



THE LIVED EXPERIENCE OF MINORITY NURSING FACULTY: A PHENOMENOLOGICAL STUDY

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The lived experience of full-time nursing faculty has recently been detailed. However, similar information is not available about minority nursing faculty. The purpose is to explore the lived experience of minority nursing faculty. The design is a phenomenological study. Five female faculty with 8 to 13 years of experience in a full-time position shared experiences through face-to-face interviews. A simplified version of Hycner's five-step explication process was used for interpretation and data analysis. Six themes emerged—missing mentorship, lack of collegial support, harnessing external support, acculturation, feeling isolated, and I feel more like a minority here. Minority nursing faculty face challenges similar to minority faculty in other disciplines in higher institutions. However, acculturation has not been discussed in phenomenological studies of similar populations. These findings have bearings on strategies for increasing minority nursing faculty and assessing mentoring practices in nursing programs. (Index words: Nursing faculty; Nursing education; Mentors; Acculturation; Qualitative research) *J Prof Nurs* 32:107–114, 2016. © 2016 Elsevier Inc. All rights reserved.

NATIONAL COUNCIL OF State Boards of Nursing data show that nursing faculty in the United States (US) are 87% Caucasian (Budden, Zhong, Moulton, & Cimiotti, 2013). The underrepresentation of minority-race nursing faculty portends a shortage of role models for minority students, which can undermine the efforts of the American Association of Colleges of Nursing to increase minority enrollment in nursing education programs (American Association of Colleges of Nursing, 2008). There is a need to recruit and retain minority faculty in order to promote race-concordant mentoring of minority students who desire such experiences.

Academe has a unique culture that is not easily changed, a set of unspoken and unwritten beliefs and assumptions that guide individual and collective behavior (Trower & Chait, 2002). The existence of a dominant culture within a group of faculty members challenges minority members to adapt in one of several ways in order to maintain individual accomplishment or achieve group collaboration (Cuyjet, 2008).

The literature on minority nursing faculty has hitherto focused on their distribution across the US and recommended strategies for their recruitment and retention (Godfrey, 2005; Stanley, Capers, & Berlin, 2007). This study explores the experience of minority nursing faculty in the context of higher education faculty culture.

Theoretical Framework

The LaFromboise model of bicultural competence focuses on the cognitive and effective processes that allow individuals to withstand acculturative stress (LaFromboise, Coleman, & Gerton, 1993). The foundation for this framework is the alternation model of second-culture acquisition, which assumes that it is possible for an individual to know and understand two different cultures. Alternation is the ability to function effectively in another culture while still maintaining the original culture, such that the individual alternates as necessary between the original and newly acquired culture. It is a valuable strength for a minority faculty member who can thereby exercise all aspects of his or her cultural identity and enhance mentorship for mentees of diverse racial or cultural backgrounds.

Achievement of bicultural competence is based on development in six dimensions: knowledge of cultural beliefs and values, positive attitudes toward minority and majority groups, bicultural efficacy, communication ability,

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role repertoire, and a sense of being grounded (LaFromboise et al., 1993). In order to achieve this, an individual needs to accept each culture's world view and develop an ability to act within that context when interacting with members of that culture. When the values of both cultures conflict, the individual may internalize the conflict in order to find resolution or fuse both cultures to reduce stress.

Holding *positive attitudes toward both majority and minority cultures* is based on the assumption that the individual recognizes bicultural competence as a desirable goal and holds each culture in positive, even if not equal, regard (LaFromboise et al., 1993). Contact with the culture is a necessary tool to develop positive feeling toward it; this is influenced by the type and length of contact. Information from other persons of one's own culture that have succeeded in dual socialization can prove invaluable.

Bicultural efficacy is the confidence that one can live effectively in a satisfying manner within two groups without compromising one's cultural identity (LaFromboise et al., 1993). Having this belief will support an individual through the challenges of developing and maintaining effective support groups in both minority and majority cultures and enable one to persevere in times of rejection from one or both cultures.

Communication ability refers to the effectiveness of an individual in communicating ideas and feelings to members of a given culture, both verbal and nonverbal; language competency may be a major building block of bicultural competence. According to LaFromboise et al. (1993), *role repertoire* refers to the range of culturally or situationally appropriate behaviors an individual has developed; the greater this range becomes, the higher the level of cultural competence attained. A *sense of being grounded* comes from the establishment of stable social networks in both cultures; it enhances an individual's ability to cope with the pressures of living in a bicultural environment. One must have skill to recruit and use external support systems in order to be culturally competent.

In addition, the model of cultural competence in health care delivery (Campinha-Bacote, 1999, 2002) posits that there is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive services. Cultural competence is thus a process, not an endpoint, in which the nurse continuously seeks the ability to work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background (Campinha-Bacote, 2002). Five constructs the nurse has to assimilate to become culturally competent are cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire.

Cultural awareness is a process whereby the health practitioner conducts a self-search and an in-depth exploration of one's own feelings and biases toward other cultures (Campinha-Bacote, 2002). It also includes awareness of one's cultural and professional background. Cultural knowledge is attained when the health care professional seeks and obtains sound information regarding variations of culture (Campinha-Bacote, 2002).

Cultural skill is the ability to conduct a cultural assessment; a cultural encounter occurs when there is encouragement to directly engage in face-to-face cultural interactions and other types of encounters with people from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

Cultural desire assesses the motivation of the health care professional to engage in the process of becoming culturally aware (Campinha-Bacote, 2002). When all these processes are completed, the individual would become culturally competent to function appropriately in a different culture. Nursing faculty are in a central position to influence health care because they become culturally competent themselves; nurses taught by such faculty will be empowered to work optimally with patients of diverse cultural backgrounds.

These conceptual frameworks share some descriptors of the process of achieving cultural competence. For instance, "knowledge of cultural beliefs and values" (LaFromboise et al., 1993) equates to "cultural knowledge" (Campinha-Bacote, 2002), and cultural desire (Campinha-Bacote, 2002) is founded on a positive attitude about that culture (LaFromboise et al., 1993).

Literature Review

Johnsrud and Sadao (1998) used phenomenology to explore day-to-day experiences of minority faculty members with their colleagues, department heads, and deans. The 22 participants represented 16 minorities (i.e., Japanese, Chinese, Korean, Hawaiian, Filipino, Black, Hispanic, Native American, and Pacific Islander). Three distinct but related experiences emerged as common across ethnic and racial minority groups: (a) the bicultural stance minority faculty are likely to cultivate, (b) the ethnocentrism they perceive on the part of White administrators and faculty, and (c) the discriminatory behavior they experience as minorities. The participants described a sense of "otherness," a difference they found stressful and draining. Minority faculty were likely to cultivate biculturalism but perceived that majority faculty had low desire to do likewise. Although this study was conducted at a university where 31% of the faculty—and 76% of the students—are of minority race, minority faculty perceived that they experienced the academy differently than their White counterparts.

Turner (2002) interviewed four Asian Pacific American, 15 African American, four Native American, and eight Latino tenured female faculty at unnamed colleges. Themes identified in this phenomenology study include feeling isolated and underrespected; salience of race over gender; being underemployed and overused by departments and/or institutions; being torn between family, community, and career; being challenged by students; and having a sense of accomplishment (Turner, 2002). Many respondents felt a need to leave their perceived identities at the doorstep of the tenure process.

A nationwide mixed methods study of 41 African American counselor educators revealed that, regardless of

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