

## The Influence of International Service-Learning on Transcultural Self-Efficacy in Baccalaureate Nursing Graduates and their Subsequent Practice

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The purpose of this study was to explain how participation in an international service-learning project during a community health course influenced transcultural self-efficacy of baccalaureate nursing graduates following graduation and their subsequent clinical practice. A qualitative, explanatory case study was used to conduct telephone interviews with 14 nursing graduates, who had previously participated in international trips to Ecuador or Guatemala. A constant comparative analysis revealed themes related to increased self-efficacy in the cognitive, practical, and affective learning dimensions of cultural competence. Additional themes focused on the importance of experiential learning, the provision of culturally congruent care, and a commitment to international service. The findings indicate that service-learning promotes social growth while providing opportunities to increase self-efficacy during cultural encounters with diverse populations. Nursing graduates were able to provide culturally congruent care as a result of their increased transcultural self-efficacy.

Members of The American Academy of Nursing Expert Panel on Global Nursing and Health, The Transcultural Nursing Society, and The American Academy of Nursing Expert Panel on Cultural Competence have established a proposed set of universal standards of practice for culturally competent care (Douglas et al., 2009) for nurses to serve as a guide for clinical practice, research, education, and administration. The challenge for educators is to apply specific pedagogies which demonstrate through research that nursing graduates are prepared to meet these standards of care. Nurse educators are investigating cultural competency outcomes for nursing students through both quantitative and qualitative research methods (Amerson, 2010; Bentley & Ellison, 2007; Jeffreys, 2000; Kardong-Edgren & Campinha-Bacote, 2008; Napholz, 1999; Nokes, Nickitas, Keida, & Neville, 2005; Rew, Becker, Cookston, Khosropour, & Martinez, 2003). Still, a need exists to identify which pedagogies are effective for teaching cultural competence. Not only is this important for nurse educators, but for any discipline which deals with diverse populations.

Service-learning is one pedagogy which supports several of the universal standards for the practice of culturally competent care. Opportunities are provided to address social justice, critical reflection, transcultural nursing knowledge, cross cultural practice, and cross cultural communication through community-based experiential learning. International service-learning is a structured learning experience where students accompanied by faculty travel to different countries and immerse themselves in a culture different than their own (Grusky, 2000). Students work in communities where they are staying, engage in cultural encounters, and experience a new perspective on daily life. According to Campinha-Bacote (2003), cultural

encounter “is the process which encourages the healthcare professional to directly engage in face-to-face interactions with clients from culturally diverse backgrounds” (p. 48). Cultural encounters are an essential component of the process of cultural competence, which involves awareness, knowledge, skill, encounters, and desire.

### Conceptual Framework

The Cultural Competence and Confidence (CCC) Model attempts to “explain, describe, influence, and/or predict the phenomenon of learning (developing) cultural competence” (Jeffreys, 2006, p. 25). This model supports the major construct of transcultural self-efficacy (TSE), which is the perceived confidence to perform transcultural skills. Cultural competence is a multidimensional learning process that involves three dimensions: cognitive, which focuses on knowledge and comprehension of cultural factors; practical, which involves the application of verbal and non-verbal communication during interviews; and affective, which entails attitudes, beliefs, and values. In this study, the researcher expanded the practical dimension to include communication during patient teaching and communication required for direct nursing care. The affective dimension encompasses self-awareness, awareness of cultural differences, acceptance, appreciation, recognition, and advocacy. The learning dimensions of cultural competence are directly influenced by TSE. As the student’s TSE (confidence) level increases in transcultural skills, the student is more likely to engage in culturally congruent care. Culturally congruent care recognizes, values, and adapts to the beliefs and values of diverse client populations. Cultural competence is most effective when all three learning dimensions are actively engaged.

Service-learning is a pedagogy which emphasizes meaningful student learning through active, project-based learning while providing service in the community. Students apply theory and classroom knowledge by addressing community issues while working with members of the community. Assessing new situations and gaining new knowledge to address problems through a wide range of skills allows the student to become an expert learner. A required reflective component encourages personal growth, social growth, intellectual growth, citizenship, and preparation for the world of work (Duckenfield & Swanson, 1992). Service-learning enhances students' engagement with the community, increases civic responsibility, and promotes cross-cultural understanding. Students must be prepared to take part in activities, engage in meaningful community service with adequate supervision, reflect critically on their experiences, and be recognized for their contributions. A lack of preparation for service-learning activities may result in stereotypes and biases being reinforced.

### Review of Literature

Nurse educators have conducted research to measure short-term and long-term outcomes of international or immersion experiences with nursing students. One of the earliest studies to evaluate the effect of an international study with nursing students analyzed the impact of a three-month international program on the cognitive development of senior baccalaureate students (Zorn, Ponick, & Peck, 1995). This quasi-experimental study collected quantitative data from eight students who had participated in a semester abroad program and 20 non-participating students. Significant differences were found between the two groups, with the international study group indicating a positive influence on their cognitive development. A grounded theory methodology was used to explore the meaning of an international experience with 14 nursing students, who had taken part in international programs to either the Dominican Republic, Nicaragua, or The Netherlands (Haloburdo & Thompson, 1998). Findings suggest that the length of the trip may be less important than the specific type of experience, since students indicated that trips longer than 2 weeks would not have been possible due to family and job obligations. St Clair and McKenry (1999) conducted a mixed-methods, exploratory study to examine the relationship between cultural immersion, cultural self-efficacy, and cultural competence. The sample included 200 undergraduate and graduate students, and 80 students (50 undergraduate and 30 graduate) who took part in an international experience over a two-year period. Cultural self-efficacy was measured with the Cultural

Self-Efficacy Scale (CSES). A statistically significant increase was noted on the total CSES score for all students. Qualitative data from participant observation and journal entries of students revealed that students who took part in the immersion experience began to challenge their own beliefs and values, increased awareness of themselves and others, began to understand other worldviews, and recognized the effects of prejudice, politics, and poverty.

Other researchers have attempted to directly link service-learning with cultural competence. Bentley and Ellison (2007) utilized a service-learning framework to provide an international experience with senior-level baccalaureate nursing students. The students enrolled in an elective nursing course, which included didactic content and field experience prior to an eight-day trip to Ecuador. The Inventory for Assessing the Process for Cultural Competence Among Healthcare Professionals-Revised 2002 (Campinha-Bacote, 2003) was used to evaluate cultural competence before and after the trip. Results indicated that all students increased their cultural competency scores, although sample size was not reported. An exploratory, descriptive study to identify key experiences of students and faculty following a service-learning experience to Guatemala (Walsh & DeJoseph, 2003) was conducted with 10 students and two faculty. Findings indicate that students and faculty increased their awareness of the global community. Amerson (2010) conducted a quantitative study using the Transcultural Self-Efficacy Tool by Jeffries (2006) and found a statistically significant increase in pre- and post-test self-efficacy strength scores for students who had taken part in a medical mission to Guatemala.

Researchers have attempted to evaluate the long-term effects of international experiences as well. Students at George Mason University travel to Nicaragua each year. Following six years of the international trips, faculty collected qualitative data from 12 students in order to document the effects of the experience on their personal and professional lives (Kollar & Ailinger, 2002). The researchers report substantive knowledge, preceptual knowledge, personal growth, and interpersonal communication as a result of the experience. A descriptive, qualitative study was conducted with six former baccalaureate students who had taken part in an international trip to Guatemala over spring break (Evanson & Zust, 2006). Most of the themes reported changes in affective learning with increased cultural awareness and advocacy. A modified grounded theory study was completed using focus groups with nine participants (Ryan, Twibell, Brigham, & Bennett, 2000) who had previously taken part in immersion experiences. Outcomes of the experience included changed values, increased communication skills, personal and professional growth. Findings from

these studies suggest that international experiences have a positive effect.

Other health-related disciplines have begun to explore the use of international service-learning as part of their curriculum to increase cultural competence. While medical students are encouraged to engage in international health care experiences, usually in the form of international clinical electives; only limited information is found in the literature related to international service-learning (Pechak & Thompson, 2009). In a phenomenological study with three medical students, Dharamsi et al. (2010) found an increased awareness of marginalization and the social determinants of health following international service-learning experiences. Martinez-Mier, Soto-Rojas, Stelzner, Lorant, Riner, & Yoder (2011) reported how international service-learning was incorporated into a dental school program. A program evaluation was conducted using questionnaires with students and faculty, in conjunction with experiential learning journals. Findings from the study indicated that most students benefitted by recognizing the impact of values and belief systems on healthcare access and making improvements in cross-cultural communication. According to Pechak and Thompson (2009), physical therapist education programs are using international service-learning. Unfortunately, few studies have been published. Pechak and Thompson (2009) did conduct a study to explore the frequency of physical therapist programs which use international service-learning, the differences between programs which choose to use international service-learning and those that do not, and the faculty perceptions of barriers and benefits to the use. Their study did not address student outcomes. Based on a review of the literature, nursing is currently leading other health disciplines in publishing the outcomes of international service-learning.

Clearly, nurse educators are providing research-based evidence that international study is important for increasing cultural awareness and sensitivity for nursing students. While much of the published studies have focused on nursing students, the basic premises can be applied to any service discipline. More research is needed to link specific educational strategies with clinical practice. Studies need to be conducted with specific pedagogies to determine their effectiveness in developing cultural competence. It is important that educators clearly identify the type of experiences that students engage in during international programs. It is apparent from the earlier research that students are gaining affective learning, however practical and cognitive learning appear limited. The process of cultural competence indicates that cultural knowledge and practical skills are important for providing culturally congruent care (Campinha-Bacote, 2003); thus it is critical to evaluate outcomes beyond just

raising awareness and increasing sensitivity. Learning outcomes for developing cultural competence need to be translated into improved patient care. Currently, only minimal research exists to explain what influence previous international service-learning has on nursing graduates as they start their careers and begin working with patients. It is this gap in the literature that provides the basis for the following research study.

### **Description of International Service-Learning Experiences**

Over a three-year period, 22 students took part in international service-learning as part of a senior level community health nursing course. Students applied to be part of the international experience. The application process required students to write a short essay explaining why they wanted to take part in the project and what they hoped to benefit from the experience, to have at least an overall 3.0 grade point average, to have two letters of recommendation, and to meet the financial obligations for the travel. Prior knowledge or experience with Spanish was helpful, but not required. Several faculty members reviewed the application materials and selected the eligible students.

Preparation for the international project began early in the semester several months prior to the trip. The faculty member leading the trip met with the selected students each week to orient them to the process of service-learning, teach medical Spanish phrases which would be necessary during the trip, introduce the culture of the host country, and assist/direct the students with collecting epidemiological data pertinent to the country of destination. In 2006 and 2007, students traveled to Guatemala. In 2008, students traveled to Ecuador.

Each year, the faculty member and the selected students traveled with a non-profit, non-denominational, Christian-oriented organization to the host country to provide medical care in rural villages. Although the organization was Christian-oriented, students were not required to be of Christian faith to participate. Devotions and prayer were common activities among the teams, yet students were not required to participate – only to demonstrate respect for the values and beliefs of others that may differ from their own belief systems. For example, if a student chose not to participate in prayer, then the student was expected to maintain a moment of silence while other team members prayed. Nursing as a profession is expected to provide care and demonstrate respect for patients from a wide variety of religious faiths, including faiths that differ from the nurse's own faith.

During each international experience, students worked with a multidisciplinary team of physicians,

nurse practitioners, dentists, nurses, and lay people to provide acute care to the indigenous people in Guatemala or Ecuador. Daily activities included setting up a make-shift clinic in a rural village, assisting physicians and nurse practitioners with medical procedures, preparing and dispensing medications in pharmacy, administering de-worming medications and vitamins, conducting home visits with physicians, conducting triage to direct the flow of care, and providing education on dental care and hygiene. Each clinic day consisted of approximately 12 hours of work with 300-500 people seen for medical services. While interpreters were available, students could not rely on having an interpreter for all communication with each patient. Students needed to have rudimentary Spanish skills to communicate directions for medications and patient teaching. Since students had varying levels of Spanish proficiency, they worked with their peers and other team members to learn the basic phrases they would need to provide care during the clinic day. The daily experiences provided opportunities for the students to recognize common health problems, practice communication in Spanish, observe the environmental issues which impacted health, and witness the impact of severe poverty in lesser-developed countries. The last day of each international experience was spent sightseeing and visiting local markets.

Reflection is an essential component of service-learning. The process of reflection began with the first meetings as students prepared for the experience. The faculty member facilitated discussions about what students would expect to see and experience during the trip. Each student was required to maintain a written journal for reflection with entries before, during, and after the international project. Key informant interviews and in-depth cultural assessments conducted prior to and during the trip allowed the students to work with leaders from the communities and adapt their teaching interventions to the needs of the unique communities. Reflecting on these interviews allowed students to recognize the value of working with the community to identify culturally appropriate interventions. Each day while in-country, the faculty member led discussions with the students to explore their perceptions or the issues encountered during their daily routine. Upon return to the United States, each group of students worked collaboratively to develop a project binder which outlined their international project. This binder included details of their host country, epidemiological statistics, samples of teaching materials, outlines of key informant interviews, benefits and weaknesses of their planned interventions, and pictures from the trip. In addition, students developed a poster presentation, which they presented at a local research forum.

## Method

### Research Design

This qualitative, explanatory case study sought to explain how participation in an international service-learning project during a community health course influenced transcultural self-efficacy of baccalaureate nursing students following graduation and their subsequent clinical practice as registered nurses. A case-study is “an in-depth exploration of a bounded system based on extensive data collection” (Creswell, 2002, p. 485). Explanatory case studies attempt to explain causal relationships by identifying data which have an influence on the cause-effect relationship (Yin, 1993). In addition, this study may be considered a collective case study since it uses multiple cases to provide insight into a group activity (Creswell, 1998). The bounded system for this study involved 22 students who had participated in an international service-learning experience while enrolled in a community health nursing course within the last three years.

Approval for the exempt research study was obtained through the university Institutional Review Board prior to implementation. Telephone interviews were conducted with 14 students. The telephone interviews were semi-structured with several demographic questions and five open-ended questions. Duration of the interviews averaged 20-30 minutes. Interviews should be short, usually about 30 minutes, (Creswell, 1998; Novick, 2008) and consist of five to six open-ended questions (Creswell, 1998). Research (Novick, 2008; Opdenakker, 2006) indicates that telephone interviews are equally as effective as face-to-face interviews.

Semi-structured questions and a telephone script were developed. In order to evaluate the appropriateness of the questions, for both content and time requirements, the sample questions were sent to a nurse educator with extensive transcultural expertise for feedback. Additionally, the questions were piloted with two nursing faculty who had recently taken students to Ecuador and one student who had taken part in a similar trip to Ecuador. All pilot interviews were completed within the allotted 30 minute timeframe.

### Sample

Between 2006 and 2008, a total of 22 (21 females and one male) senior-level baccalaureate nursing students participated in a medical mission trip to Guatemala or Ecuador over spring-break week. All students were enrolled in a public university and seeking their first undergraduate degree. No student was greater than 24 years of age at the time of the trips. The investigator used Facebook, an internet social

networking program, to locate 18 of the 22 nursing graduates (Amerson, 2011). One nursing graduate was located through the university alumni association. Five graduates chose not to participate in the study. Three graduates could not be located. All the nursing graduates who participated in the study had been employed or volunteering in a nursing role since graduation. Nursing experience varied from one to three years depending on the year of graduation.

Graduates who were located via Facebook were asked to send their current email addresses to the investigator. Once graduates responded to the investigator through a private email account; the investigator sent the invitation to participate and an information sheet describing the study, risks, benefits of the study, and issues of informed consent. If the graduates were willing to participate, they returned an email to the investigator with a phone number and a convenient time for the interview. All participants used cell phones with unlimited minutes during the interviews, so no cost was incurred for them. One graduate living outside the United States participated in the interviews, but only the investigator incurred costs for the international call.

### Data Analysis

Each telephone interview was recorded and converted to a ".wav" audio format for transcription. Each interview was transcribed verbatim and verified with the audio recording to ensure accuracy. Field notes were completed starting with the initial data collection and continued through the data analysis phase along with extensive memoing to document the process; thereby creating an audit trail. Constant comparison began with the first interview and continued through the analysis phase. Multiple data sources included public documents (newsletters, newspapers, university-sponsored magazines), which documented the activities and reflections of participants following the international trips. These additional sources were analyzed and compared with transcripts for other potential codes. Initial codes were identified in the transcripts and documents, and eventually moved to a visual grid to facilitate clustering. After codes were clustered, they were collapsed in order to demonstrate evidence of specific themes and subthemes.

Creswell (1998) refers to verification to differentiate between qualitative and quantitative research. Qualitative researchers should engage in at least two verification procedures. This researcher used triangulation between multiple sources of data to corroborate evidence (audio recordings, typed transcripts, field notes, various public documents), clarified researcher bias at the onset of the study in field notes, performed member checks, and sought peer

review with an expert in transcultural nursing. Additional procedures which added rigour to the study involved the use of an audit trail and extensive memoing. Credibility was maintained through verbatim transcripts of interviews. Confirmability was established through member checking.

### Results

The qualitative evidence was derived from the use of a constant comparative analysis of the data. According to Hewitt-Taylor (2001), the constant comparative analysis method begins with initial coding from the first case document. With the first reading of the case document or interview, codes were established for words, phrases, or sentences that addressed the research questions. Codes were established for each subsequent case and continuously compared with codes from previous cases. Once all of the study documents were coded, the codes were then clustered according to their similar elements. Clusters of codes were then used to develop the major themes and subthemes. As suggested by Creswell (2002), the major themes and subthemes were identified through a process of eliminating redundancies and codes that could not be categorized. In qualitative research, themes may be developed from the data, rather than literature-based sources, to establish a new understanding of individual perceptions (Hewitt-Taylor, 2001). Once themes were identified, they were categorized based on Jeffrey's CCC Model for learning dimensions of cultural competence. Themes were categorized according to cognitive, practical, or affective.

The following themes and subthemes provide evidence of the outcomes of international service-learning according to the learning dimensions of cultural competence. For readers interested in reviewing the frequency of data and specific codes, a supplemental file is available in the researcher's dissertation (Amerson, 2009). The exemplars are meant only to provide emphasis for each theme; therefore they are not exhaustive of the data collected in this qualitative study.

### Cognitive Theme

**Cognitive learning gained regarding family function and structure, diet practices, and health beliefs of specific ethnic groups.** Family function involves the affection within a family, socialization patterns, and health care beliefs and values. Family structure involves communication patterns, power structure, role structure, and family values (Friedman, Bowden, & Jones, 2003). Graduates discussed recognizing that Hispanic patients expressed pain differently than whites or African American patients.

Ethnic foods played an important role in the care of the patients. Many Hispanic families preferred to bring their food from home to the hospitalized patient. Observing diet practices, while in Guatemala and Ecuador, helped the nursing graduates to understand the value of bringing food from home rather than eating in the cafeteria for many Hispanic families. Many graduates spoke of the Hispanic families being family-oriented with the male in the family as being the leader of the family. Natural herbs are important in the health practices of the families they cared for in their nursing practice. They also recognized the need to incorporate the family into the plan of care. Participants spoke of experiences with communication with the decision-maker in the family. One graduate spoke of a situation where a drowning victim was brought to the intensive care unit:

We were doing everything we could to keep him alive. . . . “Is this what you want?” She’s (mother) like, “No, absolutely not. He’s already gone. We need to give him respect and not keep this on.” Whereas in the emergency department, if they had just talked to the mother, the right person in the family hierarchy, he wouldn’t even have been coded and brought to the unit. They would have just let him go peacefully, naturally, and wouldn’t have put them (family) through the trauma . . .

Cognitive knowledge learned during international experiences plays an important role in understanding family dynamics and health care practices when caring for Hispanic patients and their families in the United States (US) healthcare system.

### Practical Theme

**Practical learning resulted in improved communication skills.** Two subthemes emerged from the interviews: Spanish skills and working with interpreters. Improved communication skills focused on learning and improving Spanish skills. Most students who took part in the international trips had taken several high school or college Spanish courses. They indicated that being immersed in the culture where they were required to communicate in Spanish provided confidence that they had not attained during previous Spanish classes. Graduates expressed that working with the indigenous populations of Guatemala and Ecuador allowed them to practice their medical terminology, interview techniques, and patient teaching in Spanish. These previous experiences now allow them to communicate with patients about pain issues, patient teaching topics, and through alternative forms of communication such as touch, a smile, or simple sign language with gestures. One graduate expressed the following:

I mean I’ve had Spanish classes before; but by the third day of being in Ecuador all of a sudden I could really communicate with these people using my chopped up Spanish, but I was able to actually communicate with them through the little bit of Spanish I knew . . .

In their current practice, having knowledge of Spanish helped with patients with limited English who were attempting to communicate in English.

Knowing kind of how they form sentences in Spanish, and understanding that and the pronunciation a little bit has helped me even a little in understanding the English that some of my Hispanic patients have tried to speak to me.

Graduates spoke of the value of learning to work with interpreters. Many graduates currently work in hospitals where they must rely on their own communication skills with non-English-speaking patients until an interpreter arrives on the unit.

### Affective Themes

**Affective learning resulted in increased awareness, appreciation, and recognition.** Three subthemes emerged: (1) awareness (opened my eyes), (2) understanding leads to appreciation, and (3) recognition (privilege).

**Awareness (opened my eyes).** In eight out of 14 interviews, graduates used the phrase “opened my eyes” or some minor variation of the phrase. They expressed being more open and flexible to accepting people for who they are. Awareness also meant being aware of how people communicate needs differently. Graduates are now aware that each culture expects something (different) from their healthcare. One graduate expressed it in this manner:

Before going on the trip, you just have the feeling of your way is the right way because you’ve been doing it for so long, but (now) you’re able to understand why other people have the attitude that they do. This made me a more open-minded person.

Another comment expanded on this subtheme of being open.

I’m just more open to asking them. “Do you prefer me to do it this way or do you want me to do it that way?” You could do everything your way and totally make someone completely uncomfortable or just straight up and ask them what they like and how they prefer to get it done.

**Understanding leads to appreciation.** Graduates indicated a change in their attitudes and an appreciation for Hispanic culture. One graduate commented, “I get excited when I have a Hispanic family.” Many expressed respect and were interested to learn more about the culture. They had begun the process of seeing the patient in a different light. One person expressed it as “to fit their needs versus making them fit your mold.” They were more aware of spiritual, cultural, and food preferences. Valuing culture has the potential to lead to a trusting relationship as the following graduate explains:

. . . culture is kind of like their whole life. And so if you treat them like that doesn't matter and like you don't care about it, and you don't care about learning about it, then why are they going to think you care about them and that you want to help take care of them? Then why should they trust you?

**Recognition (privilege).** Graduates recognized privilege from new perspectives. They saw the privileges that they experienced as Americans, yet they also saw how the recipients of health care in Guatemala and Ecuador recognized health care itself as a privilege: “It's a totally different perspective on how you view . . . to us, it's a hassle to go to a doctor and to them it's a privilege.” Several students spoke of feeling as if they had been living in a box or a bubble in the United States before going to Ecuador or Guatemala.

Before I went over there, I think I lived in a box, and I didn't realize what else was out there. So it really was an eye-opener for me. And, you know, you come back to America and you're, like, boy, we are so selfish, we are so blessed and we have everything . . . They are so grateful and thankful for what little things we offer them while we were there.

Additional themes emerged which do not neatly fit into the categories of cognitive, practical, or affective.

**Seeing makes it real.** Graduates repeatedly emphasized the value of “seeing” aspects of a different culture. Seeing the people, the environment, the poverty, the religious practices, the diet, and the lack of health care resources made a huge impact. Prior to each trip, all participants had engaged in lectures, reading assignments, and conversations about the country and regions where they would be traveling. They had heard about the poverty and been prepared for the type of living conditions that they would encounter, but seeing for themselves made it real: “We learn it in textbooks, but to actually see it in practice is different.” Another graduate expressed a change in attitude on social issues being faced in the US as a result of going there.

I think overall in America there is . . . not across the board, but for the most part I would say a lot of people who are frustrated. I think it comes by the influx of the Hispanic population. But I think going there kind of gives you a new perspective and appreciation . . .

Although graduates commonly used the word “seeing,” their use of “seeing” did not seem to imply that only observation was important. Interaction with people was an important part of “seeing.”

It was beneficial for me to actually go and physically see and be able to talk to people about their specific beliefs on health care and to be able to see and witness the gender roles and the families and the communities. It was immensely more helpful than just learning in class, to actually be able to go and see that.

**Culturally congruent care.** Graduates provided numerous examples of providing cultural congruent care in their current nursing practice. They are able to communicate with Hispanic patients in the patient's native language, dependent on the graduate's experience and knowledge of the Spanish language. Overall, graduates feel that their confidence and proficiency with Spanish has improved as a result of the international experience. Graduates are able to recognize different responses to pain with Hispanic patients. They recalled how stoic the people of Guatemala and Ecuador had been in their tolerance of pain. Now, the graduates observe similar stoic responses to pain and encourage Hispanic clients to ask for and accept pain medication after surgery. Patient teaching techniques are adapted based on communication patterns. Graduates recognize that silence does not equate to agreement. During the patient teaching process, Hispanic women may not ask questions and only nod “yes” to instructions. Greater value is placed on the need to follow-up instructions with clarifying questions and to ask for return demonstrations. Interpreters are used to provide in-depth instructions if the patient or family has limited English skills. The three modes of culturally-based action and decision-making (preservation, accommodation, and restructuring) (Leininger & McFarland, 2006) are utilized during practice. Preservation allows natural herbs and teas to be included in the plan of care. Accommodation allows nurses to adapt hospital routines to fit with specific cultural values. Restructuring health care practices through education allows nurses to facilitate changes in family care for better health outcomes. One graduate recalled an experience which demonstrates a changed perspective on the need to provide culturally congruent care.

Actually, when I first started my job, we have a long list of admission questions, and one of the

things is cultural and spiritual and ethnic requests . . . it was not too long after we'd gotten back from Ecuador. I remember thinking, these people really might have something to fill this place. This isn't just a question just to be nice. These people really might have specific food requests or prayer rituals, or whatever they would like for us to recognize.

**Commitment to international service (stepping stone).** Overwhelmingly, graduates expressed desire to participate in international service in the future. All participants indicated that they planned to take part in another international medical mission at some point in their life. One graduate explained it in these terms:

It really just served as a stepping stone. I don't think if I had not gone in nursing school, I don't know if I would have gone after college or not. I don't know if I would have made time into my schedule after starting work or not. But now, I make time because I know what an incredible opportunity it is to serve . . .

Of the 14 graduates interviewed, three had already participated in trips to Peru and Honduras since graduation. Two more graduates had applied for trips to be taken in the next year. The remaining graduates commented that work, financial, and family obligations prevented them from taking part in international missions at the present. Several of the graduates had already returned to school to pursue further degrees, but planned to participate in trips following graduation.

### Discussion

The findings from this study suggest that service-learning is an effective strategy for teaching cultural competence. Several of the themes and subthemes are consistent with the benefits of service-learning. In addition, the findings from this study are consistent with previous studies on international or immersion experiences with nursing graduates. *Seeing makes it real* is consistent with the experiential nature of service-learning (Nokes et al., 2005). Participants felt that experiential learning in communities was more beneficial than classroom experience (Evanson & Zust, 2006; Haloburdo & Thompson, 1998; St Clair & McKenry, 1999). Experiential learning also involved improved communication skills (Ryan et al., 2000) by learning a second language (Kollar & Ailinger, 2002) and using alternative forms of communication (Haloburdo & Thompson, 1998).

Service-learning promotes social growth (Duckenfield & Swanson, 1992). The affective subthemes of *awareness (opened my eyes)*, *understanding leads to appreciation*, and *recognition*

*(privilege)* support this increase of social skills. Graduates' awareness of poverty and the lack of resources in these lesser-developed countries were heightened by the international experience (Grusky, 2000; Walsh & DeJoseph, 2003). Witnessing the poverty made graduates feel blessed with so much in the US (Evanson & Zust, 2006). They developed an increased awareness of cultural values and being open to interactions with diverse cultures (Evanson & Zust, 2006; Kollar & Ailinger, 2002) in order to relate to an increasingly global society.

*Culturally congruent care* is an outcome of international education experiences (Ryan et al., 2000). In order for graduates to provide culturally congruent care, they must be provided with opportunities that promote cognitive, practical, and affective learning dimensions. The findings from this study indicate that graduates did benefit from learning in all three dimensions. Following graduation, they were able to take those learning experiences and apply them to clinical practice to provide culturally congruent care. All graduates indicated they felt a desire to continue with international service during their career. This construct of desire is consistent with the Process of Cultural Competence as developed by Campinha-Bacote (2003).

Cultural encounter is also a construct associated with the Process of Cultural Competence (Campinha-Bacote, 2003). Clearly, the experiential learning during the international experience provided opportunities for cultural encounters. Based on the findings, all three learning dimensions were directly influenced by encounters. Cultural encounters play a major role in moving along the continuum toward cultural competence (Campinha-Bacote, 2003).

### Limitations

Having a pre-established framework for the learning dimensions of cultural competence may be viewed by some as a limitation of this qualitative study. The Jeffreys' CCC Model has previously been applied and evaluated based on quantitative measures with the Transcultural Self-Efficacy Tool (Jeffreys, 2000). Qualitative studies may be used to strengthen content validity of a scale (Lo-Biondo-Wood & Haber, 2002). At this time, this study represents one of the first studies to use a qualitative method to assess the learning dimensions of cultural competence. While the researcher did categorize themes based on the learning dimensions of cultural competence, the researcher remained open to potential disconfirming data.

While the literature indicates that telephone interviews are just as effective as face-to-face interviews, the limited time for interviews (20-30 minutes) as suggested by the literature did have an



impact on the ability of the researcher to explore in-depth certain data points which did not emerge in all interviews. Although Creswell (1998) suggests that three to five cases are sufficient for a collective case study, this researcher completed as many interviews as possible in an attempt to confirm information.

### Implications for Higher Education

International or immersion experiences for students can benefit from a service-learning framework to organize the learning experience. Students should be prepared with knowledge about the social and political influences of the country, the environment, the native language, and current state of health prior to the trip. While in-country, students should be provided opportunities to work directly with the indigenous people. Exposure to as many variables of daily life as possible will provide the experiential learning to influence the learning dimensions of cultural competence. Classroom or textbook learning will only provide limited knowledge and self-efficacy. Encounters or interactions are crucial to increasing transcultural self-efficacy.

### Conclusion

International service-learning provides opportunities for cultural encounters which influence the learning dimensions of cultural competence. These cultural encounters allow practice in applying transcultural knowledge with actual people in a real-life context. Students may learn numerous details about diverse ethnic groups in the classroom, but transcultural self-efficacy will only be truly increased when the student has a chance to practice these skills. Nursing has a long history of using experiential learning and has taken didactic learning from the classroom and applied it to the bedside. Learning strategies for cultural competence are no different. Students must take their knowledge of diverse cultures to the bedside or the community and apply it through direct patient interactions. It is hard to become aware of differences when the person the nurse is caring for looks just like the nurse. For service-learning to be most effective in developing cultural competence, the family or community needs to be different from the student. International service-learning provides a window to a new world with new people, different perspectives, and unique lifestyle practices.

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