s unique needs. This requires a shift from an ethnocentric view to an ethnorelative mindset (St. Clair & McKenry, 1999).

In nursing, distinct cultural components continue to dominate the education of students, instead of addressing local and global interactions. Current research raises questions as to how nursing education is meeting the American Association of Colleges of Nursing’s goal to prepare nurses to care for a diverse community (Kennedy, Fisher, Fontaine, & Martin-Holland, 2008). A recent qualitative study of nursing graduates revealed that half of the graduates felt inadequately prepared to provide culturally
competent care, and most were uncomfortable in providing care to patients whose diverse backgrounds were different from their own (Reeves & Fogg, 2006).

Driven by accreditation standards for colleges and universities, most nursing programs include cultural competency as a program outcome. Multiple curricular approaches have been implemented in nursing programs in an attempt to graduate nurses that who have the basic skills necessary to care for an increasing diverse population. After a half century of theory development, research, and practice of transcultural care, there still remains a lack of consistent and effective cultural education for nursing (Omeri, 2008).

This lack of consistent and effective cultural education for nursing students was demonstrated using Campinha-Bacote’s Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-R (IAPCC-R; Kardong-Edgren et al., 2010). This research examined 515 graduating nursing students from six different baccalaureate programs and concluded that the average student graduating from a nursing program did not score in the culturally competent range. Instead, the graduates scored lower in the culturally aware range. These results suggest that regardless of the curricular approaches used to educate nurses, nursing schools continue to graduate students who have not developed even a minimal level of cultural competence. This study did not look at whether student scores on the IAPCC-R might vary depending on the pedagogical approach of the course work.

One study comparing experiential learning outcomes with those of traditional courses suggests that pedagogy may indeed make a difference. In a quasi-experimental
cohort design by Zorn et al. (1995), students from the same program who participated in a 3-month international study program were compared with those students who remained in the traditional classroom setting. Using Perry’s theory of adult cognitive development as a conceptual basis and a quasi-experimental cohort design, data were collected from eight students participating in a semester abroad program in England. In addition to the eight students studying abroad, 20 randomly selected students not participating in the program were also studied, using the Measurement of Epistemological Reflection [MER]. The MER was used to determine the degree of the students’ cognitive development (Zorn et al., 1995) for those students who studied abroad compared with students who did not study abroad. The students participating in the study abroad program demonstrated significantly more cognitive growth \((p = .044)\). The findings from this study must be interpreted cautiously because of the small sample size, a potential source of bias. Additional studies with larger and more heterogeneous samples would be necessary, especially related to gender, age, and ethnicity. Despite several research limitations, it was found that students’ participation in an international study program had a positive influence on their cognitive development, as measured by the MER.

A study conducted on a psychology study abroad program by P. J. Pedersen (2009) examined outcomes from the perspective of employers and workforce needs. Bennett’s DMIS was used to categorize and analyze the data, and the research was two-fold. The first arm of this inquiry examined a well-planned 2-week short-term immersion experience in Amsterdam and Copenhagen with specific curricular objectives and guided pedagogy. The second part compared the short-term experience to a one-year experience
without specific pedagogical organization or objectives. The results compared pretest and posttest means between the two groups and found that deliberate and well-planned pedagogy and guided reflection resulted in the most growth and change. An interesting finding was that the group with the shorter experience demonstrated the second most positive overall scores when reflection was used as an added pedagogical approach for the short-term experience.

**International Study Abroad Programs as Pedagogy**

Internationalization through study abroad is widely recognized as a preferred teaching approach for the development of globally competent practitioners and college graduates (Salisbury et al., 2009). International cultural experiences have been found to increase the likelihood that students will achieve an optimal cultural related nursing education (St. Clair & McKenry, 1999; Zorn, 1996). Research on university study abroad programs throughout all disciplines indicates that international experiences increase cultural awareness and cross-cultural learning, and help to diminish ethnocentricity (Crampton et al., 2003; Mixer, 2008).

**Outcomes of International Cultural Experiences**

As the number of students studying abroad has expanded, so also has the research on program evaluation and outcomes increased (Stroud, 2010). Effective experiential intercultural learning can facilitate intercultural development, especially in the areas of flexible thinking, emotional resilience, openness, and perceptual acuity (X. Wang, 2011). The acquisition of cultural competence is a process that evolves from the cognitive, affective, and psychosocial domains of learning and results in increased sensitivity.
(Vande Berg, 2001), enhanced individual autonomy or self-efficacy, cognitive flexibility, and world-mindedness (Ingraham & Peterson, 2005; R. Paige, Fry, Stallman, Josic & Jon, 2009). It also helps students attain desired knowledge, skills and competencies (X. Wang, 2011). International cultural programs provide college students with experiential opportunities to learn about diverse cultures that cannot be accomplished through traditional teaching formats (Memmott et al., 2010).

Research on international programs that combine didactic and experiential learning have reported gains in the areas of cultural relativism and global interdependence (D. L. Rubin & Sutton, 2001); cultural sensitivity (Campinha-Bacote, 1999; Koskinen & Tossavainen, 2004); and personal growth and cultural awareness (Button et al., 2005; Greatrex-White, 2007; Green, Johansson, Rosser, Tengnah, & Segrott, 2008; Ruddock & Turner, 2007). Research studies also report substantial advances in intercultural competence through this combined approach (Cordero & Rodriguez, 2009; Fennell, 2009; Greatrex-White, 2008; Inglis et al., 2000; Johns & Thompson, 2010; Kitsantas, 2004; Koskinen & Tossavainen, 2004; Larson et al., 2010; Moseley et al., 2008, Ruddock & Turner, 2007; Smith-Miller et al., 2010; Walsh & DeJoseph, 2003; Wright & Clarke, 2010).

International study abroad programs not only had an unquestionable impact on developing cultural awareness and cultural sensitivity toward the host culture, but also helped students develop a keener awareness of their own culture (Haloburdo & Thompson, 1998; Koskinen & Tossavainen, 2004). Moreover, research has shown that when sojourners begin to make comparisons and notice differences, they begin to realize
that not all cultures live and function in the same manner (Catalano; 2009; Kokko, 2011; Sandin, Grahn, & Kronvall, 2004). This often increases the desire to learn about diverse cultures (Sandin et al., 2004).

The value of study abroad programs has been reported in all disciplines. Wright and Clarke (2010) investigated preparing future business and marketing students for the workplace. This study supported claims that students benefit from these experiences and were changed following an international experiential program; however, students’ global-centrism (the ability to base judgments on global rather than ethnocentric standards) remained unchanged. This study found that study abroad programs might provide an “unparalleled learning laboratory for expanding worldviews and creating globally minded students” (p. 155). The limitation of this study was that it examined students who traveled abroad over one semester in English speaking countries only.

**The Benefits of Long-Term Study Abroad Programs**

The beneficial outcomes from long-term international experiences are well documented. Researchers have found that the length of a program is just one factor that generates greater intercultural learning (Bosworth et al., 2006; Dwyer, 2004; Medina-Lopez-Portillo, 2004; Tsai, 2011; Zorn, 1996). A study by Zorn (1996) examined the effect of program duration on the development of an international perspective as well as on intellectual, personal, and professional role development for baccalaureate nursing students who graduated within five years from the time of the study. Zorn’s research examined international experiences of varying lengths and found that the longer the program, the greater the impact. However, the longer programs utilized a hands-on
approach, while the shorter programs did not include hands-on nursing care. This skewed the results since the participation in nursing care may have been the reason for the greater impact with the longer programs. In addition, Zorn studied students traveling to developed countries only.

Data collected in a longitudinal study for the Institute for International Education over a 50-year span found that the longer programs usually reaped more positive outcomes toward achieving intercultural competencies (Dwyer, 2004). However, Dwyer reported that summer students were just as likely to achieve these same outcomes when compared to students who studied abroad for an entire year. It would have been interesting to compare the outcomes of students enrolled in long, intermediate, or short study abroad programs with students enrolled in traditional classroom didactic settings.

Research by Bosworth et al. (2006) examined a long-term experience with pedagogy and provided outcome results for both faculty and students. This research design included collaboration with a nursing program in Guyana. These authors identified increased cultural competence in faculty and students who were involved in the program, acknowledged the importance of caring and the “use of self” in nursing, and confirmed the results of earlier studies demonstrating that these international experiences had a lasting effect on the participants. Additional benefits not associated with student outcomes, yet still significant, were the lasting partnership developed with the host country and the positive impact on the quality of health care provided for the local people.
The impact of program duration on intercultural learning was the focus of a quantitative study by Tsai (2011). This study found that cross-cultural adaption was greater in students who studied abroad for two years or more, and less for those who studied abroad for less than one year. However, when a one-way ANOVA was performed, this study showed that cross-cultural adaptation did not become stronger with increased length abroad. In a different study, both qualitative and quantitative data were examined looking at shorter international experiences, for two different sojourn experiences ranging from 7 to 13 weeks for 28 American students who studied in Mexico (Medina-Lopez-Portillo, 2004). This study found that students in the longer program had a higher level of intercultural sensitivity and a greater understanding of the host culture. These two studies (Medina-Lopez-Portillo, 2004; Tsai, 2011) found greater benefits with the longer sojourns; however, both studies showed gains in desirable outcomes regardless of length.

Is a Long-Term International Experience Necessary?

The 2011 report from the Institute of International Education’s Open Doors report found that approximately 270,604 U.S. students received academic credit for study abroad in 2009-2010, a 4% increase over the previous year, with most students still choosing Europe as the preferred destination. The majority of students who study abroad are now selecting shorter programs of 8 weeks or less over mid-length (one semester) or long-term (one academic year).

P. J. Pedersen (2009) disputed the length of an immersion experience as a predictor for the development of cultural competence and found that the length of a
program is not always an indicator of positive learning outcomes. Other studies support Pedersen’s findings that program length alone does not dictate positive learning outcomes for college students; rather the pedagogical approach greatly influences learning regardless of program length (Bosworth et al., 2006; Braskamp, Braskamp, & Merrill, 2009; Franklin, 2010; Green et al., 2008; Zorn, 1996; Zorn et al., 1995).

The literature reveals conflicting correlations between length of program and positive student outcomes. Some studies support longer programs and question the effectiveness of short-term programs (Medina-Lopez-Portillo, 2004; Tsai, 2011). A number of researchers have found the development of intercultural sensitivity to be greater when long-term programs with pedagogy were compared to short-term immersion programs (Medina-Lopez-Portillo, 2004; Tsai, 2011). The most important variable may be pedagogy and not simply the length of the program. When long-term programs were compared to traditional classroom teaching, the long-term programs showed much greater gains in intercultural proficiency, openness to diversity, and more global mindedness (Clarke, Flaherty, Wright, & McMillen, 2009). However, more research is needed examining the differences between long-term and short-term programs when effective pedagogy is incorporated into the program design.

As seen in this review of literature, many intercultural researchers argue that a program of fewer than two weeks will result in very little learning. However, there are only two studies looking at programs of less than two weeks (Evanson & Zust, 2006; Mu et al., 2010) and both of these studies demonstrated positive learning and growth outcomes. In addition, the “Allport Effect,” which was identified in the Georgetown
Consortium study (Vande Berg, 2009), found that any sojourn exposure is likely to result in a decrease of stereotyping and prejudice. The Georgetown study confirms that the educational design for the cultural learning process is more significant than the length of the program. What was found to be most important was the intervention in the learning process (Vande Berg, 2009) and not the length of the sojourn experience. Since many colleges and universities are moving toward shorter programs, the success of these programs relies on the pedagogical design utilizing an integrated approach. This study adds to the sparse research on short-term programs of less than two weeks using sound pedagogical choices combined with the short-term sojourn experience.

The Georgetown Consortium study also determined that students learn best when they were immersed in mixed situations with peers, other international students, and host culture individuals. M. J. Bennett (2009) highlighted the results from the Georgetown Consortium and found that home stays or immersion experiences do not necessarily enhance intercultural learning. This study contradicted commonly held beliefs that most intercultural learning occurs when students were immersed in host-culture education. Also noted was that intercultural learning had immediate, intermediate, and long-term effects. The immediate benefits of intercultural learning were the acquisition of culturally competent skills and the development of intercultural sensitivity when students interacted with the host culture. An intermediate effect was the transfer of knowledge from the exchange culture to other cultural environments, and the long-term effects resulted in a permanent awareness and respect for cultural differences (M. J. Bennett, 2009).
The Study Abroad for Global Engagement Study (SAGE) was used in a retrospective tracer study and mixed methods research design to survey over 6,000 participants in a national sample who participated in study abroad programs. Interviews were also conducted with 63 participants (Fry, Paige, & Stallman, 2009). The study empirically and systematically documented that study abroad programs of all lengths reaped significant benefits in the key domains of civic engagement, knowledge production, philanthropy, social entrepreneurship, and voluntary simplicity, but not necessarily cultural competence. There was no significant difference of global engagement between students who had studied abroad for longer or shorter time periods. This disputes the belief that longer programs are always better when it comes to study abroad (Donnelly-Smith, 2009).

**Alternative Experiential Learning Opportunities.**

The growth of international experiences has spurred many institutions to examine innovative short-term cultural experiences. Creative experiential learning programs that do not include travel abroad or sojourn experiences include the cultural plunge (Nieto, 2006), the domestic immersion experience (Kavanaugh, 1998), the tour group, and the use of simulations. Studies evaluating these innovative programs hold promise as alternative immersion opportunities and speak to the value of relatively short cultural encounters. Nieto (2006) examined a form of experiential learning identified as a “cultural plunge” teaching approach. A decade earlier Kavanaugh (1998) reported on students’ reactions to domestic immersion on the Pine Ridge Reservation in South Dakota. Both of these studies discussed domestic opportunities that eliminated logistic
difficulties such as visas, immunizations, and expensive international travel. The tour group, another alternative international experience, has a “touring” format without specific objectives or pedagogy (Inglis et al., 2000).

**Cultural Plunge.** Nieto’s (2006) cultural plunge is a form of cultural immersion that exposes students to markedly different cultures within the United States. Most plunges are very short and may be as short as one hour. There are four major objectives of the cultural plunge: to have direct contact with culturally diverse individuals or groups, to gain exposure and insights into that culture, to experience being the minority, and to become aware of one’s own biases and reactions. Student reactions of the cultural plunge range from fear to appreciation. Nieto’s survey of 93 students found that the students rated their overall experience highly, from 4.5–4.9 on a five-point scale. Qualitative data derived from reflection papers supports this conclusion. An important finding was that as a result of the cultural plunge and specific reflection objectives, the students were motivated to continue to learn about differences and to approach others who are different from themselves with a more open and inclusive perspective. This study suggested that even a very short immersion of an hour or a day still produces some benefit. What still needs to be explored is whether there are long-term lasting benefits.

**Domestic Immersion.** The domestic immersion experience by Kavanaugh (1998) employed an innovative nursing experience to investigate students’ reactions to a six-week field school on the Pine Ridge reservation. This allowed students to participate in an immersion experience within the borders of the United States to provide an “international” experience, without leaving North America. Over a four-year period, 10
to 12 different students participated in this program during one of four summers in South Dakota. Qualitative data drawn from participant observation, journals, interviews, and discussions provided the researchers with a comprehensive and multifaceted account of this field immersion experience. This experience encouraged the students to shift their perspective from trying to fix a problem to learning about different cultural groups. Student remarks supported the claim that a few weeks of immersion can equal many semesters of classroom and clinical teaching (Kavanaugh, 1998).

**The Tour Group.** The tour group is another form of international experience. Inglis et al. (2000) used a survey tool to evaluate the differences in outcomes between the traditional didactic format and the tour group. The tour group showed significant shifts in eight of the 28 items on a Likert-scale questionnaire, especially in the areas of independence, positive cultural adaption, and adjustment when compared to the traditional classroom for teaching culture care. This study indicates that even a “touring” experience may prove to be more beneficial for students than traditional classroom learning. However, it is important to keep in mind that tour groups are less than an ideal way of providing a sojourn experience. Cushner (2004) cautioned educators that when students travel abroad in a tour group, meaning is often made by the tour guides and others, rather than the traveler. The tour group experience often shields the individual from the local culture and the sojourners assume a spectator role (Cushner, 2004).

Another concern is the ethical controversy of “clinical tourism.” Levi (2009), Miller (2009), and Wall, Arrowsmith, Lassey, and Danso (2006) discussed clinical tourism whereby health care professionals travel to other areas of the world to practice
medical care in a diverse environment. These authors questioned the motivations of clinicians and students and encouraged faculty to prepare for the global experience in a thoughtful and goal directed manner. It is imperative that study abroad programs include reflection about cultural differences and the purpose of travel. Wall et al. (2006) urged nurse educators to define objectives of the international experience and to take care to avoid the pitfall of forcing patients to accept the care provided, victimizing those without the power or resources. Levi (2009) stressed that “altruism, benevolence and nursing behaviors that seem ‘good and right’ in the context of the system of care in the United States may not be considered so in another culture” (p. 94) and raised ethical concerns for patients who have no choice regarding from whom they receive care.

**Deterrents to Study Abroad or Immersion Programs**

University faculty face many obstacles in teaching intercultural competence and in implementing study abroad programs. Nurse educators are confronted with the challenges of providing students with rich and diverse learning experiences while understanding the implications of culture within multiple health care systems, on both a national and global level. Time constraints and structured rigid teaching environments limit nurse educators. Adding to this dilemma is the lack of available resources for international travel by students. Faculty are confronted with the challenges of identifying opportunities and resources for nursing students that can be incorporated into the programs of study. Because of these challenges, only a small proportion of nursing graduates have elected to participate in international cultural experiences (Maltby & Abrams, 2009).
The IIE (2012) reported that the largest group of students studying abroad was from social sciences (23%) followed by business and management (17%), the humanities (13%) science majors (12%), fine and applied arts (8%), foreign languages (7%), and physical sciences (7%). Regrettably, health care professions were not listed as a significant study abroad group. Notable barriers to study abroad for students include stringent curricular requirements, program difficulty, minimal encouragement, lack of advice from faculty, no academic credit, and poor mapping of courses (IIE, 2012).

For nursing students, the United States lags behind other countries in offering international experiences of any length. In a survey of over 780 Bachelor of Science in nursing programs, only 89 programs offered a full semester study abroad with 0-5% of the students participating. Also disheartening is that 77% of the programs offered summer, semester break immersion programs, or service trips without academic credit (Read, 2011).

Program cost remains one of the greatest deterrents in accessing study abroad opportunities. For example, a survey conducted with community colleges by the IIE (2012) cited costs and fees to students as a leading challenge to expanding education abroad. Data also revealed that the largest area of growth was in short-term study programs, surpassing the mid- and long-term programs. Much of the debate on length of study revolves around the relative value of short-term programs. Short-term programs may not provide the same opportunity for engagement in the culture; however, these short-term programs have played a significant role in role providing increased
opportunities for students to study abroad by offering flexible international options for those who might otherwise be unable to participate in traditional programs (IIE, 2012).

The first step in implementation of international cultural experiences is determining the length of the program needed to produce desired outcomes. The long-term immersion experiences are problematic in arduous academic programs such as nursing, as previously discussed. Because of curriculum requirements and the clinical component, the opportunity for study abroad experiences of many weeks is difficult for nursing students, unless they choose a summer option or choose to delay graduation.

**Challenges in Study Abroad**

Travel abroad does not automatically lead to professional or personal growth and international study is not without difficulties. It is important to keep in mind the potential for social/psychological adjustment, insurmountable cultural differences, challenges that arise with language differences, and worry from travel in potentially dangerous areas (Kinsella et al., 2008). Faculty engaging in international travel may also need to manage potential interference of the study abroad program with existing educational goals.

During the international experience or once the sojourners return home, cultural dissonance and culture shock may occur (Kinsella et al., 2008). The term *culture shock* initially was identified by the anthropologist Oberg in 1960 (Furnham, 2010; Oberg, 1966; Oberg, 1960) and is defined as a state of confusion and disorientation that results from encountering a culture, where actions, values, beliefs and behaviors are viewed as different (Oberg, 1960; Ward, Bochner, & Furnham, 2001). For individuals experiencing
a new culture for the first time, their perspective may be insufficient to cope within the
different context and environment (Stier, 2003).

Undergraduate and postgraduate business students from Australia participating in
short-term study tour to China experienced culture shock (Hutchings, Jackson, &
McEllister, 2002) even though there were clear goals and objectives and sufficient pre-
imersion preparation. This study examined internationalism and the impact of rapidly
changing political, social and economic environments on business, cultural, and social
practices over a 17-day period. A case study methodology was used and participant
observation, student feedback from debriefing sessions, and journals served as the data
sources. Five pre-immersion briefing sessions were held, ranging from 3-5 hours each,
examining issues of cultural differences, culture shock, logistical issues, infrastructure,
itineraries, language differences, tourism, and western versus eastern rituals. A
significant finding was that students may have initially experienced culture shock, but
later was able to advance to cross-cultural adaptability and understanding. This study
suggested that a more comprehensive and lengthy experience is needed for students to
achieve cultural competence. The strength of this study was that students were able to
see the business world differently and were able to appreciate what is required to function
more effectively on an international level.

Culture shock was also encountered as an outcome of a 3-week immersion
experience of nursing students in Bangladesh (Maltby & Abrams, 2009). The purpose of
this study was to discover the meaning of the immersion experience through reflective
journals. This descriptive phenomenological study focused on student experiences
during the immersion experience only, which was unique since there has have been few studies examining the effects while the students were actually immersed. Although the students expressed shock when they first arrived, they were able to manage the initial shock successfully. The four themes that emerged from the data were: (a) beginning to see, (b) thinking about what they were seeing, (c) wanting to change things for the better, and (d) being transformed by what was seen. These authors stressed the importance of study abroad programs that confront students with cultural differences.

Along with culture shock, other consequences of international study identified were a sense of disorientation (Gudykunst & Kim, 1997), sensory overload (McLachlan & Justice, 2009), and feelings of guilt (Bentley & Ellison, 2007; Evanson & Zust, 2006; Johns & Thompson, 2010; Levine, 2009; Maltby & Abrams, 2009; Stier, 2003). Also reported was self-doubt whereby sojourners were unsure as to how their behaviors would be interpreted by others (Bosworth et al, 2006; Greatrex-White, 2008). However, it is important to note that cross-cultural conflict as a result of cultural encounters often stimulates cross-cultural learning (Chang, 2007; Wei-Wen Chang, Cheng-Hue, Yu-Fu & Yu-His, 2012). Those who had experienced being a foreigner were better able to understand and empathize with issues of social inequities (Greatrex-White, 2008). Although unpleasant and troublesome emotions may occur, there are many identified advantages of study abroad, such as greater cultural competence, an increase in problem solving skills, global health awareness, and a possible a life-changing experience (Kinsella et al., 2008).
Effective Pedagogy in Study Abroad

What appears essential to successful international study abroad is effective pedagogy. For example, nearly all short-term programs are faculty-led and this format provides many benefits over the traditional long-term programs that merely incorporate study at foreign institutions (Donnelly-Smith, 2009). Faculty members who guide short-term programs often are more engaged with the students and exert more control over the experience to ensure that the study abroad program is closely integrated with course objectives to enhance learning. The general consensus from faculty members is that highly structured short-term programs that incorporate reflection and personal hands-on experiences provide the most benefit (Donnelly-Smith, 2009).

A study that sought to link student goals with outcomes found that pre-immersion education of students prior to an international experience helped students clarify goals to maximize outcomes (Kitsantas, 2004). This research explored the role of college students’ goals on the development of cross-cultural skills and global understanding. It also explored the mediating factor of student goals for participation in the study abroad program. Kitsantas examined 232 students enrolled in study abroad programs in Germany, Italy, Greece, France, and Spain in 2002. The length of the study abroad program varied from 3 to 6 weeks. Pretests and posttests were administered using the Cross-Cultural Adaptability Inventory (CCAI), which quantifies dimensions known to be associated with cross-cultural effectiveness. Paired t-test analyses found that the students’ initial scores on the CCAI were significantly different following the international experience. Moderate to strong correlations emerged between the
participants’ goals and posttest scores on the CCAI for global understanding. The results also demonstrated that most study abroad students showed higher emotional resilience, openness, and flexibility.

In a meta-analysis by Button et al. (2005), using multiple research databases of both qualitative and quantitative data from practicing nurses who had participated in a previous sojourn experience during their schooling was examined. This study found that factors such as duration of placement, pre-immersion experiences, and debriefing sessions affected the overall development of cultural competence. A very significant finding from this report was that no literature identifying greater negative outcomes associated with shorter program duration was found.

The Use of Reflection and Short-Term Immersion Experiences

There is strong evidence that reflection combined with the study abroad experience should be included in the research design as a pedagogical choice to facilitate the development of reflective nursing practice (Braskamp et al., 2009; Levine, 2009; Torvisk & Hedlund, 2008; Williams, 2009). In addition to reflective practice, Levine (2009) found that traveling abroad also greatly influenced a student’s understanding of differences, influenced the development of compassion, assisted with recognition of societal ills, and enhanced a willingness to promote change for the good of society.

Qualitative and quantitative data were investigated during a 5-week ethnographic study abroad experience of 12 advanced second language students from Hong Kong, who studied in England (Jackson, 2009). Intercultural sensitivity was measured using the IDI at three different points in the data collection process; after the pre sojourn preparation,
upon arrival, and post sojourn. Qualitative data were obtained through diaries and open-ended questions. The findings suggested that a short-term program if designed prudently with guided reflection can help to maximize intercultural learning. This study concluded that intercultural competence increased as one’s encounters with cultural differences become more multifaceted. However, this study also noted that participants tended to overestimate their level of intercultural sensitivity. This author stressed that study abroad programs should include reflection before, during, and after to guide participants toward a greater degree of ethnorelativism. This study also found that post sojourn debriefing experiences could support deeper levels of intercultural learning.

Several large-scale research studies addressed the importance of guided reflection with international programs, and disputed the thinking that length alone or immersion with a host family is sufficient (Braskamp et al., 2009; Fry et al., 2009). Fry et al. used a retrospective tracer study and mixed methods research design to survey over 6,000 participants who participated in study abroad programs. Interviews were also conducted on 63 participants. The Global Engagement Survey was used in this national sample. As a result of this study, there is now empirical and systematic documentation that study abroad programs of all lengths reaped many positive outcomes in the key domains of civic engagement, knowledge production, philanthropy, social entrepreneurship, and voluntary simplicity. Qualitative data from this research supported study-abroad experiences as having a strong impact on future graduate work and global engagement. Also suggested by these findings was that guided reflection was necessary to help the
learner develop cultural self-awareness that supports intercultural learning (Fry et al., 2009).

In a study by Braskamp et al. (2009), their Global Perspective Inventory (GPI) was used to measure three domains of global learning and development. These authors identified these domains of learning as cognitive, interpersonal, and intrapersonal and examined how students think about themselves and how they interact with others after an international cultural experience. The study’s purpose was to assess university students’ progress in global learning as a result of education abroad experiences. This study looked at 10 different semester long study abroad programs from five different universities using a pretest–posttest design to measure the changes in students’ global perspective over the period of one semester. Based on the results of this research study, education abroad was found to be an effective learning experience for students, if the desired goal of an education abroad experience is to help students develop holistically and globally. This study did document a greater growth in cognitive development than other domains of global learning. Participants did not show as much growth in their ability of learning how to think using multiple perspectives, in developing a more refined sense of self, or integrating their cultural experiences toward an interdependent global perspective. An important finding of this study was that exposure to international experiences was not enough. The missing ingredient of reflection with the international experience was vital to help students move toward a more holistic way of thinking and learning. This study was unique in that it looked at students’ holistic development and the impact of international sojourn experiences.
The Need for Short-Term International Programs

Given the constraints placed on U.S. nursing programs as well as the limitations imposed by U.S. students’ financial resources and personal obligations, it is necessary to identify realistic opportunities for international experiences for nursing students. Short-term clinical cultural immersion experiences can move nursing students toward transcultural and intercultural competence in ways currently not possible with non-immersion pedagogical approaches. For both undergraduate and graduate college students, short-term international experiences have been shown to produce many desired learner outcomes (Button et al., 2005; Caffrey et al., 2005; Chieffo & Griffiths, 2004; Edmonds, 2010; St Clair & McKenry, 1999; Ter Maten & Garcia-Maas, 2009; Wallace, 2007; Zamastil-Vondrova, 2005). Studies of short-term international experiences of less than one month reported that participants were transformed by the experience (Caffrey et al., 2005; Maltby & Abrams, 2009); were able to demonstrate flexibility (Johns & Thompson, 2010; Larson et al., 2010; Wood & Atkins, 2006); developed greater self-awareness (Wallace, 2007); gained in understanding their professional role (Caffrey et al., 2005; Ter Maten & Garcia-Maas, 2009); showed increases in intercultural sensitivity (Anderson et al., 2006; Caffrey et al., 2005); enhanced cultural adaptation and adjustment (Inglis et al., 2000) and helped students understand global interdependence (Chieffo & Griffiths, 2004).

Caffrey et al. (2005) looked specifically at the effects of short-term cultural immersion experiences on the development of cultural competence for nursing students. This study demonstrated that when students participated in a short-term immersion
experience, the perceived cultural competence gains were large. Caffrey et al. evaluated the effect of integrating cultural content didactically (ICC) into an undergraduate nursing curriculum, and compared it with a five-week clinical immersion in international nursing (ICC Plus) on students’ self-perceived cultural competence. The sample consisted of 32 nursing students in a baccalaureate nursing program. Pretest scores from admission into the program were matched with posttest scores obtained just prior to graduation. Results showed small to moderate gains for the students in the didactic course, and very large gains for the students in the five-week immersion group. The participants in the didactic course (ICC) demonstrated moderate improvement in perceived culturally competent attitudes, knowledge, and skills over the two years in the nursing program. The participants in the immersion group or the ICC Plus group gained much more than their classmates in their perceived cultural competence as a result of the short-term immersion program (Caffrey et al., 2005). One concern with the results of this study is whether or not self-perceived cultural competence has any relationship to actual practice, which is an ongoing concern for researchers studying this phenomenon. A study by Braskamp et al. (2009) supported this concern and suggested that whereas students may report that they learned a lot, it is not the same as changing one’s way of thinking. Caffrey et al. (2005) examined the students’ perceived knowledge, perceived self-awareness, and comfort with the skills of cultural competence.

An earlier study by St. Clair and McKenry (1999) explored the connection between short-term international nursing immersion experiences and cultural self-efficacy and competence. Even though this study is older, this mixed method research
design sampled a much larger population than the more recent study with 200 senior undergraduate and graduate nursing students participating. St. Clair and McKenry found that short-term immersion experiences of less than two weeks made a significant difference in students’ achievement toward cultural competence, but the participants did not achieve competence.

Often, the level of integration achieved while students are abroad has been tied to increased cultural awareness and competence as well as personal growth (Fennell, 2009; Franklin, 2010; P. J. Pedersen; 2009). In a mixed study design by Franklin (2010), 189 students who studied abroad for varying lengths of time were compared. More than half of the respondents studied abroad for a minimum of one year, 25% for a semester, and 15% percent for 4 to 7 weeks, or short-term. This study did not identify any differences between participants who studied short-term versus long-term, and most participants agreed that the study abroad experience affected their lives in a positive manner. The majority of participants reported an increase in cultural understanding and knowledge, awareness of oneself, and social and emotional growth regardless of program duration.

Other studies have reported similar findings from short-term international experiences. Ter Maten and Garcia-Maas (2009) found multiple benefits for students participating in a short-term immersion program: The participants showed gains in cultural sensitivity, a greater understanding of their professional role, and an increased ability to critically differentiate the American care model with other global models. Zamastil-Vondrova (2005) found that following a three and a half week experience in Europe for international business majors, students were able to critically reflect on their
experience and demonstrated growth in the areas of cultural awareness, linguistic awareness, and enhancement of professional competencies. Students also expressed a desire to lose the “I am proud to be an American” attitude (p. 48).

When compared to students who remained on campus, students in programs of less than one month demonstrated measurable effects on the development of intercultural awareness, personal growth, awareness of global interdependence, and functional knowledge of world languages and geography (Chieffo & Griffiths, 2004). Wallace (2007) looked at four different groups of students that studied in South Korea for 2 weeks. Students reflected on how they developed deeper caring and compassion and they spoke to the importance of caring for the client in a manner that was acceptable to the client. This study provided favorable data from international cultural experiences even though there were language difficulties. Wallace found that although culture can be taught in the classroom, short-term personal interactions with those from different cultures might have the greatest impact.

Whereas short-term study abroad programs are not considered groundbreaking, short-term international experiences merit rethinking as an effective pedagogical approach to enhance students understanding of cultural differences, cultural awareness, and global health issues. Although previous research supports the goal of increased student’s global understanding and cross-cultural knowledge through traditional long-term study abroad trips, limited research has been conducted to determine if short-term study abroad trips are achieving this goal. Yet, more than half of the students that studied abroad participated in short-term experiences of less than eight weeks (IIE, 2009).
Cultural Humility and Experiential Learning

Faculty must be clear as to what the desired outcomes for study abroad should be. If cultural competence is the endpoint, then most international experiences will fall short. However, if the desired outcome is growth toward cultural competence, then these short-term programs may provide greater opportunities for a larger number of students wishing to travel abroad. In fact, some educators argue against a full immersion. Woolf (2007) urged educators to consider that when contemplating immersion experiences over traditional didactic methods that the length is often an unacceptable measure of academic outcomes when contemplating immersion experiences over traditional didactic methods.

As seen in this review of literature, there is a dearth of research on international study programs looking at cultural competence, awareness, and other noteworthy outcomes. However, minimal research has recognized or identified cultural humility as an outcome. The uniqueness of cultural humility is that it does not have an endpoint as seen with cultural competence; the goal is not to become proficient in mastering another culture. Instead, it is the on-going life-long commitment to self-evaluation and self-critique that explores and addresses power imbalances. Cultural humility requires the health care provider to develop mutually satisfying relationships with all members of society, including those from diverse or marginalized backgrounds (Minkler, 2005). Cultural humility represents openness to new ideas and contradictory information, and demonstrates a readiness to accurately evaluate our views and our limitations as we acknowledge our gaps in knowledge (Levi, 2009; Tangney, 2000).
Despite the significant role of cultural humility in cultural competence, there is limited and almost absent research focusing on the concept of cultural humility in research of international study experiences. One study (Foster, 2009) linking cultural humility with immersion experiences stated that cultural humility can be developed through immersion programs in a foreign nation where health disparities are manifested widely, and can provide the participants with a social justice orientation. Foster examined these disparities within a long-term immersion experience.

A qualitative study by Griswold, Zayas, Kernan, and Wagner (2007) investigated cultural humility and awareness through medical student encounters with refugees. The exposure to the refugees was limited to one encounter. This study found that cultural diversity training with hands-on multicultural clinical experiences increased students’ cultural sensitivity, competence, and cultural humility. Communication was important for the development of therapeutic relationships with patients. The ability to listen to members of a different culture provided an invaluable opportunity to learn about another culture. Most importantly, the personal and trusting relationship that ensued supported the development of cultural humility. This study was limited by sample size and by the lack of documentation of previous cultural experiences by the participants. This study was unique in that cultural humility, as well as cultural competence and sensitivity, was identified as outcomes.

**Contribution of This Study to the Body of Research**

There is sparse research on the impact on students who participate in study abroad programs of less than two weeks, and only two studies looked at a program of one-week
duration or less. Research on international nursing exchange programs between 1982 and 2005 found that most of the research consisted simply of descriptions of personal experiences rather than sound research (Button et al., 2005; Levine, 2009; Read, 2011). There was also little analysis of the impact of these study abroad programs in the nursing literature (Button et al., 2005; Levine, 2009; Memmott et al., 2010) and little research looking at lasting outcomes of international experiences for both short-term and long-term programs (Read, 2011). For example, a large scale meta-analysis study conducted in the United States spanning 16 years and over 600 Baccalaureate nursing students conducted by Memmott et al. (2010) found no or very little data evaluating either the short-term or long-term impacts of international study abroad programs.

The two studies located in this review of literature examining the outcomes of short-term international experiences of one week or less were qualitative studies by Evanson and Zust (2006) and Mu et al. (2010). Evanson and Zust examined the benefits of a short-term experience for six nursing graduates who spent one week in Guatemala. The purpose of the study was to look at the lasting impact on registered nurses’ professional and personal lives two years after they returned home from their trip to Guatemala. The three themes identified by the participants were: first, coming to understand; second, feeling unsettled; and third, advocating for change.

A study of occupational therapy students by Mu et al. (2010) found similar results from a one-week program in China. The students were enrolled in an independent study course as preparation for experiential learning in China. While in China, the students provided direct care to patients. After returning from China the students participated in
reflective exercises, student presentations, and debriefing sessions. Results of this study indicated that this experiential program resulted in a lasting impact on cultural competency, clinical reasoning, and leadership skills.

Evanson and Zust’s (2006) study was the first to look at a one-week program, but differs from this dissertation in that it looked at the impact two years after returning home. In addition, this study did not incorporate daily debriefing sessions or reflective pre-immersion and post-immersion journaling. Mu et al. (2010) examined the sojourners immediately after returning home through reflective journals, presentations, and focus group discussions and looked at the immediate impact only.

The experiences of nursing students who participated in international cultural experiences have not been widely explored within the existing body of literature. Past research on international nursing exchange programs found that most of the research consisted simply of descriptions of personal experiences rather than sound research (Button et al., 2005; Levine, 2009; Read, 2011). In addition, there was minimal research looking at lasting outcomes of international experiences for both short-term and long-term programs (Read, 2011). Study abroad outcome evaluations often are conducted immediately after the sojourn and most studies examine language acquisition and changes in personal values. I was unable to find many studies that focused on professional development. Unfortunately, didactic education in cultural knowledge remains the primary option for students to learn intercultural competence.

This dissertation of a short-term cultural experience to Tanzania is also unique in that it examines both the immediate and intermediate outcomes for participants. This
research also incorporated solid learning objectives to support the pedagogical approach with pre-immersion classes, daily debriefing sessions, and reflective journaling while abroad, and followed up with focus group discussions one month after the return home. The participants were also required to be enrolled in a nursing course with global objectives immediately prior to the sojourn, and were encouraged to complete an African geography course prior to the experience in Tanzania.

Campinha-Bacote’s theory was selected since it is a transcultural nursing theory and incorporates the concept of cultural humility. Bennett’s DMIS was selected because it describes people’s reactions to cultural differences. Langer’s theory of Mindfulness supported the pedagogical approach. All three theories that informed this dissertation are presented in detail in Chapter 3.

**Summary of the Literature Review**

Human responses to life predicaments are complex and difficult to know and yet the essence of nursing is dependent on that knowledge. The misconception often seen in clinical settings is that culture can be understood as a set of separate behaviors that lead some practitioners to stereotype and inaccurately predict behaviors. The injustice to the client is that through these misunderstandings specific ethnic cultures are represented as characteristics that can be identified, modified, and/or manipulated for health care outcomes (Hunt, 2005). This chapter examined international programs of all lengths as a form of pedagogy for college students from all disciplines as well as nursing. This chapter explored the link between program duration and lasting impact. I critically analyzed the existing literature that both supported and debated the value of short-term
international cultural experiences. I included in this review the use of adjunctive pedagogical choices combined with the sojourn experience. It has been suggested that the length of the program is less important than a well thought-out learning experience. Potential obstacles to successful international cultural experiences were also discussed as well as the need for more research on short-term sojourns. Finally, the concept of cultural humility and its significance toward the development of cultural competence was presented.

In Chapter 3, I discuss the methodology of the research design. My research draws upon methodologies from the field of cross-cultural psychology, curriculum studies, and transcultural nursing in order to examine issues of transcultural and intercultural competence. I selected an interpretative qualitative research design for this dissertation with the goal of learning how participants made sense of their experience after a one-week international cultural immersion experience.
CHAPTER III
METHODOLOGY

Qualitative research was used to make sense of the meanings created by the participants both during and after a one-week international experience. The goal of my dissertation was to answer the research questions related to participant meanings of this international cultural experience and to discover how or if this international experience influenced the participants’ conceptualization of the role of the professional nurse. In this chapter, I discuss various forms of qualitative research, offer the rationale for the basic interpretative qualitative research approach, describe data collection and analysis methods, discuss ethical considerations, and describe the role of the researcher. Langer’s theory of Mindfulness, Campinha-Bacote’s model, The Process of Cultural Competence in the Delivery of Healthcare, and Bennett’s Developmental Model of Intercultural Sensitivity (DMIS) are discussed as my theoretical framework informing the study design, data collection, analysis, and interpretation of the data.

Qualitative Methodologies

Qualitative studies enable discovery by providing a deeper understanding of the research problem (Creswell, 2007; Uprety, 2009). This approach recognizes the role of the researcher in interpreting and representing the information and it recognizes the importance of discourse, issues of power, authority, and domination (Creswell, 2007). The primary purpose for selecting the qualitative approach was its exploratory nature, it was not to objectify the phenomena and control for the effects of certain interventions as
seen in quantitative research. Rather, the focus of my research was to help answer the “Why” and “How” questions (Creswell, 2007).

There are varieties of approaches to qualitative research (Creswell, 2007). Included below is a discussion of several forms of qualitative research that was considered for this dissertation: narrative, phenomenological, ethnographic, grounded theory, and the case study approach. I addressed the strengths of each method and concluded with my rationale for selecting the basic interpretive qualitative approach.

Narrative research tells the story of peoples’ lives and experiences (Connelly & Clandinin, 1990). The narrative approach is a specific form of qualitative design that focuses on one or more individuals (Bloomberg & Volpe, 2008), gathering data through the collection of their stories and reporting and chronologically ordering their individual experiences (Creswell, 2007). The narrative method was rejected because the purpose of his dissertation was not to describe one person’s life story or to advocate for members of an oppressed group.

Unlike narrative research that describes a life story, the phenomenological method takes into account the person’s participation in and reaction to a situation by using oral and written descriptions from the participant as the raw data (Creswell, 2007). Phenomenological research seeks to report on the meaning of the lived experiences of a phenomenon for a group of people (Bloomberg & Volpe, 2008). Giorgi (1994) states that in a phenomenological study the research must be descriptive, engage in reduction, and discover the essence. Phenomenological research was not selected because my research required a broader focus than phenomenology provides.
While phenomenological research emphasizes meanings constructed by people, an ethnographic research design stresses interaction, social context, and the social construction of reality by a culture-sharing group. Ethnography focuses on an entire cultural group, and serves to interpret and describe shared and learned patterns of behaviors (Creswell, 2007; H. J. Rubin & Rubin, 2005). Ethnography is most useful when the researcher is grounded in cultural anthropology and the research study seeks to understand a social-cultural system. Since the aim of my research was to interpret and understand the experience of participants in a culture very different from their own, and not the culture itself, this approach was deemed inappropriate for my research design. In addition, the time commitment for an ethnographic study is intense, often requiring years in the field (Janesick, 1999).

Grounded theory arises inductively from the research study; it is in continuous interaction with the data and the theory and is grounded in the data (Glaser & Strauss, 1967). Grounded theory should be used when a theory is not available to explain a process (Artinian, Giske, & Cone, 2009). Grounded theory was not selected as my methodological design since there are substantial theories to frame my study and the purpose of this dissertation is not to generate a new theory. Grounded theory fosters the development of a theory, whereas case study research describes and documents important moments as they happen (Bloomberg & Volpe, 2008).

The case study can be about an individual, group of people, a school, a community, or an organizational policy. The major strength of the case study is the ability to use multiple sources of data and multiple methods as forms of triangulation
(Yin, 2003). It is recommended that at least six sources of data be collected for a case study design: documents, archives, interviews, direct observation, physical artifacts, and participant observation (Creswell, 2007). The case study was not selected for my research design since only three data sources were used for my study and once again, my time and resources were limited.

These five approaches were found to be unsuitable for the purpose of my dissertation and impractical given time and other constraints. Rather, the basic interpretive qualitative approach seemed the optimal choice for my research.

**The Interpretive Qualitative Approach**

According to Creswell (2007), we use interpretive qualitative research to study problems that seek to understand the meanings of individuals or groups as they identify with a social or human problem. Interpretive constructionist researchers work to figure out shared meanings, yet recognize that each person will interpret the experience in their own unique way based on previous life experiences and socio-cultural influences (H. J. Rubin & Rubin, 2005). For the participants, multiple or differing versions of the same experience can be true at the same time (H. J. Rubin & Rubin, 2005).

Symbolic interactionism and phenomenology inform this type of research (Merriam, 2002). Symbolic interactionism focuses on the interpretation of human beings within a certain context of the larger society as the individual interacts with other people. The emphasis is on seeing things from the perspective of the other (Merriam, 2002). This intersection of the person and the research setting creates meaning for the individual. Likewise, interpretive qualitative research emphasizes the subjectivity of people’s
behaviors and the person’s interpretations are based on everyday experiences that have meaning for them. Thus meanings are not discovered; rather they are constructed by human beings as they engage in and make sense of their world. The role of the researcher does not discover this meaning; instead they interpret and present their findings (Merriam, 2002).

I explored ways in which the participants made sense of the dramatically different world to which they were exposed during their 8-day structured visit to Tanzania. Because this experience was an ongoing process of self-reflection and interactions with other participants and because the time and geographical constraints of the experience precluded the use of other qualitative methods, the basic interpretive qualitative approach was deemed the most appropriate choice.

The following section discusses my theoretical framework for this study. Subsequent sections discuss participant and site selection, benefits and risks for participants, data collection methods, the role of the researcher and ethical considerations.

**Theoretical Framework**

The theorists who informed this research were from the field of curriculum studies, cross-cultural psychology (intercultural communication), and transcultural nursing. The first theory, Langer’s theory of Mindfulness (1997) from curriculum studies, guided the pedagogical approach used for the research design. M. J. Bennett’s (1993) Developmental Model of Intercultural Sensitivity (DMIS) from the field of cross-cultural psychology, and Campinha-Bacote’s Process of Cultural Competence (1999) in
the Delivery of Healthcare from the discipline of nursing provided the framework and foundation for interpretation and analysis of the qualitative data.

**Langer and Mindfulness**

Intercultural and transcultural competence can be conceptualized using the theory of mindfulness (E. Langer, 1989). The ability to transcend context is the essence of mindfulness and central to creativity in any field (E. Langer, 2007). Mindfulness demands flexible thinking and requires reflexivity. Reflexivity is an individual’s ability to become aware, responsive, and flexible when confronting ever-changing situations and challenging environments. Reflexivity is critical to a mindful approach, as it requires tolerance for ambiguity, cognitive and behavioral adaptability, and cross-cultural empathy.

Langer suggests a unique approach to educate through what she identified as ‘sideways learning’ (E. Langer, 1992). Sideways learning means the person is attending to multiple ways of doing and learning. The sideways approach aims at openness to novelty, alertness to distinction, sensitivity to different contexts, implicit, if not explicit awareness of multiple perspectives, and orientation in the present (E. Langer, 1992).

The rationale behind using mindfulness was to help participants reflect, and thus encourage openness to new information from different and unique cultures. An important feature of mindfulness is openness not only to new information, but also to different points of view. Once we become mindfully aware of views other than our own, we start to realize that there are as many different views as there are observers. According to E. Langer (1992), such awareness can be liberating. When we cling to a
point of view, we become blind to the impact that we have on others (E. Langer, 1992). This implicit awareness guides us to develop and create new options. With mindfulness, when the same information is viewed through different perspectives, we actually become open to that information. We rely on more creative and sensitive ways of processing messages and interacting with others (E. Langer, 2007). In this state of mindfulness, basic skills and information guide our behavior in the present, rather than teaching us to respond like robots (Djikic, Langer & Stapleton, 2008; E. Langer, 1997). An interesting aspect of mindfulness supports the belief that forgetting facts may be acceptable. By forgetting previously held truths, it forces us to look at previous learned information from a new perspective or in a different context.

In combating prejudice, the issue is simply not how we might teach the majority to be less judgmental, but rather how we might learn to value, embrace, and respect different cultural or ethnic groups, diverse religions, people of all sexual orientations, disabled individuals, or anyone who is viewed as different. Most attempts to combat prejudice have been aimed at reducing our tendency to categorize other people and yet categorizing people is a fundamental and natural tendency. When confronted with someone who is clearly different we may look for more differences; these flawed assumptions tend to exaggerate the differences in people (E. Langer, 1992). By altering our perceptions of prejudice, the act of stereotyping may be more informed by noticing the many distinctions about the world. This would involve creative perceptions and consciousness raising (E. Langer, 1992).
The opposite of mindfulness is mindlessness, which is defined as entrapment in old categories (E. Langer, 1992). If we do not develop a personal drive to consistently question preconceived mindsets, the result often promotes mindlessness. Mindless behaviors are automatic behaviors that preclude attending to new signals and the person operates from a single perspective. E. Langer (1992) states that mindlessness is a result of over-learned skills that causes us to just react and not think. Mindlessness limits our control by limiting us from making intelligent choices. Even when solutions are available, a mindless sense of futility prevents us from reconsidering the situation (E. Langer, 1992). The various causes of mindlessness are repetition, premature cognitive commitment, the belief in limited resources, and the notion of linear time. Mindlessness leads the learner to hold a rigid view of mind separate from body (E. Langer, 1992).

Mindfulness was selected because it emphasizes reflexivity, looking at multiple perspectives and the ways our worldview may influence others or social issues (E. Langer, 1992). Mindfulness is a skill that supports intercultural capabilities and transcultural nursing competence. It guides us to become aware of our own personal communication approach while reflecting on the effect that our interactions have on others. It is less about how the nurse feels what he or she is communicating; it is more about how they are actually reacting and relating to others. Mindful behavior requires us to reflect on, learn from experiences, and seek cognitive discrimination and refinement in order to create new ways of relating (Kim, 2009).
Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare

Campinha-Bacote’s model describes a process in which the nurse or health care provider consistently “strives to achieve the ability to effectively work within the cultural context of an individual or community from a diverse cultural/ethnic background” (Campinha-Bacote, 2002, p. 181). The expectation of Campinha-Bacote’s model is that as health care providers, we will view ourselves as involved in a continuing process of becoming culturally competent rather than being culturally competent (Campinha-Bacote, 2007, p. 26), a characteristic of cultural humility.

Cultural encounters, the key component of Campinha-Bacote’s model, is the process of engaging in cross-cultural interactions on a personal level (2002). By seeking cultural encounters, we directly engage in interpersonal contact with individuals from culturally diverse backgrounds in an effort to minimize or to prevent stereotyping and bias (Campinha-Bacote, 2002). It is hoped that through these encounters we will be less likely to stereotype by refining and modifying our current beliefs and biases. It is vitally important during these encounters for health care providers to realize that interacting with a small number of individuals from a different cultural group will not provide expertise. The health care provider must recognize and understand that there are more variations within cultural groups than across cultural groups (Campinha-Bacote, 2002).

Campinha-Bacote spoke of “sacred” encounters in which compassion leads us, the healthcare practitioner, to develop deep respect and caring through attentiveness and understanding. This attentive listening is when we focus directly on the client and listen responsively with our “ears, eyes and heart” (Campinha-Bacote, 2007, p. 81). A
successful cultural encounter will result in a greater understanding of the client’s issues and in turn, the client will feel understood, valued, and supported.

Cultural awareness is the recognition of, and sensitivity to, the patient’s perspective. It requires health care providers to explore personal biases and prejudices in order to develop an understanding of how these reactions and behaviors can affect the care given to diverse populations. Cultural awareness and cultural sensitivity develop simultaneously. Cultural sensitivity is simply the awareness of the “values, beliefs, life ways and practices of an individual” (Campinha-Bacote, 2001, p. 11). The goal of cultural awareness is to incorporate culturally responsive care into practice that is mutually acceptable for both the patient and the health care provider, and to become sensitive to the patient’s needs.

Cultural knowledge in Campinha-Bacote’s model is the acquisition of information regarding the health beliefs and health practices of specific cultural groups. This requires both culture specific and culture general knowledge (2007). However, the danger of which we must be mindful is that through culture specific knowledge, we risk stereotyping individuals from the same cultural groups. It is imperative to remember that there is much diversity within all cultural groups and any stereotyping can affect the care of the patient in a detrimental manner (Anand & Lahari, 2009).

Another important element of this model is its emphasis on effective communication and rapport with the patient as the nurse gains the patient’s trust. This leads to the development of cultural skills, which is the ability to gather relevant cultural data through effective therapeutic communication techniques (Campinha-Bacote, 2007).
Acquiring adequate cultural skills can help the nurse refrain from engaging in behaviors that stereotype and group individuals together. Effective interview skills assist the health care provider to identify the cultural context to provide culturally congruent health care.

Cultural desire, the final principle of Campinha-Bacote’s model, includes “a genuine passion to be open and flexible with others, to accept differences built on similarities, and to be willing to learn from others as cultural informants” (Campinha-Bacote, 2002, p. 183). This appreciation and acceptance of differences guides the practitioner to be compassionate toward all recipients of care, taking into consideration cultural values, beliefs, and practices (Munoz et al., 2009). “Cultural desire is the spiritual and pivotal construct of cultural competence that provides the energy source and foundation for one’s journey toward cultural competence” (Campinha-Bacote, 2007, p. 21).

Working toward intercultural/transcultural competence is a complex process that does not begin and end with a short encounter. It takes time and thoughtful attention to develop the skills, knowledge, and attitudes to deliver safe, effective and culturally competent patient care (Spector, 2009). Health care providers can work on any of the constructs of Campinha-Bacote’s model independently to improve the balance for all five.

Campinha-Bacote (2007) cautions that it is not enough for health care providers to state that they respect a client’s values and beliefs, and provide culturally specific interventions for a particular ethnic group. It is of grave importance for health care providers to want to provide care that is culturally responsive (p. 21). Campinha-
Bacote’s model is used to ensure culturally compatible and harmonious nursing care practices. Central to the Campinha-Bacote’s theory is valuing the uniqueness of each person, which is the foundation of holistic nursing and the ontological perspective of this research. Table 1 presents Campinha-Bacote’s Model with acronyms and example statements from her IAPCC-R for each category.

Table 1

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

<table>
<thead>
<tr>
<th>Constructs of Campinha-Bacote’s model</th>
<th>Acronym</th>
<th>Example of statements reflective of Campinha-Bacote’s model (IAPCC-R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Awareness</td>
<td>A</td>
<td>I feel that cultural competence is an ongoing process.</td>
</tr>
<tr>
<td>Cultural Skills</td>
<td>S</td>
<td>I am knowledgeable in the area of ethnic pharmacology.</td>
</tr>
<tr>
<td>Cultural Knowledge</td>
<td>K</td>
<td>I find that there is a relationship between culture and health.</td>
</tr>
<tr>
<td>Cultural Encounters</td>
<td>E</td>
<td>I believe that there are more differences within cultural groups than across cultural groups.</td>
</tr>
<tr>
<td>Cultural Desire</td>
<td>D</td>
<td>I believe one must want to become culturally competent if cultural competence is to be achieved.</td>
</tr>
</tbody>
</table>

*Bennett’s Developmental Model of Intercultural Sensitivity (DMIS)*

M. J. Bennett’s (1993) Developmental Model of Intercultural Sensitivity (DMIS), illustrated in Figure 1, bridges the areas of intercultural communication with the fields of human development and curriculum studies (Endicott et al., 2003). The DMIS describes people’s reactions to cultural differences. The model’s basic assumption is that as
intercultural challenges occur, our experiences of cultural difference become more
complex, and our competence in intercultural relations increases.

The DMIS identifies six stages in the development of intercultural competence as
we move along a continuum from ethnocentrism to ethnorelativism (M. J. Bennett, 1993).
The ethnocentric period focuses mainly on the self and a frame of reference that is
reflective of our own culture. The ethnorealative phase is identified by a desire to learn
more about other cultures and an interest in meaningful interactions (Pusch, 2009).
Figure 1 illustrates the ethnocentric and ethnorealative stages of development according
to the DMIS.

![Figure 1. Bennett’s Developmental Model of Sensitivity](image)

As seen in Figure 1, the first three stages of Denial, Defense, and Minimization
describe ethnocentric progress and the last three stages of Acceptance, Adaptation, and
Integration focus on ethnorealative understandings (M. J. Bennett, 1993; Cushner et al.,
2003). During the first stage—Denial—we refuse all interactions with other cultures, show no interest in discovering cultural differences, and are unable to comprehend cultural differences. People in this stage declare tolerance for everyone, yet cannot refrain from stereotyping people. This stage exhibits an absence of contact with other cultures and a dehumanization of those from differing cultural groups.

The second ethnocentric stage of Defense recognizes cultural differences, and this becomes threatening to us, the individual. We still consider all other cultures to be inferior to our own culture. This stage of Defense can include feelings of denigration, derogatory reactions, a sense of superiority, and finally, reversal. Reversal occurs when the new culture is embraced as the better culture (M. Paige & Goode, 2009). Once reversal begins, we are ready to move to the next stage (M. J. Bennett, 1993; Cushner et al., 2003).

These first two stages of Denial and Defense represent a strong tendency toward dualistic thinking. Minimization, the third stage, still has ethnocentric tendencies but we begin to believe that all cultures share common values. During this stage, we minimize differences and we begin to recognize there are similarities across cultures. Often this stage is a transition stage as there is an increased interest in learning about other cultures; however we are still attempting to preserve our own worldview (J. M. Bennett & Bennett, 2004; M. J. Bennett, 1993).

Following Minimization, we begin to move toward ethnorelativism and enter the stage of Acceptance. We tend to recognize, appreciate, and respect attitudes, values, and
behaviors that are different from our own and we continue to show an interest in learning more about other cultures (M. J. Bennett, 1993).

The second ethnorelative stage, Adaptation, begins as we gain the ability to adapt our behavior more effectively by intentionally changing our own behaviors or communication style. We begin to develop effective communication skills with others from different cultures. We are able to interact in a meaningful way across cultures, consciously relating to other cultures, and beginning to communicate effectively. However, we still do not give up our own cultural perspective, but instead we are able to shift our worldview and become more empathetic (J. M. Bennett & Bennett, 2004; M. J. Bennett, 1993).

The final stage, Integration, is rarely achieved (M. J. Bennett, 1993; Cushner et al., 2003). This is where we become bicultural. In this stage, individuals instinctively change behavior and communication styles when interacting with other cultures. The integrated person no longer identifies with one culture and can function effectively across cultures. The person now has access to multiple worldviews (J. M. Bennett & Bennett, 2004; M. J. Bennett, 1993).

It is important to realize that if the individual reaches the Adaptation stage, he or she has attained a high level of intercultural competence that will help the individual become successful working with different cultural groups. Progressing from ethnocentrism to ethnorelativism takes time, yet it is vitally important in an increasingly global society (Pusch, 2009).
Summary of Theoretical Frameworks

All three theories selected have similarities between them, yet each theory offers an expanded way to look at intercultural/transcultural competence and effective pedagogy. The three theories selected were carefully chosen from three distinct yet related fields: curriculum and instruction, intercultural communication and nursing. The rationale for selecting mindfulness was to facilitate mindful behavior through reflexivity when interacting with diverse cultures. This theory is often used in the field of nursing and was selected not only because it incorporates a nursing perspective, but also because it is valued and respected throughout the field of intercultural communication (Spitzberg & Changnon, 2009).

Bennett’s Developmental Model of Intercultural Sensitivity from the field of intercultural communication was selected because as a constructivist model, it supports my epistemological framework for this study. Bennett’s DMIS was used as a guide for my qualitative interpretation of student journals, personal interviews and focus group discussions. The Process of Cultural Competence in the Delivery of Health Care by Campinha-Bacote (1999) from the field of nursing adds to Bennett’s model of the DMIS by providing a model for nurses to follow during their quest to become competent practitioners and it supports the ontological perspective of my study. The uniqueness of Campinha-Bacote’s model is recognizing and defining cultural humility as a precursor to intercultural/transcultural competence. Cultural humility is the journey and lifelong learning process toward competence that was referred to by Tervalon and Murray-Garcia in 1998. Cultural desire—the desire to become more knowledgeable about other
cultures—is the essential ingredient supporting the concept of cultural humility. This desire to learn about other cultures is also an important ingredient from Bennett’s DMIS and Langer’s theory of mindfulness.

Each of these three theoretical frameworks was critical to establishing both the design of my study and the means by which data was collected, analyzed, and interpreted. Much effort went into planning an experience that would encourage mindfulness and increased cultural sensitivity among the participants. Langer’s theory, Campinha-Bacote’s model and Bennett’s DMIS were instrumental in categorizing, analyzing, and interpreting the significance of the data.

The Setting for This Experiential Learning Program

This study utilized a qualitative approach to examine the meanings that emerged from a short-term international cultural experience of eight days for nursing students. The participants were comprised primarily of White first generation college students and Tanzania was selected as the site. Many colleges and universities select third world countries as a destination for their study abroad programs to provide for a more intense cultural encounter. Study abroad programs in underdeveloped countries have been shown to help participants understand the challenges and realities in which most citizens of the world live; an awareness that most students lack (Mkandawire-Valhmu & Doering, 2012). “Immersion into social spaces and clinical experiences that are very different from a student’s everyday experiences in their home country can promote the development of reflective practice and clinical reasoning” (Mkandawire-Valhmu & Doering, 2012, p. 82).
While in Tanzania, the participants engaged in clinical practice at health care facilities such as HIV clinics, the Kilimanjaro Christian Medical Centre (KCMC), and several children’s homes. In addition, several opportunities to participate in varied social experiences were provided. Finally, the participants were brought to several subcultures within this section of Tanzania in an effort to help them better understand the multiple layers of diversity and ethnicity.

**Participant Preparation for the International Cultural Experience**

Prior to the trip, the participants prepared for this international experience through required coursework and mandatory pre-international seminars. Reflexivity, which is critical to a mindful approach, was incorporated into the design of this study. During the actual international cultural experience, the participants assisted with patient care and community service as part of the course objectives and requirements from one of two nursing courses. Part of this community service was the collection of over 600 pounds of donations (flip-flops, hats, clothing, hygiene supplies, toys, medical supplies, etc.) that were brought to the children’s homes, clinics, and villages.

**Pre-international coursework.** Resources for this trip did not exist and it was clear that very few students would be able to participate. To recruit participants, I explained the purpose of the trip, the benefits for participants, and the research study. Initially, over 30 students expressed an interest. Rigorous fundraising was initiated for the students in an effort to offset the cost of the trip. After approximately three months, only 10 students remained as participants due to financial concerns. The primary motivation for participation in this program was the unique opportunity for these students
from the Appalachian area of Ohio to travel outside of North America for the first time. They often spoke of their excitement to visit parts of the world they knew only through television or reading. Eight of the 10 agreed to participate and they verbalized that this was a once in a lifetime opportunity that did not normally exist for regional campus students. Two students did not choose to participate because they were changing campuses. As soon as the participant group was determined, pre-immersion sessions began.

Each student who elected to participate in this experience was required to complete at least one of two nursing courses with a global focus, immediately prior to, or during this sojourn. The learning objectives for both courses encouraged participants to apply culturally appropriate and culturally congruent health care and to take into account the global barriers to health care. Both courses explored therapeutic communication techniques with individuals and families from diverse cultural groups and spiritual backgrounds. The participants also were required to discuss their experiences and lessons learned with their peers upon their return home.

The Transcultural Nursing and Health Care course explored the role of the transcultural nurse in the care of patients from multiple and diverse cultural groups and examined the global, demographic, and socio-economic influences on health care. The Transcultural Nursing and Health Care course encouraged participants to analyze the role of the nurse in planning nursing interventions based on mutual goals and diverse needs and understanding health traditions and the cultural phenomena that affect the patient. This course focused on general cultural concepts rather than cultural specific needs. The
Transcultural Nursing course was a junior level elective course which any nursing student may enroll once they completed sophomore level nursing courses.

The goal of the senior level nursing course, Community Health Nursing, was to work toward improving the health of a community both on a local and global level. Population focused practice was used to promote the health of people from diverse cultural and socioeconomic groups. Subgroups with populations that are at risk for disease, disability, and premature death were identified through various resources, such as the National Institute of Health, the Centers for Disease Control, or the World Health Organization. The Community Health Nursing course examined the roles of international health organizations responsible for providing global health care, investigated various global health issues, and discussed the ways varying cultural expectations, attitudes, and beliefs can affect an individual’s health. Also examined were the effects of economics on health care access. Four study participants were enrolled in this course, and Tanzania served as an alternate clinical experience for the Community Health Nursing course. The remaining four participants were entering their junior year and were enrolled in the elective Transcultural Nursing and Health Care course.

In addition to these nursing courses five of the students also participated in an elective non-nursing course, the Geography of Africa. This course examined the complex geographical and cultural elements of Africa. This course also explored how diversity and global influences affected Africa’s economic development and political evolution.
Pre-international seminars. The participants prepared for the international experience by attending a series of six pre-international seminars that covered the language, social norms, rituals, traditions, worldview, and an overview of several ethnic groups of Tanzania, specifically the Maasai and Chaga. These seminars were organized and conducted by me with the assistance of a colleague (See Appendix D). The colleague, a professor of African geography, spent several years in the Tanzanian areas of Dar es Salem and Arusha conducting research. Also assisting me in pre-immersion coursework was a student from Tanzania who was enrolled in our nursing program and had moved to the United States five years prior. This student contributed to the pre-immersion discussion by sharing her cultural experiences with her peers as well as teaching conversational Swahili. Each session lasted approximately 4–5 hours and took place every month beginning approximately six months prior to the trip. The seminars also included necessary information for acquiring passports, immunizations, visas and recommended clothing and supplies. Each week the seminar explored concepts of Langer’s theory of Mindfulness, specifically reflexivity, as well as discussions on ethnocentricity and transcultural and holistic nursing care.

The Culture General Assimilator tool. Incorporated into the pre-international seminars was the Culture General Assimilator tool and cross-cultural sensitizer (Cushner & Brislin, 1996). This tool, consisting of 110 assimilator episodes, provided role-playing opportunities and encouraged discussion and reflection by the participants regarding cultural differences. One to two case studies from the Culture General Assimilator were used both for self-study and to stimulate group discussion during each pre-international
The case studies allowed participants to explore their feelings of cultural and racial differences and to contrast their thoughts and feelings with others in the group. I attempted to provide a safe environment for the participants where they could openly discuss feelings and ask questions.

Considerable discussion and reflection on race, ethnic, and religious differences occurred, which helped participants identify their own personal biases, racial, and prejudicial behaviors. This prepared sojourners for the different experiences that they might encounter regardless of where they travel, with whom they interact, or their personal background (Cushner & Brislin, 1996).

**Pre-international preparation in Geneva, Switzerland.** The participants spent four days in Geneva, Switzerland, as further preparatory work for the experience in Tanzania. This served two purposes: it allowed a transition from their culture to a foreign culture somewhat similar to their own. It also provided a break in the travel time, allowing the participants to rest prior to departing for Tanzania. To help prepare participants for their transition from American to Tanzanian culture, the participants visited the United Nations (Palais des Nations), the World Health Organization (WHO) and the United Nations High Commission for Refugees (UNHCR). These few days in Switzerland supported a more in-depth look at global health issues, international organizations, and worldwide health initiatives.

**Palais des Nations.** While at the Palais des Nations, the participants attended a lecture aimed at fostering an awareness of pressing global challenges, such as human rights issues, the global impact of war, and the devastating effects of land mines. The
seminar ended with a focus on how each individual can assist in a small way to help address these concerns. The participants also toured the Human Rights and Alliance of Civilizations Room, the Assembly Hall (the largest room at the Palais des Nations) and the Council Chamber, where many significant and historical negotiations have occurred. As a result, participants were able to see how this agency helped to mitigate the effects of social injustice on a global level.

**The World Health Organization.** The World Health Organization (WHO) provided a health care focus where participants attended a pre-arranged seminar on global health issues such as rising cardiovascular disease, morbidity and mortality rates in underdeveloped countries, and global communicable disease concerns. Human immunodeficiency virus (HIV) prevention and treatment was especially pertinent, since the participants would be working with HIV patients in Tanzania. The participants learned the most up-to-date research and global health initiatives from the WHO. For instance, the participants learned that male circumcision and antiretroviral treatment (ART) could significantly reduce the transmission of HIV, as much as 85–95% worldwide (WHO, 2012). At the conclusion of the seminar, the participants were given literature on HIV prevention in English and Swahili to distribute while in Tanzania.

**United Nations High Commission for Refugees.** The United Nations High Commission for Refugees (UNHCR) provided a lecture specific to the status and living conditions for refugees settling in Tanzania. The purpose of the UNHCR is to inform the public about the plight of refugees around the world and the UNHCR’s humanitarian
mandates and action plans. Participants learned about the difficulties that many refugees face, the reasons for displacement, as well as safety and health care issues.

**Tanzania.** This international cultural experience took place in both rural and urban areas in the northeastern part of Tanzania between the two towns of Arusha and Moshi. The rural area of Arusha, where the majority of the children’s homes were located, is the site of game reserves and national parks of Ngorongoro, the Serengeti, and the Maasai Mara. The Maasai are known as the “most picturesque people in East Africa” (Hodgson, 1999, p. 121) and they still occupy portions of this region. The participants were introduced to this ethnic population in an attempt to demonstrate a variety of subcultures within this section of Tanzania. The Maasai are legendary as herders and warriors and at one time dominated the plains of East Africa. They are now restricted to a small portion of their former land due to the fencing off of large rural areas in Arusha for game reserves and tourism (Ndaskoi, 2003). Many foreign investors control the hotels and tourism in this area and little money finds its way back to the people of Arusha (Ndaskoi, 2003). The participants were asked to make comparisons and contrast the Maasai with other indigenous people from the United States and other parts of the world. This was important to help the participants gain a better understanding of issues of dominance and power.

The participants also spent time with the Chaga near Moshi on the southern and eastern slopes of Kilimanjaro. The Chaga are more affluent than the Maasai, and many Chaga are coffee exporters (Ndaskoi, 2003). Chaga is the ethnic background of Lillian, the student from Tanzania. During their time in Moshi, the participants were invited
guests at a post wedding celebration held in the village where Lillian spent most of her life. This provided an opportunity for social interactions with the Chaga people. In addition to the wedding celebration, the participants spent four days in both rural and urban areas of Moshi and visited a rural HIV clinic run by a nurse from Lillian’s village.

**Health care sites in Arusha: Homes for children.** Both the Chaga and the Maasai served as our guides and escorted us to various children’s homes: Malaika home, Mama Fred’s home, Francesca’s home, and the Good Samaritan Orphanage during the first four days in Tanzania. The purpose of visiting these homes was to gain a better understanding of the socio-cultural effects of poverty and global health issues on children. Each participant packed an extra duffle bag filled with clothing, toiletries, medical supplies and toys for the children and HIV patients. These supplies were distributed throughout the trip.

The first home visited was Mama Fred’s. This home survived through donations from community members. While at this home, the children offered prayers of gratitude for donations of clothing, hygiene products, and toys brought to the children by the participants. Mama Fred lived in a crowded area of Moshi in a small home and began taking in abandoned children from her community and neighborhood over 10 years ago. Mama Fred’s home was overcrowded with approximately 20 abandoned children sharing two bedrooms. The youngest child was preschool age and most of the children were school aged. The participants gained an understanding of the lack of resources and healthcare as well as the limited opportunities for these previously homeless children.
The next home visited was the largest, the Good Samaritan orphanage, directed by a Catholic priest. This home had approximately 100 children and these children occupied two structures. The children were separated by age and gender; the older children lived in a newly built dormitory style home with two bedrooms, one for girls and one for boys. The common centers for both structures were supplied with books and educational materials. This home was supported primarily by donations from the local community as well as contributions from European and American benefactors. Many of these children were brought to the home due to neglect, abuse, or issues related to abandonment. The youngest child was 6 months old and the oldest was 16–17 years old. The participants’ focus was the overall health and well-being of these children and much of the day was spent interacting and playing with the children. Some of the previously abused children had difficulty walking or learning. A physical therapist that accompanied us was able to evaluate the children and offer plans of care; however, most children were in excellent health. The participants helped the physical therapist to evaluate and treat the few children with physical disabilities.

The Malaika home was the only home staffed with a nurse to help care for the children. This home had over 50 children, with ages ranging from newborn to the teenage years; approximately 10% were HIV positive. The HIV positive children’s ages ranged from 5–12 years old. The children in this home were not aware of each other’s HIV status and those who were HIV positive were unaware of this diagnosis. The HIV children received the proper medication through private donations and governmental support. While at this orphanage, the participants were able to provide hands on nursing
care, such as health assessments, health screenings, and health referrals. They were also able to observe and assess children diagnosed with HIV as well as the non-HIV children. Since hands-on-care was given during this experience, the participants were acutely aware of limited resources and treatment options available.

Francesca’s home of about 40 children provided a strong emphasis on education. All children at this site were trilingual, being fluent in English, Italian, as well as Swahili. The children’s ages ranged from the neonate to teenagers. Most of the health care for these children relied heavily on donations with some governmental support. This home had access to a nurse when necessary and the participants were once again able to assess the health care needs of the children and to provide hands-on nursing care.

**Health care sites in Moshi: An HIV clinic.** Mamma Leone’s HIV clinic was located in Moshi and housed or supported over 50 adult women, 23 men and approximately 18 children, all of whom were HIV positive. Mamma Leone was a retired public health nurse from Tanzania and was the mother-in-law of one our hosts. At this site, the participants interacted with the HIV patients and learned of the treatment and challenges of HIV patients in this section of Tanzania. Again, the participants were able to dance, eat, and interact with these patients, experiencing both social interaction as well as a health care focus.

**Kilimanjaro Christian Medical Centre.** Finally, the participants visited the Kilimanjaro Christian Medical Centre (KCMC) located at the foothills of Mount Kilimanjaro, a referral hospital for over 11 million people with 450 beds and a staff of approximately 1,000 people (Kilimanjaro Christian Medical Centre, 2012). The beds
were completely filled and the patients overflowed onto mattresses placed between the beds in the patient ward areas and the hallways. The participants interacted with patients, nurses, and doctors in the general wards, intensive care units, labor and delivery, newborn and neonatal intensive care nurseries, emergency room, and the outpatient departments.

**Study Design**

The remainder of this chapter discusses the design of the study, including participant selection and access, benefits and risks for participants, ethical considerations, data collection methods, and the role of the researcher and the limitations of my research.

**Participant Selection and Gaining Access**

According to Bogdan and Bilken (1998), a critical element for qualitative research is gaining access to the participants. For this study, I had access to these participants as a faculty member in the nursing program. I also designed, developed, and implemented the international experience. The pre-immersion classes and sites were selected specifically to help participants gain a deeper understanding of the concepts of intercultural/transcultural competence, mindfulness, and cultural humility. Participants were drawn from students enrolled in the nursing program at the Salem campus of Kent State University and were required to enroll in one of two nursing courses, Community Health Nursing (senior level course) and Transcultural Nursing and Health Care (junior level course). A description of the pre-international preparation and research site selection are described in detail in subsequent sections.
Participant Demographics

It is important to realize that all people “are born, live, become ill, and die within a cultural belief and practice system” (Leininger, 1988, p. 155). In order to understand the cultural belief and practice systems with which each participant began, it was necessary to identify the relevant participant data, including race, educational experiences, and previous cultural experiences. None of the participants had ever visited a developing country and only one participant had travelled outside of North America. Most of the participants had little exposure to people of color, and had limited understanding of issues related to global health care. All of the participants were from a European-American background and were predominately nontraditional students.

The participants in this study were students from the Salem campus of Kent State University located in a rural community in Northeast Ohio, where 42% of the individuals live at or below the poverty level (U.S. Census Bureau, 2010). The majority of citizens do not attend college and 14.7% do not have a high school diploma. Other than the Kent State University’s Regional Campus, there are no 4-year or 2-year public or private colleges or universities in Columbiana County. Most of the participants are first generation college students. Past research has shown that a parent’s educational level was positively related to the probability of planning to study abroad (Salisbury et al., 2009).

For the participants in this research, the process of deciding to participate in this 8-day cultural experience was comprised of a range of decisions based on affordability, time constraints, and curricular viability. All students who participated in this study
attended school full-time and worked at least 16 hours per week. Their ages ranged from 23–38. The participants in this study were predominately female, with one male and seven females participating. Research on study abroad programs revealed that males were less likely to study abroad than females (Desoff, 2006). This ratio was also reflective of the male-female ratio that existed in the nursing program at this campus.

Each participant in this study was identified by a pseudonym. Table 2 displays the relevant demographics of each participant followed by a summary of the participants.

Table 2

*Participant Demographic Characteristics*

<table>
<thead>
<tr>
<th>Participant Identification Name</th>
<th>Age</th>
<th>Race</th>
<th>College Level</th>
<th>Travel Outside Ohio</th>
<th>Travel Outside U.S. or Canada</th>
<th>Number of Prep Courses</th>
<th>First-Generation College student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meghan</td>
<td>27</td>
<td>Non-Hispanic White</td>
<td>Pre-nursing</td>
<td>Yes</td>
<td>No</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Vanessa</td>
<td>24</td>
<td>Non-Hispanic White</td>
<td>Sophomore</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Marissa</td>
<td>27</td>
<td>Non-Hispanic White</td>
<td>Sophomore</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Michael</td>
<td>28</td>
<td>Non-Hispanic White</td>
<td>Sophomore</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Kahlen</td>
<td>24</td>
<td>Non-Hispanic White</td>
<td>Sophomore</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Laura</td>
<td>23</td>
<td>Non-Hispanic White</td>
<td>Junior</td>
<td>Yes</td>
<td>No</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Denise</td>
<td>25</td>
<td>Non-Hispanic White</td>
<td>Junior</td>
<td>Yes</td>
<td>No</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Alysse</td>
<td>38</td>
<td>Non-Hispanic White</td>
<td>Junior</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Meghan is a 27-year-old pre-nursing student who began her first nursing course after Tanzania. She did not know anyone from the group prior to the international experience. Meghan completed the Transcultural Nursing and Health Care course before this international cultural experience. Meghan was initially withdrawn, but became close with Michael, Alysse, Vanessa, and Marissa during the trip. Meghan had minimal exposure to people of color prior to the trip.

Vanessa is a 24-year-old entering her junior year. She completed the elective Transcultural Nursing and Health Care and the Geography of Africa courses prior to departure. She had never traveled out of the country and traveled out of Ohio six times for vacation. Vanessa is quiet and very accommodating when interacting with her peers and those whom she met during the trip. Vanessa attended a predominately-white high school.

Marissa, a 27-year-old junior-level nursing student, completed the Transcultural Nursing and Health Care course and the African Studies course. Marissa has never traveled outside of the United States, other than a visit to Niagara Falls, Canada. The only other travel outside of Ohio was to visit family. Marissa was outgoing and supportive of her peers and was very compassionate and helpful to all members of the group. Marissa had almost no exposure to diverse population groups prior to this trip.

Michael, 28-year-old student with an infant daughter, was in his junior year of nursing. Michael completed the African Geography course as well as the Transcultural Nursing and Health Care course. He and his wife both worked part-time while attending school full-time. His wife is a graduate student and she strongly encouraged him to take
advantage of this opportunity. His only travel out of the country was to the Canadian side of Niagara Falls and he had limited travel outside of Ohio. Michael was quiet and reserved and only knew some of the participants superficially before the trip began. During the trip, Michael was very thoughtful and polite and added humor to the group. Michael became close with Meghan and Alysse. Michael had minimal exposure to diversity prior to this trip. Michael was one of two married students.

Khalen is a 24-year-old junior-level student with one child. She traveled out of Ohio nine times to Florida, as well as New York City and Washington D.C. Khalen also lived in Florida and traveled to the Bahamas. To prepare for the Tanzania trip, Khalen completed the Transcultural Nursing and Health Care and the Geography of Africa courses. Although very friendly, helpful, and easygoing, Khalen did not bond with any one person more than another did. Khalen also had very little exposure to minority or diverse populations.

Laura, 23, completed the first senior-level nursing course Community Health Nursing, which included a global perspective as part of the course content. Her only travel was within the United States for family vacations. Laura was raised in an affluent town and was looking forward to the Safari experience. She had almost no contact with diversity prior to this trip and was a close friend of Denise who also participated in this program. Laura was quiet, reserved, and a little more fearful than most of the participants. Although considerate, she did not interact easily with the rest of the group, with the exception of Denise. Laura was also from an all-White high school and town.
Denise, a 25-year-old senior, lived in Florida and New York State briefly during childhood. Out of country travel included one trip to Niagara Falls, Canada. Denise also completed the Community Nursing course prior to departure. Denise’s motivation for this trip was the Safari and she is a close friend of Laura. Denise was very outgoing, outspoken, assertive, and at times intimidating to the rest of the students. Denise stated that she had many Black friends and she “does not think of race or color when she sees people.”

Alysse, a 38-year-old senior, completed the African Geography course as well as the Transcultural Nursing and Health Care course prior to departure. She had never traveled outside of the United States, but has traveled outside of Ohio for vacations. She had a strong social justice orientation, was extremely compassionate, caring, and open. She was accepting of her peers and embraced everyone in the group. This trip was difficult for Alysse since she and her husband were actively trying to adopt a child and she encountered so many children during this experience who needed a home. Alysse funded this trip by selling her car.

**Benefits for the Participants**

Benefits for participation in this study were two-fold. First, it provided first-hand knowledge of qualitative research. The intent of baccalaureate programs in nursing was to prepare students with basic understanding of research process and the significance of structuring nursing care based on scientific evidence. Through participation in this research, the participants became closely involved with the research process and were
provided an opportunity to gain an understanding of the basic elements of evidence-based practice and qualitative research (AACN, 2012).

Second, through participation in the actual travel abroad experience, the participants were provided an additional experiential opportunity that otherwise was not routinely available. These additional benefits were not a result of the actual research; rather the participation in the study abroad experience provided an opportunity to develop a greater understanding of transcultural nursing care. An added benefit was that the participants experienced clinical nursing in a distinct setting within a different culture, unlike any of their previous clinical experiences. These participants were able to see nursing care that was much less dependent on technology and more contingent on the skill and intuition of the nurse. They also were able to see the impact of family support on the care of the patient.

Ethical Considerations

Prior to beginning the research study, the consent form was given to the participants to read (see Appendix A). I also read the consent form to the potential participants prior to their signing in order to answer any questions that they might have. The consent was treated as on “ongoing process” whereby participants were able to withdraw at any time without explanation. I disclosed my background and the purpose of this research to avoid any possible exploitation of the participants.

Issues Related to Risk and Consent

No one under age 18 participated in this study; all participants were over the age of 21. Confidentiality and privacy were maintained through rigorous protection of
pseudonyms in all written documentation. Consent forms explained all of the details of the study and assured potential participants that their participation was voluntary. Ethnic background, gender, sex, and age had no influence on the selection of participants. In addition, the participation or refusal to participate did not affect the participants’ grade or progression in the program. Of the 10 participants who chose to travel to Tanzania, eight agreed to participate in this study.

**On-Site International Experiences in Tanzania**

It was imperative that the participants visit pertinent clinical sites, children’s homes, the Kilimanjaro Christian Medical Centre, rural villages, urban towns, churches and historical sites to gain a perspective on the multifaceted aspects of the Tanzanian culture. Participants performed community service and health care assessments in Tanzania as part of the course requirements for the Community Health Nursing course and the Transcultural Nursing and Health Care course. Participants also spent a day visiting a Maasai Boma and not only interacted with the children and members of this ethnic group, they also were provided the opportunity to meet with the Maasai Healer and midwives.

**Health Care Facilities**

The participants volunteered in children’s homes, the Kilimanjaro Christian Medical Centre (KCMC), and in a rural HIV health clinic. At these sites, the participants were encouraged to reflect on the necessary skills needed to provide appropriate and culturally congruent health care. Participants were also encouraged to utilize therapeutic communication techniques when interacting with the children and adults at each site,
employing aspects of Langer’s Mindfulness, as well as Campinha-Bacote’s model specific to cultural encounters. The hospital experience at KCMC provided the participants an opportunity to interact with nurses and patients in the emergency department, the intensive care unit, the neonatal nursery and the general floors.

**Social Opportunities**

The participants were invited guests to a post-wedding celebration in Rombo village in Moshi, an event that allowed them to experience the traditional food, dance, and celebration of the Chaga people. During the day, the participants assisted the family members in preparing food, decorating, and preparing the tables and chairs for the guests. The participants were encouraged to notice differences and similarities with their own families and traditions, such as how the women of the village prepare the food in open pits instead of ovens. The participants danced and shared in the festivities, enabling them to make a personal connection to the culture.

**Daily Reflection and Debriefing**

In line with the study design, each evening the participants returned to their room to relax, reflect, and complete an entry in their reflective journal. Each evening prior to dinner the participants and I met for debriefing sessions and discussions focused on the events of the day. The participants also used this time to ask questions concerning the day’s encounters and experiences. Cordero and Rodriguez (2009) found that interactive group process and reflective learning could facilitate and support a greater appreciation and understanding of different worldviews. Terhune (2006) stated that this reflection and
dialogue can be effective in supporting the changing of attitudes and learning new behaviors.

The participants were encouraged to engage in dialogue during the debriefing sessions and critically reflect on what they experienced. I guided these debriefing sessions and helped the participants gain an understanding of cultural similarities and differences. The geography professor and the Tanzanian student also provided clarification and offered a different perspective to support student learning and understanding.

**Data Collection**

The data collection for my research evolved over a 6- to 7-month period beginning with pre-international and international reflective journals, focus group discussions, and finally individual interviews. I also employed procedures to establish trustworthiness (triangulation, member checking, and peer review).

**Data Collection Methods**

Data collection methods used included reflective journaling, focus group discussions, and individual interviews (see Table 3). Direct quotes, narratives, and personal observations were included in the data interpretation and analysis section of this paper to convey participants’ responses to their experiences during and following the program (Ross, 2008).
### Table 3

*Data Collection Methods*

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
<th>Location</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflective Journals</td>
<td>Daily while abroad</td>
<td>On-site in Tanzania</td>
<td>8 Journal entries</td>
</tr>
<tr>
<td>Focus Group Discussion #1</td>
<td>Once 4 weeks after the return home</td>
<td>Campus</td>
<td>2.5 hours</td>
</tr>
<tr>
<td>Focus Group Discussion #2</td>
<td>Once 4.5 weeks after the return home</td>
<td>Campus</td>
<td>2.0 hours</td>
</tr>
<tr>
<td>Personal Interview</td>
<td>Six months after the return home</td>
<td>Researcher’s Office</td>
<td>45 minutes to 75 minutes</td>
</tr>
</tbody>
</table>

While in Tanzania, participants were required to reflect on what they were encountering, to describe their feelings, to self-evaluate, and analyze their reactions, behaviors, or responses after reflection, and to develop personal goals (See Appendix B for reflective questions). Participants reviewed their journals independently two weeks after the international experience to add comments, if so desired. One month after returning, the participants met with me in two focus group discussions to reflect on, interpret, describe, discuss, and share their experience with their peers. The two focus group discussions each lasted about two hours over two different days within a one-week period. Six months after returning home, I conducted individual interviews (See Appendix C for interview and focus group questions). The personal interview for each participant was approximately one hour long and was audio-recorded; permission was obtained from all participants prior to recording the conversations. These audiotapes were later transcribed and given to each participant to review, correct, add comments, or
further expand on their conversation. Again, none of the participants made any changes to the transcripts. At times data collection occurred concurrently with data analysis through my ongoing self-reflection and by asking analytic questions of both the participants and myself, as the researcher. I also used researcher memos to ensure that the data was accurate and complete throughout the data collection process (Creswell, 2009).

**Self-Reflective Journaling**

All participants were required to keep a reflective journal describing and making sense of their experiences while abroad over the 8-day period. The purpose of these reflective journals was to guide the participants to reflect on their personal assumptions and to engage in self-evaluation to develop a greater understanding of culture issues. The journaling assignment began immediately after the pre-international introduction in Geneva and continued each day during the remainder of the sojourn program. The reflective journal was selected for primary data collection because it minimized data alteration or skewing during the analysis process (Miles & Huberman, 1994). I used prompts to encourage reflection, such as “how,” “why,” and “what if” questions. Langer’s theory of Mindfulness was used to support self-reflexivity. Some additional guidelines given to the participants encouraged them to try to determine why they felt a certain way, how they arrived at a certain conclusion, how it affected the way they thought about others, and to consider how they would feel if the situation were reversed.
Focus Groups

Focus groups are advantageous when the interaction among participants can serve to produce more information, when participants have similar experiences and are cooperative with each other, and when one-on-one interviewing may cause hesitancy in the participants (Creswell, 2007). The intent of the focus group discussions was to provide a non-threatening environment wherein participants might be more likely to express and clarify their views than they would in the personal interview format (Fain, 2004). The focus group discussion also provided a forum to follow up on comments made by the participants in their reflective journals as well as comments made during the international experience. I facilitated the discussion to ensure that the conversation did not diverge too far from the original topic and that no single participant dominated the discussion. Again the “how,” why,” and “what if” questions were used to encourage deeper reflection (See Appendix C for focus group discussion questions). All eight participants attended two focus group sessions. For the first focus group discussion, both faculty were present; however, during the second focus group, I was the only faculty person present.

It should be noted that there are disadvantages associated with focus group discussions. During focus group discussions, the participants may behave differently from how they would otherwise behave if alone. It is possible that they might be influenced by other group members. This can influence the quality of the data and ultimately the research results. In addition, there is the danger that some members can monopolize the conversation, especially when the researcher is inexperienced. It is also
difficult to have the participants share their real feelings towards some sensitive topics, such as issues of racism and bias.

The questions asked during the focus group were both structured and unstructured. Some examples of questions asked were: How did you feel when interacting with patients at KCMC? What did you find uncomfortable or confusing during your time in Tanzania? Did you ever feel like you were lost? Frightened? Can you identify any of your actions that may have been misconstrued by others? Was there anything that you would like change about how you felt or reacted while in Tanzania? Talk about the nurses . . . how are they different from you, or are they? How are they similar? Is there anything that you can learn from them? What was the greatest lesson that you took away from Tanzania? Would you like to return . . . and why or why not?

**Participant Interviews**

The interview, a guided conversation between the participant and myself (H. J. Rubin & Rubin, 2005), is the most common form of data collection for qualitative research (Bogdan & Bilken, 1982). The interview elicited detailed information about the research question and topic, provided understandings and meanings, and/or portrayed specific events or processes. The interview format differed from survey research where all questions are asked in the same manner to each participant (H. J. Rubin & Rubin, 2005). Open-ended interviews were used to obtain a general idea of what the participant experienced. I altered the questions depending on how much the participant was willing to share. Face-to-face interviews were conducted six months after the international experience. Each interview was scheduled at a convenient time for the participant and
lasted approximately one hour. The participants were sent an e-mail reminding them of their scheduled interview time. The interview and focus group questions consisted of questions derived from my review of relevant literature. The questions were both predetermined structured questions and spontaneous unstructured questions. The unstructured questions were used to facilitate a deeper understanding of what the participant was trying to convey. In addition, the time spent in Tanzania inspired further questions not considered initially.

Interviews should be designed around main questions, follow-up questions, and probes according to H. J. Rubin and Rubin (2005). The interview questions and format for my research reflected the philosophical approach of the interpretive constructionist and I followed the responsive interviewing model described by Rubin and Rubin. I was most interested in obtaining the participants’ experiences during and after their study abroad, and as such, I tried to remain acutely aware of my nonverbal cues, opinions, and biases. In addition, I was aware of power differences between the participants and me, since I was also a faculty person in their nursing program. To help diminish this threat, I provided reassurance that they were free to express themselves without fear of retribution, and if they felt diminished or vulnerable, they were encouraged to report these feelings to the Dean or other faculty. I used support and humor to help reassure the participants, as well as an open and transparent approach to help diminish any threat that they may have felt. I sincerely attempted to portray deep respect and appreciation for their participation in this research. I tried not to impose my beliefs on the participants
and I structured the interviews in a format that was flexible and adaptive (H. J. Rubin & Rubin, 2005).

Information obtained from the individual interviews was more personal than the focus group discussion and was used to help clarify items from the reflective journals and the focus group discussions. Again, very specific questions were asked and the questions were the same questions used during the focus group discussions as described above and in Appendix C. Once again, open-ended questions were used during the interviews and I encouraged the participants to provide as much depth to their answers as possible. This also gave the participants the opportunity to tell their story after a 6-month period of reflection.

Two of the eight participants requested to be interviewed together because they felt that they would help each other to remember and reflect on their experiences while in Tanzania and that this would enhance the interview. I wanted to make the participants as comfortable and secure as possible during the interviews; therefore, I honored this request. These two participants were very talkative and forthcoming during the interview process. I later asked these two participants to be re-interviewed again separately and they agreed. Their comments from the joint interview were compared with their second interview, looking for both consistencies and inconsistencies.

**Data Analysis and Interpretation**

Miles and Huberman (1994) described three major phases of data analysis: data reduction, data display, and conclusion drawing/verification. To begin the process of data analysis, I first needed to organize and reduce the data. Data reduction involved the
process of choosing, focusing, reducing, conceptualizing, and transforming the data that appeared in the participant journals, interviews, and focus group discussions. As recommended by Miles and Huberman, data that were determined insignificant were set aside; the remaining were condensed for the sake of manageability. I used extended pieces of texts and organized these texts into categories that provided me a way of analyzing and arranging the embedded data. For the second phase of data analysis, I needed to go farther than data reduction to provide an organized, condensed construction of information that permitted conclusion drawing. At times I arranged the data into tables to help me begin to uncover and recognize systematic patterns and interrelationships. At this stage, additional, higher order categories and themes emerged that extended beyond those that I first discovered during my initial data reduction process (Miles & Huberman, 1994). The final and third component of qualitative analysis according to Miles and Huberman is conclusion drawing. As the researcher, I needed to take time and re-consider what the analyzed data meant to the participants and how this applied to my study. Verification of the data required me to revisit the data multiple times to cross-check or verify these emergent conclusions. I remained alert to the possibility of additional unexpected themes as the data was collected (Richards & Schwartz, 2002).

**Recognition: Dividing the Data Into Units and Coding**

I took great effort to avoid preconceived notions, as I wanted my analysis to develop from the ground up. I conducted ongoing coding of the data to look for themes and concepts during and following the data collection process. Rather than beginning
with any preconceived notions and then attempting to prove or disprove my assumptions, I sought to have my analysis develop inductively.

My intent was to accurately portray the meanings of each participant to ensure that their voice was heard. To do this, I wrote frequent memos about my observations during the data collection process and asked off script questions to help me clearly report on what the participants were trying to convey. After the last interview when all data were collected, I returned to the data and reconsidered issues of voice and representation. I looked for codes or themes that emerged from the voices of the participants. I used the following self-reflective questions as a guide: (a) How can I ensure that I am accurately representing the participants’ meaning? (b) How are notions of “giving voice” complicated when I am also a faculty person? and (c) How can this impede their accurate portrayal of their meanings?

I also used my experience as a nurse and educator to assist with data analysis and interpretation. When interpreting the data, I remained cognizant of the stages of ethnocentricty according to Bennett’s DMIS or Langer’s mindful characteristics. In addition, I remained alert to the ontology of holism and looked to see if there was interplay between meaning making by the participants and holistic nursing practice. Initial codes were assigned to participant statements and quotes that related to the theoretical framework for this research. I then began to organize these codes. After several readings for each set of journals and transcripts from the focus groups and personal interviews, various themes, concepts and connecting strategies began to emerge (Maxwell, 2005). Data summary tables were used to track and record the individual
responses from each participant. This allowed me to track how each participant responded to the same questions during the experience through the reflective journals, one month later during the focus group discussion, and six months later during the personal interview. This also provided me a method to compare and contrast each of the participant responses with earlier responses as well as those of their peers to look for consistencies, patterns, or discrepancies. Finally, these tables allowed me to compare the participant responses against the specific categories of Bennett’s DMIS and Campinha-Bacote’s Process of Cultural Competence.

**Looking for Concepts and Themes in the Literature**

My goal for this research was to discover how the participants understood what they saw, heard, or experienced. I tried to elicit data that would explain and shed light on the participants’ stories. Published literature was reviewed once again to identify concepts, themes, and codes as well as other concepts and themes unrelated to the literature. Themes were clarified through ongoing review of pertinent literature. As suggested by Strauss and Corbin (1994), through constant comparison I was continuously gathering more data, analyzing it, comparing the analyses to past analyses, and then gathering more data in order to clarify emerging themes. I began by sorting the data and then ranking the materials within each coded file. I then sorted the data again, looking for more concepts or themes, to support or disqualify the data. The data were then weighed further to help me synthesize different versions of the same concept so that I could pull together different data pieces into a congruent and descriptive narrative (H. J. Rubin & Rubin, 2005). For instance, the participants often spoke of feelings of sensory
overload, overstimulation, and of being overwhelmed. After combining the data and checking for accuracy, an overarching concept was that of shock and disequilibrium. The participants also spoke of feelings of shame, guilt and prejudicial behaviors that developed into the theme of self-awareness. Tables 4 and 5 are examples of one way in which I organized the data.

Table 4

*An Example of Organization of Data for the Concept of Shock*

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Participants</th>
<th>Sample Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory overload</td>
<td>All</td>
<td>I feel like the first time, there was like so much shock factor going on that I didn’t know what was happening sometimes. I was so shocked and over-stimulated basically.</td>
</tr>
<tr>
<td>Overwhelming</td>
<td>All</td>
<td>I was just so emotionally overwhelmed that I just went up to my room and lay down.</td>
</tr>
<tr>
<td>Overstimulation</td>
<td>All</td>
<td>Adam warned us of the flies before we got out of the car but I didn’t think anything of it. I’ve lived on a farm all my life so I’m used to flies. Boy was I wrong! The flies were absolutely disgusting! The kids had them all over their mouths and in their eyes.</td>
</tr>
</tbody>
</table>
Table 5

An Example of Organization of Data for the Concept of Self-Awareness

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Participants</th>
<th>Sample Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame and Guilt</td>
<td>All but Laura</td>
<td>I feel so guilty for everything that we have and I am embarrassed just wearing new clothes.</td>
</tr>
<tr>
<td>Self-doubt</td>
<td>All</td>
<td>I realized that I felt completely embarrassed and ashamed at my lack of knowledge about the world.</td>
</tr>
<tr>
<td>Combating Prejudice</td>
<td>All but Laura and Denise</td>
<td>You can’t just judge people by how they look . . . people deserve more than that.</td>
</tr>
</tbody>
</table>

**Trustworthiness**

Trustworthiness dictates that I make every effort to represent the experiences of the people being studied as accurately as possible. For my qualitative study, trustworthiness was established using dependability, confirmability, transferability, and credibility (Lincoln & Guba, 1985). Dependability (Lincoln & Guba, 1985) provided a means by which the reader can track the techniques and methods that I used to collect and examine the data. This was done through data summary tables as well as the detailed description and explanation of how I collected and managed the data. For my research, I also completed a subjectivity audit to ensure confirmability whereby the data and findings were not a result of my bias (Bloomberg & Volpe, 2008). Confirmability emphasizes the importance of accurately representing the voices of the participants though the use of rich descriptions. All transcripts and journals from this research are available upon request and are stored in a locked cabinet in my office.
Transferability was established when the results could be found to be applicable to similar situations under similar circumstances. It is the way in which “the reader determines whether and to what extent this particular phenomenon in this particular context can transfer to another particular context” (Bloomberg & Volpe, 2008, p. 86). Last, credibility required me to accurately represent what the participants thought, felt, and communicated. Credibility was established through member-checks, peer debriefing, and triangulation of data (Bloomberg & Volpe, 2008).

**Peer debriefing.** Peer debriefing was used to enhance the accuracy of the data collected. Two nursing faculty colleagues were asked to review several transcripts and the codes assigned to the data. As inconsistencies arose, these discrepancies were discussed and resolved before proceeding further (Bloomberg & Volpe, 2007). Initially the intent was to bring the faculty together to discuss the themes and the data; however, this was difficult since the faculty members had different schedules. Instead, I spoke privately with each of the faculty who agreed to read the data. The faculty was asked to review the identified themes and to provide suggestions for additional themes that may have been missed. In addition, meetings with the participants occurred to further clarify meanings.

**Member checks.** Credibility and confirmability, which reflects the voices of the participants (Lincoln & Guba, 1985) was accomplished by member checks. The participants received a copy of their journals, the transcripts from the focus group and their individual interview as well as my interpretation for validation of accuracy. Through member checks, each participant reviewed their reflective journals, and
transcripts of the focus group discussions and personal interviews to ensure accuracy. Member checking asked the participant to check the data for accuracy and validate that the reconstructions were accurate representations of their reality. Member checking was the most crucial technique utilized to establish credibility (Lincoln & Guba, 1985). The summaries of participant journals, focus group discussion, and interview were presented to each participant for their input. Validation of these summaries for each participant was performed individually and confidentially.

**Triangulation.** The use of multiple data collection strategies helps to increase the credibility of the findings through triangulation of the data (Roger & Shapira, 2000). Triangulation incorporated different sources of information to clarify meaning to increase the validity of the study (Bloomberg & Volpe, 2008). Participant interviews, reflective journals, and personal interviews were used for triangulation. Since the conclusions from each of the methods were the same, validity was established (Guion, Diehl, & McDonald, 2011).

**The Role of the Qualitative Researcher**

As a qualitative researcher, I first began with personal insight, self-reflection, and a self-critique of strengths and weakness. In addition, I tried to remain cognizant of my ontological and epistemological beliefs. Peshkin (1988) asserted that when researchers acknowledge and understand the subset of personal qualities that are released when in contact with their research phenomenon, “these qualities have the capacity to filter, skew, shape, block, transform, construe and misconstrue what transpires” throughout the research process (p. 17).
Research should be a reflective praxis; however, according to Schoorman and Bogotch (2010), reflective practice by researchers is not typical. Reflection allows for discourse regarding the researcher’s ontological and epistemological worldview, thereby generating greater understanding, knowledge, and skill as a researcher. It requires the person to evaluate and understand the limitations of their way of thinking and knowing. Through reflection, I tried to be diligent in uncovering iterative, subjective, and contextually bound interpretations of data that otherwise may have gone unnoticed (Andrist, Nicholas, & Wolf, 2006).

Current definitions of a good researcher are typically restricted to discussions of methodology, but Schoorman and Bogotch (2010) ask the investigator to re-conceptualize the role of a good researcher as one who not only links practice to research but also considers the wellbeing of individuals or a population. They remind us that especially when conducting multicultural research, the research should primarily benefit the researched. These authors highlighted the emergent characteristics of the multicultural researcher: the commitment to a common good; the re-definition of the researcher–researched relationship; and the reevaluation of the traditional roles, norms, and power dynamics of academic research and researchers. Although these authors presented the perspective of the critical researcher, it is important for all researchers to remember that research is not done on members of the community but with them. I tried to be very respectful of the patients and people that we met in Tanzania and we only provided nursing care or engaged in social activities when voluntary permission or personal invitations were given. Finally, it was important for me to be conscious of any
of my biases maintained or confronted through the knowledge construction process (Schoorman & Bogotch, 2010).

I employed an active and systematic reflective process to evaluate my personal subjectivity and biases. One way this was accomplished was through my personal reflective journal. The challenge was to identify and evaluate the effect that my subjectivity had on the study at any given point in time. During time in the field, a notebook was used to record a subjectivity audit to identify any behaviors by me that may have enhanced or misconstrued the research process. I consciously sought biases before, during, and after the research process, mindful of my weaknesses as a researcher and how this could influence my study and results. I also asked the faculty member traveling with the group to watch for biases. The goal was for me to become acutely aware of things not only that I expected to see, but also those things that are not easily discerned.

Summary

This research was framed using a design that was consistent with a qualitative approach by taking care to present multiple realities, using my role as researcher as an instrument of data collection, and accurate presentations of the participants’ views (Creswell, 2007). I tried to follow the highest ethical standards for both the participants and members of the diverse culture. I took great care to ensure that learning experiences of the participants never compromised or de-valued the integrity of any individual.

Chapter 3 described the methodology that was used for my dissertation and the theoretical framework that guided this research. Included in this chapter was the interpretive qualitative approach with a rationale for this approach and a review of other
research methodologies. This chapter presented an overview of the theoretical framework that guided this research. Also provided was an explanation and justification for the selection of participants, gaining access, benefits for the participants, the pedagogical design, issues related to consent, and pre-international preparation. Finally, data sources, data collection methods, and the procedures used to analyze the data, measures used to ensure the trustworthiness of the study, and my role as the researcher were discussed.

Tanzania was selected because the health disparities were manifested widely and the participants were exposed to a culture and race that was vastly different from their own. This country was also selected because many health care workers and citizens speak English. Participants were drawn from students enrolled in one of two nursing courses. The participants prepared for the Tanzanian experience by multiple pre-immersion workshops, visits to the World Health Organization and other pertinent sites in Geneva, Switzerland. The participants also prepared for this international cultural experience through pre-immersion workshops, course readings, and assignments prior to departure. Participants were asked to reflect on their experiences at the conclusion of each day, and once they returned home, through reflective journals.

The following chapter presents a discussion and analysis of data. I took care to identify and include any appropriate personal history, culture, and experiences that provided a unique lens to this research. The study results were conveyed clearly, and hopefully persuasively, so that readers can begin to understand what the participants experienced. Chapter 4 discusses the participants’ efforts to make meaning from their
experience from this 8-day international experience (as reflected in the collected data) in
the context of the three models that I presented in Chapter 3, for understanding the
process toward becoming a culturally competent health care practitioner. The data in
Chapter 4 were analyzed through the reflective journals while participants were on site,
as well as one month later through focus group discussions, followed by personal
interviews after six months. I also examined the data to see whether the participant
descriptions remained consistent over the 6-month period.
CHAPTER IV
FINDINGS

The American Association of Colleges of Nursing (AACN) set the tone for this study through a strong commitment for the education of transcultural nurses who are able to meet the emerging needs of diverse individuals, families, and communities. Rather than promoting transcultural care in a traditional classroom format, through this dissertation, I examined the meanings that participants drew from an 8-day international cultural experience. My dissertation was informed by a constructivist epistemological lens and is consistent with the profession of nursing’s ontological view of holistic nursing practice. This chapter uncovered positive outcomes such as greater self-awareness, leadership skills, a new perspective of professional nursing, and a desire to learn more about other cultures. It also discussed drawbacks, such as shock, depression, and guilt.

The data were reviewed across several data sources multiple times to amend, reduce, and revise the themes for a more complete and accurate portrayal of the findings. Two faculty peer-reviewed the transcripts and journals and offered input into the consistency of the themes. I used the theories of Langer, Bennett, and Campinha-Bacote, as well as pertinent research studies, to inform my data interpretation. I employed inductive reasoning in this descriptive qualitative study to interpret data from the reflective journals, focus group discussion, and personal interviews to answer the two research questions:

1. How do the participants describe their experience of a one-week international cultural experience in the short term and six months after returning home?
2. How do the participants re-conceptualize their role as nurses six months after returning home?

**Research Question One**

How do the participants describe their experience of a one-week international cultural experience in the short term and six months after returning home?

To explore the first research question, I prepared and analyzed data that examined the thoughts and feelings of the participants gleaned from student reflective journals, focus group discussions, and personal interviews. For the first research question, I examined the initial reactions of participants’ written statements from the reflective journals and then proceeded to review the audiotaped conversations that occurred one month later during focus group discussions. I then compared the data collected six months later through the personal interviews, looking first for changes in the participants’ perspectives and for similarities and/or inconsistencies. For the first research question, I examined how the participants described the one-week international cultural experience in the short term. I identified six major themes as a response to the first research question:

1. Feelings of disequilibrium and culture shock;
2. Greater self-awareness and personal responsibility for issues of prejudice and bias developed;
3. A deeper understanding of similarities and differences occurred;
4. An enhanced awareness of “others” and the development of cultural empathy;
5. A sense of loss ensued after returning home; and
6. Descriptions of the international cultural experience as life-changing (See Table 6).

Table 6

*How Do the Participants Describe Their Experience of a One-Week International Cultural Experience in the Short Term and Six Months After Returning Home?*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Participants</th>
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<tbody>
<tr>
<td>The participants described feelings of disequilibrium and culture shock.</td>
<td>8 of 8</td>
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<tr>
<td>A greater self-awareness and personal responsibility for issues of prejudice and bias developed.</td>
<td>6 of 8</td>
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<tr>
<td>A deeper understanding of similarities and differences occurred.</td>
<td>8 of 8</td>
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<tr>
<td>An enhanced awareness of “others” and the development of cultural empathy.</td>
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<tr>
<td>A sense of loss ensued after returning home.</td>
<td>7 of 8</td>
</tr>
<tr>
<td>The international cultural experience was described as life changing.</td>
<td>7 of 8</td>
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**Feelings of Disequilibrium and Culture Shock**

According to previous research, entering into a new environment often results in feelings of disorientation (Gudykunst & Kim, 1997), sensory overload (McLachlan & Justice, 2009), shock, and a sense of being overwhelmed (Ruddock & Turner, 2007). Stier (2003) described this as a state of being “disconnected from real life” (p. 81) and Hutchings et al. (2002) reported loneliness, fear, and anger as symptoms of culture shock.

Oberg (1960) was the first person to use the term “culture shock” over 50 years ago as a normal and anticipated reaction when experiencing an unfamiliar culture for the first time (Furnham, 2010; Oberg, 1960). Culture shock often results from the realization
that others do not necessarily share the same perspectives and actions of the individual (Furnham, 2010). Stier (2003) found that for individuals experiencing a new culture for the first time, “their frame of reference may be inadequate when it comes to comprehending and adapting to the host culture” (p. 80). It is important to understand that culture shock can also be seen as a normal stage of development toward acculturation and adaptation for the sojourner (Furnham, 2010; Oberg, 1960). The participants came face-to-face with a culture that challenged some of their personal beliefs and values, which may have contributed to this state of shock and disequilibrium as they struggled to understand and acclimate to this new culture.

Disequilibrium is often a precursor to change and results from personal and/or moral conflict. According to Cushner and Brislin (1997), cross-cultural conflict often occurs when people confront different cultures, customs and ways of living. Although expected, these authors suggested that the degree and depth of this conflict is often surprising to the sojourners. The participants identified conflict and described unfamiliar noises, language barriers, unusual foods, different ways of living, and chaos on the streets as contributing factors for disequilibrium and culture shock. Evidence of culture shock and disequilibrium were also identified from reflective journals and focus group discussions.

All participants stated that they were overwhelmed when interacting with children and patients at the various orphanages, clinics, and the Kilimanjaro Christian Medical Centre, due to the health issues observed and to the lack of available resources. Below
are excerpts from participant journals and focus group discussions that demonstrate feelings of shock and disequilibrium:

Khalen: It was depths of poverty that I had never even imagined were possible other than what you see on TV. I started to cry, all of it began to catch up with me. I just was not ready for what we were exposed to.

Meghan: So much was going on around us . . . everything was different. In the hospitals, on the streets . . . even in the orphanages, I didn’t know which way to turn, or who to help.

Marissa: I think I went through some of the stages of grief such as shock, denial, anger, and sadness, initially, but it got better as the trip progressed.

Laura: I was just blown away by all of it. I am not sure if I ever really got over the shock of all of it. I was just glad that I was with our group the whole time.

Michael: We had brought big duffel bags filled with clothes and supplies for all of the little kids, but I don’t know that any of us were prepared for this visit. I knew that it was going to be upsetting because of some of the things we knew beforehand about the orphanages, but I had no idea.

Marissa: It was just for me, culture shock . . . everything, the way of life . . . so many new things, no traffic laws, crowding on the streets, animals in the street, the clothing, the food.

Alysse: The streets were filled with cars, bikes, cows, goats, chickens and everything you could imagine . . . people balancing everything on the tops of their heads. I didn’t know which way to look; it was confusing at first.
Vanessa: My mind was truly in a state of confusion, visiting the Maasai, seeing how hard everyday life is for people that live in the country. Wow!

Denise: Today was such an emotionally draining day. After flying all that way from Switzerland, then visiting the orphanage and just being in an underdeveloped country was a lot to take in on our first day.

The participants had difficulty acclimating to their new environment and an array of emotions erupted. As seen in the above excerpts, all participants expressed varying degrees of shock. Culture shock can stem from sensory overload or simply separation from normal routines and a lack of the familiar. McLachlan and Justice (2009) reported on disequilibrium and shock as a result of interactions with a new country and culture, encountering different ways of living, new foods, diverse customs, religions and dress. The participants described this sensory overload during the trip and recalled these feelings one month later:

Denise: When we were driving down some of those roads, there were so many people in the street. So much going on all around us that was new and different, I liked it . . . but I remember feeling as if I was on overload.

Khalen: Everything was so new . . . I never saw anything like this before. I really think I was suffering from sensory overload.

Michael: There was so much going on, the noise, the people, the animals . . . it was so much, I remember that I had trouble adjusting.

Even though shock occurs, it is not always because of negative encounters. The participants were in awe of the streets, the people, the animals, and the crowds.
Nonetheless, the participants described their initial experience as one of sensory overload. There were also sights that were upsetting for the participants. A few days later, adding to a feeling of disequilibrium were feelings of sadness and confusion over the care of individuals with HIV. The participants expressed dismay and heartbreak when confronted with the plight of HIV patients after the visit to the HIV clinic:

Marissa: Seeing them wear those white shirts symbolizing the disease broke my heart. I felt like crying again but could not in front of everyone. How can such nice perfect people be suffering like that? It was not fair. I still cannot get them out of my mind.

This was difficult for Laura because she could not understand why people with illnesses were segregated from the general population. Laura also had difficulty knowing how to react and what to expect, especially when interacting with the children from the HIV clinic and the many children’s homes:

I [remember that I] was still tired from our plane ride and then meeting these children. It was kind of intimidating . . . they were so eager to hug us and jump into our arms or show us around their home. Just so many kids, they all wanted attention from us . . . I got so many hugs from these kids as soon as I walked in that I didn’t know what to do with myself. It was hard . . . I had to keep myself from crying.

All of the participants experienced unsettling feelings of shock to varying degrees. The participants did not anticipate the openness and friendliness of the children, the pain and suffering seen in the hospitals and the HIV clinics, and the hardships that which
many people of Tanzania must cope with. They were trying to make sense of what they were experiencing. The participants were distressed by the condition of the hospitals, clinics, and homes where people lived. They were unaccustomed to crowds and diverse sights that they saw on the streets, such as animals, bikes, cars, carts, and so forth. However, the presence of disequilibrium and culture shock can serve as a trigger for cross-cultural learning (Chang, 2007). Ruddock and Turner (2007) identified culture shock as part of the transition process and claimed that cultural shock is a prerequisite to learning. Cultural shock often sparks learning that leads to the development of new viewpoints (Wei-Wen Chang et al., 2012).

Culture Shock and Disequilibrium Continues After Returning Home

Once the participants returned home, they described the after-effects of culture shock as they tried to make sense of social differences, differences in health care, resources, and different lifestyles. The sense of being too overwhelmed by the international experience can actually result in a potential block to transformation, according to a study by Foronda and Belknap (2012). During the focus group discussions, the participants were very forthcoming and verbalized their feelings. For example, “It was worse than I expected” (Laura); “It was almost too much to take in” (Khalen); “There was so much to process” (Marissa); “The level of poverty was unlike anything I have seen before” (Denise); “I am still physically and emotionally drained” (Michael). This is consistent with findings from Ward et al. (2001), who reported that culture shock often produces a sense of confusion, disorientation, anxiety, and difficulty coping with the new environment. Difficulty coping was particularly evident with
Michael, as he did not open up to his peers about his emotions and feelings while in Tanzania. However, after one month had elapsed, he shared the following with the group during the focus group discussions:

I struggled with hints of depression after seeing the conditions that many people in the villages have to cope with on a daily basis, such as the lack of clean water, inadequate shelter and available food. I remember that I just wanted to go back to my room and curl up into a little ball.

Michael needed time alone to deal with his experiences and to cope. He often retreated to his room and reflected before the group met for dinner. The participants were often placed in situations that were outside their comfort zone, resulting in depression and confusion. It is important to keep in mind that through discomfort and sense of being overwhelmed, learning can begin and the process of acculturation and adaptation can be triggered (Furnham, 2010).

Meghan: Everything in Tanzania was overwhelming. There wasn’t a minute, besides when I was sleeping, that my mind wasn’t busy processing everything around me.

Vanessa agreed and remarked:

It was worse. I mean, we see pictures before we go, but to actually experience it first hand is entirely different than what you just expected . . . but it made me rethink so many things.

Vanessa not only was able to discern the differences in resources, she also expressed an appreciation of experiential encounters over a purely didactic approach.
This is supported by research and it is reported that international experiential programs that combine didactic and experiential learning have demonstrated that these opportunities produce significant gains in the areas of cultural relativism (D. L. Rubin & Sutton, 2001), as well as personal growth and cultural awareness (Button et al., 2005; Greatrex-White, 2007). Many of the participants spoke of the importance of experiencing first-hand a different way of life. They felt that didactic learning would not provide the same educational experience as actually “being there.”

The participants often spoke of the differences in infrastructure and the availability of resources in the U.S. when compared to Tanzania. When participants were brought to the Kilimanjaro Christian Medical Centre (KCMC) where they were to be assigned to work side by side with the nurses from Tanzania, many of them broke into tears and asked to stay with the group. All expressed feelings of inadequacy over the lack of resources and the overcrowded conditions. The following conversation occurred approximately one month later during the focus group discussions.

Alysse: I felt as if I was in a war movie and all these patients were affected by it.

A hall was filled on both sides with patients . . . They were lying on the floors and suffering, and it was just a sight that was so hurtful.

Khalen: The first room that we went into was with a fresh burn victim. I think that was pretty shocking for a lot of us because some of us had not seen anything of that nature before. What really was shocking to me was that you could clearly see his burns and tell that he was in pain. His whole body was shaking, he was just grimacing and he had no pain meds yet. The only thing he seemed to care about
was getting a picture with us. I don’t know, it just kind of, shook me up a bit, just
the fact that he didn’t care about how much pain he was in. He just wanted a
picture with us to tell his friends that he was taken care of by “Obamaland”
nurses.

Meghan: It was rough. The hospital, it was definitely shocking . . . so many
people suffering, it was so crowded you could not even move from one patient to
another without stepping over someone.

The personal interviews conducted six months later also reflected the continued
sense of being overwhelmed and in a state of shock. Michael remarked “I still am
confused and shocked by how people have to live and cope with on a daily basis.”
Meghan stated that “it was so confusing. I remember being overwhelmed. It was great to
have others students with me. They helped a lot and so did Mrs. F.” Vanessa found that
she “was shocked and felt over stimulated most of the time . . . but I wouldn’t trade this
experience foe anything in the world.” Laura commented that “there was so much
happening all the time. I don’t think I ever really got used to it.” Alysse “just loved it,
but I remember crying every day. My sunglasses helped me hide the tears; I made sure I
kept a smile on my face behind my glasses.”

The participant comments suggest that they experienced a sense of culture shock
and disequilibrium as well as sensory overload, overstimulation, the need to confront
differences, and feeling disconnected from the familiar. Once they returned home, the
participants continued to verbalize these feelings six months later.
This state of disequilibrium and culture shock can help nudge the individual toward self-awareness or can reinforce feelings of bias and racism. Greatrex-White (2008) found that students who had experiences as foreigners were better able to empathize and understand issues of injustice. Bosworth et al. (2006) found that when sojourners were placed in challenging situations, personal and professional growth often ensued. Through the data from this study, strong evidence was found for a greater self-awareness for most of the participants, and this was the next theme identified as a response to the first research question. From this self-examination, the participants began to explore previously held values, beliefs and behaviors; this produced feelings of shame and guilt, self-doubt and a new understanding of issues of prejudice.

**Greater Self-Awareness and a New Understanding of Prejudice and Bias**

Self-awareness is the deliberate and conscious process of re-examining one’s personality, knowledge, values, beliefs, and ethics and the impact of these factors when interacting with the other culture (Campinha-Bacote, 2007; Purnell & Paulanka, 2008; St. Clair & McHenry, 1999). Self-awareness is one aspect of mindfulness through which the person begins to understand the other person’s behaviors and traditions from multiple cultural angles (Gudykunst, 1991; E. Langer, 1989, 1997). Mindfulness guides us to be aware of our own personal approach while reflecting on the effect that our interactions have on others. Mindfulness is less about how we feel that we are doing; it is more about how we are actually reacting and connecting to others. Mindfulness requires us to reflect on and learn from experiences and create new ways of relating (Gudykunst, 1991) and is critical for professional development and decreasing ethnocentrism. Mindfulness is the
first step toward becoming culturally competent (Campinha-Bacote, 2007; Purnell & Paulanka, 2008).

The participants worked with people who had fewer material goods, and yet, according to the students’ comments, they appeared to be happier, kinder, and more giving. These encounters evoked strong feelings in most of the participants; as a result of these observations, they elaborated on feeling embarrassed, guilty, or ashamed of their past actions and behaviors. All of the participants struggled with the wealth and materialism of the United States and the scarcity of supplies and resources for the people with whom they interacted in Tanzania, especially the children. This is consistent with the literature that reports students participating in international travel who have reported feelings of guilt, especially once they return home (Bentley & Ellison, 2007; Evanson & Zust, 2006; Levine, 2009; Maltby & Abrams, 2009; Stier, 2003). According to Johns and Thompson (2010), sojourners often have difficulty coping with the disparities that they see between the United States and other countries; yet they observe that those with less appear to be happier than many in the United States who have so much more. The participants shared feelings of guilt and shame in their reflective journals:

Marissa: I just felt so bad because we have so much material things at home and take all of it for granted and the people of Tanzania literally have close to nothing and are just amazing.

Meghan: It’s crazy that we have so much here, yet we complain that we don’t have anything.
Denise: One thing that I noticed, is that people in the United States stress over little things, and become upset if they don’t have a can of soda. It makes me feel bad and ashamed. Many people in Tanzania have real problems . . . they don’t have enough food, or there is no running water, and yet they don’t focus on what they don’t have like we do in the U.S.

Alysse: I will never complain about my kitchen floor again!

The participants were beginning to develop a new perspective and an expanded worldview. They began to recognize those things that they take for granted might be considered luxury items by others. They often spoke of the difference between “wants” and “needs.” They had difficulty with the realization that they had so much more available to them. Compounding their sense of guilt was the manner in which they were greeted by many people of Tanzania. The following comment describes the uncomfortable and embarrassing feeling of being treated like a celebrity by many of the children and adults:

Kahlen: I hit rock bottom at one point with just feeling so useless and pathetic because of all that I have been exposed to from people who were helpless. Who are we that they think we are so important? Isn’t it wrong to be looked up to? We are no better than any of them. They are the ones struggling and going through such hard times. It’s like they worshiped us and I feel we are not worthy of it.

Most of the participants could not understand why they were held in high esteem by the people they met. This was difficult for most of them and they described feelings
of “discomfort,” “being embarrassed,” and “unworthy.” This caused them to reflect, and challenged them to explore their motivations for being there. They described not only feelings of shame and guilt, but also challenges to their self-concept (M. Paige & Martin, 1996).

The qualitative data from journals, discussions, and interviews indicated that the participants were unsure of how their behaviors might be interpreted by the Tanzanian people. Alysse shared in her journal her distress with the possibility of offending one of the nurses at an HIV clinic:

The baby was burning up with fever, listless, moaning and had a wet, mildly productive cough. I didn’t know what to do. I held the baby until it was time to go. I prayed for her silently. When our guide came to tell me it was time to go, I handed the baby back to the little girl who was caring for her. My go-to smile was failing me. I could not hold my tears. It broke my heart to put the sick baby back into the child’s arms. My timing could not have been worse. I apparently offended the head of the clinic. She was fully aware of the child’s condition and had her on medication. It wasn’t that I was questioning anyone, or was I? Why was that child outside with another child caring for it (who could have gotten sick as well)? What was she sick from? How long had she been sick? Who am I to question these people? Am I turning into one of those women who have never had children but know the best way everyone should raise theirs? Am I so egocentric to think they were not taking proper care of this baby because we are in Africa, at an AIDS clinic, and she is an orphan?
Alysse became aware of her nonverbal cues and behavior that may have been interpreted negatively. Awareness of the negative impact of an ethnocentric worldview was an important lesson learned.

Hoskins (1999) stressed how important it is for individuals to allow themselves to feel vulnerable when working across cultures. Participants in a study abroad program by Ruddock and Turner (2007) reported that students expressed self-doubt, as “uncertainty,” “inner feelings of chaos,” and “feeling strange” (p. 364). Bosworth et al. (2006) reported that self-doubt or moving outside one’s comfort zone resulted in enhanced growth personally and professionally for 26 study abroad students from the United Kingdom. Greatrex-White (2008) described self-doubt as the feeling of suddenly realizing that they were foreigners.

A journal entry by Laura explained that she “did not venture away from the group even when we were at Lillian’s family’s house . . . I was just so unsure of how to act.” Michael was alone without the group for about 30 minutes when he retrieved supplies with one of the guides. He commented:

I was unsure of myself, just because there wasn’t anybody I knew even though he was talking and speaking in English to me. I didn’t necessarily kind of get what he was saying the whole time . . . that made me a little more anxious. There were other people all around in the village . . . I didn’t know if I could talk to them. I was uncomfortable.

Vanessa’s journal also indicated her insecurity and self-doubt: “I realized that I felt completely embarrassed and ashamed at my lack of knowledge about the world.”
Finally, Khalen recognized her limited skills and knowledge and offered this self-criticism: “I now realize I know very little about the world . . . I am angry thinking I had enough experience to make a difference. I was fooling to myself.” Khalen began to understand that simply being from the United States did not necessarily mean that she had more to offer to others. She realized that she was ill-equipped to make a difference in the everyday lives of those whom she encountered. The participants began to realize what they did not know and they began to recognize the effect of mindless behaviors, as described by E. Langer (1999). Mindlessness is a result of over-learned skills that cause us to just react and not think. Mindlessness limits our control by limiting us from making intelligent choices. By moving away from mindless behaviors, the participants were beginning to reflect on and learn from their experiences, in order to create new ways of relating and thinking (Kim, 2009).

**Six Months Later**

Self-awareness continued for many of the participants after a period of six months and this was evident in the personal interviews. Reflection helped participants appreciate that there was no single way to do things, and one culture should not be viewed as superior to another (Edmonds, 2010). The participants spoke of self-discovery, and re-evaluated how personal communication and their behaviors influenced others. After a period of reflection, Marissa showed characteristics of transitioning from the ethnorelative stage of Defense to Defense/Reversal. An aspect of the Defense stage is that of reversal, wherein the new culture is embraced as the better culture (M. Paige & Goode, 2009).
Marissa: This trip for me was self-discovery. I learned so much about me, some good things and some not so good. I love different things. At first, I almost put it [the Tanzanian culture] on a pedestal. So when I went to Africa, I thought I was totally comfortable and [I was] really excited. I was nervous about myself. [I thought] oh, my culture is not as cool as their culture. I learned that nothing is that simple . . . At first I thought, wow, everyone is so much nicer, but after I came home, I realized that I was only there for a short time and there was so much that I didn’t see. I oversimplified much of what I saw and saw only the good . . . I was more concerned with my experiences, and me. Now that I look back, I wonder if I did anything that might not have been good. I just don’t know. I do know that I need to and want to learn more about different people and other cultures.

An important realization for Marissa is she recognized that there were many things that she failed to see while she was in Tanzania. She understood the importance of not only seeing what is there, but also seeing what is not there.

The participants were encouraged to self-reflect and evaluate their own thoughts and feelings, past and current behaviors of bias and racism, through reflective journaling and sharing their feelings with their peers. It was helpful that their classmate (Lillian, who was born and raised in Tanzania) was there to provide the Tanzanian perspective.

Meghan stated, “I think this trip brought out the best in all of us; it made us stop and rethink how we approach people.” Alysse added, “I never even gave it a second thought before, but now I stop and think a lot more before I act.” Vanessa expressed the
desire to reflect and think before she responds; “I realize that I need to take time and think about things more, before I come to a conclusion about people or things.” Marissa began to understand the importance of structuring nursing care to meet the diverse needs of her patients.

I need to pay closer attention to people, especially my patients. Before, I just kind of treated everyone the same. That’s not the best way to take care of people. I now understand better what they [faculty] mean by “holistic care.”

Marissa became more cognizant of the concept of holism and the need to develop individualized approaches to people. The other participants also described the importance of evaluating and becoming aware of both verbal and nonverbal cues when interacting with others. Michael stated, “This experience really made me look at things differently and how I react to others.” Alysse expressed an understanding of the impact of her impulsive reactions on others; “I am definitely more aware of my reactions both verbal and nonverbal, especially after I insulted the nurse taking care of the HIV baby.”

Again, the participants began to indicate that they were moving away from mindless and reactive behaviors toward thoughtful and mindful actions and responses. The participants began to understand the importance of thinking and reflecting before acting or speaking. Study abroad encounters often place participants in countries where they are no longer part of the dominant culture. For many of the participants, this was the first time they experienced what it was like to be part of the non-dominant culture. The following entries from the reflective journals describe the participants’ first reactions to issues of prejudice and bias:
Michael: On the way to Lake Manaira twice the Tanzanian police pulled us over. Both times Chui had to get out of the vehicle to talk to them. When we started moving on Chui explained to us that they just wanted to see what they could get from us. He said that they pull over vehicles full of white people because they know we have money.

Meghan added: They felt that we were vulnerable and they knew that and so they took advantage of us. They assume that just because our skin is white we have a lot of money to give to them.

Vanessa when arriving at the Maasai Boma: The children were intrigued and terrified. They cautiously approached us, as if we were a different species from another planet. They were afraid to touch us and ran as fast as they could away from us when we put out our hands to say hello. . . it was so weird having someone afraid of me just because I look different.

All of the participants experienced being a foreigner, and although unpleasant and troublesome emotions may have occurred, there were also significant advantages, such as an increase in problem solving skills and global health awareness, and possibly a life-changing experience (Kinsella et al., 2008). Denise realized that other people’s view of Americans may be inaccurate and this made her re-examine her past thoughts and behaviors; “It is crazy how the people in Tanzania view Americans. It is so different from reality . . . it makes me realize how differently I viewed Africa before I got here.”

An important learning experience for the participants was an awareness of how Americans are perceived. They verbalized feelings ranging from humor to anger. They
began to understand that most attempts to combat prejudice have been aimed at reducing the tendency to categorize other people. They also realized that categorizing people was a fundamental and natural tendency (E. Langer, 1997). The participants began to identify their own biases and their personal responsibility in dealing with issues of racism and prejudice. Several participants became acutely aware of their own negative reactions and thoughts and were disturbed by this self-discovery. This prompted some of the participants to confront their own racist behaviors as seen in the following comment from Khalten’s journal.

I always thought that as a nurse I would never turn down the opportunity to care for any patient. But while I was walking through that hospital, I realized that maybe there is a little bit of close-minded in me. I felt like I didn’t want to touch anybody or get near too many people. That was a weird situation for me. I don’t know if I would react the same way if we were in a hospital in the United States or if it was just because of the environment that we were in.

During the focus group discussions (after their return home one month later), several of the participants further discussed their reactions to prejudice and stereotyping. Alyasse described a situation that she encountered days after she returned home. She found the courage to speak up rather than remain silent when confronted with a racist statement. She explained that this was a first for her; in the past she had remained silent and felt that her silence was a sign of disapproval. Alyasse shared the following scenario with her peers during the focus group discussion:
As soon as I returned home I went to a party in my little town, and somebody said, so what was it like being around those n*##ers all the time? I looked at him and I said—you’re mistaken. I wasn’t around any n*##ers. However, I’m in the company of trash right now, excuse me. You know, I wanted to say go f*@k yourself. So that’s it, I finally spoke up.

This remark by Alysse encouraged others to offer their comments on past racist behaviors in others. Vanessa responded that

I think that I will be more likely to stand up to somebody who is being racist than I would have before . . . and I don’t know if I would have had the balls to do something about it before.

Meghan added, “I will not stay silent anymore. I know what it is like to be part of a minority population as a gay woman.” Marissa was able to recognize her role in combatting racist behaviors and statements: “I never thought that I was prejudiced, but now after getting to know so many people with dark colored skin, I just don’t think I can be quiet anymore when people make ignorant statements.” Khalen realized her part in providing a strong role model for her daughter. “I have to speak up as an example for my daughter.” Michael became more aware of personal nonverbal cues that indicated his reflexive reaction of bias:

When I was home after a few days, I went into a store and there was a black man that came up behind me in line, and all of a sudden, I stepped away a little . . . then I realized what I was doing. Oh my God I felt like a jerk!
The students’ acceptance of personal responsibility for combating prejudice and racism was an important finding. Langer described this as an aspect of Mindfulness—the realization of how our worldview may influence others—and suggested that we develop a different approach to combating prejudices (E. Langer, 1992). In combating prejudice, the issue is not how we might teach others to be less judgmental, but rather how we might learn to value, embrace, and respect different cultural or ethnic groups, diverse religions, and people of all sexual orientations, disabled individuals, or those who are viewed as different. Stereotyping, discrimination, bias, racism and prejudice act as barriers to culturally effective care, interfere with communication and precipitate mistrust between minority patients and their health care providers (E. Langer, 1999).

However, not all participants were able to recognize their own biases. Prejudice involves the refusal of individuals to modify beliefs when presented with contrary evidence (Campinha-Bacote, 2007). Laura entered this comment in her journal after an afternoon shopping trip in the town of Moshi:

Dr. Smiley took us to the market and to some stores along one of the main roads. It was a little scary at times when people would follow us and even stop when we stopped. You never know what these people are going to try to do. I really didn’t trust them. No one else seemed bothered by these people’s behavior.

Laura had difficulty dealing with diversity and struggled to hold onto past beliefs. She was often confused by the enthusiasm and openness of her peers. Campinha-Bacote (2007) stressed that the most significant obstacle to culturally competent care is our failure to develop self-awareness and respect toward diverse beliefs. It is imperative that
the individual recognize that there are multiple ways of looking at the world. This requires an understanding and appreciation of similarities and differences within and between cultural groups, which is the next theme that emerged from the qualitative data.

**Deeper Understanding of Similarities and Differences**

Making comparisons and recognizing differences leads to a re-evaluation of an individual’s values and often increases the desire to know more about a different culture (Sandin et al., 2004). Making comparisons by noticing differences requires individuals to look at their personal assumptions as they begin to see unfamiliar behavior from multiple angles (M. Paige & Goode, 2009). Kokko (2011) found that making comparisons and noticing differences resulted in nursing students re-evaluating their own assumptions about other cultures and systems of value. E. Langer (1997) stated that once a person becomes aware of distinctions or differences, it may no longer be possible to view others in a stereotypical manner. People are then less likely to categorize and stereotype differences, especially in those areas unrelated to their status or level of ability.

Through reflective journals and daily debriefing sessions, the participants were encouraged to make sense of what they were experiencing. Seven out of eight participants felt that the Tanzanian people had a greater grasp on what was important in life when compared to people from the United States. Most of the participants were able to make comparisons during the trip and shared these comparisons with others during the focus group discussions. During the debriefing sessions, interviews, and discussions, the participants were encouraged to voice their concerns, ask questions, and describe their
feelings. I took care to provide a safe and non-threatening environment that reflected mutual respect (Terhune, 2006).

The participants commented on the overall hospitality of our host families and many of the people that we met while in Tanzania. Marissa saw the spirituality aspect of this culture and Vanessa reported on the kindness and warmth of the people that they encountered while in Tanzania.

Vanessa: There is a difference with how we treat each other here in the States than how they treat each other in Tanzania. I can honestly say they made me feel like a family member that I have been a part of for years.

Marissa: I really appreciate that they go to church every week, it’s just amazing, and I love it, you know. So, they have a lot of morals and things—people here seem to be out for themselves a lot more. People [in the United States] do not work together as much.

The participants also drew comparisons between family life in the United States and family life in Tanzania, and again noted the commitment to religion. This was evident from Khaled’s focus group comment.

Family is a big thing [in Arusha], and here you don’t see those close-knit families. I mean, you’re talking generations upon generations that are so close. Lillian said her great-great-grandmother lived up in the hills. I mean, we didn’t get to go up there to see her, but . . . they’re so close . . . you don’t see that here. I mean, my family is not as close as any of the families that we saw, and I think we’re missing
that . . . and I think church has something to do with that, too. They had church services that were jammed packed.

Recognizing these differences is an important step for individuals to grasp that not all cultures live and function the same (Catalano, 2009). As Meghan began to comprehend the need for a more open minded and global perspective, she said, “I realize that I need to rethink how we see the world compared to how others see the world.” Alysse added, “I never thought about this before, but there are many different ways of doing things . . . probably as many different ways as there are people.” They also noted some behaviors that they would like to emulate.

Meghan: We as a culture are so angry and thankless and we have so much about some of the things that have made me mad in the past and I just shake my head. I can’t believe how worked up I got over such trivial things after seeing how happy and courteous people can be with so little.

Khalen: I found it very interesting how they live and how different it is compared to how we live. That’s their culture; I mean they would probably feel the same way about our culture if they came over here. Just accepting this difference is important.

Michael: We get upset if there is a storm and the power goes out for an hour or two. The people here lose power multiple times a day, if they even have it. It really makes you look at your life and realize just how much we take for granted in our everyday lives.
Cushner et al. (2004) reminded us that people experience strong affective and cognitive reactions when others confront them with unpredictable behavior. Hopefully, through these reactions the individual begins to shift behavioral, emotional, and cognitive dimensions of learning toward a more sophisticated understanding of differences (M. Paige & Goode, 2009). The participants, however, had difficulty understanding the Maasai way of life, and seven of the eight participants expressed dismay by the way in which the Maasai lived and cared for the children. For instance, when the participants were brought to the Maasai Boma, the participants noticed many scars on the children’s faces and asked about these scars. It was explained by one of the young warriors that a form of discipline caused these scars. The adults would make a small cut on the child’s face with a blade to encourage children to stop crying. Marissa felt that this form of discipline was “cruel;” Vanessa stated that she felt that it was “horrible.” Michael just could not “understand how someone can place cuts on a child intentionally” and Denise found this form of discipline “terrible.” Laura stated that she was “freaked out” by this practice. It was explained that this form of punishment can be viewed as a survival technique, and the participants were reminded that the Maasai were widely known and respected as great warriors and hunters.

The participants also identified issues of unequal power relations between men and women, the subservient roles of women, and the existence of female genital mutilation, which caused many of the participants to express discomfort with the men. Marissa was uncomfortable with the roles of men and women: “It bothered me the way that the men held all of the power and took control of the money.” Meghan also noted,
“Just that the women do so much more than the men do overall. They do a lot of the physical labor for the men.”

Michael was suspicious of the authenticity of the Maasai interpreter and felt that he took advantage of the Maasai women and that this interpreter embellished his stories to impress us.

He was carrying around a cell phone and had on designer sneakers. He tried showing us how he killed the lions. I really had a hard time believing him. He spoke English very well and was from a different village. I just thought that he was putting on a show from us. I also didn’t like the way he pushed the women aside and collected money from us from the jewelry made by the women.

Alysse added, “The women there were quieter; they almost knew their place so to speak. They were in the background many times doing the cooking and cleaning or whatever. That’s not how it is at our house!”

The participants exhibited characteristics of ethnocentrism. I asked the participants to consider the women’s movement of the 1920s and 1960s in the United States. I also reminded the participants that their culture was also much more male-dominated several generations ago. Although this experience may have been challenging for the participants, several participants also were able to appreciate the self-reliance and beauty of this unique culture. The participants began to recognize differences and to reflect on those differences. The individual displays aspects of mindfulness when basic skills and information guide their behavior in the present rather than responding in an automated manner (E. Langer, 1999). Marissa admired the
resourcefulness of the Maasai: “What I liked about them was that they’re very self-reliant and they don’t waste things. I feel like we’re wasteful.” Vanessa appreciated their dance; “When we danced with the Maasai it was just really freeing. It was completely art. In our country it’s very . . . it’s a sexualized thing.” Denise added, “I loved how they lived off the land. They didn’t pollute the environment.” Alysse identified family bonds and a strong sense of community: “They were a family and they cared for each other.” Laura was fascinated by the stark differences between the American and Maasai cultures: “It was so interesting to see how different [the Maasai] really are from us. The women build their houses or huts by themselves, they also gather food, cook, and care for the children.”

One participant reflected on miscommunication that took place with the Maasai when Laura was accused of not paying for her beaded jewelry. Laura gave her money to one of the women instead of paying the tribal leader as instructed. The participants began to develop an understanding of the importance of effective communication and respecting rules, as portrayed by a comment from Vanessa:

I really had to be honest with myself to look at the situation in an unbiased way. Two cultures met with a huge communication gap. Complications arise from miscommunications and misunderstandings. Although I am a little jaded from the experience, I loved it and wouldn’t trade it for anything. I saw how easily things could be blown out of proportion, and that money complicates everything. I also reflected that there is a delicate balance in dealing with people. The balance lies between treating people with genuine kindness and remaining cautious and aware.
This experience took my “blindly trustful” attitude away. Looking back, I still think the Maasai are an amazing people but I’m definitely over the honeymoon phase.

Many of the participants were now becoming more thoughtful in their reactions. For instance, Vanessa clearly displayed Denial/Reversal behaviors, wherein she saw only the good with everyone whom she met, and felt that their culture was “better.” She now saw that people and their cultural experiences were more sophisticated and complex. She articulated the importance of effective communication and respect for others’ norms and rules.

The participants also noticed differences in the health care delivery system and resources. For example, the participants noticed that although the Kilimanjaro Christian Medical Centre’s (KCMC) labor and delivery ward had fewer resources and technology when compared with hospitals in the United States, and yet the neonates looked healthier and more active. It was noted that the mothers appeared to interact with their sick infants in a more attached manner. Laura commented during the focus group discussion:

That hit me as well, because when I was in the [Neonatal Intensive Care Unit] NICU at Akron Children’s I realized how many parents don’t visit their babies, and if they do, it’s for a short time, whereas these women [Kilimanjaro Christian Medical Centre] stayed with their babies the entire time, sleeping on the floors.

The participants commented on the physical condition of the babies and the welcoming approach of the nurses in the hospital. An example of this is seen in the following comment from Khalen:
I don’t think I lasted two minutes in the room with the babies in the incubators before I started to cry. The babies were so small, and they were just lying in these wooden boxes with a light on the bottom of them. It hit me hard and caught me off guard. However, one thing I did notice, after reflecting on it later, is that these babies seemed to be a lot louder and healthier than most premature infants that I have seen in the U.S.

The participants also remarked on the resources for the general population of people in Arusha, such as the availability and differences in food, clothing, and other necessities. The following conversation occurred in the focus group discussion.

Denise: I did see food just out on the streets that you could buy there, but no grocery stores. People bought food for that day, not for a week or a month. I know clothing-wise, either they had made their own clothes or they had to use clothing from Goodwill shipped over here, and then sold on the streets or in the markets.

Alysse found it “weird to think that many women walked to the markets to get sugar cane or supplies for the daily meals. I also saw women gathering twigs to use as firewood just to cook on.” Laura also noticed the abundance of open markets: “There was nothing even remotely similar to a shopping mall. They had open markets in the towns that were always busy.” Denise added, “if you needed a dresser or a chair, you just bought what was there. There was not like 50 different styles to choose from. Michael was uncomfortable with the shopping experience. “I didn’t like shopping or buying
things while I was in Tanzania. You had to haggle over the price for everything. This really was difficult for me.”

Although it was easy for the participants to recognize differences between cultures, it was equally important to identify similarities and to become cognizant of their own ethnocentricity. According to the DMIS (M. J. Bennett, 1993, 2009), it is important to help sojourners advance through the ethnocentric stages of the DMIS by nudging them to see some commonalities. Each evening during the debriefing sessions, as well as during the focus group discussions and the personal interviews, I asked the participants several questions to prompt deeper reflection and thought. An example of a question that I asked participants to help them identify similarities was, “What are some common things seen between your culture and that of the Tanzanian culture?”

During the focus group, Meghan stated, “I liked the family unity that they had, especially with Lillian’s family. That’s similar to my family, we’re like that.” Michael began to understand and accept differences within and between cultures:

Some things would bother me before—why are they doing that or why do they have to do that? Now, just because I don’t understand why they’re doing that doesn’t mean there’s not a reason behind it and that they . . . they’re doing it that way for a reason.

In recognizing that not all cultures must respond and act in a pre-determined way, Michael began to grasp an important skill for intercultural sensitivity. The more skilled we become in recognizing differences and similarities, and empathizing with others, the more we will benefit from alternate ways of viewing others and the world (Andrist et al.,
Developing empathy is a significant step to help reduce prejudice and enhance intercultural learning (M. J. Bennett, 2009). The participants described growth toward empathy as another evolving theme.

**Developing Cultural Empathy**

Empathy “is the capacity for participating in or vicariously experiencing another’s feelings” (Andrist et al., 2006, p. 132). Learning cultural empathy involves the two processes of “vicarious affect” and “expressive concern” (P. B. Pedersen, Draguns, Lonner & Trimble, 1996). Vicarious affect refers to the ability to try to experience as the other person is experiencing. It means that the empathizing person is using his or her own subjective experience as a reference for empathizing. An example of this can be seen with Michael, who had a difficult time with a neonate diagnosed with an umbilical hernia and a high risk for testing positive for HIV:

The one baby girl, Agnes, was found to have an umbilical hernia; she was also one of the infants whose parents had AIDS. This little girl really pulled at my heart. I held her for quite a while as I hummed and rocked her to sleep. This reminded me of doing the same thing with my daughter only months before this. That was very hard for me; not only did it make me think of my daughter, who I missed a lot, but my heart went out to this little girl.

Many participants verbalized empathy when interacting with the patients that were HIV positive. Expressive concern, a form of empathy, refers to the ability to articulate feelings that are genuine and demonstrate caring (Andrews & Boyle, 2008). Many sights at the hospitals and clinics moved the participants to comment on their
overall feelings of affection and caring toward the nurses, the volunteers, the health care workers, and the patients. An example of this can be seen from the journal entry by Denise after visiting the HIV clinic:

They [patients with HIV] were so happy to have human interaction due to the stigma placed on them for contracting HIV and AIDS. In the United States, there may be people who don’t want to be around HIV patients, but they are not sent away from family and friends.

Vanessa remarked that “the men and women were so happy that we were willing to eat with them, dance with them and hug them . . . that really hurts!” Khalen found it heartbreaking when interacting with the HIV patients; “As soon as we arrived, they began cheering because we came to spend time with them. I had to walk away because I started to cry.” Laura began to empathize, “It would be bad enough knowing that I will probably die from this disease, but to also be treated as a Leper . . . That would make me feel so ashamed and so sad.”

The participants also spent time in the emergency room at KCMC hospital. The participants were visibly affected by a badly burned patient who was thrilled to have the attention of American student nurses. This was seen by the multiple journal entries concerning this man. Marissa and Vanessa felt that we were interfering with his care. Marissa stated “I didn’t want my picture taken with him . . . I wanted to help him! Where was his pain medication?” Vanessa was upset by the amount of pain that the patient was experiencing. “I couldn’t believe that he wanted to take a picture with us . . . he was in so much pain. I had to leave the room because I couldn’t control my tears.” Michael added,
“I was so afraid for him. Would he be ok? I know that fresh burn patients don’t necessarily look as bad as they really are in the first few hours.”

Although communication at times was a problem, the participants learned quickly from our hosts, guides and the many people that they met over the weeklong experience, that hugging was an acceptable way of showing empathy and concern. As Vanessa wrote in her journal, “I have learned that sometimes a smile and a hug is just as effective as taking action.” Although the participants went through a period of intense disequilibrium and experienced feelings of shock, guilt, and self-doubt, they were also able to see the uniqueness of this culture.

By examining differences and making comparisons, the participants demonstrated empathy. Seven of the eight participants verbalized empathy and deep respect and affection for the health care workers, children, patients, and those with whom they interacted on the streets, shops, orphanages, clinics, and the hospital while still in Tanzania. Laura was the sole participant who was unable to move from a state of disequilibrium and remained in a state of shock throughout the trip, and this continued six months later.

A Sense of Loss

The return home for participants was met with mixed emotions, ranging from excitement to see family members, to depression and sadness, or a re-affirmation of an ethnocentric view. Although this international educational experience was short, it was also intense and afforded the participants diverse opportunities to interact with many people on many different levels. As a result, many participants went through conflict and
change and felt a sense of loss when they returned home. Re-entry shock can occur in several ways and can pose a challenge to our self-concept, or experience as a sense of loss (Cushner, 2004; Wang, 1997). In addition, re-entry shock can create an overwhelming and stressful environment for the participant (Cushner et al., 2003). Most of the eight participants had difficulty initially readjusting to the American way of life and several described feelings of depression and anger or continued ethnocentrism.

Alysse: It was so depressing to see this side of the world and [I was] so naïve as to how I thought it would be before I left for this trip. I have realized that all of us have this illusion of Africa either by the commercials for donating money to the kids or pictures from the National Geographic magazine . . . but let me tell you how wrong I was; it was so different actually being there and experiencing that side of the world. People will not get it unless they experience it.

Michael found it hard to get back into a normal routine: “I was still overwhelmed by memories and experiences months later. It was hard to study and I must say that my grades suffered at first.” Khalen commented, “I had trouble when I came home. I was just so blown away by everything. It now is much better, but I will never forget it.”

Meghan stated that she had difficulty processing everything that she experienced: “Too much was happening all at once. I think the next time I go I may be more aware of what to look for and less choked up by all of it.”

Seven of the eight participants indicated that they were not the same person as they were before the trip and six of the eight had difficulty in the first few weeks after returning home. As Marissa stated during the focus group discussion, “Some of the
changes within my own mind can’t be described yet in words. I’m not sure that I fully understand them myself.” Meghan had difficulty adjusting to her normal routine: “When I got home, honestly I did not want to do anything. I didn’t do anything; all I did was sleep and eat.” Khalen added, “depression, I felt it too.” Michael withdrew from the people he loved; “I didn’t want to be around my family. I didn’t want to do anything at all. Even my wife noticed it.” Vanessa was one of the most enthusiastic members of the group and shared this during her personal interview:

I just came back and I was sad. I didn’t like it here. Like, I was mad for some reason at the United States. I wanted to be in Tanzania . . . I don’t know why. I just felt, I don’t know, I felt like all my problems were back on my shoulders. No hakuna matata right now. But it got better, I mean, I was okay, and then I just appreciated Tanzania.

The participants missed many things, including the strong bonds of friendship that they developed with each other, the excitement of new and novel experiences, and meeting with people from around the world. Marissa spoke of her return home as difficult and this surprised her:

I was not prepared for the exhaustion, stomach upset and depression, of which I have experienced for several weeks now. I can’t seem to pull myself out of this slump. I fight to get through the day without a nap. We were constantly surrounded by beautiful people and unique places . . . In this time we formed new relationships, laughed together, cried together, listened to secrets and told a few.
Vanessa also expressed the same sentiment: “I couldn’t help but think of all of those people in that other world that I knew I was missing already.”

The return home was varied for the participants. Laura and Denise verbalized comfort with being home and did not report any difficulty with depression, sadness, or frustration. However, for the remainder of participants, the return home was very difficult. They also expressed sadness over the realization that many of the children and “friends” whom they met in Tanzania were no longer a part of their everyday lives, and they realized that they might never have the opportunity to see them again.

This sense of loss as described by six of the participants continued to arise during the focus group discussions and personal interview six months later. This sense of loss can be seen as outgrowth of the participants’ deep connections made with the host community during this short sojourn.

**Life Changing**

Cushner (2004) reminded us that the context of a well-structured international experience provides the sojourners with an opportunity to see others and themselves through a new lens. The participants commented on these life-changing experiences during focus group discussions that occurred one month after returning home and then six months later in a personal interview. I reviewed the transcripts carefully for consistencies, inconsistencies, and patterns of growth or regression from each of the participants’ statements. Seven of the eight participants, after reflection, offered very similar and consistent comments six months later when compared to their comments one month after returning home. Many of the participants described increased confidence
and an openness to others. Laura remained in a state of shock throughout the trip, and her comments remained consistent after six months. Denise was the only participant whose remarks differed from her initial reactions as reported through her journals and focus group comments when compared to her personal interview six months later. This is discussed in greater detail later in this section.

**One month later.** This need to learn about others is consistent with Campinha-Bacote’s concept of cultural encounters. Cultural encounters are those processes that encourage direct interactions with others (Campinha-Bacote, 2007). It is hoped that by refining and modifying our current beliefs through these encounters we will be less likely to stereotype.

Marissa: The trip to Tanzania makes me want to learn more about all kinds of cultures now, like even more so. So, it just potentiated that need to learn about other people.

Khalen: I think the whole trip in general kind of opened me up a little bit as a person. I always thought I was open-minded, and I wasn’t as nearly as open-minded as I am now, I would say.

Michael: It made me more interested in learning more about other cultures and I think I have become more aware and accepting of difference.

Alysse: I loved learning about another culture and I feel that I am so fortunate to have gone to Tanzania. I plan on going to as many places as I can to help people and learn about different cultures.
For Marissa, Khalen, Michael, and Alysse this trip has opened their eyes to the importance of leaving the comfort of the familiar. The desire to acquire new knowledge is an important step toward cultural competence, which requires the perpetual process of self-reflection and life-long learning (Smith-Miller et al., 2010).

During the focus group discussion, Vanessa relayed the following story to her peers, which was also repeated six months later during her personal interview:

As soon as we got back, I went to Applebee’s with my family to eat, and it was just weird because we all ordered tons of food . . . I was upset immediately with my dad because he was complaining about how his food was done. I said . . . Dad you have food. Stop complaining and eat it. It just got frustrating; I’m having a harder time tolerating this than I usually do.

Vanessa came face to face with inequities that exist in the world and was uncomfortable with her father’s behavior in a restaurant immediately after returning home. She has developed a keener awareness of differences in resources and available food, and she may have become more aware of the “have” and “have-nots” in this world. The realization that not all people have enough to eat was in stark contrast to the overabundance of food and services readily available in the United States. The goal, however, was not for her to become judgmental of her father; rather, it was to expand her knowledge, level of awareness, and personal insight, and continue a journey of learning.

**After a period of reflection six months later.** Six months following this experience, the participants met with me in a semi-structured personal interview with specific open-ended questions. However, I deviated at times from the original questions
when the situation warranted gaining a deeper understanding of what the participant was attempting to communicate. The data from this interview were compared with the data from the reflective journals and focus group discussion for each participant as I looked for changes over time.

Participant descriptions of personal experiences and impact remained consistent for Alysse, Denise, Michael, Khalen, Vanessa, Marissa, and Meghan at the 1-month and 6-month period. These six participants articulated a new perspective when looking at the world, especially when reflecting on materialistic values between the two cultures.

Meghan, Vanessa, Marissa, Alysse, Khalen, and Michael spoke of sustained growth and a desire to learn about new cultures:

Vanessa: I know that my perspectives on life and how I treat people have been transformed at their core. I truly feel happier as a person and it’s probably because I think less about myself. I truly hope to be like Mama Fred and all the loving people we’ve met so far in Tanzania.

Denise initially agreed with the group and made this remark during the focus group: “As I look back on everything I witnessed I feel as if I am missing something now. I need to go back soon and help.” However, six months later, Denise stated that she wanted to travel, and was not interested in returning to an underdeveloped country or in helping people: “When I graduate I want to go to warm, fun places; maybe I will be a traveling nurse and work in Hawaii or Florida, or I will move to Myrtle Beach and hang out with friends there.” When asked about returning to Tanzania and her desire “to go back and help,” she did remember stating that and went on to talk about the safari as her
favorite memories. She also stated that what she “liked most was when we went to the church and the people lined up to shake our hands, and we didn’t even do anything. That was very rewarding.” This shift in perspective by Denise from a desire to learn about others back to a more ethnocentric viewpoint is addressed in Chapter 5.

When Laura was asked six months later if she was more interested in learning about cultures she responded, “I don’t know. I don’t know if it’s stronger than it was, but I’m not sure . . . it really hasn’t changed anything.” Laura had difficulty seeing many similarities between the two cultures and when asked about any similarities she answered, “I don’t know . . . like what?” When asked about differences, she stated, “I guess there is because they’re not getting as much care as we give our patients here.” When asked about strengths of the Tanzanian culture that she experienced, she stated, “how they go about life in general is definitely strength for them, I think.”

Laura was the participant who had the misunderstanding with the Maasai women, and felt that she was glad to see Africa, but she would probably not go back. Her comment about learning other cultures was also less enthusiastic. “I guess I want to learn about other cultures maybe a little more now, than before the trip, but I am more comfortable in my own culture and I think it is better.” Laura also added, “When I was there, I was kind of like, I’m ready to go home.”

Laura and Denise were relieved to be home and an ethnocentric perspective of Denial prevailed. This perspective supports the belief that one’s own cultural group is seen as the only feasible choice. During the first ethnocentric stage of Denial, individuals avoid interactions with other cultures, show little interest in discovering cultural
differences, or are unable to comprehend cultural differences. Laura often avoided contact with many of the people in Tanzania, including the children, even after encouragement and support from faculty and peers. During the Denial phase, cultural differences are not experienced and the subject of diversity is often avoided. Individuals in this stage justify superiority based on genetics or social hierarchy. Those who experience denial often refer to others as “those people” or “them,” and they tend to dehumanize those of differing cultures (J. M. Bennett & Bennett, 2004). Denise exhibited characteristics of denial in the following manner:

Personally, before we even went, I was always, I always viewed people as the same. I’ve never been like, oh, you know, they’re black, they’re not as good as me. So, I think that that just enhanced that we are all people. We’re all human beings. So, we all deserve to be treated the same.

However, Denise commented that many of the people in Tanzania “look alike” or they were “hard to tell apart.” Laura seemed to demonstrate Denial through her written journals and conversations during the focus groups and interview process. Laura stated in her personal interview, “You never knew what those people were going to try and do.” She went on to say:

They did a dance for us, that was cool to see; but I didn’t want any part of being in the middle of all of them and holding their hands. I would have probably started crying. It was weird to have that type of reaction to people. Normally I am very accepting and non-judgmental, but there was something about those people that I just don’t understand.
Laura was motivated for this international experience by the safari rather than by an interest in learning new cultures or global health care; “The safari was what caught my attention . . . I said, this, who knows if I would ever get this opportunity again to see this part of the world.” Below is an excerpt from her personal interview:

Q: What did you expect to find when you arrived in Tanzania?”
A: Honestly, jungles I guess. Desert. I did not really expect to see any cities like we did because you just see stuff that’s on TV, and you know, movies. Yeah, I mean they were all . . . it was surprising to me how positive they were in their situation.

Q: And what was that situation?
A: Well, just the living conditions that they were in, but that’s . . . I guess that’s what they’re used to, you know. Well, like the women have to walk like five miles just for water that’s not even clean. But you know, as time went on, I don’t know. I guess they weren’t upset about it or negative about it, and that made me think differently . . . It’s all they know and that is OK for them.

The next ethnocentric stage of Defense includes Reversal when “us versus them” is switched (J. M. Bennett & Bennett, 2004). The culture that one was socialized into becomes the target of oversimplification of stereotypes and the new culture is embraced as the better culture. This is often referred to as “going native” (J. M. Bennett & Bennett, 2004, p. 154). Marissa and Vanessa demonstrated evidence of Defense/Reversal:

Marissa stated, “when I went to Africa . . . I was like, oh, my culture isn’t as cool as their culture.” Vanessa wrote in her journal, “I feel like the majority of people are
comfortable in their culture and have a hard time with others, and I’m the opposite.” In the Reversal stage the new culture is often seen as better than one’s own cultural group and this new adopted culture is idealized and viewed in a much more favorable manner (M. Paige & Goode, 2009).

The comments from participants overall remained consistent over a six-month period. Meghan reported at both one month and six months later: “I think now I’m more open and I, now I ask more questions.” Michael said that his minimal exposure to different religions while in Tanzania made him “a lot more accepting, for example, of other religions, of other, people, and [he tries] to understand and accept different ways of doing things.” Michael added, “I think it helped to broaden my beliefs or what I think about, and I think it opened me up a lot in that respect.” Vanessa stated that she “learned that there are so many different cultures and ways of life . . . we do not have the right to force our culture and our beliefs on anyone.” Alysse continued to verbalize an appreciation for differences: “It’s not black and white that’s for sure; you know I mean people are all different in their own way and it is okay to be different.”

Marissa offered this self-evaluation:

In the past I’d get mad over petty things, like traffic jams, now I stop myself. I do get mad at other people because they would ask me about my trip and they had these preconceived notions about Africa that just were crazy. Like, they asked me if I ate bugs, and acted like the people from Tanzania were barbarians. It seemed barbaric what they were asking me. I’m like, no, do you understand this is a special and unique culture, and better than ours in so many ways.
Meghan, Marissa, and Vanessa did participate in another short-term cultural experience one year after their trip to Tanzania. Alysse spent one month in Japan after winning a scholarship to study the care of geriatric patients in Japan. Most participants expressed a strong desire to travel again and six of the eight participants expressed a strong desire to return to Tanzania, begging me to plan another trip. The following quotations summarize what many of the participants expressed in their journals and personal interview in response to the first research question:

Meghan: There are a lot of things about the Tanzanian culture that I have come to respect and hope to adopt into my own life, the friendliness, the humbleness, and their resourcefulness just to name a few.

Vanessa: As I was reflecting [on my trip to Tanzania] on the way over here for the interview, my whole attitude has changed toward everything. I don’t have bad days anymore. It’s been a long-term change for me because I just think back at how the people [in Tanzania] have so much less and I have so much more. I’m always thinking in my head that I am so lucky . . . and appreciative of what I have.

Khalen was able to speak to the importance of sharing her feelings and experiences with her peers that accompanied her to Tanzania. Maintaining an open attitude and reflecting on experiences with peers helped the participants cope and understand different perspectives. The participants valued this opportunity to share their enthusiasm and new experiences with fellow participants.
Kahlen: It’s just like a bubble inside. You can tell people about it all you want and until you are blue in the face; they don’t get it. But being able to talk about it with people that went there with me really makes a difference. They get it.

The life-changing experience reported by Vanessa and other participants was one that helped them grasp the “big picture.” They were able to see a world outside of themselves (Read, 2011). This life-changing experience has the possibility of immediate and intermediate effects and long-term growth. The immediate benefits of intercultural learning can be seen through the acquisition of culturally competent skills and the development of intercultural sensitivity when interacting with a different culture. An intermediate effect would be transfer of knowledge from what was learned in Tanzania to other cultural environments. Long-term effects should result in a permanent awareness and respect for cultural differences especially when caring for patients (M. J. Bennett, 2009).

**Summary of Participant Comments for Research Question One**

Meghan began this experience very unsure of herself and slightly withdrawn from the group. She began her first nursing course after Tanzania and did not know anyone from the group prior to the international experience. She had very little exposure to diversity and described difficulty in processing everything that she had initially experienced. She was overwhelmed in Tanzania and especially uncomfortable at Kilimanjaro Christian Medical Centre (KCMC). This was somewhat understandable, since she had no previous hospital experience prior to this trip. During and after the trip, she exhibited characteristics of the Defense stage of the DMIS. She began to
differentiate how people from her culture view the world compared to how others see the world. She described returning home and feeling the effects of depression, saying, “all I did was sleep.” She also said that the trip brought out the best in her and developed a new awareness of privilege and resources as exemplified in the following comment: “There are a lot of things about the Tanzanian culture that I have come to respect and hope to adopt into my own life, the friendliness, the humbleness, and their resourcefulness just to name a few.” Through this sojourn experience, Meghan described gaining in self-confidence, leadership skills, and openness, and she finds herself asking more questions. Six months later, she described the impact of the trip as helping her to rethink how she approaches people. She described a deep appreciation and respect for the Tanzanian people that she met and a desire to learn more.

Vanessa’s initial reaction was confusion, shock, self-doubt, and guilt. After a period of reflection, she realized, “I too take time and think about things more, before I come to a conclusion about people or things.” She also felt that this experience gave her more courage “to stand up to somebody who’s being racist than [she] would have before.” She recognized differences between “how we treat each other here in the States than how they treat each other in Tanzania,” and found the Tanzanian people, kinder, more accepting, generous, and gracious than what she saw when compared to people from the United States. She also was challenged by the discipline practices of the Maasai, but also appreciated the complexity of this subculture. She described her return home as one of sadness and depression, and had difficulty with behaviors of family members when she returned home, particularly her father who complained at a restaurant
the day she arrived back in the United States. Vanessa was one of two participants who felt that the Tanzanian culture was better than her own culture and displayed Defense/Reversal. Six months later she stated that her “perspectives on life and how I treat people have been transformed at their core . . . I truly feel happier as a person.”

Marissa described her initial response to Tanzania as the stages of grief, shock, denial, anger, and sadness, but stated that as the trip progressed, those feelings lessened. She described the level of poverty as unlike anything that she had seen before. She had trouble with the amount of material items available in the United States compared to Tanzania. Marissa began this trip demonstrating Defense/Reversal exemplified by this statement “my culture is not as cool as their culture.” After reflection, she realized “that nothing is that simple.” She was also one of four participants who made comments regarding issues of prejudice and her role in standing up to racist comments and behaviors. While she did have difficulty with the roles of men and women and the forms of discipline used by the Maasai, she also appreciated their self-reliance and resourcefulness. She indicated a better understanding of holistic care and the need to pay closer attention to people, whereas before the trip she found that she treated everyone the same. Marissa had a very difficult time after returning home with depression and loss of focus and motivation. However, she successfully progressed through the program and emerged in leadership roles. She also became very active in community service projects on campus. Six months later, her comments remained consistent with her reflective journals and the focus group discussion.
Khalen was the most traveled of all participants. She lived for a short time in Florida and had traveled to the Bahamas. She described feelings of shock, overload, guilt, shame, and self-doubt. She spoke of her lack of confidence and was very hard on herself when confronted with her lack of knowledge about the world: “I now realize I know very little I know and lack confidence. I am angry thinking I had enough experience to make a difference.” After seeing some of the patients at KCMC hospital, she expressed fear of her contracting a disease and came to the self-realization that she may have refused to care for a patient. Khalen articulated the need for others to experience diverse cultures firsthand. Khalen expressed a desire to participate in future sojourn experiences, and commented that she wanted her young daughter to experience and see what she has seen. Her comments remained consistent at the one-month and 6-month timeframes. Khalen’s comments and behaviors reflected the DMIS second ethnocentric stage of Defense. An example of this was seen in Khalen’s comment: “You still get that first knee-jerk reaction, but then you realize, well that’s dumb, it is not so much their fault.”

Michael described himself as having very little exposure to or interactions with diverse or minority populations, and often described his wife’s Italian family as a “strange culture.” Michael appeared to have characteristics of the Denial/Defense stage of the DMIS initially. When he first arrived in Tanzania, he had difficulty adjusting. He often retreated to his room and described depression both during and after this trip, as well as intense feelings of shock and overstimulation. He was bought to tears, especially when interacting with children or people experiencing pain. He was seen often with
children, holding them and singing quietly to them. However, he seemed to make great strides and demonstrated a shift from the DMIS stage of Denial initially, to that of Defense. He stated that this opportunity “made [him] look at things differently and how [he responds] to others.” He also demonstrated characteristics of shifting more toward minimization as seen in the comment,

I have that in the back of my head that they are different . . . but after being in Tanzania and having the different cultures and realizing the differences, I think I still have that reaction because I’ve grown up with it . . . but it goes away faster . . . maybe we really are not that different after all.

Michael was able to understand differences and commented, “Just because I don’t understand why they’re doing that doesn’t mean there’s not a reason behind it and that they . . . they’re doing it that way for a reason.” He also described an enhanced awareness of his nonverbal reactions when in close proximity to African Americans once he returned home. He described difficulty adjusting to home by initially withdrawing from those he loved. He also reported difficulty studying and returning to a normal routine. He expressed a strong desire to continue to learn about new cultures, but did not see travel in his near future due to personal family responsibilities. His reaction after returning home was the most intense, according to the qualitative data as described by the participants, and as a result, he may have demonstrated greatest growth.

Alysse was the oldest member of the group. She spoke of the need to increase awareness and understanding of diverse cultures through experiential learning: “It was so different actually being there and experiencing that side of the world. People will not get
it unless they experience it.” She also became aware of her nonverbal interactions and how she might have offended the nurse caring for a sick child. She stated that she now stops and thinks more before she acts. She found the courage to speak out against racism when she was confronted with racist comments once she returned home. She began to understand and appreciate that “there are many different ways of doing things . . . probably as many different ways as there are people.” Alysse exhibited behaviors and made comments throughout the trip that pointed toward the Defense stage of development of the DMIS as reflected in her comment: “I think all cultures are unique and sophisticated in their own way.” However, she also showed movement toward minimization when she stated, “I just never want to feel better than anyone else does . . . we are all people.”

Laura was the youngest of all participants and came from an all-White affluent town of a neighboring county. Laura had the least amount of course preparation for this trip and had difficulty interacting with peers as well as the people of Tanzania. Laura remained in a state of shock during most of the trip, as seen by her comment, “I am not sure if I ever really got over the shock of all of it,” and “it was worse than I expected.” She also was very fearful during the entire sojourn: “You never know what these people are going to try and do . . . I really didn’t trust them.” Those who experience denial often refer to others as “those people” or “them,” and they tend to dehumanize those of differing cultures (J. M. Bennett & Bennett, 2004). When visiting the Maasai she indicated that she was “freaked out.” She did recognize the differences in how mothers at KCMC were more interactive with their critically ill neonates, but for the most part had
had difficulty seeing any similarities between the two cultures. Laura exhibited behaviors consistent with Denial according to the DMIS, as exemplified by her comment, “I am more comfortable in my own culture and I think it is better.” She remained in a state of shock throughout the trip. Her comments remained consistent after six months and she did not express a strong desire to travel again. Laura resisted change and demonstrated the least growth. Laura’s motivation for this trip was less about learning and more about her interest in experiencing a safari.

Denise was the only participant who revealed inconsistencies with earlier journal entries and focus group discussion comments when compared to her personal interview six months later. Her motivation for this trip was also different than most. She was very excited about traveling out of the country, especially to Africa, and experiencing a safari. In fact, she commented, “I wish we could have spent more time seeing the animals.” She also stated initially that she wanted to go on this trip to help others in an underdeveloped country. However, the memory that had the most impact for her was the safari. She also stated that what she “liked most was when we went to the church and the people lined up to shake our hands and we didn’t even do anything . . . [She] felt like a rock star.” She often referred to the people of Tanzania as “those people” and stated that they all “looked alike.” Most of Denise’s comments that reflected empathy and compassion concluded with her feeling good about herself.

As much as I didn’t like being there [the children’s homes] I also loved it . . . It made me feel so good to know that for the time we spent there, we were able to make these kids feel loved.
The assumption Denise made was that the children did not feel loved by their friends or those caring for them. The participants also had a difficult time when the group visited an HIV clinic and learned that many people with HIV were ostracized by the community. “I just couldn’t stop the tears,” she said. “I guess it is a lack of education and fear. It made me feel good to be able to dance and eat with them.” Denise appeared to say all of the right things when she interacted with her peers during the focus group discussions, and this was consistent with her journal entries while she was in Tanzania. She may have initially tried to conform to her peers’ comments and feelings. During Denise’s personal interview, she showed signs of regression six months later, exhibiting stronger characteristics of the Denial stage. It appeared she knew what to say when monitored by her peers, but when she was not in their company, as in the personal interview, she was more open with her feelings.

**Summary of Research Question One**

To summarize, the first research question was: “How do the participants describe their experience of a one-week international cultural experience in the short term and six months after returning home?” As noted earlier, six major themes evolved from the data:

1. Feelings of disequilibrium and culture shock;
2. Greater self-awareness and personal responsibility for issues of prejudice and bias developed;
3. A deeper understanding of similarities and differences occurred;
4. Enhanced awareness of “others” and the development of cultural empathy;
5. A sense of loss after returning home; and
6. A description of the international cultural experience as life-changing.

During this 8-day experience in Tanzania, culture shock and disequilibrium, as well as feelings of sensory overload and a sense of being overwhelmed, were observed. The participants also developed a keener awareness of who they were and examined their understanding of cultural differences and issues of racism. The participants verbalized respect, admiration, and empathy. Since this trip was intense, the participants also experienced depression and issues of re-entry acculturation once they returned home. Lasting benefits reported by the participants six months later were supported in the literature for both long-term and short-term programs as enhanced self-awareness (Braskamp et al., 2009; Caffrey et al., 2005; Franklin, 2010; Fry et al., 2009; Ingraham & Peterson, 2005; P. J. Pedersen, 2009; Wallace, 2007); and personal growth and cultural awareness (Button et al., 2005; Greatrex-White, 2007). The following comment by Vanessa reflects the consensus of the participants: “These past few days will always be imprinted on my heart as memories that I will cherish for the rest of my life. I cannot elaborate on the significance of this trip.”

**Research Question Two**

The results from the second research question, “How do the participants re-conceptualize their role as a nurse six months after returning home?” were guided by the standards required of a professional nurse as defined in the *Essentials of Baccalaureate Nursing* by the American Association of Colleges of Nursing (AACN, 2011), and by Campinha-Bacote’s Model. Baccalaureate nurses plan, coordinate, and manage the care of the patient in a holistic manner. The professional nurse functions autonomously in
cooperation and collaboration with other members of the health care team and assumes accountability for his or her professional practice. Professional nurses advocate for their patients as well as the profession. It is expected that the professional nurse values and is committed to the ideal of lifelong learning to support excellence in nursing practice (AACN, 2011). The three themes that evolved from the data to answer this second research question were:

1. The development of a changing nursing perspective;
2. A new understanding of professional role development toward client-care; and
3. The desire for lifelong learning (See Table 7 for the three themes from the second research question).

Table 7

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<th>How do the Participants Re-Conceptualize Their Role as a Nurse Six Months After Returning Home?</th>
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<td>Themes</td>
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<td>The development of a changing nursing perspective</td>
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<td>A new understanding of professional role development toward client-centered care</td>
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<td>The desire for lifelong learning</td>
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A Changing Nursing Perspective

Kavanaugh (1998) and Nieto (2006) found that international experiences helped to guide the participants toward a new way of thinking and a new perspective. The nursing care and the professional demeanor of the nurses in Tanzania left an impression on all of the participants, and they used this opportunity to re-evaluate the professional aspects of care when comparing nurses in the United States with those in Tanzania.

Kahlen: The more we toured this hospital the more I realized how easy we have it here in the U.S. Some of the floors had a patient to nurse ratio 40 to one. That’s just hard to take in. The hospitals I’ve been to, it might get up to five to one. When you walk down the halls [in Tanzania’s KCMC], there are people sleeping on the floors in the hallways and rooms because there isn’t enough space left in the rooms.

All participants recognized and appreciated the amount of work and the hurdles with which the Tanzanian nurses had to cope on a daily basis, compared to the nurses in the United States. After the participants spent time in the hospital clinics and orphanages, they came away with a different outlook on nursing care and personal responsibility to their patients and families. The following comments offer examples of a changing nursing perspective:

Vanessa: The one unit had close to 80 people and there was only supposed to be like 40. There were two nurses taking care of everybody . . . that definitely makes you look at it differently when somebody here says things like, “Oh my goodness.
I have 12 patients . . . it makes me think that if I’m complaining, there had better be a good reason because I’ve seen a lot worse.

Marissa: Nurses in the U.S. complain if they have a few more patients than they feel they should. Nevertheless, the nurses at KCMC didn’t seem to whine or complain about the work they had to do, even if they were completely overcrowded and understaffed.

Michael: They taught me to appreciate things and not be so negative and my main reason for being there should be my patients.

Laura: The nurses and doctors were all very welcoming and were willing to stop what they were doing to talk to us a little bit and show us around. I could not imagine what it would be like to have to provide care in that type of environment.

The participants were able to articulate the fact that the nurses in Tanzania, with much less support and fewer resources, had a different focus and a more positive approach to patient care. They realized the Tanzanian approach was not about staffing issues, resources, or the personal comfort of the nurse; it was about how the nurses cared for their patients. The participants were also able to discern the differences in technology, equipment, and resources. They noticed the lack of equipment, few ancillary staff, and the absence of staffing regulations; yet the nurses in Tanzania appeared to be more gracious, compassionate, and giving.

Alysse found that “most of the equipment in the hospital would have been in our hospitals many years ago, but they still did impressive nursing care and research without the latest equipment.” Vanessa also noted care given even with less than optimal
resources; “they had such old equipment, if they had any equipment at all . . . the nursing staff, however, was amazing . . . they do such a wonderful job with how little they have; it’s unbelievable.” Michael developed a fresh outlook with his expectations of what resources are needed for effective nursing care:

I think going over there [Tanzania] helped in that I do not get upset about little things as much. In the U.S. if nurses don’t have something on the unit, or if they have to do something not on the schedule as planned, they get upset and it completely throws them off. You just have to realize that, at least I have it in the hospital, and I’ll get it in an hour. It is all on how you look at it.

Through the varied health care experiences, the participants developed a new perspective on what it means to be a nurse. They noted that the practice of nursing in the United States focused more on technology and technical skills rather than on the “art” of nursing. The participants observed that the Tanzanian nurses practiced a mode of nursing care that was holistic and caring. They also were able to see how the nurses at KCMC incorporated both the art and science of nursing into their care, even while working with a large patient-nurse ratio that greatly exceeded U.S. norms. However, some participants were more troubled with the staffing patterns that they witnessed while at KCMC. Denise and Laura saw this nurse-patient ratio as a block to safe patient care. Laura felt that there was “no way that I could work in a place like this; I don’t see how they can get anything done.” Denise felt that the care was inadequate:
They really need more help in the hospitals . . . they can’t really be able to give the care that these people need. I would like to come back someday and help . . . I am sure that they would be grateful for any help that they can get.

Denise and Laura were intimidated by the number of patients and stayed close by me as we spent time at health care facilities. They were fearful of venturing out or communicating with nurses and patients. The number of patients each nurse cared for also stunned them. They saw the American way of nursing as the “right” way, and could not see how the nurses could care for the patients in an effective or safe manner. The remainder of the participants developed a fresh perspective on what it means to be a nurse and how the professional nurse should act.

Vanessa: We had clinical this semester, and they got rid of a bunch of LPNs at the hospital we are at . . . and every time we’re there, all the RNs are just mad. They complain all the time that there is not enough help. We need more people. We have too much stuff to do, and they have only five patients. I do not want to act like that.

Alysse: I think I will use the experience to educate others as to how good we have it, and hopefully keep myself grounded. I just never want to feel better than anyone else does in the hospital or anything like that . . . we are all people. I hope I never get that attitude, well, I’m an RN, and I don’t have to. I hope I don’t. You know, you see it so often, and then you hear people complaining and I hope to take that experience to keep me grounded, and share it with others so they are more appreciative of what we have here.
After reflection, the participants began to express the wish to model some of the behaviors of the Tanzanian nurses:

Marissa: Something that was real key to me that I noticed was the nurses in the hospital, here, a nurse might have four or five patients, and even then, they get frustrated because they have four or five patients. In Tanzania, they had 30-40 patients per nurse or more. That is a big difference, and they’re not upset about it. They are happy—they’re there to help. The nurses here complain if they have more than five patients; over there they can have over 40 patients and they smile and give the best care that they can. They didn’t complain like nurses in the U.S.

Vanessa, Marissa, and Meghan commented during the focus group discussion one month after the return home. Meghan “was so impressed with the nurses that we met. They were so kind and patient. They were also much more professional than the nurses in the U.S.” Vanessa was upset by the attitudes of nurses in this country compared with those in Tanzania:

I had an RN tell me a few weeks ago “I hate being an RN because they’re overworked, understaffed, unappreciated.” So, I don’t know. I mean, in the same time, she took four cigarette breaks. It is just that over in Tanzania they were all about helping the patients, which they are here, too . . . don’t get me wrong. It just stuck in my head all semester; I don’t want to become that nurse.

Marissa expressed the importance of understanding professional behaviors and attitudes on quality nursing care:
I didn’t really realize it until she said it, but I wish I would’ve known this at the beginning of my nursing career because I take everything so much more seriously now. I feel like I can do so much more than before. I know I was going to be a nurse either way, but now that I went to Africa, I feel like I’m going to be a better nurse.

I anticipated that the participants would see culture care as a priority; however, they drew many more distinctions and conclusions about the manner in which the nurses in Tanzania conducted themselves, rather than focusing on the cultural care of the patient. This was in part because the participants spent more time interacting with the nurses rather than with the patients while at Kilimanjaro Christian Medical Centre. I chose not to assign participants to patient care since they appeared to be quite overwhelmed by the setting.

Six months after returning home the participants’ perspectives remained unchanged. During personal interviews, the participants retained respect and admiration for the Tanzanian nurse’s professional demeanor, staffing, and nursing care issues.

Vanessa: It’s ridiculous, and I just remembered how happy they were and how hard it would be to be so happy when you’re so understaffed . . . but they were all about loving what they do.

Meghan: The nurses in Tanzania seemed more approachable and more open. I hope to model some of their behaviors, such as their kindness and patience.

Laura, however, was less than impressed with the medical care in Tanzania, and her perspective remained unchanged six months later when she commented, “there were
people lined up cot after cot in the hallways. I guess the only benefit is they are not turning people away that need care.”

The participants were able to articulate that the nurses in Tanzania, with much less support and resources, had a different focus and a more positive approach to patient care. They realized the Tanzanian approach was not about staffing issues, resources, or the personal comfort of the nurses; it was about how the nurses cared for their patients. However, as seen with the above examples, people react to cultural encounters differently. The majority of participants demonstrated growth and change; others were unable to see the positive aspects of nursing care in Tanzania. According to Campinha-Bacote (2007), interactions or encounters with a small number of individuals from a different cultural group does not always provide change or greater expertise.

**Professional Role Development Toward Client-Centered Care**

Zorn (1996) found that participants who were able to participate in nursing care while abroad had a greater impact on professional role development than those who were not exposed to any nursing care. The participants in my study provided nursing care in the orphanages and interacted with patients at the HIV clinic and KCMC hospital. When asked to think about the quality of nursing care and identify similarities and differences, the participants made numerous comments concerning the professional demeanor of the Tanzanian nurses as well as teamwork and collaboration among the nurses in comparison to the United States. They felt that the nurses in the United States were more concerned with how many patients for whom they were assigned to care. In Tanzania, the nurses were seen together helping each other with the patients. Laura remarked, “in the
hospitals in Tanzania, everybody seems like they have to work together and they do the best they can for people.” Vanessa saw the value of teamwork: “they work as a team and really do put their patients first. We could learn a lot from these nurses.” Khalen was dismayed by what she saw as obstacles to care; yet she found the nurses to be accommodating, professional, and gracious:

Most of us had broken down at least once due to the poor conditions and people we saw. The lack of equipment and shortage of nurses were only a part of what was so upsetting. I think what upset me even more was the fact that the nurses were unconditionally gracious, bright, loving, cheerful, and doing the absolute best they could in their situation. During the time spent in the hospital, we hardly heard any complaints from the patients. The nurses were kind and anyone could see that they worked together as a team for the benefit of their patients.

The professionalism and work ethic of the Tanzanian nurses made a profound impact on the participants. They gained an appreciation for the resilience and professionalism of the nurses, who had fewer resources and greater demands on their time and skills. The participants began to understand the importance of kindness, compassion and a sense of pride in being a nurse. They also appreciated the effectiveness of teamwork. They noted that the nurses in Tanzania had a strong commitment to the needs of the patient over the needs of the nurse. As Alysse stated, “It was all about the patients and the families . . . not the nurse or the doctors.” Michael and Denise also were able to identify the significance of patient-centered care.
Michael: I feel like us going over there and seeing what is going on in other parts of the world will help us as RNs appreciate everything more and so we don’t have that attitude of “oh we need more help” or “we have too many patients.” I think it’s going to help us see what it’s like other places. I know I took that from the nurses [in Tanzania] that it’s about the patient and not about the nurse.

Denise: No one was talking about “breaks” or how tired they were. They were all smiling and just working together . . . it seemed to be about the patient and not how hard the work was.

Gains in understanding the professional role of the nurse after study abroad were reported by several studies (Caffrey et al., 2005; Ter Maten & Garcia-Maas, 2009). The participants were able to identify the patient as the priority, rather than the work environment or workload of the nurses. The participants identified the impact of the nurse’s approach on patient care outcomes. Again, the participants recognized understanding effective communication and teamwork as essential skills for optimal nursing care.

The comparison of the professional demeanor of the nurses in Tanzania to that of nurses in the United States continued during the focus group discussions one month later:

Meghan: The nurses in Tanzania seem to be more professional. They were so nice to us. They had so many patients and yet they never complained and took time to show us around. They were kind and interested in their patients. In the United States if we had that many patients and people came from another country,
we wouldn’t care. We would probably be too busy, and [we would tell them] find someone else.

Marissa: In the U.S., people seem to be out for themselves a lot more, no real teamwork. People don’t work together as much. There’s a lot of bickering I hear in the hospitals and stuff like that. Things are a little more intense in the United States. In the hospitals in Tanzania, everyone seems like they work together and do the best they can for the people that they are caring for.

Khalen: There is such a difference in how the nurses conduct themselves. They were so professional and willing to help anyone, us, the patients, the family, etc.

**Professional Behaviors: Six Months Later**

Five of the participants felt that this experience gave them confidence to speak up and no longer follow the crowd. In fact, these participants became extremely active in the organization for baccalaureate student nurses, The Society for Professional Nursing (SPN). Two participants became officers at the senior level, two became officers at the junior level, and one became an officer at the sophomore level the following semester after returning home. Six participants were also very active in fundraising activities to help support the orphanages and HIV clinics that they visited. Two of the participants also identified fundraising activities to help fund their trip the following year to the Pine Ridge Lakota Indian reservation. An example of this growth in self-confidence and leadership skills can be seen in the following statements from personal interviews conducted six months after returning home. Marissa felt that by “just going to Tanzania gave me the balls to become a leader . . . I do not want to follow the crowd anymore. I
am my own person.” Vanessa added, “I want to be a leader; I don’t want to wait for someone else to tell me what to do. I never thought that I could do that, but now I feel that it is in me.” Alysse found it “easier to advocate for my patients, where before I would have kept quiet.” Khalen stated that “I think I have something to offer; my ideas are just as good as someone else’s. I hope that doesn’t sound arrogant, but I just want to do more.” Meghan found that before this cultural experience that she was more introverted and less confident. However following this sojourn she noticed a marked difference in her confidence level:

Before, in classes, I would just go there and sit and not talk to anybody, not make myself known, and I would leave. I didn’t really have any friends per-se from classes, but now I talk to people and I interact more. So it has brought me out a lot more. I speak up and I don’t follow the crowd.

They also were able to see that thoughtful attention was necessary to develop the skills, knowledge, and attitudes to deliver safe, effective, respectful, and culturally competent patient care (Spector, 2009). This experience helped the participants recognize the importance of client-centered care and gave some the confidence to assume leadership roles. Similarly, Mu et al. (2010) also identified the acquisition of leadership skills as an outcome after a one-week immersion experience in China.

The following comment from Alysse summarizes the consensus of the group when reflecting on the professional characteristics of the nurse.

We have a lot to learn from the nurses. It is all about the attitude. I hope I can be as pleasant and easy to deal with when I am having a bad day like these nurses.
The big difference is that they don’t think that they are having a bad day. They just come to work to take care of people. That is what it is all about!

The Desire for Lifelong Learning

The desire for lifelong learning is the foundation of cultural humility. Cultural desire requires humility and a genuine passion to deliver culturally responsive care. Cultural desire is the “motivation of the healthcare professionals to want to engage in the process of becoming culturally competent; not the have to” (Campinha-Bacote, 2007, p. 21). Six participants stated a strong desire to travel again to explore cultures and see nursing in different parts of the world; three of the participants accompanied me to the Pine Ridge Indian reservation one year after the Tanzanian trip. Another participant applied for and received a grant to study geriatric nursing in Japan, which took place May 2012. Marissa and Vanessa formed a strong bond with each other and expressed a wish to travel together:

We want to go everywhere, but we both want to be a package deal and travel for nursing and not just in the United States, but every chance we can get to go out of the country, we just want to go.

Seven of the eight participants indicated that they were more sensitive to their patients’ needs, specifically cultural needs and they expressed a desire to learn about other cultures more now than before the trip. As Khalen explained,

I think it has changed me . . . I try to open up a lot more when talking to families, I am not afraid to ask questions so that I can help the patient more, especially about religion and culture.
Michael felt that “going over there gave me a better understanding of that culture and how important it is to know different cultures.” Experiential opportunities have been shown to motivate students to provide culturally competent care as they gain confidence in their ability to care for those from diverse cultures (Mixer, 2008). Other comments made by the participants reiterated this desire to learn more about cultures. Most of the participants stressed the need for nurses to be more open and accepting toward their patients and families. Vanessa encouraged others not to “shut them out; welcome them and learn more about them.” Marissa expressed the need “to learn more about people and cultures. I want to travel and see how nursing is different or the same in other parts of the world.” Khalen felt that this experience changed her and increased her desire “to learn more about the world . . . I want to take my daughter with me so she can experience some of these things.” Meghan verbalized that “there are just so many different cultures; different people . . . I think it’s made me just enjoy life more. I’m more open.” Michael shared his comments about the need to be more open and receptive to all people and cultures:

This trip taught me that you got to be open to the fact that other people have different cultures and different religions, and you have to . . . I don’t want to say tolerate, because that means you think you are better . . . you have to learn to accept the fact that they have this different way of living or different religion, and it’s ok. I never thought about that before. There is so much to learn about people before you can take care of them.
For most of the participants a greater understanding of the importance of openness and acceptance developed. Nieto (2006) found that through qualitative data derived from a short encounter with culturally diverse groups, coupled with specific reflection objectives, the participants expressed a desire to approach others with a more open and inclusive perspective. A qualitative study by Griswold, Zayas, Kernan, and Wagner (2007) investigated cultural humility and awareness through medical student encounters with refugees. Even with a very short encounter of one day, the ability to listen to members of a different culture provided an invaluable opportunity to learn about another culture and increased the desire to become more culturally aware.

The participants also expressed a desire to travel and/or continue their education. Alysse applied for and received an award to travel to Japan and to study Geriatric care. Five of the eight participants expressed a strong desire to continue their education at the graduate level. The remaining three (Laura, Denise, and Michael), while interested in graduate education, were more concerned with graduating and finding a job first. Michael, a young father, planned to pay off school loans first. Meghan felt that this trip provided knowledge of additional options for professional nursing practice:

Going on this trip has increased my desire to finish my nursing degree and go on to help people. Before the trip, my goal after earning my BSN was to work in a children’s hospital somewhere, preferably in an oncology unit. Now that I have been on this trip, I realize the possibilities with a nursing degree are almost endless. I was very impressed with what the World Health Organization does, how they try to help everyone.
Many of the participants began to see opportunities for growth and service that did not occur to them before this international cultural experience, and they demonstrated behaviors reflective of cultural humility. They began to see that we never fully reach a level of complete cultural competence, since there is no endpoint to learning about others (Tervalon & Murray-Garcia, 1998). The participants began to realize that patients might think or feel differently from the nurse. It requires recognition of the uniqueness, dignity, and value of others to begin the process of becoming culturally competent (Campinha-Bacote, 2007). The following section provides a synopsis of each participant’s responses from the second research question.

**Reconceptualization of the Professional Role and Participant Summary**

Meghan noted that the nurses in Tanzania seemed more approachable and open than the nurses in the United States. She expressed a desire to model some of the behaviors, “such as their kindness and patience.” She articulated an increased awareness of the nurse’s role and professional behaviors. She also identified a patient-centered focus. Since returning home, Meghan has spoken of leadership skills as part of her professional role and expressed a desire to learn more about others. Meghan’s comments remained consistent over this 6-month period. Meghan took part in another short-term experience in the United States with the Lakota people from the Pine Ridge Reservation.

Vanessa stated that she now reflects on her interactions and modifies her past behaviors. She found that the nurses in the United States complained about poor staffing, and yet they have many more resources available to them and a much better nurse-patient ratio. She identified teamwork and patient centered care as behaviors that she would like
to emulate, saying, “we could learn a lot from these nurses.” She also stated that she would like to be in a leadership role: “I don’t want to wait for someone else to tell me what to do. I never thought that I could do that, but now I feel that it is in me.” Finally, she expressed a strong desire to learn about other cultures and encouraged others to do the same: “Don’t just shut them out; welcome them and learn more about them . . . I want so badly to learn more about people and cultures.”

Vanessa also stated that she would like to explore global nursing opportunities. She expressed a strong desire to learn about other cultures, and she showed an increase awareness of the cultural aspects of others when providing nursing care. She participated in a trip nine months later to the Pine Ridge Reservation, delivering nursing care to the Lakota people in clinics and the hospital. She also demonstrated stronger leadership skills after this sojourn experience; she became president of the SPN and was actively involved in many fundraising and community service opportunities. Her comments from the interview, discussion group and reflective journals remained unchanged over the 6-month period.

Marissa noted that the nurses in the United States complained if they have a few more patients than they felt they should take care of. She also reported that nurses in the United States were more narcissistic than those in Tanzania; “In the U.S. people seem to be out for themselves a lot more; no real teamwork . . . in Tanzania everyone seems like they work together and do the best they can for the people that they are caring for.” Six months later she said that she needs and wants “to learn more about different people and other cultures,” and she participated in another immersion experience at the Pine Ridge
Reservation of the Lakota people in South Dakota almost one year later. Again, she demonstrated an increase in desire, awareness, and cultural encounters. She has asked me to continue to notify her of upcoming international experiences and expressed a desire to accompany faculty and students after she graduates.

Khalen noted that there were many differences between the nurses in Tanzania and the United States, and she spoke specifically about “the fact that the nurses were unconditionally gracious, bright, loving, cheerful, and doing the absolute best they could.” She also gained confidence in the development of leadership skills: “I think I have something to offer; my ideas are just as good as someone else’s. I just want to do more.” She also began to understand the importance of asking a patient about cultural and religious preferences and needs: “I am not afraid to ask questions so that I can help the patient more, especially about religion and culture.” She stated that she also had a desire to learn more about other cultures and would like to encourage her young daughter to share in these experiences with her. She has also become very active in community service and fundraising activities for the Guatemalan population in Salem, Ohio, where the campus is located. She plans to continue her education toward a nurse practitioner role. Six months later Khalen’s feelings remained unchanged.

Michael stated that the nurses in Tanzania taught him to be more patient-focused and to “appreciate things and not be so negative.” He also noted the importance of patient-centered care by his statement: “It’s about the patient and not about the nurse.” He identified the Tanzanian nurses’ “positive morale and high enthusiasm” as their most admirable traits. He found that by experiencing health care in Tanzania, he developed a
better understanding of the importance of learning different cultures: “There is so much
to learn about people before you can take care of them.” Michael’s comments remained
consistent six months later.

Denise spoke more of the lack of nurses in the hospital and the high nurse-patient
ratio as an obstacle to optimal care: “They really need more help in the hospitals . . . they
can’t really be able to give the care that these people need.” Nevertheless, she also noted
the professionalism of the Tanzanian nurses. She did express a desire to learn more about
different cultures initially; however, six months later Denise’s desire to travel and learn
about different cultures was much less.

Laura felt that she would not be able to work in the environment in which the
Tanzanian nurses worked. She found the nurse-patient ratio was overwhelming and did
not understand “how they can get anything done.” However, she found that the nurses
and doctors were all “very welcoming.” Laura expressed no desire to travel outside of
the United States in the near future. Laura did assume leadership responsibilities after
her return from Tanzania and was a class officer. Her comments remained steadily
similar over the next six months.

Alysse commented that she would “use the experience to educate others as to how
good we have it, and hopefully keep myself grounded . . . I never want to feel better than
anyone else or anything like that.” Alysse stated that most of the equipment in the
hospital was old, but the nurses still were able to deliver impressive nursing care and
research without the latest equipment. Alysse spoke of the nurses in Tanzania as being
more focused on their patients and families “and not on the nurse or the doctor.” She
expressed a desire to model some of the behaviors from the Tanzanian nurses. Alysse applied for and received an award to travel to Japan for one-month studying geriatric health care. She has graduated and is returning to Japan.

**Summary Research Question Two**

As demonstrated in the section above, the participants were able to begin to re-conceptualize some aspects of the role for the professional nurse. They reflected on what behaviors were acceptable and developed a new perspective of their work ethic; they also developed a different view of staffing issues, available resources, and they reflected on the characteristics of patience, teamwork, and a client-centered approach. In addition, many of the participants developed leadership skills and became active participants in fundraising and volunteering opportunities. Finally, the majority of participants felt that they became more sensitive to the cultural needs of their patients and showed a greater interest in learning about other cultures.

**Closing Thoughts**

Research on university study abroad programs throughout all disciplines regardless of length of time abroad supports findings that international experiences change the participants’ perspective on cultural issues and increase cultural awareness and cross-cultural learning, as well as help to diminish ethnocentricity (Crampton et al., 2003; Mixer, 2008). Personal growth and cultural awareness were also documented outcomes of international experiences (Button et al., 2005; Greatrex-White, 2007; Green et al., 2008; Ruddock & Turner, 2007).
All participants in this study were Caucasian nursing students with limited exposure to diversity and travel abroad. The intention of this research was to make sense of how this short-term international experience affected the lives of the participants. It also sought to discover whether this experience altered the conceptualization of the role of the professional nurse. I identified many positive outcomes, such as greater self-awareness, a new understanding of prejudice, bias, similarities and differences, empathy, professional growth toward client-centered care, and a desire to learn more about culture and diversity. The data showed that most participants were able to successfully navigate through their feelings of shock and disequilibrium and develop a keener sense of their role in caring for the diverse individual. However, for two of the eight participants, there was little personal or professional growth identified, and this experience may have re-enforced previously held feelings of bias and racism.
CHAPTER V

DISCUSSION OF FINDINGS

Introduction

The findings from this qualitative study affirm that an 8-day international cultural experience can result in the development of enhanced self-awareness, an initial understanding of cultural differences and similarities, greater empathy, and a new perspective of the role for the professional nurse. A theme that emerged from both research questions for most of the participants was the desire to learn more about diversity and culture, which shows growth toward cultural humility. Several participants articulated a new awareness of race and bias and took action against racist behaviors following this international cultural experience. Finally, for six of the eight participants, this experience was described as life-changing. In this chapter, I provide a discussion of the results, issues raised, implications for practice, limitations, and suggestions for future research.

Discussion of Findings

The findings are consistent with previously reported research of short- and long-term programs. The results suggest that an intense, 8-day cultural experience can have many lasting benefits if structured using guided reflection, pre-immersion preparation, daily debriefing sessions, and post sojourn follow-up discussions. The benefits that I identified in this study were supported by previous studies mentioned in the review of the literature section of this paper (Greatrex-White, 2008; Inglis et al., 2000; Johns & Thompson, 2010).
Research Question One

What meanings do the participants make of this short-term international cultural experience? As noted in Chapter 4, through my qualitative analysis of the participants’ journals, focus group discussions, and personal interviews, six major themes emerged from the data as an answer to the first research question:

1. Feelings of disequilibrium and culture shock;
2. A greater self-awareness and personal responsibility for issues of prejudice and bias developed;
3. A deeper understanding of similarities and differences occurred;
4. An enhanced awareness of “others” and the development of cultural empathy;
5. A sense of loss ensued after returning home; and
6. Descriptions of the international cultural experience as life-changing.

The participants first expressed responses of culture shock and disequilibrium, and they described difficulty with sensory overload. They described excitement but also disorientation due to the rigorous schedule and the vast amount of new sights, sounds, smells, and people they encountered. The literature describes shock as a frequent outcome during or following sojourn experiences (Furnham, 2010; Maltby & Abrams, 2009; Ward et al., 2001) stating that when a person encounters a new culture for the first time, their initial perspective may be insufficient to cope and function within the different context and environment (Stier, 2003). This is also true even with adequate pre-immersion preparation (Hutchings et al., 2002). A sense of disequilibrium for the participants resulted from the overcrowding of the hospitals, the living conditions, the lack of
infrastructure, food and language differences, and diversity in dress, religion, and ways of living. None of the participants had prior international travel, except for vacations to Canada and the Bahamas. It is important to note that cross-cultural conflict as a result of cultural encounters often stimulates cross-cultural learning, as was evident in this dissertation (Chang, 2007; Wei-Wen Chang et al., 2012).

Greater self-awareness, the second theme that I identified, was also found in previous studies (Braskamp et al., 2009; Caffrey et al., 2005; Franklin, 2010; Fry et al., 2009; P. J. Pedersen, 2009; Wallace, 2007). Comments by the majority of participants reflected feelings of shame, guilt, self-doubt, and a new understanding of prejudice and bias. Participants recognized they had many more material goods and other advantages when compared with the people of Tanzania. Research by Mkandawire-Valhmu and Doering (2012) found evidence of feelings of anger and guilt from sojourners visiting third world countries. In contrast, the participants expressed a new appreciation of others in the world and spoke often of respect and admiration for those whom they met while in Arusha and Moshi. Mapp, McFarland, and Newell (2007) reported that short-term programs can help students develop awareness and insight into their own values and belief system as well as foster an appreciation of other cultures.

An important finding after the return home was the effect this trip had on participants’ perception and awareness of their individual responsibility in combating prejudice. Six of the eight participants recognized personal past behaviors of bias and subtle signs of prejudice. While I was unable to determine if participant behavior changed permanently, this result supported predictions from the Georgetown Consortium
that found any exposure to cultural differences is likely to decrease stereotyping and prejudice (Vande Berg, 2009). One participant reported the courage to speak up when racial slurs or statements were made, where in the past she remained silent. Four other participants stated they now felt that they would also speak up, and one participant recognized non-verbal behaviors of bias in themselves. Stereotyping, discrimination, bias, racism, and prejudice all act as barriers to culturally effective care, break down communication, and precipitate mistrust between minority patients and their health care providers (E. Langer, 1999). The literature suggests that to decrease health care disparity, nurses are urged to come to terms with their own prejudices and biases regarding other cultures and to advocate on behalf of patients and families who experience discrimination in treatment (Tervalon & Murray-Garcia, 1998). This willingness to battle prejudice is also an aspect of mindfulness, wherein the mindful person not only strives to become less judgmental, but also learns to value differences in people (E. Langer, 1999).

The data revealed that participants also were able to see differences between cultures as well as within cultures. After visiting the Maasai, the participants were able to see different subcultures within Tanzania, and this helped them see that not all people of a cultural group are alike. Their transcripts and comments demonstrated their belief that people cannot take information learned about a particular culture and assume that it applies to everyone within that culture. The participants were able to see that, while people from one culture share similar behaviors and beliefs, each person is also very unique. This was an important finding since the foundation of holistic nursing is valuing
this uniqueness. Research has shown that when sojourners begin to make comparisons and notice differences, they may begin to realize that not all cultures live and function in the same manner (Catalano; 2009; Kokko, 2011; Sandin et al., 2004).

The fourth theme that I identified from the data was greater cultural empathy as the participants began to understand the complexity of the Tanzanian culture. Cultural empathy is the ability to connect with others and to understand the feelings, thoughts, and behaviors of individuals from different cultural backgrounds. Developing empathy significantly reduces prejudice and enhances intercultural learning (M. J. Bennett, 2009), and is also identified as a cultural skill by Campinha-Bacote (2002). Empathy is the desire and feeling that provides understanding and energy for helping other people (Rasoal, Eklund, & Hansen, 2011).

The return home was not without difficulties, and through participant descriptions I pinpointed “a sense of loss” as the fifth theme. This resulted from re-entry shock, which can pose a challenge to one’s self-concept; and the sojourner often experiences a sense of loss (Cushner, 2004; M. Wang, 1997). Re-entry shock created an overwhelming and stressful environment for the participants (Cushner et al., 2003). All but one of the participants had re-entry acculturation issues, such as depression and anger, which extended into the subsequent semester.

The final theme from the first research question was that this trip was life-changing. Many of the participants described increased confidence, the development of leadership skills, and four of the participants took part in other culture-related trips. Three participants (Meghan, Marissa, and Vanessa) traveled to the Pine Ridge
Reservation, where they provided nursing care at the Indian Health Services’ clinics, dialysis units, and geriatric facilities. One participant (Alysse) traveled to Japan to work with geriatric patients.

Seven of the eight participants, after a period of reflection, offered similar and consistent comments six months later when compared to their comments one month after returning home. Six of the eight participants described being changed by the experience and articulated a desire to travel and learn more about different cultures. Lasting benefits reported by the participants six months later were supported in the literature for both long-term and short-term programs as enhanced self-awareness (Ingraham & Peterson, 2005; M. Paige & Goode, 2009) and as personal growth and cultural awareness (Button et al., 2005; Greatrex-White, 2007). Although unpleasant and troublesome emotions may occur, previous research identified significant advantages, such as greater cultural competence, an increase in problem solving skills and global health awareness, and a possible a life-changing experience (Kinsella et al., 2008).

**Congruence with the theoretical framework.**

The constructivist approach and affective dimension of the DMIS (M. J. Bennett, 1993) helped me in understanding the meanings and complexities of this cultural experience. The DMIS describes people’s reactions to cultural differences, and the basic assumption of the model is that, as our experiences of cultural difference become more complex, our competence in intercultural relations increases (M. J. Bennett, 1993).

Campinha-Bacote (2007) cautioned us that the most significant barrier to culturally competent care is the failure by the provider to develop self-awareness and a
respectful attitude toward diverse viewpoints. One of the major themes that I identified from the first research question was that of self-awareness. This self-awareness can be tied to mindfulness and mindful reflexivity, which requires the individual to become cognizant of internal assumptions and biases. Self-awareness is sensitivity to the values, beliefs, lifestyle, and practices of the patient and is the process that is necessary to prevent the nurse from imposing her or his cultural beliefs onto the patient (Campinha-Bacote, 2007).

From a mindful perspective, it was important to reflect on ethnocentric tendencies so that the participants would maintain an open-minded attitude and learn alternative ways to construct the world (E. Langer, 2007, p. 139). Mindfulness guides people to develop and create new options and to rely on more creative and sensitive ways of processing messages and interacting with others. A mindful approach was imperative in the development of both transcultural awareness and in the recognition that personal inattention to the cultural aspects of care could compromise patient outcomes (Hirst, 2003).

Bennett’s stages of the DMIS and Campinha-Bacote’s concepts of awareness, skills, knowledge, encounters, and desires were useful in interpreting participant comments. According to Campinha-Bacote (2007), nurses strive to become competent by seeking out cultural encounters, obtaining the necessary knowledge, possessing skills, such as empathy, that enhance culturally competent care; and finally, realizing that all cultures are valuable, dismissing an ethnocentric view.
Most participants demonstrated behaviors and articulated comments that were reflective of the first two ethnocentric stages of the DMIS. During the first ethnocentric stage of the DMIS, Denial, individuals refuse all interaction with other cultures, show no interest in discovering cultural differences, or are unable to comprehend cultural differences. During the Denial phase, cultural differences are not experienced and the subject of diversity is often avoided. One participant (Laura) appeared to be unable to move from this stage of Denial.

Defense, the second ethnocentric stage, is characterized by discriminating against other cultures in a more complex manner, yet the people in this stage do not see the newly encountered culture as equally complex as their own. During this stage the individual recognizes cultural variances; however, they may see their own cultural group as the only feasible choice (J. M. Bennett & Bennett, 2004; M. J. Bennett, 1993; Cushner, 2004). In this stage the person clearly recognizes another culture, but regards this culture in a negative manner, often with stereotyping.

Most of the participant comments reflected the DMIS stage of Defense, which recognized cultural differences. These differences become threatening to the individual and the individual still considers all other cultures to be inferior to their own culture (M. J. Bennett, 1993; Cushner et al., 2003). Two participants exhibited behaviors of Defense/Reversal (Marissa and Vanessa); once Reversal begins the person is ready to move to the next stage, Minimization (M. J. Bennett, 1993).

People move from Denial to Minimization when they recognize that many cultural differences are superficial. They believe that all human beings are essentially the
same (M. J. Bennett, 1993; Cushner et al., 2003). Based on the student journals, discussion groups, and personal interviews, Laura demonstrated characteristics of the Denial stage and showed no real movement away from this stage. Denise’s comments and actions reflected both the Denial and Defense stages. Michael, Meghan, and Khalen appeared to have a stronger tendency toward the Defense stage, and Vanessa, Marissa, and Alysse may have demonstrated characteristics of moving toward Minimization. In the following section, I offer a more detailed discussion of each participant’s reaction to this sojourn experience.

**Research Question Two**

How do the participants re-conceptualize their role as a nurse six months after returning home? The participants spent much less time with the nurses in Tanzania than I originally planned. The participants spent just 2 days with nurses at the Kilimanjaro Christian Medical Centre and Mamma Leone’s HIV clinic where they observed the nursing care. They did, however, deliver care with nurses at two of the children’s homes. Several studies have documented that participating in international opportunities—even without actually delivering nursing care while abroad—still resulted in personal and professional growth (Bosworth et al., 2006; DeDee & Stewart, 2003; Lawson, 2008; Lee, 2004; Mu et al., 2010; Sawyer & Lopopolo, 2004; Sloand, Bower, & Groves, 2008; St. Clair & McKenry, 1999). After reflection, the participants were able to identify behaviors of the Tanzanian nurses that were admirable, which helped them to develop new perspectives on what behaviors are required for the professional nurse. The three themes that emerged through interpretation and analysis of the qualitative data were: (a)
the development of a changing nursing perspective, (b) a new understanding of professional role development toward client-centered care, and (c) the desire for lifelong learning.

International experiences have been shown to promote a new way of thinking and a changing perspective (Kavanaugh, 1998; Nieto, 2006). After the participants spent time in the hospital, clinics, and orphanages, they came away with a different outlook on nursing care and personal responsibility for their patients and families wellbeing. The participants were able to observe that the nurses in Tanzania, with much less support and resources, had a different focus and a more positive approach to patient care.

A changing nursing perspective was demonstrated through the understanding of professional behaviors, professional demeanor, and personal responsibility. The participants began to question their own behaviors and approach to workload issues, breaks, and professional attributes. The participants drew many more distinctions and conclusions about the manner in which the nurses in Tanzania conducted themselves, rather than the actual nursing care delivered. The participants’ new perspective involved a greater understanding of what it means to become a professional, and the importance of respect for self and others. Also noted were the participants’ attention to professional demeanor and behaviors, which are core elements identified by nursing’s professional standards (AACN, 2008). All participants began to seriously reflect on and evaluate unprofessional behaviors of nurses at home. There comments reflected disapproval of the many complaints and self-centered approaches to nursing care they observed with U.S. nurses when compared to the nurses in Tanzania. Research has shown that travel abroad
can result in a greater understanding of one’s professional role (Caffrey et al., 2005; Ter Maten & Garcia-Maas, 2009).

The acquisition of leadership skills was demonstrated by the participants as another example of their changing nursing perspective. The American Association of Colleges of Nursing’s document, the Essentials for Baccalaureate Education for Professional Nurses (2008), emphasizes specific core values for professional nursing practice. The expectations for professional practice by the AACN require the registered nurse to demonstrate leadership in the professional practice setting as well as in the profession (Standard, #12, ANA, 2010).

Following this international experience, one sophomore (Meghan) became vice-president of her class, two junior level participants (Marissa and Vanessa) became the president and vice-president of the junior class respectively, and two seniors (Laura and Denise) became the officers overseeing the entire SPN (students for professional nursing). None of the participants reported participation in leadership activities prior to this trip, but often remarked on how this trip gave them the confidence to assume leadership roles. All of the participants became active in campus fundraising activities to send clothing, toys, and hygiene supplies to the children’s homes that we visited while in Tanzania. Khalen continued independently to raise funds to buy toys for Guatemalan and other underserved children in her hometown.

A core expectation for the professional nurse is a patient-centered approach that values human dignity, respect, and a belief in the inherent worth and uniqueness of all people, which is the cornerstone for holistic nursing (AACN, 2008). Following a
short-term international experience, Zamastil-Vondrova (2005) found that students were able to critically reflect on professional practice and enhancement of professional competencies resulted. The participants in this study spoke of a greater understanding of the importance of patient-centered care, and the importance of translating these affective characteristics into compassionate, sensitive, and holistic care. Holistic nursing is the central unifying force for the science of nursing and it addresses the multiple ways that people differ on the basis of culture, race, gender, ethnicity, sexual orientation, religion, and socioeconomic status (Pesut, 2010).

The participants also saw the importance of teamwork and collaboration among the nurses, physicians, and other members of the healthcare team. This communication and collaboration among healthcare professionals is critical to delivering high quality and safe patient care (AACN, 2008). The participants remarked often on the high level of teamwork in Tanzania between the nurses, doctors, and students and a desire to emulate these behaviors.

**Campinha-Bacote’s process of cultural competence.** Campinha-Bacote’s construct of cultural encounter is the experiential exposure to cross-cultural interactions with people who are culturally and/or ethnically diverse. According to Campinha-Bacote (2007), contact with others leads to further reflection, learning, and assimilation in the delivery of culturally congruent care, and often triggers the desire to learn more. Professionalism involves accountability for ourselves and our nursing practice, and baccalaureate graduates are expected to focus on continuous self-evaluation and lifelong learning. This cultural encounter facilitated many of the participants’ expressed desire to
learn more. Meghan, Vanessa, Marissa, Alysse, Khalen, and Michael spoke of a desire to learn about new cultures. However, Laura was less enthusiastic, and was not interested in foreign travel in the near future. Denise was initially enthusiastic about future encounters and future travel, but six months later she did not verbalize this. Alysse, Marissa, Michael, Vanessa, Meghan, and Khalen demonstrated that this experience enabled them to develop a degree of cultural empathy, a concern for advocacy against racism, and an appreciation for a holistic approach to nursing care. An important aspect of lifelong learning for professional nurses includes a social justice perspective in caring for all patients, “acting in accordance with fair treatment regardless of economic status, race, ethnicity, age, citizenship, disability, or sexual orientation” (AACN, 2008, p. 28).

**Intercultural Desire and the DMIS**

In previous research by Koskinen and Tossavainen (2004), intercultural desire was found to be the major factor that helped the participants successfully negotiate cultural differences. The six participants who began with cultural desire accepted cultural differences more readily and altered their behavior to adapt to the situation. The two participants who were unable to negotiate this transition reacted by withdrawing or regressing.

Bennett’s stages of the DMIS and Campinha-Bacote’s concepts of awareness, skills, knowledge, encounters, and desires were useful in interpreting participant comments. All participants reported an increased awareness of cultural differences and similarities, and most verbalized or demonstrated empathy. Most of the participants expressed a desire to learn more about different cultures and four of the eight participants
actively pursued further cultural related encounters following this international cultural experience.

**Implications**

Research on short-term international cultural experiences remains underdeveloped, and yet it is the largest growing format for study abroad programs. This study enhanced the literature by confirming the results of previous studies on the efficacy of short-term programs. The findings from this study support and extend the sparse literature on short-term international cultural experiences of less than two weeks by demonstrating that a short-term program of 8 days can lay the groundwork for the development of intercultural/transcultural growth. Short-term international cultural experiences programs provide more options for university students by limiting costs, as well as time away from home and studies.

Results from this short-term study abroad program identified gains in self-awareness and leadership skills, which can serve as a springboard for further learning and meaning making. In particular, through meaning making, the participants may be better able to focus on a greater understanding of social issues, privilege, and stereotyping, as well as reframing what it means to be a professional nurse. For most participants, they stated this experience was life-changing.

This study has shown that program length for international cultural experiences alone is not sufficient to result in positive learning outcomes by college students; rather the pedagogical approach is as significant as duration and greatly influences learning regardless of program length. Others can argue that the pedagogical approach, although
valuable, does not have enough “power” to overcome the benefits of the duration of a longer trip. This dissertation study was unique in that reflection and journaling occurred during the sojourn and guided reflection and data collection occurred one month and six months after the return home. This allowed for evaluation of the immediate and intermediate outcomes.

The above implications challenge researchers to rethink the value of short-term experiences. As stated in the review of literature, P. J. Pedersen (2009) disputed the length of an immersion experience as a predictor for the development of cultural competence, and found that deliberate and well-planned pedagogy and guided reflection resulted in the most growth and change. Pedersen used the DMIS to evaluate a well-planned 2-week short-term immersion experience with specific curricular objectives and guided pedagogy, and compared the results with a one-year experience without specific pedagogical organization or objectives. This study found that deliberate and well-planned pedagogy and guided reflection seen with the short program resulted in the most growth and change. I would argue that the length of a program is not always an indicator of positive learning outcomes, and other studies support P. J. Pedersen’s (2009) findings that the pedagogical approach greatly affects learning regardless of program length (Braskamp et al., 2009; Bosworth et al., 2006; Franklin, 2010; Green et al., 2008; Zorn, 1996; Zorn et al., 1995).

As I reported in the literature review in Chapter 2, some researchers have disputed the value of any program of less than two weeks. Unfortunately, more research is needed to evaluate the effectiveness of short-term sojourns of less than two weeks. I was able to
uncover only two studies examining programs of less than two weeks (Evanson & Zust, 2006; Mu et al., 2010), and both of these studies demonstrated positive learning and growth outcomes. In addition, the Georgetown Consortium study disputed the argument that duration is the most important variable. The Georgetown Consortium study emphasized the educational design for the cultural learning process and reported that the pedagogical approach and the intervention in the learning process was much more important than the length of the sojourn (Vande Berg, 2009) experience. In addition, the “Allport Effect,” which was identified in the Georgetown Consortium study (Vande Berg, 2009), found that any sojourn exposure is likely to result in a decrease of stereotyping and prejudice. This was demonstrated by four of the eight participants in my study. In fact this was one of the most profound outcomes, when several participants began to understand their role in combating stereotyping and racist behaviors in others as well as themselves.

It is important to define the goals for each study abroad program. If the goal for a study abroad program is cultural competence, I would argue that a single experience is not sufficient to result in that particular outcome, regardless of duration. However, if the goal of the study abroad is to spark a desire to learn about others and begin the journey toward cultural competence and understanding the value of cultural humility, then the one-week programs hold much promise.

Implications for Future International Cultural Experiences

Although international and study abroad programs are an important method for intercultural training and learning, Gudykunst, Guzley, and Hammer (1996) reminded
educators that if they choose an experiential learning environment, it must be created to support the learners’ different needs and learning styles. What I learned from this experience is that in-depth pre-immersion coursework is vitally important as well as reflection and debriefing during the actual experience. Missing from this 8-day international experience were adequate debriefing sessions immediately upon the return home to help the participants cope with issues of shock and re-entry. Educators are urged to consider both the advantages and disadvantages of intercultural training before, during, and after the sojourn experience (Gudykunst et al., 1996).

I found multiple advantages to intercultural training in this study: (a) the motivation to learn was high for six of the eight; (b) the participants had some choice on a personal level in what they needed to learn (course selection for pre-immersion preparation); (c) self-study and self-reflection were used; and (d) new knowledge and attitudes were immediately experienced and cultivated. When international experiences are used without proper support, this learning can produce negative consequences and can create an overwhelming and stressful environment for the student (Brislin, 1997; Cushner et al., 2003). For future research in this area, early and frequent debriefing sessions upon the return home may help to alleviate some of the difficulty that returning sojourners experience. This may be true especially when the host culture is vastly different from the participant’s culture, regardless of duration.

As the researcher, I spent much time with advance planning for the trip with numerous pre-immersion workshops, lectures from the WHO, the United Nations, and the International Refuge center prior to the trip. Tanzania was selected for this
international cultural experience for several reasons. First, one of our students had recently moved to the United States from Tanzania and had volunteered to serve as a translator. Second, a colleague fluent in Swahili would also be accompanying the group and she assisted with pre-immersion activities. Finally, I had several physician friends who traveled to Tanzania and helped organize and arrange for additional clinical and cultural experiences. I was also able to meet with our Tanzanian hosts while they were visiting the United States. Nonetheless, I had no prior travel experience to Tanzania and did not meet with health care professionals personally prior to the trip, which may have altered the experience at Kilimanjaro Medical Centre as well as other experiences while in Tanzania. Unfortunately, cost and professional responsibilities do not always allow for travel prior to an international cultural experience. It would be advantageous to visit and meet with potential contacts when planning any international experience in advance, as this can only enhance the quality of the study itself.

Although I put much thought into daily debriefing sessions while abroad, and much time encouraging self-reflection, the first meeting after the return home did not occur until one month later. I mistakenly assumed that since this was a short trip, the participants would have little difficulty with re-entry acculturation. The participants returned very late on a Tuesday evening and began school six days later. This gave participants insufficient time to readjust and re-acclimate to school and their personal lives. According to Cushner and Brislin (1997), cross-cultural training requires educators to remain aware of the key stages that participants will go through not only during the international experience, but also after the return home. It is important to have students
become aware of the issues that they will encounter (Cushner & Brislin, 1997). I would urge future researchers to add more debriefing sessions immediately after the return home as well as continued reflection. Not only can this provide rich and valuable data that may have been missed, it also provides an extra layer of support and guidance for the participants. This would help to establish a higher standard of ethical practices and consideration for the participant engaging in qualitative research studies.

**Limitations**

This study is limited in several areas. The first limitation is the sample size. This study had a sample size of only eight participants, and the participants who chose to participate in this immersion experience may have possessed a greater interest and sensitivity to cultural issues than those who declined to participate. This may have artificially inflated the construct of cultural desire and the development of cultural humility as a result of this international experience alone.

Additional focus group discussions would have been helpful for two purposes: first, more data could be collected, and second, further support and debriefing could have been provided to the participants. The personal interview session may have been problematic, since I was a faculty member from the participants’ home campus and area of study, possibly limiting the ability of the participants to speak freely. In addition, not all people are comfortable with one-on-one conversations. In fact, two participants requested to be interviewed together and that request was respected. However, these participants agreed to be interviewed separately at a later date.
Third, it would have been beneficial to have the participants continue reflective journaling extending over at least one year, with quarterly entries. This would have provided more exhaustive and reflective data with deeper insight into the process of acquiring intercultural skills, the effects of culture shock with short-term sojourns, and whether there is continued development of cultural desire and humility.

Fourth, the study extended over a period of only seven months from August 2011 to March 2012. I would like to follow up with these participants one year and two years later to determine the lasting effects if any of this 8-day international sojourn.

Finally, it would have been beneficial to have quantitative data by the IDI, the IAPCC-R, or both, to determine objectively the impact of this program on the participants’ developmental stages of the DMIS, or whether the level of cultural competence according to the IAPCC-R improved. Adding this quantitative information to qualitative data could shed light on the relationship between cultural desire, awareness, and intercultural sensitivity.

The Development of Cultural Desire and Cultural Humility

Cultural humility incorporates the lifelong commitment to self-evaluation and self-critique, as we redress the power imbalances in the patient-health care professional relationship (Campinha-Bacote, 2007). Cultural humility was proposed as a more suitable goal than cultural competence in healthcare education (Tervalon & Murray-Garcia, 1998), and was identified as an outcome for professional nursing practice, according the AACN Essentials Document under Standard VIII, Professionalism and Professional Values (2008). A major theme that evolved from data
from each research question was the “desire” to continue to learn and to participate in additional experiential opportunities. Cultural desire means that we enthusiastically seek to care for culturally diverse patients (Campinha-Bacote, 2007).

Cultural desire is crucial for the development of cultural competence. According to Campinha-Bacote (2007), cultural desire is key for the development of cultural competence because it shows a genuine drive to care for persons with different values and beliefs. Increased desire to care for patients from diverse cultural backgrounds usually results in increased cultural encounters, greater cultural knowledge, acquisition of cultural skills, enhanced cultural awareness and growth toward cultural competence; all of which are necessary when caring for culturally diverse populations (Ingram, 2012).

Campinha-Bacote’s cultural desire construct is linked to the concept of cultural humility, which is the ability recognize the worth and dignity of others. It asks the question “Do I really want to become culturally competent?” (Campinha-Bacote, 2007, p. 86). Nurses and other healthcare professionals must be driven by the desire to become competent before they can begin the journey toward competence (Campinha-Bacote, 2005). Cultural desire does not evolve out of desperation, rather it develops as a result of one’s aspiration (Campinha-Bacote, 2007) and is a necessary prerequisite to cultural competence. We must want to learn about cultures before we can become competent. This is also echoed by Bennett’s ethnorelative stage of minimization, moving toward ethnorelativism, where the person begins to express a desire to learn more about diversity and cultural differences. Cultural humility means that we never fully reach the level of
intercultural competence; rather it is the lifelong learning, adapting, and integrating that provides for the foundation for culturally congruent and effective care.

**Recommendations for Further Research**

The American Association of Colleges of Nursing (AACN, 2008) states that the development of cultural competence occurs best when students engage in environments that expose the student to diversity facilitated by guided experiences. More research needs to be completed focusing on guided short-term experiences of one week or less. Since many colleges and universities are moving toward shorter programs, the success of these programs relies on the pedagogical design utilizing an integrated approach. This study hopes to add to the sparse research on short-term programs of less than two weeks, using sound pedagogical choices combined with the short-term sojourn experience. More studies are needed to examine the effects of one-week programs with guided pedagogy.

A good extension of the study would be to perform similar research examining the concept of cultural humility more in-depth, using Campinha-Bacote’s IAPCC-R tool to determine the level of cultural desire quantitatively. This can be combined with qualitative data that can provide narrative data on the development of cultural humility. In addition, it would have been helpful to use Bennett’s quantitative tool to compare the participants who went on this one-week international experience with participants who stayed at home and enrolled in a didactic transcultural nursing course, as well as against a control group that did not choose any elective courses. This tool would also provide valuable insight into the stages of development with which each participant began to determine whether growth or regression resulted from this short sojourn experience.
This study reported awareness and a desire to learn more that remained relatively stable over a 6-month period. It is difficult to say the extent to which these outcomes enhanced the development of intercultural competence, since there was no qualitative or quantitative data collected prior to the trip to compare the degree or presence of growth. This area warrants further research. Another area that needs further exploration is research on the optimal venue for mitigating the effects of post-trip depression described by participants from this short-term experience. Also, it would be interesting to see if, or how, post-trip depression affected the performance of participants in subsequent coursework and learning.

Mixed research that compares the quantitative results of the IDI or IAPCC-R to participants’ qualitative responses can provide valuable insight into how growth toward intercultural sensitivity and cultural humility occurs. This can aid future educators in developing programs that will enhance learning. Quantitative, mixed, and qualitative research is needed to examine the amount of growth before during and after these very intense short-term experiences. Finally, future research programs can investigate what forms of support are necessary for returning sojourners, as well as the length of time required for successful re-entry acculturation, specifically when examining short-term international cultural experiences.

Conclusion

The concept of intercultural or transcultural nursing is complex and dynamic. It is fueled by the desire to increase the interaction, respect, cooperation, and understanding among individuals, institutions, communities, health care agencies, geopolitical
communities and international organizations. Human responses to life predicaments are complex and difficult to predict, and yet the essence of nursing is dependent on that knowledge. The misconception often seen in nursing as well as in other disciplines is that culture can be understood and taught in a strictly didactic format. This can lead nurses and other professionals to view culture as a set of separate behaviors, and that may increase the tendency to stereotype and inaccurately predict behaviors. The injustice to the patient is that through these misunderstandings, specific ethnic cultures are represented as characteristics that can be identified, modified, and/or manipulated for health care outcomes (Hunt, 2005).

According to the Human Rights Position statement from the Transcultural Nursing Society (2011), despite today’s burgeoning of multi-cultural populations, the number of health care providers worldwide prepared to deliver culturally congruent care is limited. Many health care providers do not acknowledge and are often ill-equipped to provide care that does not fit into their own cultural belief system. Unfortunately, they often impose health care interventions on people that were ineffective or detrimental, rather than working cooperatively with patients and their families. Deardorff (2006) reminded us that we must be aware of cultural barriers that can impact care. It is imperative that all individuals working in the health care system who provide direct care must develop culturally competent skills. Nurses need to take into consideration the patient’s perspective and frame of reference, and to consider there are different and opposing health care belief systems, as well as different approaches and perceptions of
health and wellness. Intercultural competence is the main ingredient for closing the disparities gap in health care (USDHHS, 2010).

Actions related to ethnocentrism, lack of awareness, and moral blindness perpetuates and exacerbates healthcare inequities. The need to provide culturally diverse experiences for nursing students as they pursue a college degree is great. This short-term international study can serve as a model for providing the opportunity for more students to participate in international experiences. As one of the primary providers of global healthcare, the profession of nursing is in a unique position to guide and conduct practice-based international research (Chiang-Hanisko, Ross, Ludwick, & Martsolf, 2006). The goal of an international cultural experience is to help students appropriately and effectively care for the cultural needs of people, and skillfully integrate the values, beliefs, and life-ways of individual cultures with respect to health and well-being (Transcultural Nursing Society, 2011).

International cultural experiences can help health care practitioners to understand and become sensitive to the many health behaviors that are deeply rooted in culture and can serve to motivate students to provide culturally competent care. Intercultural competence does not just occur—instead it must be deliberately attended to (Deardorff, 2006). Thoughtfully addressing intercultural competence through a pedagogical approach that is both comprehensive and integrated is essential if we are to graduate global-ready students. It is essential that nurse educators and leaders today move quickly to produce nurses who are skilled in transcultural content. By doing this, we change our goal from producing nurses who are conformists and compliant to producing nurses who
are skilled in culture content. Transcultural nursing education remains fundamental to improving the cultural lives of those that are cared for by the professional nurse.

As seen through this study, international cultural experiences can provide participants with a unique opportunity to reach out into the world and to gain a more global perspective and worldview. Acquiring cultural humility, the desire to want to know more about diverse people and other cultures, is the first step along the journey toward intercultural competence and transcultural proficiency. Often researchers are not aware of the concept of cultural humility, and therefore it is overlooked as a possible outcome when interpreting and analyzing research data. According to Miller (2009), we have begun to shift our focus from cultural sensitivity, which was a helpful way of approaching individuals who held diverse health beliefs, to cultural competence, which focuses on the ability of nurses to interact work together capably with people of distinctive cultures, to cultural humility.

By examining the meanings participants created during and after a short-term experience guided by curricular goals and objectives, this study contributes to empirical understanding in nursing education and practice by offering insights into how students can acquire cultural humility through a short-term cultural encounter. This short-term international cultural experience has shown that an 8-day travel abroad experience is a viable and exciting option for students to begin their educational journey toward transcultural/intercultural competence.

Maxine Greene (1988) urged us to recognize that there are “always multiple perspectives and multiple vantage points” (p. 128), and that no learning or exploration
can ever be finished or complete. “There is always more . . . there is always possibility . . . [that people] have the capacity when authentically attended to . . . to hear and see what they would not ordinarily hear and see” (p. 129). Educators have the responsibility to open up the world for students to examine the familiar and then to explore visions of consonance and dissonance that are unfamiliar in order to transfigure and transform thinking and acting by the individual (Greene, 1988).
APPENDICES
APPENDIX A

INFORMED CONSENT FORM

KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD
Appendix A

Informed Consent Form Kent State University Institutional Review Board

Informed Consent to Participate in a Research Study

Study Title: An interpretive qualitative study of baccalaureate nursing students following an eight-day international cultural experience in Tanzania

Principal Investigator: Mary Lou Ferranto MSN, CNP, Assistant Professor of Nursing.

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose: The purpose of this research is to examine the reactions, perceptions and outcomes of nursing students immersed in an intense short-term study abroad experience. This research will follow the summer immersion experience of Kent State University nursing students from the Bachelor of Science Nursing program in Tanzania.

Procedures: Eight participants will be traveling to Geneva Switzerland and the World Health Organization and Tanzania as part of their Community Nursing course or Transcultural Nursing and health Care courses. You will be asked to journal each day during this experience and to reflect on what you have learned each day, interpret your experiences and describe how you perceive this new culture. The first journal will follow the pre-immersion introduction, and then you will continue to journal daily while immersed both in Tanzania.

If you choose to participate, several data collection methods will be used in this research study, in addition to the class assignment of reflective journaling. By agreeing to participate, you will allow me to review your reflective journals and include them in this research study.

If you choose to participate, you will be asked to review your journals independently two weeks after the immersion experience to add additional comments, if so desired. Two months after returning participants will meet in a focus group to discuss and share their experiences, and five months after returning individual interviews will be conducted with the researcher. The participation in this experience is voluntary and you may withdraw at any time.

Prior to the trip, you will be prepared for the immersion experience through pre-immersion seminars informing you about the norms, rituals, traditions, world view and expectations. During your time in Geneva, seminars will be given by members of the WHO, United Nations and other global organizations. The immersion experience will be lead by myself another faculty person and one guide who will be traveling with us and are well-versed on the culture of the
Tanzanian people. During the actual immersion experience, you will perform patient education and community service as part of your course requirements. At the conclusion of each day you will return to your room and journal focusing on the experiences of that day.

Your identity will be kept confidential. Consent forms will be kept in a locked filing cabinet in either my office or my advisor’s office. All documentation will use pseudonyms.

The researcher will obtain the informed consent, in the form of a signature on the consent form, prior to the pre-immersion experience. The participant will have a copy of the consent form to keep. Also, the consent form will be read aloud and participants will have the opportunity to ask questions.

**Audio and Video Recording and Photography:** Audio recording will take place during the focus group discussion and the interviews. Again, pseudonyms will be used and all material will be kept in a locked file in my office at the Salem campus.

**Benefits:** As a participant in this study, you may feel a sense of satisfaction that you were able to experience a culture different from your own, assist those in need and appreciate the uniqueness Tanzania. This also will provide you with the opportunity to travel outside of country. More immediately, the potential benefits of participating in this study may include the opportunity to tell your story of your experiences. You will also have the added benefit of involvement in a research study.

**Risks and Discomforts:** There are no anticipated risks beyond those encountered in everyday life.

**Privacy and Confidentiality:** No identifying information will be collected. Your signed consent form will be kept separate from your study data, and responses will not be linked to you.

**Compensation:** You will receive a thank you gift (Kent State mug) after participating in the project. These gifts are not used as recruitment or as compensation. Instead, they will be used to express my thanks and appreciation of you sharing of your time and your story with me. Gifts will cost approximately $10.00 U.S.

**Voluntary Participation:** Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. There will be no extra work required of the participants. I will only ask permission to read and analyze your journals, the focus group discussion and conduct one interview with you.

**Contact Information:** If you have any questions or concerns about this research, you may contact Mary Lou Ferranto (Principal Investigator) at 330-337-4273, or Dr. Teresa Rishel, Dissertation Chair, Dr. Kenneth Cushner and Dr. Tricia Niesz (Advisors) at 330-672-3000. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.
**Consent Statement and Signature:** I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

_____________________________  __________________
Participant Signature          Date
APPENDIX B

QUESTIONNAIRE FOR THE REFLECTIVE JOURNALS
Appendix B

Questionnaire for the Reflective Journals

An interpretive qualitative study of baccalaureate nursing students following an eight-day international cultural experience in Tanzania

Date___________
Time ___________
Location____________
Focus group____________ or Interview____________
Description of scene____________________
Recorder_________________________
Facilitator_________________________

After arriving in Tanzania, what was your first or initial reaction?
What was surprising about the Tanzanian culture?
How would you describe the people of Tanzania?
Was there anything that you found uncomfortable or difficult to understand?
What differences do you notice and how do you feel about these differences?
Can you identify any characteristics of the Tanzanian culture that you would like to emulate?
How has this experience changed your attitudes about cultural differences?

Please explain in depth when compared to the United States:

• What are the commonalities or similarities?
• Strengths of each culture?
- Weaknesses of each culture?

Do you think that this experience will have a lasting effect on you? Please explain.

How did you communicate with members of the other culture and do you think you were effective?

What were some mistakes in behaviors or approaches that you identified for yourself or your peers with members of the Tanzanian culture?

What behaviors in yourself or others would you like to change and why?

Will this experience change how you approach nursing care of patients in the US?

How has this experience shaped how you will care for your patients in the future? Please explain:

Do you see a difference in the roles of nursing in Tanzania?

How is patient care different or similar?
APPENDIX C

QUESTIONNAIRE FOR THE FOCUS GROUP DISCUSSION
AND PERSONAL INTERVIEW
Appendix C

Questionnaire for the Focus Group Discussion and Personal Interview

An interpretive qualitative study of baccalaureate nursing students following an eight-day international experience in Tanzania.

Date__________

Time __________

Location______________

Focus group_____________ or Interview____________

Description of scene____________________

Recorder_________________________

Facilitator_________________________

After arriving in Geneva and participating in the presentations on world health care, how has your perceptions of the world changed, if at all?

Please describe your feelings at this point before leaving for Tanzania.

What do you expect to find when you arrived in Tanzania?

After arriving in Tanzania, what was your first or initial reaction?

What was surprising about the Tanzanian culture?

How would you describe the people of Tanzania?

Was there anything that you found uncomfortable or difficult to understand?

What differences did you notice and how did you feel about these differences?
Can you identify any characteristics of the Tanzanian culture that you would like to emulate?

How has this experience changed your attitudes about cultural differences?

Please explain in depth when compared to the United States:

- What are the commonalities or similarities?
- Strengths of each culture?
- Weaknesses of each culture?

Would you like to return to Tanzania? Please explain.

Do you still have a desire to explore new cultures? Please explain.

Do you think that this experience will have a lasting effect on you? Please explain.

How did you communicate with members of the other culture and do you think you were effective?

What were some mistakes in behaviors or approaches that you identified for yourself or your peers with members of the Tanzanian culture?

What behaviors in yourself or others would you like to change and why?

Will this experience change how you approach nursing care of patients in the US?

How has this experience shaped how you will care for your patients in the future? Please explain:

Do you see a difference in the roles of nursing in Tanzania?

How is patient care different or similar?
APPENDIX D

PRE-IMMERSION WORKSHOPS
Appendix D

Pre-Immersion Workshops

An interpretive qualitative study of baccalaureate nursing students following an eight-day international cultural experience in Tanzania.

Pre-Immersion workshops 4- 5 hours each workshop on prearranged meeting dates.

**Day 1 (March 2011):** 12 noon-5 p.m. (snacks provided)

Introduction to the Tanzanian culture

Presentation by Dr. Sarah Smiley, Professor of Geography of Africa and researcher on clean water supply in Tanzania.

Presentation by Lillian Kavishe, Nursing student from Tanzania

Review of Immunizations, passport and visa requirements by M.L. Ferranto

Conversational Swahili

**Day 2 (April 2011):** 12 noon-5 p.m. (snacks provided)

World Health Initiatives by the World Health Organization

Review of Healthy People 2012

Case study simulations: M.L. Ferranto

Conversational Swahili: Dr. Smiley and Lillian Kavishe

**Day 3 (May 2011):** 12 noon-5 p.m. (snacks provided)

Review of transcultural theories

Case Study simulations
Conversational Swahili: Dr. Smiley and Lillian Kavishe

**Day 4 (June 2011):** 12 noon-5 p.m. (snacks provided)

Health Care needs in Tanzania per the World Health Organization: M.L. Ferranto

Cultural subgroups within Tanzania: Lillian Kavishe and Dr. Smiley

Safety and international travel: Dr. Smiley

Case Study simulations: Dr. Smiley and M.L. Ferranto

Conversational Swahili: Dr. Smiley and Lillian Kavishe

**Day 5 (July 2011):** 12 noon-4 p.m. (snacks provided)

Packing of donated items

Question and answer

**Day 6 (July 28) 6 p.m.: Dinner with friends and families**

Meeting with participants/parents/spouses

Question and answer period
APPENDIX E

DEMOGRAPHIC DATA SHEET
Appendix E

Demographic Data Sheet

An interpretive qualitative study of baccalaureate nursing students following an eight-day cultural immersion experience in Tanzania.

Name

Ethnicity/Race

Age

Are you a full time or part time student?

How many hours per week do you work?

Previous Travel in the US/ Where/How many times? Length of Stay?

Previous Travel in North America/ Where? How many times? Length of Stay?

International Travel/ Where? How many times? Length of Stay?

Previous Exposure to Diversity

Reason for participation in this international experience.

Have you ever assumed a leadership role? Explain?
APPENDIX F

COURSE OBJECTIVES: NURS 32050
Appendix F

Course Objectives: NURS 32050

Below is an example of one option of a pre-requisite nursing courses required for this international cultural experience in Tanzania

KENT STATE UNIVERSITY

COLLEGE OF NURSING

Course Objectives

NURS 32050

Transcultural Nursing and Health Care

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Kent State University College of Nursing

Course Description: This course provides students with the opportunity to explore and understand the role of the transcultural nurse in the care of patients from multiple and diverse cultural groups.

Credit Hours: 3 hours

Course Objectives:

At the completion of this course the student will be able to:

1. Use critical thinking in the application of the nursing process for diverse cultures
   - Assess the health status of diverse patient populations
   - Compare and contrast health needs and goals for the diverse culture groups
   - Plan nursing interventions based on mutual goals and diverse needs
   - Understand health traditions and the cultural phenomena that affect them
   - Discuss the meanings of culture, ethnicity, religion and socialization
     a. Contribution to health beliefs and practices

2. Use therapeutic communication techniques with individuals and families of diverse cultural and spiritual backgrounds

235
• Assess the impact of socioeconomic and cultural factors on nurse/client interactions
• Understand ethno cultural heritage and socialization

3. Apply the epidemiologic approach to identify subgroups within population that are at risk for disease, disability, and premature death

• Apply the epidemiologic model to improve the health of the community
• Discuss diversity, demographic and economic influences on health care
• Understand the behavioral variations in health and illness
• Plan nursing interventions to reduce client risk factors
• Implement and evaluate plan of care if permitted

4. Collaborate with members of the multidisciplinary team including to promote the health of the individuals, families, and communities with unique needs

• Analyze the role of the health nurse in health planning for diverse patients groups
• Reexamine and redefine the concepts of health and illness
• Understand the multiple relationships between health and illness
• Describe physiological variations of people from varying backgrounds
• Describe barriers to health care

5. Utilize ethical principles according to the Baccalaureate essentials document of the AACN in care of all individuals from diverse backgrounds

• Practice according to legal, ethical, and professional nursing standards
• Demonstrate scholarly preparation for the practice of nursing

6. Apply current theories of transcultural nursing to the care of all individuals

• Demonstrate personal development of cultural humility
• Develop long-term awareness of self and health, and health traditions of people from different cultural and religious backgrounds.
• Develop an understanding and respect for health traditions of people from varying cultural backgrounds
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