

An Investigation of the Relationship between Nursing Faculty Attitudes toward Culturally  
Diverse Patients and Transcultural Self-Efficacy

by

Emma Kontzamanis

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy, The City University of New York

2013

© 2013

Emma Kontzamanis

All Rights Reserved

This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction  
of the dissertation requirement of the degree of PhD

---

Date

---

Keville Frederickson  
Chair of Examining Committee

---

Date

---

Keville Frederickson  
Executive Officer

Kathleen Nokes

Donna Nickitas

Marilyn Jaffe-Ruiz

Kevin Nadal

Supervision Committee

THE CITY UNIVERSTIY OF NEW YORK

---

(Keville Frederickson, Sponsor)

---

Date

## Abstract

### An Investigation of the Relationship between Nursing Faculty Attitudes toward Culturally Diverse Patients and Transcultural Self-Efficacy

by

Emma Kontzamanis

Advisor: Professor Keville Frederickson

This descriptive study was designed to examine the relationship between nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy (perceived confidence in performing transcultural nursing skills). Nursing faculty are the educators of the largest group of health care providers. As such, they can have the greatest impact on student development of cultural competence and the provision of culturally competent care which promotes positive patient health outcomes.

It was hypothesized that there would be a significant relationship between the variables of attitude toward culturally diverse patients and transcultural self-efficacy. The Cultural Attitude Scale (CAS), the Transcultural Self-Efficacy Tool (TSET), the Social Desirability Scale and a demographic information sheet were completed by a sample of nursing faculty (N=65) from a large northeastern public college system. Psychometric evaluation of each vignette of the CAS, subscales of the TSET and the Social Desirability Scale indicated instrument reliability for the sample. Several significant findings were that older, longer licensed faculty had a more positive attitude toward the White and Asian patient and faculty who received their basic nursing education in the United States had a more negative attitude toward the Black patient. A decline in the means of total CAS scores over the last 20 years indicated a more negative attitude toward culturally diverse patients. There was no difference in TSET scores for faculty with formal

and/or informal education in transcultural nursing and those with no formal or informal education in transcultural nursing. Recommendations for future research include investigating the variables separately, conducting qualitative studies with faculty, and instrument refinement and development.

## Acknowledgements

My doctoral journey has provided me with professional and personal insights that have transformed me. I am grateful to the faculty, friends, and colleagues who have supported and encouraged me throughout the process. Words are inadequate to express my deepest appreciation to Dr. Keville Frederickson. Her tireless efforts and faith in me gave me the courage to accomplish this milestone. Dr. Marianne Jeffreys gave so generously of her time and experience to ensure I was knowledgeable in my area of study. Thank you. To my dissertation committee members, Dr. Kathleen Nokes, Dr. Donna Nickitas, Dr. Marilyn Jaffe-Ruiz, and Dr. Kevin Nadal, I am honored and humbled to have had your support and interest in my work. Thank you to the faculty in the program. Your knowledge and guidance have provided the foundation for my future work. To my dearest friends, Susann Farraye, Carol Nuzzo and Alsacia Pasci, thank you for your patience and understanding. To my colleagues at New York City College of Technology, St. Francis College, and Jewish Guild Healthcare, thank you for your respect and support. Lastly, I would like to thank my parents, James and Angelina, and my grandparents, Emma, Louis, Madeline, and Jerry, who realized the importance of education. I am grateful that I could fulfill their dream.

## **Dedication**

This dissertation is dedicated to my wonderful sons, Peter and Andrew, who I am so proud of and who inspire me to be the best I can be.

## Table of Contents

Abstract.....	iv
Acknowledgements.....	vi
Dedication.....	vii
Chapter I: The Problem.....	1
Need for the Study.....	2
Statement of the Problem.....	3
Definition of Terms.....	4
Significance.....	4
Summary.....	8
Chapter II: Review of the Literature.....	9
Attitude and Cultural Diversity .....	9
Transcultural Self-Efficacy.....	12
Theoretical Rationale.....	13
Hypothesis.....	15
Summary.....	15
Chapter III: Method.....	16
Sample.....	16
Instruments.....	18
Cultural Attitude Scale.....	18
Transcultural Self-Efficacy Tool.....	20
Social Desirability Scale.....	22
Protection of Human Subjects.....	23

Data Collection Procedures.....	23
Data Analysis.....	24
Summary.....	25
Chapter IV: The Results.....	26
Description of Sample.....	26
Instrument Reliability.....	30
Cultural Attitude Scale.....	30
Transcultural Self-Efficacy Tool.....	32
Social Desirability Scale.....	32
Data Distribution.....	33
Relationship of the Cultural Attitudes Scale Factor Scores and Total Scores.....	34
Relationship of the Cultural Attitude Scale, the Transcultural Self- Efficacy Tool and Background Variables...	36
Hypothesis Tests.....	45
Summary.....	47
Chapter V: Discussion.....	49
Research Hypothesis.....	50
Ancillary Findings.....	50
Cultural Attitude Scale.....	50
Transcultural Self-Efficacy Tool.....	52
Social Desirability Scale.....	53
Theoretical Framework.....	53

Summary.....	55
Chapter VI: Conclusion, Implications, and Recommendations....	56
Conclusion.....	57
Implications for Nursing Education.....	58
Implications for Nursing Research.....	59
Recommendations for Future Research.....	60
Study Limitations.....	60
Appendices.....	63
References.....	75

## List of Tables

4.1: General Sample Characteristics.....	27
4.2: General Nursing Characteristics.....	29
4.3: Nursing Faculty Characteristics.....	30
4.4: Descriptive and Reliability Statistics for 34-item Cultural Attitude Scale (CAS).....	31
4.5: Factor Score Descriptive and Reliability Statistics for Four Cultural Groups of CAS.....	31
4.6: Descriptive and Reliability Statistics for the Transcultural Self-Efficacy Tool (TSET).....	32
4.7: Descriptive and Reliability Statistics for the Social Desirability Scale.....	33
4.8: Skew and Kurtosis for CAS, TSET, and the Social Desirability Scale.....	34
4.9: Three Factor Score Means of Responses for the Four Cultural Groups on the 34-item CAS.....	35
4.10: Four Factor Score Means of Responses for the Four Cultural Groups on 20-item CAS.....	35
4.11: Differences on CAS and TSET by Type of Basic Nursing Program Attended.....	37
4.12: Differences on CAS and TSET by Country of Basic Nursing Program Attended...	38
4.13: Differences on CAS and TSET by Attending an Academic Course in Transcultural Nursing.....	39
4.14: Differences on CAS and TSET by Attending Continuing Education in Transcultural Nursing.....	40
4.15: Differences on CAS and TSET by Participant Ethnicity.....	41

4.16: Relationship between CAS and TSET and Continuing Education in Transcultural Nursing.....	42
4.17: Relationship between Formal or Informal Education and No Formal or Informal Education in Transcultural Nursing.....	43
4.18: Pearson Correlations of Participant Age and CAS and TSET.....	44
4.19: Pearson Correlations of Years Licensed as RN and CAS and TSET.....	45
4.20: Pearson Partial Correlations of TSET and CAS.....	46
4.21: Pearson Partial Correlations of Social Desirability Scale with TSET and CAS...	47
5.1: Comparison of CAS Total Score Means from 1993 to 2012.....	51
5.2: Comparison of TSET Subscale Mean Scores of Nurses, Recent Nurse Graduates (AD/BS), and Current Sample (AD Nursing Faculty).....	53

**Appendices**

A: Permission Responses for Instrument Use.....	63
B: Institutional Review Board Approval.....	67
C: Letter to Nursing Department Chairpersons.....	70
D: Letter to Participants (Consent Form).....	72

## **Chapter I**

### **The Problem**

Nursing faculty in the United States interact with students and patients from diverse cultural backgrounds. The effects of globalization are reflected in the diversity of populations in most parts of the world, each with their own values and beliefs about health and health care. The cultural diversity of patients in need of and receiving health care is further evidenced by the regulatory and accreditation standards in the United States that require health care organizations to provide information and care that respects patients' language, culture and ethnicity (The Joint Commission, 2010). Nursing programs in academic institutions are also required to provide education about caring for culturally diverse patients in a culturally competent way (Commission on Collegiate Education in Nursing (CCNE), 2009; National League for Nursing Accrediting Commission, Inc. (NLNAC), 2008). Nursing students, however, are taught by nursing faculty who may or may not be culturally competent (Jeffreys, 2006; Sealey, Burnett & Johnson, 2006). The educational interaction between faculty and student may be affected if faculty have ethnocentric beliefs about the superiority of Western health care practices and beliefs, minimize the significance of the diverse beliefs and practices of patients or have negative attitudes about cultural diversity. How these factors affect the faculty-student relationship may be a function of faculty attitudes toward culturally diverse patients and perceived confidence in their ability to perform transcultural nursing skills (transcultural self-efficacy). This study will investigate the relationship between nursing faculty attitudes towards culturally diverse patients and transcultural self-efficacy in the academic setting.

## **Need for the Study**

Culture plays an important part in all human interactions. One's perception of the world is influenced by culture. Nurse educators are in the unique position of teaching students how to provide culturally competent care while at the same time having to be culturally competent themselves. The literature on culturally competent faculty addresses racial and ethnic minorities and suggests continued faculty development programs on cultural competence and increasing faculty opportunities for cross cultural interaction (Sealey, 2003; Kossman, 2003). Davidhizar & Shearer (2005) propose several strategies for faculty to meet the needs of culturally diverse students. Individual student assessment, personalizing approaches, planning interventions and evaluating their effects are suggested as multidimensional approaches. Sanner, Wilson & Samson (2002) found international Nigerian nursing students experienced antagonistic faculty attitudes and difficulty integrating into the college community in the United States. The lack of role models for African American students and failure to connect with non-minority faculty were identified in the work of Mills-Wisneski (2005). Students from an Asian culture need faculty to have a working knowledge of their culture in order to respond in a culturally competent manner (Xu, Davidhizar & Giger, 2005).

Nursing program accrediting bodies have mandated the inclusion of cultural competence education in curricula (CCNE, 2010; NLNAC, 2010). However, most nursing faculty have not had formal cultural competence education which Jeffreys (2006) suggests is the most effective preparation for teaching cultural competence. Missing in the nursing literature is research on the factors that influence the development of faculty cultural competence.

The classic studies by Bonaparte (1977) and Jaffe-Ruiz (1981) on attitudes toward culturally different patients investigated ego-defensiveness and dogmatism of nurses and

intolerance of ambiguity, ethnocentrism (pervasive and rigid ingroup/outgroup distinction) and dogmatism of nursing faculty respectively. Bonaparte's (1979) findings suggested the need for further investigation of the impact of attitude in providing culturally competent care in the practice setting. The correlation between high ethnocentrism scores and negative attitudes towards culturally different patients found by Jaffe-Ruiz (1981) suggested that ethnocentric faculty may not teach about cultural differences or convey a positive attitude about culturally diverse patients when interacting with students. Recently, studies on the need for faculty development in teaching cultural competence are found in the literature (Canales & Bowers, 2001; Jeffreys, 2004; Kardong-Edgren, 2007; Kossman, 2003; MacDonald, Carnevale & Razack, 2007; Sealey, 2003; Symington, Cooper & Wallace, 2006). Jeffreys (2006) contends that the use of learner-centered approaches rather than teacher-centered pedagogy has the potential to facilitate the process of cultural competence development in faculty. Much of the literature on cultural competence in the academic setting uses student samples. There is a significant lack of research on the attitude of nursing faculty toward culturally diverse patients and their confidence in performing transcultural nursing skills (transcultural self-efficacy).

### **Statement of the Problem**

The importance of preparing a nursing workforce to provide culturally competent care and the lack of research on nursing faculty attitudes toward culturally diverse patients as well as confidence in performing transcultural nursing skills demonstrate the need to investigate the relationship between faculty attitudes toward culturally diverse patients and transcultural self-efficacy. This research is both timely and important to health care in the 21<sup>st</sup> century. Integrating cultural competence development throughout nursing curricula enhances the development of cultural competence in faculty and students (Andrews, 1995; Jeffreys, 2002;

Leininger, 1995b). Since nurse educators prepare students to provide care to diverse patients, an investigation of the attitudes of faculty toward culturally diverse patients and transcultural self-efficacy provides evidence that may assist in faculty development and in curricular design to promote cultural competence.

### **Definition of Terms**

For purposes of this study the following definitions are used:

Attitude is the predisposition of the individual to evaluate some symbol or object, or aspect of one's world in a favorable or unfavorable manner and is influenced by knowledge, feelings and behavior (Katz, 1960). Attitude will be measured by an adaptation of the Cultural Attitude Scale (Bonaparte, 1977).

Culturally Diverse Patients are identified in four vignettes of the Cultural Attitude Scale. Each vignette uses a standardized male patient health situation and describes the family unit, type of employment, church affiliation, health care practices, and ethnic identity of the patient. Each vignette describes a White, Black, Asian, and Hispanic patient.

Transcultural Self Efficacy (TSE) refers to the perceived confidence for performing general transcultural nursing skills among diverse populations and is based on self-efficacy and transcultural nursing theories (Jeffreys, 2006). TSE will be measured by the Transcultural Self-Efficacy Tool (Jeffreys, 2006).

Nursing Faculty are females teaching full time in an accredited publicly funded associate degree nursing program in the northeastern United States.

### **Significance**

A culturally competent health care workforce who provides culturally congruent health care to everyone improves the health of the United States' population and assists to eliminate

health disparities (Institute of Medicine, 2004). The Sullivan Commission (2004), the National League for Nursing (2008), the Pew Commission (1998), the Joint Commission (2010), the Institute of Medicine (2004), and the Agency for Healthcare Research and Quality (2008) support the development of a health care workforce sensitive to the health issues and needs of a diverse patient population.

In addition, Healthy People, the nation's agenda for promoting the health of all its citizens, proposes to increase life expectancy, improve quality of life and eliminate health disparities among different segments of the population (U.S. Department of Health and Human Services, 2000). For three decades, Healthy People has provided a comprehensive set of national 10-year health promotion and disease prevention objectives aimed at improving the health of all Americans. It is grounded in the notion that establishing objectives and providing benchmarks to track and monitor progress over time can motivate, guide, and focus action. Healthy People 2020 continues to define the vision and strategy for building a healthier nation by eliminating health care disparities

(<http://www.healthypeople.gov/hp2020/Objectives/files/Draft2009Objectives.pdf>, p. v). The longstanding national and local debates as well as current legislation on health care reform speak to the fact that many people in the United States are not receiving quality health care. A health care system based on Western health care practices alone may be limited in providing quality health care to people who come from all parts of the world, are from varied backgrounds, and have a myriad of cultural values and beliefs about health and health care. These individuals may have experiences with healthcare systems that are more holistic and offer services irrespective of financial resources. This is in sharp contrast to the illness focused system in the United States. Providing quality health care, improving life expectancy and eliminating health disparities for

the United States' population may occur only if practitioners are culturally competent and provide culturally congruent healthcare (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007). Registered nurses, the largest group of healthcare providers in the country (Bureau of Labor Statistics, 2013), may have the greatest impact on quality patient care by engaging in the process of cultural competence and providing culturally congruent care.

Nursing faculty, as the educators of this group, must be able to effectively teach students to care for diverse patients. In order to do that, faculty must be culturally competent. Cultural competence development requires a committed, sincere, and continuous effort. In the academic setting, nursing faculty as teachers can promote learning by engaging in this process (Jeffreys, 2006). On the other hand, faculty may be unconsciously incompetent when they are not aware of cultural differences or when they unknowingly act in culturally incongruent ways (Purnell & Paulanka, 2008). These behaviors may cause cultural pain to others (Leininger & McFarland, 2006). Faculty immersed in the culture of nursing education and their own cultural values and beliefs may not be aware of behaviors that could cause cultural pain. An assessment of faculty knowledge about different cultural values and beliefs as well as commitment to cultural competence development may identify areas for faculty development (Jeffreys, 2006). According to Campinha-Bacote (2003), cultural desire, cultural knowledge and self-reflection are major components of cultural competence. Faculty self-appraisal and active engagement in cultural competence development are the foundation of promoting cultural competence development in themselves and their students (Campinha-Bacote, 2007; Jeffreys, 2006). This may lead to positive attitudes toward culturally diverse patients and culturally competent health care.

Barbee and Gibson (2001) propose that talking and writing about cultural diversity without aggressively dealing with it in nursing education will only perpetuate the status quo. In addition, the Eurocentric culture of power in nursing education influences faculty roles which necessitates reconsidering academic traditions and standards that continually and negatively affect minority faculty and students ( Waite & Calamaro, 2010; Hassouneh, 2008).

Nursing education must be the best it can be for all. The difficulty in accomplishing this goal originates from strong common attitudes and values in the culture of nursing and the subculture of nursing education. One such value, uniformity, prevents some faculty from seeing the changes that a diverse population demand or even recognizing the need for change (Bednarz, Schim & Doorenbos, 2010). Nurse educators are also challenged to employ diverse teaching-learning strategies beyond the classroom which are needed to enhance the success of diverse students (Jeffreys, 2006). It is essential to prepare nurses for contemporary practice and leadership roles. Communicating and understanding ethnically and linguistically diverse patients is a challenge that can be met through transforming nursing education to include rich student opportunities to develop their practice (Benner, Sutphen, Leonard & Day, 2009). Ultimately, nurses caring for diverse patients may improve patient health outcomes by providing culturally competent care. The elimination of health disparities is predicted to occur through a holistic, integrated effort by increasing the numbers of culturally competent nurses providing culturally congruent care (Institute of Medicine, 2002; Jeffreys, 2004; Leininger & McFarland, 2006; Purnell & Paulanka, 2008; Smedley, Stith & Nelson, 2009). The results of this research that investigated the relationship between nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy provides answers that will assist nurse educators in their crucial role of educating nursing students to care for culturally diverse patients.

## Summary

This study was undertaken to examine the attitudes of nursing faculty towards culturally diverse patients and their perceived confidence in performing transcultural nursing skills (transcultural self-efficacy). Several assumptions underpin the study. First, cultural diversity is inherent in the world today. Second, nurses care for patients from all parts of the world. Third, culturally competent care promotes positive patient health outcomes. Lastly, nursing faculty are responsible for educating nurses to practice competently in a culturally diverse world.

An introduction to the importance of nurses being prepared to care for patients in a culturally competent way is presented in Chapter 1, along with the statement of the problem, definition of terms and significance of the study.

In Chapter II, a review of the literature and research pertinent to nursing faculty attitudes towards culturally diverse patients and transcultural self-efficacy is presented as well as the theoretical rationale for the study and hypothesis. The research method used to collect and analyze the data for the investigation is discussed in Chapter III. The results of the data analysis are presented in Chapter IV. Chapter V discusses the results found, the psychometric evaluation of the instruments, ancillary findings, and the theoretical framework. Lastly, conclusions, implications for nursing education and research, recommendations for future research, and study limitations are presented in Chapter VI.

## **Chapter II**

### **Review of the Literature**

In order to provide a framework for the systematic consideration of the variables to be investigated (attitudes toward culturally diverse patients and transcultural self-efficacy) and bring clarity to the proposed relationships, relevant research is presented. The first section discusses attitude and cultural diversity. The second section discusses transcultural self-efficacy. The theoretical basis which leads to the formation of the hypothesis is summarized in the third section.

#### **Attitude and Cultural Diversity**

Many definitions of attitude are found in the literature. Since the concept of attitude holds a key position in social psychology, that definition will be used in this research. One of the early social psychologists studying attitude, suggests a functional approach, i.e. trying to understand the reasons people hold the attitudes they do (Katz, 1960). According to Katz (1960), attitudes can serve a utilitarian, ego defensive, value expressive (positive expression of one's central values) or knowledge function for individuals. The conditions needed to modify an attitude are based on motivation and can be the stimulus for attitude change. Motivation for the attitude or the goal one is trying to achieve is the basis of Katz's perspective and, therefore, can help explain and predict human behavior. Parental and group influences as well as personality characteristics contribute to attitude development. Attitudes, however, are demonstrated within the contexts established by culture.

The concept of culture is generally accepted as meaning the way of life of a group of people including the patterns of learned behavior which have passed from one generation to the next (Leininger, 1970). In social science, research in the first half of the twentieth century found

that culture is universal, dynamic and in many ways determines the course of our lives (Herskovits, 1955). Studies are found in the literature on nursing faculty attitudes toward culturally diverse students (Davidhizar & Shearer, 2005; Jeffreys, 2006; Kossman, 2003; Mills-Wisneski, 2005; Sealey, 2003; Sealey, Burnett & Johnson, 2006; Xu, Davidhizar & Giger, 2005). The findings suggest strategies for student retention and success and curricular changes to enhance student cultural competence, including immersion experiences, assessment of cultural competence, and integration of cultural competence into the curriculum and courses. One of the major influences on nursing students is nursing faculty. The attitude of nursing faculty toward culturally diverse patients may influence the cultural competence development of nursing students.

This research focused on the attitudinal components of the nursing faculty and patient relationship within the academic setting. In academic systems, as in any other interactive system, the interaction process is affected by the attitudes, values, beliefs and expectations of the participants. Nursing education must consider the cultural attitudes, values and beliefs of patients in the educational process to enhance cultural competence and, in turn, nursing practice. Nursing faculty must be aware of their own cultural attitudes, values and beliefs in order to effectively engage in the interaction with patients (Jeffreys, 2006).

Cultural competence is most often the concept measured or investigated in the literature about cultural diversity. Investigation and measurement of attitudes about cultural diversity are generally subsumed within cultural competence. A review of more than 50 quantitative measures of cultural competence over the past 20 years found that existing measures embed highly problematic assumptions about what constitutes cultural competence (Kumas-Tan,

Beagan, Loppie, MacLeod & Frank, 2007). The findings also suggest several underlying assumptions about culture and cultural competence: culture is equated with ethnicity and race and is considered an attribute possessed by the ethnic or racialized other; cultural incompetence is said to arise from a lack of exposure to and knowledge of the other, and from individual biases, prejudices, and acts of discrimination. Many instruments assume that practitioners are white and Western and that greater confidence and comfort among practitioners signify increased cultural competence. They ignore the power relations of social inequality and assume that individual knowledge and self-confidence are sufficient for change. The authors recommend developing measures that assess cultural humility and/or assess actual practice to facilitate educators in the health professions moving forward in efforts to understand, teach, practice, and evaluate cultural competence.

Few measures of attitudes toward cultural diversity are found in the literature. Bonaparte's Cultural Attitude Scale (CAS) (1977) has been used in several studies (Brown, 1986; Jaffe-Ruiz, 1980; Kardong-Edgren, 2005; Rooda, 1990; Smith, 1998). Designed specifically for nurses, it measures positive and negative attitudes towards culturally diverse patients. It identifies and measures three factors: nursing care-patient interaction, cultural health behavior, and cultural health attitudes and beliefs. After reading vignettes about a consistent patient from different cultural backgrounds, participants are asked to respond to 34 items on a 5 point Likert scale (strongly disagree to strongly agree). The tool can be adapted to add vignettes or change ethnicities depending on the research needs and setting. The adaptability and ease of use of the CAS make it appropriate for use in this research to identify faculty attitudes toward culturally diverse patients.

## **Transcultural Self-Efficacy**

The importance of faculty cultural competence is underscored in the general and nursing education literature and is compounded by the cultural diversity of patient populations, the homogeneity of nursing faculty, and the extent of their contact with diverse populations. Kardong-Edgren (2004) found that nursing faculty teaching in states with large numbers of immigrants were more comfortable with cultural diversity than those from states with low immigrant populations. A qualitative study on faculty cultural competence conducted by Leonard (2001) at 13 schools accredited by the National League for Nursing found the following major themes: People Different Than Us, Struggling Toward Diversity, Reflections of Diversity, Insuring Diversity and Religious Based Institutions. There are several frameworks for assessing the construct of cultural competence. However, only one of them encompasses the assumption that cultural competence is an ongoing, multidimensional learning process. Jeffreys' (2006) Cultural Competence and Confidence (CCC) model focuses on the teaching learning process of cultural competence development as influenced by transcultural self efficacy (TSE). It also incorporates the cognitive, practical and affective domains and transcultural nursing theory. The CCC model provides the framework for teaching and learning cultural competence development in self and others. It is based on self-efficacy theory (Bandura, 1986) and on the motivation to engage in the process of becoming culturally competent (Jeffreys, 2006). Self-efficacy theory proposes that strong self-efficacy perceptions result in higher levels of goal commitment, motivation, persistence, learning, and skill performance (Bandura, 1986); essential components in achieving cultural competency are commitment and motivation (Campinha-Bacote, 1999, 2003; Chang, 1995). Transcultural Self-Efficacy (TSE) is the perceived confidence one has to perform behaviors that are culturally competent despite hardships and obstacles as well as the

degree to which individuals perceive they have the ability to learn or perform specific transcultural skills needed for culturally competent and congruent care (Jeffreys, 2006, p. 37). It can be assumed that TSE perceptions will directly influence cultural competency through commitment and motivation (Jeffreys, 2006).

### **Theoretical Rationale**

The Cultural Competence and Confidence (CCC) model (Jeffreys, 2006) integrates the cognitive, behavioral and affective domains to provide a framework for teaching and learning about cultural competence. The model posits that through explaining, describing, influencing and/or predicting the phenomenon of cultural competence culturally congruent healthcare is promoted (Jeffreys, 2006). Transcultural self-efficacy (TSE), a predominate factor in the CCC model, draws from self-efficacy, teaching/learning and transcultural nursing theories and is the degree to which individuals perceive that they have the ability to perform transcultural nursing skills needed for culturally competent care. TSE is developed through actual performance, vicarious experience, encouragement or emotional arousal (Bandura, 1977; Jeffreys, 2006). The most significant development of TSE occurs through actual performance of culturally competent actions. Jeffreys (2010) found that students were most confident about their attitude and least confident about their knowledge and skill in caring for culturally diverse patients. Use of the CCC model in studies with nursing faculty is not found in the literature.

Culturally diverse patients may have health care attitudes, values and beliefs that are unfamiliar or incongruent with those of nursing faculty. Cultural patterns are learned and are an expression of the way of life of a group of people that influences their life. Attitudes are also learned and manifested within the limits of culture. Faculty and patients are influenced by

culture and attitudes. This researcher postulated that faculty attitudes toward culturally diverse patients influences faculty perceived confidence in performing transcultural nursing skills (transcultural self-efficacy).

This study expanded the concepts of nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy. Inherent in this investigation was the complex problem that nursing faculty attitudes toward culturally diverse patients are multi-dimensional in nature. Therefore, variables such as education, age, years of practice and cultural identity of faculty have relevance and information about those variables was collected. Additionally, since bias towards socially desirable responses in case study and survey methods of research may be a source of error, the Social Desirability Scale (Crowne & Marlowe, 1960) was administered to evaluate any influence on study results.

Nursing faculty are positioned to teach cultural competence to students who will join the largest group of health care providers in the United States (Bureau of Labor Statistics, 2013). Since positive health outcomes are achieved when culturally competent care is provided (Smedley, Nelson & Stith, 2004), nursing faculty can impact health care delivery by promoting the cultural competence of students.

This research focused on the attitudinal components of the nursing faculty and patient relationship within the academic setting. In academic systems, as in any other interactive system, the interaction process is affected by the attitudes, values, beliefs and expectations of the participants. Nursing education must consider the cultural attitudes, values and beliefs of students in the educational process to enhance cultural competence and, in turn, nursing practice. Nursing faculty must be aware of their own cultural attitudes, values and beliefs in order to effectively engage in the interaction with students and patients (Jeffreys, 2006).

The review of the literature relative to each of the variables revealed that nursing faculty attitudes toward culturally diverse patients is influenced by knowledge, feelings, and beliefs about culturally diverse patients and that transcultural self-efficacy is influenced by knowledge, skill and one's attitude, values and beliefs about providing culturally competent care.

### **Hypothesis**

There will be a significant positive relationship between associate degree nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy (the perceived confidence in performing transcultural nursing skills).

### **Summary**

The literature reviewed in this chapter focused on attitude and cultural diversity from the perspective of nurses' behavior in health care and academic settings as well as nurses' perceived confidence in performing transcultural nursing skills (transcultural self-efficacy). It also described the influence of nursing faculty on students and a model for culturally competent care. Finally, the theoretical rationale for the study and hypotheses are presented. These ideas endorse the need for additional research on the relationship between nursing faculty attitudes towards culturally diverse patients and transcultural self-efficacy.

The methodology used in collecting data for this study and the statistical analyses to test the hypothesis are presented in Chapter III.

## Chapter 3

### Method

This research examined the relationship between nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy. Attitudes toward culturally diverse patients were measured by Bonaparte's Cultural Attitude Scale (Bonaparte, 1977). Transcultural self-efficacy was measured by Jeffreys' Transcultural Self-Efficacy Tool (Jeffreys, 2006). The Social Desirability Scale (Crowne & Marlowe, 1960) and a background information questionnaire were also administered.

### Sample

The targeted population was full time nursing faculty in accredited, associate degree programs. Participants were employed in several programs of a large, urban, publicly funded university system. A purposive, convenience sample consisted of full-time, female nursing faculty (N=65) who teach in National League for Nursing Accrediting Commission, Inc. (NLNAC) accredited associate degree nursing programs in the New York City area. The NLNAC is responsible for the specialized accreditation of nursing education programs and is the only accrediting body for associate degree programs in the United States (NLNAC, 2010). The sample was limited to full-time, female faculty, since most nursing faculty are female (National League for Nursing, 2009) and traditionally have formal workload and institutional responsibilities when employed full time. In addition, nursing program accrediting standards require culturally competent curricula. NLNAC Standard 4.4 states that *the curriculum includes cultural, ethnic, and socially diverse concepts and may also include experiences from regional, national, or global perspectives* (NLNAC, 2010). To accomplish this, the assumption is that

nursing faculty will teach cultural competence and provide clinical experiences with culturally diverse patients.

Associate degree nursing programs have the highest enrollment of new students in the United States. According to the National League for Nursing (NLN), of the 20,000 students who entered nursing programs in 2006-2007, 18,000 entered associate degree programs (NLN, 2009). The sample of faculty was drawn from a large, public college system that has eight accredited associate degree programs in the northeastern United States. The system is positioned in a city that is culturally diverse. The patient population served and the students enrolled in the nursing programs come from all parts of the world. In 2010, New York City had over 3 million foreign-born residents, the largest number in its history (New York City Department of City Planning, 2013). This diversity is also reflected in the student population of the programs studied. From 2005 to 2012 demographic information of associate degree graduates from the university studied showed that eighty to eighty-five percent were women, thirty-one to forty percent were Black, eleven to fifteen percent were Hispanic, and fifteen to twenty percent were Asian. Sixty-two to seventy three percent of the graduates were not born in the United States. (CUNY Annual Data Report Nursing Degree Programs, 2013).

A sample size of at least 65 participants was needed to produce significant results according to Cohen's Power Chart (1988). Oversampling was not done. Consistent with acceptable standards for research in nursing, alpha .05, power .80 and moderate effect size .50 were used to determine sample size (Knapp, 1998).

## **Instruments**

**Cultural Attitude Scale.** Bonaparte (1977; 1979) created the Cultural Attitude Scale (CAS) to measure nurses' attitudes towards culturally different patients based on Katz's

functional approach to the study of attitudes (Katz, 1960). The CAS contains four vignettes that describe three minority cultural groups (Hispanic, Jewish and Black) and the dominant white group described by Bonaparte as WASP. Each vignette uses a standardized male patient health situation and describes the family unit, type of employment, church affiliation, health care practices, and ethnic identity of the patient followed by 34 items asking about attitudes toward that patient. Choices range from strongly disagree (5) to strongly agree (1). Higher scores indicate a more positive attitude while lower scores indicate a more negative attitude. Initial estimates of the psychometric properties of the CAS were obtained from a pilot study of fifty female registered professional nurses (Bonaparte, 1977). Validity was established through construct and criterion-related validity. Principal factor analysis was performed on the responses to each of the four patient vignettes. Orthogonal varimax rotations identified three meaningful and statistically independent factors underlying registered professional nurses' attitudes toward minority culture patients: nursing care/patient interaction, cultural health behaviors, and cultural health attitudes and beliefs. The factor formations indicated potential for measuring attitude toward patients of varying cultures. The reliability of the CAS was reported as the variances of the three sets of factor scores (.94, .95 and .77). The reliability for the total instrument was reported as .86 (Bonaparte, 1979).

The CAS has been used in studies with registered nurses (Bonaparte, 1977; Brown, 1986; Rooda, 1993; Smith, 1998), multidisciplinary hospital staff (Jones, Cason & Bond, 2004), nursing students (Bond, Kardong-Edgren & Jones, 2001), and baccalaureate nursing faculty (Jaffe, 1980; Jaffe-Ruiz, 1981; Kardong-Edgren, Bond, Schlosser, Casar, Jones, Warr, & Strunh, 2005). Jaffe (1980) reduced the 34-item CAS to measure positive and negative attitudes of baccalaureate nursing faculty toward culturally different clients. The vignettes remained the

same as Bonaparte's. The specific items remained the same but 14 items were removed and the instrument was shortened to 20 items. Scoring was changed to agree very strongly +3, agree strongly +2, agree +1, disagree -1, disagree strongly -2, disagree very strongly -3. Orthogonal varimax rotations identified four meaningful and statistically independent factors underlying baccalaureate nursing faculty attitudes toward minority culture patients: nursing care/patient interactions, "annoyance"; cultural attitudes and beliefs, "superstitious"; "good" patient behavior profile; and "ethnocultural" care were identified. Reliabilities of the four factor score scales were found to be, respectively, .79, .62, .64, and .69 (Jaffe-Ruiz, 1981).

Rooda (1990) used the 34-item CAS as Section 2 of her new Cultural Fitness Survey to measure nurses' attitudes towards culturally different patients. The vignettes described four ethnic individuals: Hispanic, Black American, Asian American, and Anglo-American. Total scores for each vignette were calculated and alphas were calculated as .88 for white, .92 for Black American, .87 for Asian American, and .92 for Hispanic. Alphas were not reported for the three subscales: nursing care/patient interaction, cultural health behaviors, and cultural health attitudes and beliefs. Bond, Kardong-Edgren & Jones (2001) administered a shortened CAS, described as the Ethnic Attitude Scale, to nursing students (BSN, RN to BSN, and master's). Three vignettes (Anglo, African American, Hispanic) were followed by 20 items designed to measure attitudes about providing care to patients in each group. Scoring ranged from strongly agree to strongly disagree with higher scores indicating a more positive attitude. Total scores for each vignette were calculated. The alpha for Anglo was .70, for African American was .72, and for Hispanic was .61. Lastly, Kardong-Edgren, Bond, Schlosser, Cason, Jones, Warr & Strunk (2005) used a 20-item CAS to investigate the attitudes of baccalaureate nursing faculty towards Anglo, African American, Asian and Hispanic patients. Total scores were computed, ranging

from strongly agree to strongly disagree, with higher scores indicating a more positive attitude. Reliabilities for the CAS vignettes were .58 for Anglo, .76 for African American, .58 for Asian, and .70 for Hispanic. Scores for the 34-item and 20-item CAS used in previous studies were calculated from either factors/subscales (Bonaparte, 1977; Jaffe-Ruiz, 1981) or total vignette scores (Rooda, 1990; Bond et al., 2001; Kardong-Edgren et al., 2005). The 20-items used by Bond et al. (2001) and Kardong-Edgren et al. (2005) could not be validated despite emails and phone calls to the authors.

The CAS was modified for use in this study. The White, Black, and Hispanic vignettes were unchanged from Bonaparte's study (1977). The Jewish vignette was eliminated and replaced with an Asian vignette. It was validated as comparable by B. H. Bonaparte (Personal Communication, October 26, 2010). The 34-item CAS was used in this research. To date, the CAS has not been used in studies with associate degree nursing faculty. Permission to use the modified CAS in this research has been given (Appendix A).

**Transcultural Self-Efficacy Tool.** Jeffreys (2000) developed the Transcultural Self-Efficacy Tool (TSET) to measure and evaluate nursing students' confidence for performing general transcultural nursing skills among diverse populations. The 83-item TSET was developed based on the literature and results of a two-phase evaluation study (Jeffreys & Smodlaka, 1996). The TSET has three subscales. The Cognitive subscale (25 items) asks respondents to rate their confidence about their knowledge of the ways cultural factors influence nursing care. The Practical subscale (28 items) asks respondents to rate their confidence for interviewing patients of different cultural backgrounds to learn about their values and beliefs. The Affective subscale (30 items) addresses respondents' attitudes, values, and beliefs about themselves and patients of different cultural backgrounds (Jeffreys, 2006). Items are closed

ended and positively phrased as self-efficacy theory recommends (Bandura, 1977, 1982, 1989). A 10-point rating scale from 1 (not confident) to 10 (totally confident) is used to elicit a more discriminate response (Jeffreys & Smodlaka, 1996). Despite the limitations of self-report instruments, the construct of self-efficacy can only be evaluated by self-appraisal and self-report (Bandura, 1997).

Initial estimates of the psychometric properties of the TSET resulted from four studies (Jeffreys, 2006). Validity was established through content validity, construct validity and criterion-related validity. Content validity was established by six doctoral- prepared nurses certified in transcultural nursing (Jeffreys & Smodlaka, 1996). A contrasted group approach and a factor analysis were conducted to establish construct validity. The TSET detected differences in TSE perceptions within groups and between groups on all subscales (Jeffreys, 2000; Jeffreys & Smodlaka, 1999a, 1999b). A principal component analysis with varimax rotation yielded nine-factors, all with eigen values greater than 1.00 (Jeffreys & Smodlaka, 1998). A focus on the predictive potential of the TSET was the approach used to assess criterion-related validity. Results indicated statistically significant differences in TSE perceptions of undergraduate nursing students between the first and fourth clinical semester (Jeffreys & Smodlaka, 1999a). Reliability was tested by Cronbach's alpha (0.92-0.98) and split-half reliability (0.76-0.92) for internal consistency and test-retest reliability (0.63-0.75) for stability (Jeffreys, 2006, p.49).

Recent analysis of the factor structure of the TSET using common exploratory factor analysis (CEFA) yielded four factors with internal consistency ranging from 0.94 to 0.98 and 0.99 reliability of the total instrument (Jeffreys & Dogan, 2010). Factor 1 (Knowledge and Understanding) incorporated all 25 items on the Cognitive subscale. Twenty two of 28 items on the Practical subscale loaded on Factor 2 (Interview). Factors 3 and 4 (Awareness, Acceptance

and Appreciation and Recognition) loaded on the Affective subscale. The authors suggest that the current analyses may indicate a different type or level of affective learning among the respondents. The authors recommend using different health care professional populations in repeated CEFA studies as well as focus groups to identify perceived differences in Factors 3 and 4.

In terms of scoring, the TSET is consistent with Bandura's (1986) recommendations for assessing the strength and magnitude of self-efficacy. Subscale calculations of self-efficacy strength (SEST) provide information on understanding initial TSE perceptions. SEST refers to the average strength of self-efficacy perceptions within a subscale of the construct (Jeffreys, 2010). The TSET has been used with associate and baccalaureate degree nursing students (Amerson, 2009; Blackstock, 2003; Ferguson, 2007; Jeffreys, 1999; Rudnick, 2005) and in community health (Toney, 2004) and hospital (Dolgan, 2001; Platter, 2005; Smith, 1998; Velez, 2005) practice settings. Permission to use the tool in this research has been granted (Appendix A). The TSET was used in this study to appraise the level of transcultural self efficacy of associate degree nursing faculty. Since the instrument had not been used with nursing faculty appropriate psychometrics were conducted on the use of the tool with this population.

**Social Desirability Scale.** The bias towards socially desirable responses in case study and survey testing methods of research may be a source of error. Crowne & Marlowe (1960) developed the Social Desirability Scale to gain insight into this issue. The 33-item True/False survey asks respondents about their behavior in a variety of personal and social situations. Total scores obtained from the scale identify participants' tendency to give a culturally appropriate acceptable response. Low scorers may be more willing than most people to respond truthfully despite social disapproval. Average scorers tend to demonstrate an average concern for social

desirability and their general behavior may represent an average degree of conformity to social rules. High scorers may be overly concerned about social approval and may respond in ways to avoid disapproval of people reading their responses. High conformity to social rules may be demonstrated in their general behavior. Reliability of the Social Desirability Scale has been reported as alphas ranging from 0.64 to 0.89 (Thompson & Phua, 2005). Aggregate results rather than individual scores are reported in this study.

### **Protection of Human Subjects**

Institutional Review Board (IRB) approval was obtained from CUNY Central Office of Research Conduct (Appendix B). A written consent to administer the instrument package to faculty was obtained from the chairpersons of six accredited associate degree nursing programs within the university. Written consent was waived for faculty completing the questionnaire packet. Faculty anonymity was maintained since there were no personal identifiers in the packet. All completed questionnaire packets are kept in a locked file cabinet with one key in the possession of the researcher to ensure confidentiality. The results of data analysis are described as aggregated results.

### **Data Collection Procedures**

A letter of introduction, including a description of the study and request for permission to distribute questionnaire packets to faculty (Appendix C), was sent to the chairpersons of eight accredited associate degree nursing programs within a publicly funded university system in the northeast United States. A follow-up phone call by the researcher was made to those who did not respond within two weeks. Six chairpersons (75%) agreed to participate in the study. A mutually acceptable method for distribution of the packets was determined by each chairperson and the researcher. The researcher delivered the packets to four programs in mid-May, 2011 and

to two programs at the end of September, 2011. One hundred and twenty-two packets were distributed to the six programs. Sixty-five (53%) were returned in a postage paid envelope addressed to the Program Assistant of the Doctoral Nursing Program at the Graduate Center. The questionnaire packets contained the following: a letter of introduction, explanation of the study, request for participation, statement as to how confidentiality and anonymity will be maintained (Appendix D); the Cultural Attitude Scale; the Transcultural Self-Efficacy Tool; a background information sheet; the Social Desirability Scale; a \$5 Dunkin Donuts gift card; a postage paid envelope addressed to the Program Assistant of the Doctoral Nursing Program. The researcher contacted the Program Assistant regularly to monitor the number of response envelopes received. Each time ten envelopes were received, the researcher picked them up from the Program Assistant.

### **Data Analysis**

The study used a descriptive, correlational design that explored within and between group differences through instruments that assessed the study variables (attitude toward culturally diverse patients and transcultural self-efficacy). Frequencies and descriptive statistics were computed to obtain information about the sample participants. Descriptive statistics were obtained for scores on the instruments. For each respondent in this research, the total scores for each of the four vignettes of the CAS, for each of the three subscales of the TSET, and for the Social Desirability Scale were calculated in SPSS Version 18.0 software. After obtaining the scores, univariate analysis and Pearson correlation coefficients were calculated. Cronbach alpha coefficients were computed for each vignette of the CAS, for the subscales of the TSET, and for the Social Desirability Scale to determine internal consistency and reliability for this sample. Between and within group ANOVA was computed. All responses were aggregated and

analyzed as were responses to the background information questionnaire. ANOVAS and correlation statistics were computed to investigate whether demographic variables accounted for significant variance in the two variables of interest, attitude toward culturally diverse patients and transcultural self-efficacy.

### **Summary**

The population and sample selection, instrumentation, data collection, and data analysis procedures used in the study are described in Chapter III. After IRB approval to conduct the study was received, the chairpersons of six accredited associated degree nursing programs in a publicly funded university agreed to allow faculty to participate in the study. The Cultural Attitude Scale, the Transcultural Self-Efficacy Tool, the Social Desirability Scale, and a background information questionnaire were completed by a sample of faculty (N=65). Responses to the instruments, the Social Desirability Scale and background information questionnaire were analyzed. The results of the data analysis are discussed in Chapter IV.

## **Chapter IV**

### **The Results**

This study investigated the relationship of the attitudes of associate degree nursing faculty toward culturally diverse patients and transcultural self-efficacy. It was hypothesized that there would be a significant positive relationship between faculty attitudes towards culturally diverse patients and transcultural self-efficacy. This chapter presents a description of the sample, the psychometric evaluation of the Cultural Attitude Scale (CAS), the Transcultural Self-Efficacy Tool (TSET), and the Social Desirability Scale, the analysis of the scores of those instruments, and the results of the hypothesis testing.

#### **Description of Sample**

An analysis of the responses of the sample ( $N = 65$ ) was done to establish the number of participants who completed all of the components of the instrument packet. After looking at the patterns of missing data, it was decided that participants who had more than 10% missing on at least one scale would be removed from the sample. Three participants were in this category and were removed from the analysis leaving a final sample of 62.

All participants were female. The average participant was 54 years old, white, heterosexual, Catholic, born in the United States, and spoke English as their first language (Table 4.1).

Table 4.1

*General Sample Characteristics (N=62)*

Characteristic	<i>n</i>	%
Age: <i>M</i> = 53.69 ( <i>SD</i> = 7.942), Range: 27 to 68 years		
Under 30	1	2%
30-39	4	7%
40-49	7	11%
50-59	35	57%
60 and over	11	18%
No Response	4	7%
Ethnic Characteristics		
White	35	57%
Black/African American	15	24%
Asian	4	7%
Hispanic	3	5%
Multiracial	3	5%
Asian: other	1	2%
Pacific Islander	1	2%
Gender Orientation		
Heterosexual	61	98%
Bisexual	1	2%
Religion		
Catholic	33	53%
Christian	6	10%
No Response	6	10%
Protestant	5	8%
Presbyterian	4	6%
No Religion	3	5%
Islam	2	3%
Place of Birth		
United States	45	73%
Outside of U.S.	17	27%
Language		
English as primary language	55	89%
Other language primary	7	11%

Regarding general nursing characteristics, the average participant was licensed as a registered nurse for about 30 years and received their basic nursing education in a baccalaureate program in the United States. Most respondents had either a formal or informal course in transcultural nursing. Ten participants did not have a formal or informal course in transcultural nursing. All participants had an advanced nursing practice degree (Table 4.2). Lastly, the average participant was employed full time in nursing education at an assistant professor rank and was untenured (Table 4.3).

Table 4.2

*General Nursing Characteristics (N=62)*

Characteristic	<i>n</i>	%
<b>Years Licensed as Registered Nurse: <math>M = 30.10</math> (<math>SD = 8.975</math>), Range: 4 to 47 years</b>		
Under 10	1	2%
10-19	8	13%
20-29	13	21%
30-39	27	45%
40 and over	10	17%
No Response	3	5%
<b>Basic Nursing Education Program</b>		
Baccalaureate	29	47%
Associate Degree	25	40%
Diploma	5	8%
No Response	2	3%
Masters	1	2%
<b>Location of Initial Nursing Program</b>		
United States	52	84%
Outside of U.S.	10	16%
<b>Advanced Nursing Practice Role</b>		
Nurse Educator	29	47%
Nurse Practitioner	22	35%
Clinical Nurse Specialist	11	18%
<b>College Course in Transcultural Nursing</b>		
Yes	32	52%
No	30	48%
<b>Continuing Education in Transcultural Nursing Without College Course in Transcultural Nursing</b>		
Yes	20	70%
No	10	30%

Table 4.3

*Nursing Faculty Characteristics (N=62)*

Characteristic	<i>n</i>	%
Employment Status		
Full time	60	97%
No Response	2	3%
Academic Rank		
Assistant Professor	34	55%
Associate Professor	18	29%
Professor	8	13%
Lecturer	2	3%
Tenure Status		
Untenured	43	70%
Tenured	19	30%

**Instrument Reliability**

Mean scores, standard deviations, and range were calculated for the CAS (Table 4.4), the TSET (Table 4.6), and the Social Desirability Scale (Table 4.7) as well as Cronbach's alpha for each instrument to determine internal consistency for the current sample.

**Cultural Attitude Scale.** The Cultural Attitude Scale (CAS) is comprised of four vignettes about the same man who is White, Black, Asian, or Hispanic that is followed by 34 items asking about attitudes toward that patient. Each vignette uses a standardized male patient health situation and describes the family unit, type of employment, church affiliation, health care practices, and ethnic identity of the patient. Item choices range from strongly disagree (5) to strongly agree (1). Higher scores indicate a more positive attitude while lower scores indicate a more negative attitude. Twenty-eight items are negatively worded. The remaining six items are positively worded. These items were reversed scored prior to tabulation of the total score. Total scores for the 34-items rather than subscales, as reported by Bonaparte, were used in the

calculation because total scores were reported by Rooda (1980), Bond et al. (2001), and Kardong-Edgren et al. (2005). Cronbach's alpha for the four vignettes of the CAS ranged from .85 to .89 while Cronbach's alpha for the subscales Nursing Care-Patient Interaction, Cultural Attitudes and Beliefs and Cultural Health Attitudes and Beliefs ranged from -.137 to .892 for this sample (Table 4.5). Of note is the very low reliability for the Cultural Attitudes and Beliefs Subscales

Table 4.4

*Descriptive and Reliability Statistics for 34-item CAS (N=62)*

Instrument	Minimum	Maximum	M (SD)	Alpha
<b>Cult AttitudeScale</b>				
CAS White	1.56	3.38	2.34 (0.39)	.88
CAS Black	1.65	3.48	2.41 (0.39)	.87
CAS Asian	1.50	3.00	2.36 (0.35)	.85
CASHispanic	1.62	3.47	2.45 (0.39)	.89

Table 4.5

*Factor Score Descriptive and Reliability Statistics for Four Cultural Groups of CAS (N=62)*

Group	Factor/Subscale	Means	S.D.	Variance	Alpha
White	Nursing Care/Pt. Interaction	2.29	0.44	.192	.837
	Cultural Attitudes and Beliefs	2.36	0.42	.179	.306
	“Good Pt. Behavior Profile”	2.48	0.52	.271	.612
Black	Nursing Care/Pt. Interactions	2.23	0.48	.228	.892
	Cultural Attitudes and Beliefs	2.79	0.43	.185	.195
	“Good Pt. Behavior Profile”	2.68	0.57	.323	.690
Asian	Nursing Care/Pt. Interaction	2.20	0.41	.166	.826
	Cultural Attitudes and Beliefs	2.62	0.35	.122	-.137
	“Good Pt. Behavior Profile”	2.92	0.60	.366	.721
Hispanic	Nursing Care/Pt. Interactions	2.21	0.46	.214	.857
	Cultural Attitudes and Beliefs	2.77	0.39	.151	.186
	“Good Pt. Behavior Profile”	2.78	0.61	.378	.765

**Transcultural Self-Efficacy Tool.** The Transcultural Self-Efficacy Tool (TSET) is comprised of three subscales with a total of 83-items. The Cognitive subscale (25 items) asks respondents to rate their confidence about their knowledge of the ways cultural factors influence nursing care. The Practical subscale (28 items) asks respondents to rate their confidence for interviewing patients of different cultural backgrounds to learn about their values and beliefs. The Affective subscale (30 items) addresses respondents' attitudes, values, and beliefs about themselves and patients of different cultural backgrounds. A 10-point rating scale from 1 (not confident) to 10 (totally confident) is used for each item. Cronbach's alpha ranged from .96 to .99 for the three TSET subscales and total reliability of the TSET was .99.

Table 4.6  
*Descriptive and Reliability Statistics for TSET (N=62)*

Instrument	Minimum	Maximum	<i>M (SD)</i>	Alpha
<hr/>				
Transcult Self-Eff				
TSETCognitive	3.16	10.00	7.81 (1.69)	.99
TSET Practical	3.14	10.00	7.70 (1.78)	.99
TSETAffective_	6.30	10.00	9.02 (0.87)	.96

---

**Social Desirability Scale.** The Social Desirability Scale is a 33-item True/False survey that asks respondents about their behavior in a variety of personal and social situations. Total scores obtained from the scale identify participants' tendency to give a culturally appropriate acceptable response. Low scorers (0-8) may be more willing than most people to respond truthfully despite social disapproval. Average scorers (9-19) tend to demonstrate an average

concern for social desirability and their general behavior may represent an average degree of conformity to social rules. High scorers (20-33) may be overly concerned about social approval and may respond in ways to avoid disapproval of people reading their responses. High conformity to social rules may be demonstrated in their general behavior. Results for this sample indicate an above average concern for social approval.

Table 4.7

*Descriptive and Reliability Statistics for Social Desirability Scale (N=62)*

Instrument	Minimum	Maximum	M (SD)	Alpha
Soc Desirability	5	31	18.87 (6.30)	.83

The range of Cronbach's alpha for the CAS, TSET and Social Desirability Scale was .83 to .99 indicating good to excellent reliability for this sample (Waltz, Strickland & Lenz, 2005).

### **Data Distribution**

Skew and kurtosis were calculated for each instrument to determine if the data were normally distributed (Table 4.8). Skewness values ranged from -.899 to .452. Values for kurtosis ranged from -.094 to .583. The results indicated no significant deviations from normality and no significant skew or kurtosis (Field, 2009).

Table 4.8

*Skew and Kurtosis for CAS, TSET, Social Desirability Scale*

Instrument	Skewness	Kurtosis
<b>Cultural Attitude Scale</b>		
CAS White	.290	.303
CAS Black	.452	.583
CAS Asian	-.138	.043
CAS Hispanic	.097	.352
<b>Transcultural Self-Efficacy Tool</b>		
TSET Cognitive	-.620	.053
TSET Practical	-.747	-.094
TSET Affective	-.899	.752
TSET Total		
Soc Desirability	-.260	-.087

**Relationship of CAS Factor Scores and CAS Total Scores**

The classic works of Bonaparte (1977; 1979) and Jaffe-Ruiz (1980; 1981) used a 34-item CAS and 20-item CAS respectively. Jaffe-Ruiz used Bonaparte's items but shortened the length of the scale to 20 items. Factor analyses for each ethnic group of the CAS (White, Black, Jewish, Spanish) were performed. Bonaparte (1977; 1979) identified three factors: Nursing Care-Patient Interaction, Cultural Attitudes and Beliefs, and Cultural Health Attitudes and Beliefs from the 34-item instrument. Jaffe-Ruiz (1980; 1981) identified four factors: Nursing Care/Patient Interaction, "Annoyance", Cultural Attitudes and Beliefs, "Superstitious", "Good" Patient

Behavior Profile, and “Ethnocultural” Care. This researcher analyzed the relationship between the three factor (Table 4.9) and the four factor (Table 4.10) solutions and the results of the total CAS scores obtained in this study.

Table 4.9

*Three Factor Score Means of Responses for the Four Cultural Groups on 34 item CAS (N=62)*

Factor	White	Black	Asian	Hispanic
Nursing Care/Pt. Interactions	2.29	2.23	2.20	2.21
Cultural Attitudes and Beliefs	2.36	2.79	2.62	2.77
“Good Pt. Behavior Profile”	2.48	2.68	2.92	2.78
<b>Total Means CAS</b>	2.38	2.57	2.58	2.59

A repeated measures ANOVA was conducted to determine whether the total mean scores for the different racial groups differed. The White mean score was found to be significantly lower than the other three scores [ $F(3, 59) = 7.31, p = .000$ ] indicating a more negative attitude.

Table 4.10

*Four Factor Solution and Means of Responses for the Four Cultural Groups on 20 item CAS (N=62)*

	White	Black	Asian	Hispanic
Nursing Care/Pt. Interactions	2.36	2.19	2.23	2.25
Cultural Attitudes and Beliefs	2.20	2.39	2.42	2.36
“Good Pt. Behavior Profile”	2.42	2.37	2.17	2.26
Ethnocult care	2.31	2.48	2.87	2.75
<b>Total Means CAS</b>	2.32	2.35	2.42	2.40

A repeated measures ANOVA was conducted to determine whether the total scores for the means for the different racial groups differed. No significant differences were found [ $F(3, 59) = 1.58, p = .20$ ].

Further analyses were performed for the total scores on the 34-items controlling for social desirability and ethnicity of respondent. A repeated measures ANOVA was conducted to determine whether the total scores for the 34-item means for the different racial groups on the patient vignettes differed after controlling for social desirability as measured on the Social Desirability Scale. No significant differences between total scores were found [ $F(3, 55) = 0.610, p = .61$ ]. A repeated measures ANOVA was conducted to determine whether the total mean scores for the different racial groups differed after controlling for the ethnicity of the respondent using the respondent ethnic group classification of White, Black, Other (Asian, Hispanic, Multiracial, Asian: Other, Pacific Islander). Significant differences between total scores were found [ $F(3, 57) = 6.32, p = .001$ ]. The White scores were significantly lower than the Black ( $p < .001$ ), Asian ( $p < .001$ ), and Hispanic ( $p = .006$ ).

### **Relationship of CAS and TSET to Background Variables**

One way analyses of variance (ANOVA) for the total scores of each of the four vignettes of the CAS and the three subscales of the TSET was conducted to determine if there was a relationship with the following nursing related variables: type of initial nursing program attended (Table 4.11), country of initial nursing program attended (U.S. vs. non-U.S.) (Table 4.12), completion of a college course in transcultural nursing (Table 4.13), completion of continuing education units in transcultural nursing (Table 4.14), and participant ethnicity (Table 4.15). The only significant difference found was between attitude toward the Black patient and country of basic nursing program attended, such that U.S. educated faculty scored lower on the Black

patient vignette. ( $M = 2.36$ ;  $SD = .34$ ) than did non-U.S. educated faculty ( $M = 2.81$ ;  $SD = .51$ ) indicating that U.S. educated faculty scored a more negative attitude toward the Black patient.

Table 4.11

*Differences on CAS and TSET by Type of Basic Nursing Program Attended (N = 62)*

Instrument	F (3, 56)	<i>p</i>
Cultural Attitude Scale		
CAS White	0.598	.62
CAS Black	0.870	.46
CAS Asian	0.883	.46
CAS Hispanic	2.570	.06
Transcultural Self-Efficacy Tool		
TSET Cognitive	0.009	.99
TSET Practical	0.979	.41
TSET Affective	0.437	.73

Table 4.12

*Differences on CAS and TSET by Country of Basic Program Attended (U.S. vs. non-U.S.)*  
(*N* = 62)

Instrument	F (1, 57)	<i>p</i>
Cultural Attitude Scale		
CAS White	2.999	.09
<b>CAS Black</b>	<b>9.841</b>	<b>.003</b>
CAS Asian	1.061	.31
CAS Hispanic	1.761	.19
Transcultural Self-Efficacy Tool		
TSET Cognitive	0.004	.95
TSET Practical	1.040	.31
TSET Affective	1.979	.17

Table 4.13

*Differences on CAS and TSET by Attending an Academic Course in Transcultural Nursing  
(N = 62)*

Instruments	F (3, 58)	<i>p</i>
Cultural Attitude Scale		
CAS White	1.187	.323
CAS Black	1.045	.380
CAS Asian	1.839	.150
CAS Hispanic	0.925	.434
Transcultural Self-Efficacy Tool		
TSET Cognitive	0.771	.515
TSET Practical	0.161	.922
TSET Affective	0.757	.523

Table 4.14

*Differences on CAS and TSET by Attending Continuing Education in Transcultural Nursing (N = 62)*

Instrument	F (4, 57)	<i>p</i>
Cultural Attitude Scale		
CAS White	0.833	.51
CAS Black	0.753	.56
CAS Asian	0.619	.65
CAS Hispanic	0.415	.80
Transcultural Self-Efficacy Tool		
TSET Cognitive	1.556	.20
TSET Practical	1.210	.32
TSET Affective	1.045	.39

Table 4.15

*Differences on CAS and TSET by Participant Ethnicity [White, Black, Other (Asian, Hispanic, Multiracial, Asian: Other, Pacific Islander)] (N = 62)*

Instrument	F (2, 58)	<i>p</i>
Cultural Attitude Scale		
CAS White	0.598	.62
CAS Black	0.870	.46
CAS Asian	0.883	.46
CAS Hispanic	2.570	.06
Transcultural Self-Efficacy Tool		
TSET Cognitive	0.009	.99
TSET Practical	0.979	.41
TSET Affective	0.437	.73

Analysis by independent samples *t*-test was done to determine if continuing education in transcultural nursing was associated with faculty attitudes and transcultural self-efficacy (Table 4.16). There was a significant difference between those in continuing education and those participants not in continuing education on the cognitive subscale ( $p = .037$ ). Further analysis by independent samples *t*-test was done to determine if there was a significant relationship between faculty with formal and informal education in transcultural nursing and faculty without either formal or informal continuing education in transcultural nursing (Table 4.17). There was no significant relationship which raises questions about the effect of formal or informal education in transcultural nursing on transcultural self-efficacy.

Table 4.16

*Relationship between CAS and TSET and Continuing Education in Transcultural Nursing**(N=62)*

Instruments	<i>t</i> (60)	<i>Sig</i> (2-tailed)
Cultural Attitude Scale		
CAS White	.762	.449
CAS Black	.430	.669
CAS Asian	-.032	.974
CAS Hispanic	-.197	.844
Transcultural Self-Efficacy Tool		
<b>TSET Cognitive</b>	<b>2.134</b>	<b>.037</b>
TSET Practical	1.818	.074
TSET Affective	1.548	.127

Table 4.17

*Relationship between Formal or Informal Education and No Formal or Informal Education in Transcultural Nursing (N =62)*

TSET Subscale	Levene's Test for Equality of Variances		t-test for Equality of means	
	F	Sig.	t	df
Cognitive	.290	.592	1.241	60
Practical	.319	.574	.764	60
Affective	2.761	.102	.785	60

Pearson correlation coefficients were computed for the CAS and the TSET and the demographic variables of age (Table 4.18) and years licensed as a registered nurse (Table 4.19). A significant correlation was found between the CAS vignette White and age ( $p = .013$ ) and years licensed ( $p = .017$ ) indicating that older nursing faculty who had been licensed for longer duration had more positive attitudes toward the White patient. A significant correlation was also found between the attitude toward the Asian patient and age ( $p = .048$ ) and years licensed ( $p = .015$ ) indicating that older nursing faculty who had been licensed for longer duration had a more positive attitude toward the Asian patient. There are, however, weak to moderate effect sizes for these two findings. The significant findings of the relationships between the vignettes of the CAS and the subscales of the TSET and the demographic variables analyzed indicate that age, years licensed, and country of nursing program attended were covariates in this study.

Table 4.18

*Pearson Correlations of Participant Age and CAS and TSET (N = 62)*

Instruments	<i>r</i>	( <i>p</i> )
Cultural Attitude Scale		
CAS White	-.321	(.013)
CAS Black	-.209	(.111)
<b>CAS Asian</b>	<b>-.259</b>	<b>(.048)</b>
CAS Hispanic	-.012	(.926)
Transcultural Self-Efficacy Tool		
TSET Cognitive	.223	(.089)
TSET Practical	.249	(.057)
TSET Affective	.016	(.905)

Table 4.19

*Pearson Correlations of Number of Years Licensed as R.N. and CAS and TSET (N =62)*

Instruments	<i>r</i> ( <i>p</i> )
<b>Cultural Attitude Scale</b>	
CAS White	-.305 (.017)
CAS Black	-.224 (.083)
<b>CAS Asian</b>	<b>-.311 (.015)</b>
CAS Hispanic	-.145 (.266)
<b>Transcultural Self-Efficacy Tool</b>	
TSET Cognitive	.098 (.455)
TSET Practical	.181 (.163)
TSET Affective	-.058 (.654)

### **Hypothesis Test**

The purpose of the study was to investigate the relationship between associate degree nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy (the perceived confidence in performing transcultural nursing skills). It was hypothesized that these two variables would be significantly related. Pearson correlation coefficients were computed to determine the relationship between the CAS and the TSET. The analysis revealed no significant correlation between nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy, failing to support the hypothesis (Table 4.20).

Table 4.20

*Pearson Partial Correlations of TSET and CAS (N=62)*

TSE	TSE Cognitive	TSE Practical	TSE Affective
	<i>r (p)</i>	<i>r (p)</i>	<i>r (p)</i>
CAS White	.079 (.54)	.108 (.40)	.032 (.81)
CAS Black	-.096 (.46)	-.034 (.79)	-.065 (.62)
CAS Asian	-.062 (.63)	.001 (.99)	-.067 (.61)
CAS Hispanic	-.203 (.11)	-.120 (.35)	-.205 (.11)

Pearson correlation coefficients were also computed to test whether the Social Desirability Scale and the CAS and the TSET were associated (Table 4.21). The analysis revealed no significant correlations between the Social Desirability Scale and nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy. It can be assumed that faculty responses on the CAS and TSET were not influenced by the socially desirable response.

Table 4.21

*Pearson Partial Correlations of the Social Desirability Scale with TSET and CAS (N = 62)*

Instrument	<i>r</i>	( <i>p</i> )
Transcultural Self-Efficacy		
TSET Cognitive	-.01	(.95)
TSET Practical	.24	(.06)
TSET Affective	.16	(.22)
Cultural Attitude Scale		
CAS White	-.08	(.53)
CAS Black	-.12	(.35)
CAS Asian	-.19	(.15)
CAS Hispanic	.01	(.93)

### Summary

The results of the data analysis of the responses of associate degree nursing faculty to the CAS, TSET, Social Desirability Scale and the background information questionnaire were presented in Chapter IV. General and specific sample characteristics were also presented. Psychometric evaluation of the CAS, TSET and the Social Desirability Scale indicated good to excellent reliability. Comparison of CAS factor/subscale scores reported in several studies and CAS total scores in this study was also presented. Univariate analysis of demographic variables and instrument responses were discussed. Correlation statistics failed to support the hypothesized positive relationship between the attitudes of associate degree nursing

faculty toward culturally diverse patients and transcultural self-efficacy. Chapter V discusses the results of this research.

## **Chapter V**

### **Discussion**

The purpose of this study was to investigate the relationship between the attitudes of associate degree nursing faculty toward culturally diverse patients and transcultural self-efficacy (the perceived confidence in performing transcultural nursing skills). A review of the literature on attitude toward cultural diversity and transcultural self-efficacy suggested that the factors of motivation, commitment and perceived confidence in performing transcultural nursing skills would provide insight into the relationship between them. It was hypothesized that there would be a significant positive relationship between the attitudes towards culturally diverse patients and transcultural self-efficacy. This research focused on the attitudinal components of the nursing faculty and patient relationship within the academic setting and perceived confidence in performing transcultural nursing skills. In academic systems, as in any other interactive system, interactions are affected by the attitudes, values, beliefs and expectations of the participants. Nursing education must consider the cultural attitudes, values and beliefs toward patients in the educational process to enhance the cultural competence of their students and, in turn, nursing practice. Awareness of cultural attitudes, values and beliefs promotes effective engagement with culturally diverse patients and students (Jeffreys, 2006). Failure to acknowledge one's attitude toward culturally diversity may lead to behaviors that cause cultural pain. (Jeffreys, 2006).

The research hypothesis was not supported; specifically there was no significant relationship between associate degree nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy. This chapter presents discussion of the findings related to the research hypothesis, the ancillary data findings, and the theoretical framework.

## Research Hypothesis

The research hypothesis was not supported since the findings did not result in a significant positive relationship between faculty attitudes toward culturally diverse patients and confidence in performing transcultural nursing skills. Univariate and correlation statistical analyses were performed, no significant relationship between the variables was found. The CAS has not been used that often in the literature on attitudes of nursing faculty toward culturally diverse patients. However, given the available instruments, it has been used with nursing faculty, but these studies explored attitudes of baccalaureate faculty rather than associate degree faculty (Jaffe-Ruiz, 1980; Kardong-Edgren et al., 2005). In addition, the TSET has not been used in studies with nursing faculty. It has been used in studies with associate and baccalaureate nursing students and nurses in various practice settings.

## Ancillary Findings

**Cultural Attitude Scale.** The significant findings of the relationships between the vignettes of the CAS and the subscales of the TSET and the demographic variables of age, years licensed, and country of nursing program attended indicate that they were covariates in this study. Older faculty who were licensed for a longer period of time had a more positive attitude toward the Asian patient and the White patient. The findings regarding the Asian patients may be related to the Model Minority Myth. The Myth is a perception that Asian Americans have greater success than other minorities because of a strong work ethic, perseverance, and drive to succeed as well as being studious, intelligent, successful, elitist and passive. The perception is also that Asians are treated fairly and do not experience racism (Yoo, Burrola & Steger, 2010). The stereotype is damaging to Asian Americans in many ways that go beyond the scope of this

study. The finding that faculty who received their initial nursing education in the United States had a more negative attitude toward the Black patient may be related to racism, ethnocentrism and stereotypical beliefs about this group (Markey & Tilki, 2007). The positive attitude toward the Asian patient and the negative attitude toward the Black patient found in this study are of serious concern since these attitudes may indicate faculty beliefs about false, damaging stereotypes that have the potential to negatively influence students.

Additionally, a comparison of total score means for each vignette of the CAS showed a decline in scores from 1993 to 2012. Current results were compared to those obtained in previous studies (Table 5.1). Results showed current mean scores were lower than those obtained in earlier studies indicating a more negative attitude toward culturally diverse patients. The White patient three factor score mean was also found to be significantly lower than those of the Black, Asian, and Hispanic patients [ $F(3,59) = 7.31, p = .000$ ]. This may be due to the low instrument reliability (-.137 to .306) for the factor, Cultural Attitudes and Beliefs.

The influence of the socioeconomic status of the respondents may also be a factor in these findings. Specific income information was not obtained, but respondents were asked to identify their current position in the community compared to the position of their birth family. Sixty-one percent saw themselves in a higher position, twenty-nine percent saw themselves at the same level, and sixteen percent saw themselves in a lower position. Regarding educational level, respondents were not asked specifically about the highest educational degree achieved. They were asked if they had an advanced practice nursing degree, limiting the ability to analyze educational level. These findings may indicate the influence of factors, such as racism, ethnocentrism, socioeconomic status, educational level, and world events, such as terrorist attacks, on attitudes toward culturally diverse patients.

Table 5.1

*Comparison of CAS Total Score Means 1993 to 2012*

Group	Rooda (1993)	Kardong-Edgren (2005)	Current Sample (2012)
White	3.70	3.35	2.38
Black	3.63	3.35	2.57
Asian	3.54	3.20	2.58
Hispanic	3.31	3.20	2.59

**Transcultural Self-Efficacy Tool.** The significant finding of the relationship between the vignettes of the CAS and the subscales of the TSET indicated that faculty who attended informal education in transcultural nursing had an increased score on the cognitive subscale of the TSET. It was also found that there was no significant difference in scores of faculty who had formal or informal education in transcultural nursing and those who did not. Table 5.2 presents a comparison of TSET subscale mean scores of staff nurses (Toney, 2004), recent nursing graduates from associate (AD) and baccalaureate (BS) degree programs (Ferguson, 2007), and the current sample. The staff nurses had graduated from BS (41%), diploma (31%), and AD (29%) programs. Most (79%) had attended conferences on cultural competence and some (38%) had classes on cultural competence in their nursing education (Toney, 2004). Ferguson (2007) found no difference in the scores of AD (49%) and BS (51%) graduates. All had transcultural nursing concepts in their curriculum.

Table 5.2

*Comparison of TSET Subscale Mean Scores of Nurses, Recent Nursing Graduates (AD/BS), and Current Sample (AD Nursing Faculty)*

TSET Subscale	Staff Nurses	AD Graduates	BS Graduates	AD Faculty
Cognitive	6.6	7.63	7.62	7.81
Practical	6.7	6.95	7.11	7.70
Affective	8.3	8.52	8.46	9.02

**Social Desirability Scale.** There was no significant relationship between the CAS and TSET and the Social Desirability Scale indicating that there was no social approval selection bias in faculty responses to the CAS and TSET. It was also found that mean scores on the Social Desirability Scale indicated an above average concern for the socially acceptable response.

### **Theoretical Framework**

The theoretical framework for this study which combined the constructs of attitude toward culturally diverse patients and transcultural self-efficacy was not sustained in that the hypothesis was not supported. This was the first reported study to investigate the relationship between associate degree nursing faculty attitudes toward culturally diverse patients and transcultural self-efficacy (the perceived confidence in performing transcultural nursing skills).

The functional approach to attitudes (trying to understand the reasons people hold the attitudes they do) (Katz, 1960) and the Cultural Competence and Confidence model (Jeffreys,

2006) were the conceptual frameworks used in this study. These models were the basis for development of the CAS and the TSET respectively.

According to Katz (1960), attitudes can serve a utilitarian, ego defensive, value expressive (positive expression of one's central values) or knowledge function for individuals. The conditions needed to modify an attitude are based on motivation and can be the stimulus for attitude change. Motivation for the attitude or the goal one is trying to achieve is the basis of Katz's perspective and, therefore, can help explain and predict human behavior. Parental and group influences as well as personality characteristics contribute to attitude development. Attitudes, however, are demonstrated within the contexts established by culture.

Jeffreys' (2006) Cultural Competence and Confidence (CCC) model focuses on the teaching learning process of cultural competence development as influenced by transcultural self-efficacy (TSE). It incorporates the cognitive, practical and affective domains and transcultural nursing theory. The CCC model provides the framework for teaching and learning cultural competence development in self and others. It is based on self-efficacy theory (Bandura, 1986) and on the motivation to engage in the process of becoming culturally competent (Jeffreys, 2006). Self-efficacy theory proposes that strong self-efficacy perceptions result in higher levels of goal commitment, motivation, persistence, learning, and skill performance (Bandura, 1986); essential components in achieving cultural competency are commitment and motivation (Campinha-Bacote, 1999, 2003; Chang, 1995). TSE is the perceived confidence one has to perform behaviors that are culturally competent despite hardships and obstacles and the degree to which individuals perceive they have the ability to learn or perform specific transcultural skills needed for culturally competent and congruent care (Jeffreys, 2006, p. 37). It is assumed that

TSE perceptions will directly influence cultural competency through commitment and motivation (Jeffreys, 2006).

Motivation is a key component of the functional approach to attitudes and the Cultural Competence and Confidence model. This led the researcher to hypothesize a significant relationship between the attitude of associate degree nursing faculty toward culturally diverse patients and transcultural self efficacy. However, the findings of this research that there is not a significant relationship between the variables may be due to their complexity and the population sampled. This study raises the questions of faculty motivation to have positive attitudes toward culturally diverse patients and their perceived confidence in performing transcultural nursing skills.

### **Summary**

The discussion of the research hypothesis, ancillary findings and theoretical framework were presented in Chapter V. The research hypothesis was not supported since the findings did not result in a significant positive relationship between faculty attitudes toward culturally diverse patients and confidence in performing transcultural nursing skills. Ancillary findings indicated that older, longer licensed faculty had more positive attitudes toward the White and Asian patient and faculty who received their nursing education in the United States had a more negative attitude toward the Black patient. Regarding transcultural self-efficacy, faculty who had no formal or informal education in transcultural nursing had the same mean scores on the TSET. The theoretical framework of the study was not supported. Conclusions, implications for nursing education and research, and study limitations are discussed in Chapter VI.

## Chapter VI

### Conclusions, Implications, and Study Limitations

The effects of globalization are reflected in the diversity of populations in most parts of the world, each with their own values and beliefs about health and health care. The cultural diversity of patients in need of and receiving health care is further evidenced by the regulatory and accreditation standards in the United States that require health care organizations to provide information and care that respects patients' language, culture and ethnicity (The Joint Commission, 2010). Nursing programs in academic institutions are also required to provide education about caring for culturally diverse patients in a culturally competent way (Commission on Collegiate Education in Nursing (CCNE), 2009; National League for Nursing Accrediting Commission, Inc. (NLNAC), 2008). Nursing students are taught by nursing faculty who may or may not be culturally competent (Jeffreys, 2006; Sealey, Burnett & Johnson, 2006). The educational interaction between faculty and student may be affected if faculty have ethnocentric beliefs about the superiority of Western health care practices and beliefs, minimize the significance of the diverse beliefs and practices of patients or have negative attitudes about cultural diversity.

In this study, the researcher investigated the relationship between the attitudes of associate degree nursing faculty toward culturally diverse patients and transcultural self-efficacy. The Cultural Attitude Scale and the Transcultural Self-Efficacy Tool were completed by 65 associate degree nursing faculty from a large publicly funded university in the northeastern United States. The Social Desirability Scale and a demographic background questionnaire were also completed. The findings of this study are relevant for nursing education and research. This

chapter presents the investigator's conclusions, implications for nursing education and research, recommendations for future research, and study limitations.

## **Conclusions**

The conclusions that can be drawn from this study relate to the constructs of the study, the procedure used for data collection, and the population sampled. A negative attitude toward people that are different from faculty can be a disturbing realization. Bonaparte (1977) and Jaffe (1980) identified dogmatism and ethnocentric beliefs as factors influencing nurses and nursing faculty attitudes toward diverse patients. The more closed-minded and ethnocentric an individual, the more negative their attitude is toward culturally diverse patients. More recent studies investigate cultural attitudes and knowledge about cultural diversity without exploring the influence of personality variables (Kardong-Edgren et al., 2005; Bond et al., 2001; Jones et al, 2004; Kardong-Edgren, 2007). These studies also mention the influence of socially desirable responses on the study results and recommend measuring that variable. In this study the results on the Social Desirability Scale showed that the sample had an above average concern for social approval. There was not, however, a statistically significant relationship between responses to the CAS and TSET and the Social Desirability Scale.

The complexity of the elements that define attitude needs to be explored to provide potential areas for faculty preparation and development as educators in a diverse world. The question of how faculty form their attitude about culturally diverse patients needs to be asked. The decline in mean scores on the CAS over the past 25 years, indicating a more negative attitude toward culturally diverse patients, is a surprising finding in view of the mandated emphasis in nursing programs on cultural competence. The impact of world events, such as terrorist attacks, the negative media portrayal of diverse ethnicities, economic hardship, the increasing diversity of New York City, and high unemployment rates may be factors in this finding. Exploring faculty professional and personal

experience with diversity and personality characteristics of faculty may provide insight into the decline in attitude scores found in his study.

Transcultural self-efficacy is an ongoing, multidimensional process. It may be confused with cultural competence (knowing about different ethnicities). Classifying people by race and ethnicity continues in the 21<sup>st</sup> century and contributes to the many health and social disparities in the United States (IOM, 2002). The finding of no difference in mean scores between faculty who had formal or informal transcultural nursing education and those who had no education is worthy of future study. This may validate the contention that faculty are not adequately prepared to teach or value cultural competence (Jeffreys, 2006). Faculty in this study are teaching in colleges with diverse students who interact with diverse patient populations. This may account for the scores indicating they are confident in caring for culturally diverse patients (McMillan, 2012; Burke, 2011; Wilson, Sanner & McAllister, 2010).

Data collection procedures and the sample chosen may have influenced response rates. Faculty could self-select to participate or not. The use of online surveys with open-ended questions rather than paper and pencil forced choice surveys may increase response rates and provide additional data not captured in this study. The demographics of nursing faculty (older and predominately white) may have influenced the findings of this research in ways that reflect the culture, values, and beliefs of their age, race, academic, and professional experience.

### **Implications for Nursing Education**

Based on the findings of this research, there are several implications for nursing education. The use of standardized patient case studies and patient simulators (human or computerized) with culturally diverse patients can enhance faculty and student knowledge and skill in caring for this

patient population. Carefully designed debriefing sessions with participants can provide an opportunity for improved practice as well as self-reflection on one's attitude toward culturally diverse patients. Disseminating the results of this study in peer reviewed journals and at professional conferences can challenge faculty to reflect on how they are teaching students about cultural diversity and how students are being prepared to care for diverse patients. Lastly, faculty development activities that focus on the issues of negative attitudes toward diversity, such as racism and ethnocentrism, may address the barriers to positive faculty attitudes toward diversity in the clinical and academic setting.

### **Implications for Nursing Research**

There are several implications for nursing research based on the findings of this study. The use of current technologies, such as online surveys and simulation activities, to further investigate the variables, may address the limitation of the number of respondents in this study. Mixed method and qualitative studies to explore faculty experience with diverse patients and students can provide insight into the complexity of the variables of attitude toward culturally diverse patients and transcultural self-efficacy. Collecting more comprehensive demographic data, such as faculty economic status and highest level of education, would provide a clearer picture of the sample studied and the possible relationship of that data to the variables studied. The use of shorter, valid, reliable, quantitative instruments may increase response rates and provide a different perspective on cultural competence. Campinha-Bacote's (1999) Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Revised (IAPCC-R) is one such instrument. This 24-item, four choice Likert scale measures cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters. Lastly, refinement of the Cultural Attitude Scale to include a question about what race and/or ethnicity the participant thinks the patient is, may elicit an accurate

indication of the participant's perception of the race and ethnicity of the person portrayed in the vignettes.

### **Recommendations for Future Research**

Separate studies that examine nursing faculty cultural attitudes and transcultural self-efficacy are warranted because of the lack of significance in the relationship between the two variables in this research. The classification of generic ethnic groups (White, Black, Asian, Hispanic) does not account for the subgroups within each of these groups. The development of valid, reliable quantitative instruments to measure the attitude toward subgroups within each ethnic group, such as Dominican, Colombian, Puerto Rican for the generic Hispanic group, may provide more specific information about attitudes toward cultural diversity. Qualitative investigations with nursing faculty about their experience with culturally diverse patients and students may also provide insight into the complexities of cultural attitudes and cultural competence.

### **Study Limitations**

The limitations identified for this study are related to sample size, sample studied and instruments used. There were not enough participants for generalization of the study findings. Several reasons may account for this. The use of paper and pencil instruments and their length may have contributed to the number of participants. Several participants wrote on the instruments that they were too long. Questionnaire packets were distributed at the end of the spring and at the beginning of the fall academic semester when faculty responsibilities for teaching rather than completing a lengthy questionnaire packet may have been their priority. Cultural competence competes with many other areas nursing faculty are required to know and teach. Simulation, online teaching, and electronic health records are only a few of the current technologies faculty are expected to integrate in nursing curricula. This may account for a shift in faculty focus to areas of interest to

them rather than areas, such as cultural diversity, that may make them feel uncomfortable or are of little interest. Interest in cultural competence may have prompted some faculty to respond to the surveys while those who have negative attitudes about culturally diverse patients, no interest in the concept, or think they are knowledgeable may not have responded.

This study was also limited by the instruments used to measure attitudes toward culturally diverse patients and transcultural self-efficacy. The vignettes of the Cultural Attitude Scale did not clearly indicate the race or ethnicity of the patients described. The description of Mr. Andrews, the White patient, could have been interpreted from a social class rather than a race or ethnicity perspective. Refinement of the instrument to include a question at the end of each vignette about the race and ethnicity of the patient may provide a more accurate indication of attitude toward culturally diverse patients. The low reliability of the factor, cultural attitudes and beliefs, is another limitation of the CAS. A factor analysis of the instrument may identify different factors measured in this study. Regarding the Transcultural Self-Efficacy Tool, even though the instrument had high reliability, the length of the instrument was of concern to some of the faculty participating in the study. Administering these instruments in separate studies or at different times may provide a more accurate measure of attitudes toward culturally diverse patients and transcultural self-efficacy.

Lastly, the background information collected in this study was incomplete for faculty. Asking specific questions on socioeconomic status and educational level may provide information that adds insight into the factors influencing the variables investigated. The inclusion of questions on personality characteristics may also contribute to identifying traits that influence attitudes toward culturally diverse patients and transcultural self-efficacy.

In summary, although there was not a significant relationship found between the variables studied, this study contributes to the knowledge base of nursing by identifying the need for further

study of faculty attitudes toward cultural diversity and transcultural self-efficacy. Faculty may not be able to meet the mandate of accrediting bodies to include cultural competence in nursing education if they do not consider it a priority, are not prepared to teach the concepts, or are uncomfortable in culturally diverse settings. The development and refinement of instruments that measure attitudes toward diversity, including ethnic subgroups, and qualitative studies of faculty experiences with diversity may provide answers that may ensure students are taught about and provide culturally competent health care.

## Appendix A

### Permission Responses for Instrument Use

Re: Fw: Dr. Beverly Bonaparte's Email or Contact information

From: <BBonaparte@sgu.edu>

To: <rblair@sgu.edu>

CC: <ekontzamanis@CityTech.Cuny.Edu>, <keville.frederickson@lehman.cuny.edu>

Date: Tuesday - October 19, 2010 9:18 AM

Subject: Re: Fw: Dr. Beverly Bonaparte's Email or Contact information

Attachments: Part.002; Mime.822

Ms. Kontzamanis has my permission to use my Cultural Attitude Scale. Both she and Dr. Frederickson may contact me directly if she needs additional assistance. My contact information is attached

Regards,

Beverly

**Ranel L Blair/USL/SGU\_LN**

10/19/2010 08:43 AM

To Beverly Bonaparte/FACULTY/SGU\_LN@SGU\_LN

cc

Subject Fw: Dr. Beverly Bonaparte's Email or Contact information

Ranel Blair  
Assistant Director, USS Registrar  
631-665-8500 ext. 9242  
1-800-899-6337 ext. 9242  
631-665-2047 fax

----- Forwarded by Ranel L Blair/USL/SGU\_LN on 10/19/2010 08:43 AM -----

**"Emma Kontzamanis" <ekontzamanis@CityTech.Cuny.Edu>**

10/18/2010 06:00 PM

To: <regmail@sgu.edu>

cc:

Subject: Dr. Beverly Bonaparte's Email or Contact information

To Whom It May Concern:

I am a doctoral student in nursing at the Graduate Center, City University of New York, NYC. My advisor, Dr. Keville Frederickson, suggested I use Dr. Bonaparte's Cultural Attitude Scale (CAS) in my dissertation, An Investigation of the Relationship between the Attitudes of Associate Degree Nursing Faculty towards Culturally Diverse Patients and Transcultural Self-Efficacy. Could you please forward me her address? I would like to request her permission to use the CAS.

Thank you very much for your time and attention to my request.

Sincerely,

Emma Kontzamanis

---

This email has been scanned by the MessageLabs Email Security System.  
For more information please visit <http://www.messagelabs.com/email>

---

---

This email has been scanned by the MessageLabs Email Security System.  
For more information please visit <http://www.messagelabs.com/email>

---

**Re: Permission Request**

**From:** "Carrie Neff" <cneff@springerpub.com>  
**To:** <ekontzamanis@citytech.cuny.edu>  
**Date:** Tuesday - November 24, 2009 3:53 PM

Dear Ms. Kontzamanis,

Thank you for your interest in using the Transcultural Self-Efficacy Tool (TSET) from *Teaching Cultural Competence in Nursing and Health Care: Inquiry, Action, and Innovation* in your research study. Due to the fact that this material will be used for academic rather than commercial purposes, only a proper citation of the title within your own work will be required.

Thank you,

Carrie Neff

**Carrie Neff**

**Sales Administrator**

**11 W. 42<sup>nd</sup> Street, Fl. 15**

**New York, NY 10036**

**212.431.4370 x221**

**212.941.7848 (f)**

**cneff@springerpub.com**

**[www.springerpub.co](http://www.springerpub.co)**

Appendix B

Institutional Review Board Approval

CUNY REVISED: DECEMBER 2006 PAGE 1 OF 2

CUNY-Wide IRB  
Office of Research Conduct  
535 E 80<sup>th</sup> Street  
New York, New York 10075  
212.794.5504  
212.794.5378, fax

TO: Emma Kontzamanis RN  
New York City College of Technology  
FROM: Reverend David Kossey  
CUNY-Wide IRB: IRB00000149  
SUBJECT: IRB Approval (Expedited Review)  
STUDY: **11-02-027-0149 An Investigation of the Relationship between Nursing Faculty Attitudes toward Culturally Diverse Patients and Transcultural Self-Efficacy**  
DATE: May 18, 2011

The CUNY-Wide IRB: IRB00000149 has approved the above study involving humans as research subjects. This study was Approved - Expedited Category: 7 - based on 45CFR46.

**IRB Number: 11-02-027-0149** This number is a CUNY-Wide IRB: IRB00000149 number that should be used on all consent forms and correspondence.

**Approval Date: May 17, 2011**

**Expiration Date: May 16, 2012**

**THIS APPROVAL IS FOR A PERIOD OF ONE-YEAR OR LESS. YOU SHOULD RECEIVE A COURTESY RENEWAL NOTICE BEFORE THE EXPIRATION OF THIS PROJECT'S APPROVAL. HOWEVER, IT IS YOUR RESPONSIBILITY TO INSURE THAT AN APPLICATION FOR CONTINUING REVIEW APPROVAL HAS BEEN SUBMITTED BEFORE THE EXPIRATION DATE NOTED ABOVE. IF YOU DO NOT RECEIVE APPROVAL BEFORE THE EXPIRATION DATE, ALL STUDY ACTIVITIES MUST STOP UNTIL YOU RECEIVE A NEW APPROVAL LETTER. THERE WILL BE NO EXCEPTIONS. IN ADDITION, YOU ARE REQUIRED TO SUBMIT A FINAL REPORT OF FINDINGS AT THE COMPLETION OF THE PROJECT.**

**Consent Form:** All research subjects must use the approved and stamped consent form. You are responsible for maintaining signed consent forms for each research subject for a period of at least three years after study completion.

**Mandatory Reporting to the IRB:** The principal investigator must report, within five

business days, any serious problem, adverse effect, or outcome that occurs with frequency or degree of severity greater than that anticipated. In addition, the principal investigator must report any event or series of events that prompt the temporary or permanent suspension of a research project involving human subjects or any deviations from the approved protocol.

**Amendments/Modifications:** All amendments/modifications of protocols involving human subjects must have prior IRB approval, except those involving the prevention of immediate harm to a subject. Amendments/modifications for the prevention of immediate harm to a subject must be reported within 24 hours to the IRB.

**Stipulations:** None

If you have any questions, please do not hesitate to contact Arita Winter in the IRB Office at 212.794.5504.

Good luck on your project.

cc: Keville Frederickson EdD

Sign the Verification Statement below. Return the original signed copy of this memo to the IRB Office and retain a copy for your records. The IRB Office must receive a copy of the signed verification statement before research may begin.

**VERIFICATION:**

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THIS APPROVAL AND AM AWARE OF, AND AGREE TO**

**ABIDE BY, ALL OF ITS STIPULATIONS IN ORDER TO MAINTAIN ACTIVE APPROVAL STATUS, INCLUDING TIMELY SUBMISSION OF CONTINUING REVIEW APPLICATIONS AND PROPOSED PROTOCOL MODIFICATIONS, AS WELL AS PROMPT REPORTING OF ADVERSE EVENTS, SERIOUS UNANTICIPATED PROBLEMS, AND PROTOCOL DEVIATIONS. I AM AWARE THAT IT IS MY RESPONSIBILITY TO BE KNOWLEDGEABLE OF ALL FEDERAL, STATE AND UNIVERSITY REGULATIONS REGARDING HUMAN SUBJECTS RESEARCH INCLUDING CUNY'S FEDERALWIDE ASSURANCE (FWA) WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF HUMAN RESEARCH PROTECTIONS.**

Signature of Principal Investigator Date

Signature of Faculty Advisor for Student Research Date

Appendix C

Letter to Nursing Department Chairpersons

Graduate Center Letterhead

Dear Chairperson:

I am a doctoral student in the Department of Nursing Science at the Graduate Center of the City University of New York (CUNY). I am conducting a study about nursing faculty and their attitudes toward culturally diverse patients and perceived confidence in performing transcultural nursing skills. Nursing faculty teaching in associate degree programs are being asked to participate. It is anticipated that about 65 individuals will do so. Completion of a demographic data sheet, a social desirability scale and two instruments is required. Total completion time is about 45 minutes.

If possible, I could come to a faculty meeting early in the semester to ask for participation and completion of the documents mentioned above. Participation is voluntary, but would be helpful in improving nursing education as well as having an impact on professional nursing practice by promoting positive patient health care outcomes.

If you have any questions about the study, you can contact me at (347) 922-8036, [ekontzamanis@gc.cuny.edu](mailto:ekontzamanis@gc.cuny.edu) or my dissertation sponsor, Dr. Keville Frederickson at (212) 817-7985, [keville.frederickson@lehman.cuny.edu](mailto:keville.frederickson@lehman.cuny.edu).

Thank you for your time and consideration of my request.

Sincerely,

Emma Kontzamanis, RN, MA, DNS (c)

Appendix D

Letter to Participants (Consent Form)

Graduate Center Letterhead

### **CONSENT FORM**

My name is Emma Kontzamanis and I am a doctoral student in the Department of Nursing Science at the Graduate Center of the City University of New York (CUNY). I am conducting a study about nursing faculty and culturally diverse patients. You are being asked to participate in a study which explores attitudes towards culturally diverse patients and perceived confidence in performing transcultural nursing skills. You have been identified as a possible participant because you are a nursing faculty member in an associate degree program. It is anticipated that about 65 individuals will participate in this study. Participation in this study is voluntary and refusal to participate will involve no penalty to you.

You are being asked to participate by completing a demographic information sheet, a social desirability scale, and two instruments. Completion time will take about 45 minutes.

The risks from participating in this study are no more than encountered in everyday life; however, it is possible that the questions could raise sensitive issues for you. In the event that this happens, you may stop completing the packet at any time without penalty.

There is no direct benefit to you by participating in this study. However, participating in this study may increase understanding of nursing faculty attitudes about cultural diversity which could improve nursing education and practice.

The packets containing the demographic data sheet, a social desirability scale and the two instruments will be distributed and collected. No personal identifiers will be linked to the data. All materials will be kept in a locked cabinet. Only my faculty advisor and I will have access. The data will be stored for a minimum of three years. After that time, all materials may be destroyed. As long as the data exists it will be kept secured. The information will be used to

produce a doctoral dissertation. The results of the study may be published; however, all identifying information about you and others who participate will be omitted or disguised. I, as the researcher, am mandated only to report to the proper authorities if there is any concern of imminent danger of harming yourself or others.

You may discontinue participation at any time without penalty. If you have questions about the study, you can contact me, Emma Kontzamanis, at (347) 922-8036, [ekontzamanis@gc.cuny.edu](mailto:ekontzamanis@gc.cuny.edu), or my dissertation sponsor, Dr. Keville Frederickson at (212) 817-7985, [keville.frederickson@lehman.cuny.edu](mailto:keville.frederickson@lehman.cuny.edu). A summary of results will be provided to you upon request. If you have any questions about your rights as a participant in this study, you can contact Arita Winter, IRB Administrator, Office of Research Conduct, CUNY, at (212) 794-5504, [arita.winter@mail.cuny.edu](mailto:arita.winter@mail.cuny.edu).

Thank you for your participation in the study.

---

I have read the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give consent to participate in this study. I have received a copy of this form for my records and future reference.

## References

- Agency for Healthcare Research and Quality. (2008). *2008 National Healthcare Disparities Report*. Retrieved from <http://www.ahrq.gov/qual/qdr08.htm>
- American Psychological Association. (2009). *Publication Manual of the American Psychological Association* (7<sup>th</sup> Edition). Washington, D.C.: Author.
- Amerson, R. (2009). *The influence of international service-learning on cultural competence in baccalaureate nursing graduates and their subsequent nursing practice*. (Unpublished doctoral dissertation). Clemson University, South Carolina.
- Andrews, M. (1995). Transcultural nursing: Transforming the curriculum. *Journal of Transcultural Nursing*, 6(2), 4-9.
- Bandura, A. (1977). *Social Learning Theory*, New Jersey: Prentice-Hall, Inc.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37(2), 122-147.
- Bandura, A. (1986). *Social foundations of thought and action: A Social Cognitive Theory*. Prentice-Hall, Inc.: Englewood Cliffs, N.J.
- Bandura, A. (1989). Regulation of cognitive processes, through perceived self-efficacy. *Developmental Psychology*, 25(5), 729-735.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W.H. Freeman.
- Bandura, A., Adams, N. E., & Beyer, J. (1977). Cognitive processes mediating behavioral change. *Journal of Personality and Social Psychology*, 35(3), 125-139.
- Barbee, E. L., & Gibson, S. E. (2001). Our dismal progress: The recruitment of non-whites into nursing. *Journal of Nursing Education*, 40(6), 243-245.
- Bednarz, H., Schim, S., & Doorenbos, A. (2010). Cultural diversity in nursing education:

- perils, pitfalls and pearls. *Journal of Nursing Education*, 49(5), 253-260.
- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.
- Blackstock, S. (2003). *An examination of senior nursing students' perceptions of culturally competent nursing practices and their self-efficacy in delivering quality healthcare to culturally diverse patients*. (Unpublished doctoral dissertation). The University of North Carolina at Greensboro, North Carolina.
- Bonaparte, B. H. (1977). *An investigation of the relation between ego defensiveness and open-closed mindedness of female registered professional nurses and their attitude toward culturally different patients*. (Unpublished doctoral dissertation). New York University, New York.
- Bonaparte, B. H. (1979). Ego defensiveness, open-closed mindedness, and nurses' attitude toward culturally different patients. *Nursing Research*, 28(3), 166-172.
- Bond, M. L., Kardong-Edgren, S., & Jones, M. E. (2001). Assessment of professional nursing students' knowledge and attitudes about patients of diverse cultures. *Journal of Professional Nursing*, 17(6), 305-312.
- Brown, P. S. (1986). *A survey of nurses' attitudes toward culturally diverse patients*. (Unpublished master's thesis). Southern Illinois University at Edwardsville, Illinois.
- Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Registered Nurses, Retrieved from <http://www.bls.gov/ooh/healthcare/registered-nurses.htm> (visited February 17, 2013).
- Burke, P. M. (2011). *Cultural competence of associate degree nursing faculty*. (Unpublished

- doctoral dissertaton) Capella University, Minneapolis, MN.
- Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(3), 203-207.
- Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of healthcare services: A culturally competent model of care*. (4<sup>th</sup> Edition). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Campinha-Bacote, J. (2007). Becoming culturally competent in ethnic psychopharmacology. *Journal of Psychosocial Nursing & Mental Health Services, 45*(9), 26-33.
- Canales, M. K., & Bowers, B. J. (2001). Expanding conceptualizations of culturally competent care. *Journal of Advanced Nursing, 36*(1), 102-111.
- Chang, M. K. (1995). Bridging the cultural gap. *Urologic Nursing, 15*(14), 123-126.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2<sup>nd</sup> Edition). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Commission on Collegiate Nursing Education (CCNE). (2009). *Standards for Accreditation of Baccalaureate and Graduate Degree Nursing Programs*. Retrieved from <http://www.aacn.nche.edu/accreditation/>
- Crowne, D. P., & Marlowe, D. A. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24* (4), 349-351.
- CUNY Annual Data Report Nursing Degree Programs. (2013). Retrieved from <http://www.cuny.edu/about/administration/offices/hhs/AnnualDataReportNursingDegreeProgramsCUNY2013FINAL.pdf>
- Davidhizar, R., & Shearer, R. (2005). When your nursing student is culturally diverse. *The Health Care Manager, 24*(4), 356-363.

- Dolgan, C. M. (2001). *The effects of cultural competency training on nurses' attitudes*. (Unpublished master's thesis). Cleveland State University, Cleveland OH..
- Ferguson, P. (2007). *Transcultural self-efficacy in graduating nursing students*. Doctoral dissertation. Illinois: Illinois State University.
- Giger, J., Davidhizar, R. E., Purnell, L., Harden, J. T., Phillips, J., & Strickland, O. (2007). American Academy of Nursing Expert Panel report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, 18(2), 95-102.
- Hassouneh, D. (2008). Reframing the diversity question: challenging Eurocentric power hierarchies in nursing education (editorial). *Journal of Nursing Education*, 47(7), 291-292.
- Institute of Medicine. (2002). *Guidance for the national health care disparities report*. Washington, D.C.: National Academies Press.
- Jaffe, M. C. (1980). *An Investigation of the Relationship between Ethnocentrism of Nursing Faculty and their Attitude toward Culturally Different Clients*. (Unpublished doctoral dissertation). Teachers College, Columbia University, New York.
- Jaffe-Ruiz, M. C. (1981). Open-closed mindedness, intolerance of ambiguity and nursing faculty attitudes toward culturally different patients. *Nursing Research*, 30(3), 177-181.
- Jeffreys, M. R. (1993). *The relationship of self-efficacy and select academic variables on academic achievement and retention*. (Unpublished doctoral dissertation). Teachers College, Columbia University, New York.
- Jeffreys, M. R. (2000). Development and psychometric evaluation of the Transcultural

- Self-Efficacy Tool: A synthesis of findings. *Journal of Transcultural Nursing*, 11(2), 127-136.
- Jeffreys, M. R. (2002). A transcultural core course in the clinical nurse specialist Curriculum. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, 16(4), 195-202.
- Jeffreys, M. R. (2004). *Nursing student retention: Understanding the process and making a difference*. New York: Springer Publishing Company.
- Jeffreys, M. R. (2006). *Teaching cultural competence in nursing and health care*. New York: Springer Publishing Company.
- Jeffreys, M. R. (2010). *Teaching Cultural Competence in Nursing and Health Care*. (2<sup>nd</sup> Edition). New York: Springer Publishing Company.
- Jeffreys, M. R., & Dogan, E. (2010). Factor analysis of the Transcultural Self-Efficacy Tool (TSET). *Journal of Nursing Measurement*, 18(2), 120-139.
- Jeffreys, M. R., & Smolaka, I. (1996). Steps to the instrument design Process: An Illustrative approach for nurse educators. *Nurse Educator*, 21(6), 47-52.
- Jeffreys, M. R., & Smolaka, I. (1998). Exploring the factorial composition or the Transcultural Self-Efficacy Tool. *International Journal of Nursing Studies*, 35, 217-225.
- Jeffreys, M. R., & Smolaka, I. (1999a). Changes in students' transcultural self-efficacy perceptions following an integrated approach to culture care. *Journal of Multicultural Nursing and Health*, 5(2), 6-12.
- Jeffreys, M. R., & Smolaka, I. (1999b). Construct validation of the transcultural self-efficacy tool. *Journal of Nursing Education*, 38(5), 222-227.

- Jones, M. E., Cason, C. L., & Bond, M. L. (2004). Cultural attitudes, knowledge, and skills of a health workforce. *Journal of Transcultural Nursing, 15*(4), 283-290.
- Kardong-Edgren, S., Bond, M. L., Schlosser, S., Casar, C., Jones, M. E., Warr, R., & Strunh, P. (2005). Cultural Attitudes, Knowledge and Skills of Nursing Faculty toward Patients from Four Diverse Cultures. *Journal of Professional Nursing, 21*(3), 175-182.
- Kardong-Edgren, S. (2007). Cultural competence of baccalaureate nursing faculty, *Journal of Nursing Education, 46*(8), 360-366.
- Knapp, T. R. ((1998). *Quantitative nursing research*. Thousand Oaks, CA: Sage.
- Kossman, S. (2003). *Student and faculty perceptions of nursing education culture and its impact on minority students*. (Unpublished doctoral dissertation). Illinois State University, Illinois.
- Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence. *Academic Medicine, 86*(6), 548-557.
- Leininger, M. M. (1970). *Nursing and anthropology: Two worlds to blend*. New York: John Wiley & Sons.
- Leininger, M. M. (1995b). Teaching transcultural nursing in undergraduate and graduate programs. *Journal of Transcultural Nursing, 6*(2), 10-26.
- Leininger, M. M., & McFarland, M. (2006). *Culture Care Diversity and Universality: A worldwide nursing theory* (2<sup>nd</sup> Edition). Boston: Jones and Bartlett.
- Leonard, B. J. (2001). Quality nursing care celebrates diversity. *Online Journal of Issues in Nursing, 6*(2), 14p.
- Macdonald, M. E., Carnevale, F. A., & Razack, S., (2007). Understanding what residents

want and what residents need: the challenge of cultural training in pediatrics.

*Medical Teacher*, 29(5), 464-471.

Markey, K., & Tilki, M. (2007). Racism in nursing education: A reflective journey. *British Journal of Nursing*, 16(7), 390-393.

McMillan, L. R. (2012). Exploring the world outside to increase cultural competence of the educator within. *Journal of Cultural Diversity*, 19(1), 23-25.

Mills-Wisneski, S. M. (2005). Minority students' perceptions concerning the presence of minority faculty: Inquiry and discussion. *The Journal of Multicultural Nursing & Health*, 11(2), 49-55.

National League for Nursing. (2008). *Annual survey of schools of nursing: academic year 2006-2007- Executive summary*. Retrieved from

[http://www.nln.org/research/slides/exec\\_summary.htm](http://www.nln.org/research/slides/exec_summary.htm)

National League for Nursing. (2009). *Sex of Nurse Educators by Employment Status*.

*NLN DataView™*. Retrieved from

[http://www.nln.org/research/slides/pdf/FC0809\\_F13.pdf](http://www.nln.org/research/slides/pdf/FC0809_F13.pdf)

National League for Nursing Accrediting Commission, Inc. (NLNAC). (2008). *NLNAC*

*Accreditation Manual*. Retrieved from

<http://www.nlnac.org/manuals/Manual2008.htm>

New York City Department of City Planning (2013). B05006: Place of birth of the foreign born,

*POPULATION 2010 Demographic Tables*. Retrieved from

[http://search1.nyc.gov/search?q=cache:ta6chnSZeM8J:www.nyc.gov/html/dcp/download/census/nyc\\_boros\\_2010\\_place\\_of\\_birth.xlsx+foreign+born+population&output=xml\\_no\\_dtd&site=defa](http://search1.nyc.gov/search?q=cache:ta6chnSZeM8J:www.nyc.gov/html/dcp/download/census/nyc_boros_2010_place_of_birth.xlsx+foreign+born+population&output=xml_no_dtd&site=defa)

[ult\\_collection&proxystylesheet=agency\\_frontend&client=agency\\_frontend&ie=UTF-8&access=p&oe=ISO-8859-1](#)

Pew Health Professions Commission. (1998). *Recreating health professional practice for a new century*. San Francisco: Pew Health Professions Commission.

Platter, B. (2005, October). *Clinical nurse cultural competency pre and post transcultural nursing education*. Paper presented at the annual conference of the Transcultural Nursing Society, New York, NY.

Purnell, L. D., & Paulanka, B. J. (2008). *Transcultural health care: A culturally competent approach*. (2<sup>nd</sup> Edition). Philadelphia, PA: F.A. Davis.

Rooda, L. A. (1990). *Knowledge and attitudes of nurses toward culturally diverse patients*. (Unpublished doctoral dissertation). Purdue University, West Lafayette, Indiana.

Rooda, L. A. (1993). Knowledge and Attitudes of Nurses toward Culturally Diverse Patients, *Journal of Nursing Education*, 32(5), 209-213.

Rudnick, L. A. (2005). *Nursing students' perceived self-efficacy to provide culturally competent nursing care: An educational outcomes assessment study*. (Unpublished doctoral dissertation). Wilmington College, Delaware.

Sanner, S., Wilson, A. H., & Samson, L.F. (2002). The experiences of international students in a baccalaureate nursing program, *Journal of Professional Nursing*, 18(4), 206-213.

Schunk, D. ((1987). *Self-efficacy and cognitive achievement*. Paper presented at the annual meeting of the American Psychological Association, New York, NY. (ERIC Document Reproduction Service No. ED 287 880).

Sealey, L. J. (2003). *Cultural competence of faculty of baccalaureate nursing programs.*

(Unpublished doctoral dissertation)., Louisiana State University and Agricultural & Mechanical College, Louisiana.

Sealey, L. J., Burnett, M., & Johnson, G. (2006). Cultural competence of baccalaureate nursing faculty: Are we up to the task? *Journal of Cultural Diversity*, 13(3), 131-140.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2009). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.

Smith, L. S. (1998). Cultural competence for nurses: Canonical correlation of two culture scales. *Journal of Cultural Diversity*, 5(4), 120-126.

Sullivan Commission. (2004). *Missing persons: minorities in the health professions.*

Retrieved from

[http://www.kaisernetwork.org/health\\_cast/uploaded\\_files/092004\\_sullivan\\_diversity.pdf](http://www.kaisernetwork.org/health_cast/uploaded_files/092004_sullivan_diversity.pdf)

Symington, S., Cooper, C., & Wallace, L. (2006). A description of cultural competency education in physician assistant programs. *The Journal of Physician Assistant Education*, 17(1), 18-22.

The Joint Commission. (2009). *Facts about the Hospitals, Language and Culture: A*

*Snapshot of the Nation (HLC) Study.* Retrieved from

[http://www.jointcommission.org/AboutUs/Fact\\_Sheets/facts\\_hlc.htm](http://www.jointcommission.org/AboutUs/Fact_Sheets/facts_hlc.htm)

The Joint Commission. (2010). *New and Revised Hospital EP's to Improve Patient-*

*Provider Communication.* Retrieved from <http://www.jcrinc.com/Joint-Commission-Requirements/Hospitals/#PC>

- Thompson, E. R., & Phua, F. T. (2005). Reliability among senior managers of the Marlowe-Crowne short form of the social desirability scale. *Journal of Business and Psychology, 19*(4), 541-554.
- Toney, D. (2004). *Exploring the relationship between levels of cultural competence and the perceived level of quality care among registered nurses caring for culturally diverse patients*. (Unpublished doctoral dissertation). Capella University, Minneapolis, MN.
- U. S. Department of Health and Human Services. (2000). *Healthy people 2010: Undertaking and improving health*. 2<sup>nd</sup> ed. Washington, DC: U.S. Government Printing Office.
- U. S. Department of Health and Human Services. (2010). *Healthy people 2020: National health promotion and disease prevention objectives*. Washington, DC: Author.
- Retrieved from  
<http://www.healthypeople.gov/hp2020/Objectives/TopicAreas.aspx>
- Velez, J. (2005). *The effects of cultural competency training using self-instruction on obstetrical nurses' awareness, knowledge, and attitudes*. (Unpublished master's thesis). Cleveland State University, Cleveland, OH.
- Waite, R., & Calamaro, C.J. (2010). Cultural competence: A systemic challenge to nursing education, knowledge exchange and the knowledge development process. *Perspectives in Psychiatric Care, 46*(1), 74-80.
- Wilson, A. H., Sanner, S., & McAllister, L. E. (2010). A longitudinal study of cultural

competence among health science faculty. *Journal of Cultural Diversity*, 17(2), 68-72.

Xu, Y., Davidhizar, R., & Giger, J. N. (2005). What if your nursing student is from an Asian culture? *Journal of Cultural Diversity*. 12(1), 5-11.

Yoo, H. C, Burrola, K. S., & Steger, M. T. (2010). A preliminary report on a new measure: Internalization of the model minority myth measure (IM-4) and its psychological correlates among Asian American College Students. *Journal of Counseling Psychology*, 57(1), 114-127.