5-2018

An Interpretive Phenomenological Study of How RN to BS Students Experience and Make Meaning of Participating in a Poverty Simulation

Carrie McNamer

St. Cloud State University, cmcnamer@winona.edu

Follow this and additional works at: http://repository.stcloudstate.edu/hied_etds

Part of the Higher Education Commons

Recommended Citation


http://repository.stcloudstate.edu/hied_etds/23

This Dissertation is brought to you for free and open access by the Department of Educational Leadership and Higher Education at theRepository at St. Cloud State. It has been accepted for inclusion in Culminating Projects in Higher Education Administration by an authorized administrator of theRepository at St. Cloud State. For more information, please contact modea@stcloudstate.edu, rsweelbaum@stcloudstate.edu.
An Interpretive Phenomenological Study of How RN to BS Students Experience and Make Meaning of Participating in a Poverty Simulation

by

Carrie J. McNamer

A Dissertation
Submitted to the Graduate Faculty of St. Cloud State University
in Partial Fulfillment of the Requirements for the Degree Doctor of Education in Higher Education Administration

May 2018

Dissertation Committee:
Michael Mills, Chairperson
Steven McCullar
Shirley Newberry
Cindy Bork
Abstract

The purpose of this research was to explore the lived experience of nursing students as they participated in, and reflected upon, a poverty simulation using the techniques of interpretive phenomenology. Eight registered nurses enrolled in a bachelor’s degree completion program were interviewed about their experience including the ways they made meaning of new information and whether or not it influenced their perspective on providing culturally competent patient care. The theoretical framework consisted of the constructivist learning theory and Campinha-Bacote’s Development of Cultural Competence in Healthcare theory. Data were analyzed according to van Manen’s six steps to guide phenomenological research. Three essential themes, and three subthemes, were identified. These themes were, (a) being in poverty, (b) background gap/overlap, and, (c) reflection points with the subthemes reconsideration, reaffirmation, and reframing. These themes were used to expand the description of the poverty simulation experience, provide insight into how students made meaning of new information, and assess resulting changes in the participants’ perception of culturally competent patient care. Students found the experience unsettling but described it as meaningful. Evidence of increased levels of cultural competency was noted in relationship to caring for socioeconomically vulnerable patients. Recommendations were offered to nurse educators to continue use the activity in higher education nursing programs, to incorporate resources from community service agencies, and to prepare for potential emotional reactions during the simulation and the debriefing period. Recommendations for new research areas included the use of poverty simulations with practicing healthcare personnel.
Acknowledgements

I would like to acknowledge the many wonderful people who have supported me on this academic and professional journey. I have great appreciation for Dr. Shirley Newberry who has been an encouraging mentor and role model to me for over two decades. I am thankful for my advisor, Dr. Michael Mills, for imparting wisdom and sound guidance throughout the completion of this project. I am also thankful to my dissertation committee members, Dr. Steven McCullar and Dr. Cindy Bork for being giving of their time and advice.

I am forever indebted to my friends and family for their years of support in this and many other academic endeavors. I am inspired by my three children, Stormy, Tristin, and Ezekiel, whose varied abilities have never ceased to amaze me. Stormy’s fierce independence, Tristin’s brilliant and unique world perspective, and Ezekiel’s relentless pursuit of excellence, have all made me proud every single day. I am grateful to my parents, Barb and Jim, who have provided a loving environment for myself and my siblings for fifty years and counting. I am blessed to have my grandmother, Gloria, who at 93 years old, continues to demonstrate a level of poise, class, and elegance that I can only hope to someday achieve. I am incredibly thankful for my dearest friends Julie and Misun, whose countless hours of conversation, guidance, and humor, have helped me grow as a person in ways I never could have imagined.

My final expression of gratitude goes to the wonderful person I am fortunate enough to share my life with, Daryl. I am beyond thankful for his unwavering confidence, gentle guidance, and the expressions of kindness he shown to me as I completed the final phases of this dissertation.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Figures</td>
<td>7</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>I. Introduction</td>
<td>8</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>14</td>
</tr>
<tr>
<td>Purpose and Significance of the Study</td>
<td>16</td>
</tr>
<tr>
<td>Description and Scope of Research</td>
<td>17</td>
</tr>
<tr>
<td>Research Questions</td>
<td>21</td>
</tr>
<tr>
<td>Summary</td>
<td>21</td>
</tr>
<tr>
<td>II. Literature Review</td>
<td>23</td>
</tr>
<tr>
<td>The State of Poverty in the U.S. and Associated Health Consequences</td>
<td>23</td>
</tr>
<tr>
<td>Healthcare Provider Attitudes Towards Diverse Patients</td>
<td>26</td>
</tr>
<tr>
<td>Teaching Strategies</td>
<td>40</td>
</tr>
<tr>
<td>RN to BS Nursing Students</td>
<td>43</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>46</td>
</tr>
<tr>
<td>Summary</td>
<td>51</td>
</tr>
<tr>
<td>III. Methodology</td>
<td>52</td>
</tr>
<tr>
<td>Research Design</td>
<td>52</td>
</tr>
<tr>
<td>Population/Sample</td>
<td>57</td>
</tr>
<tr>
<td>Data Collection</td>
<td>59</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>61</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Researcher Positioning</td>
<td>66</td>
</tr>
<tr>
<td>Ethical Considerations &amp; Human Subject Approval</td>
<td>67</td>
</tr>
<tr>
<td>Procedures and Timelines</td>
<td>68</td>
</tr>
<tr>
<td>Summary</td>
<td>68</td>
</tr>
<tr>
<td>IV. Findings</td>
<td>69</td>
</tr>
<tr>
<td>Demographics</td>
<td>70</td>
</tr>
<tr>
<td>Themes</td>
<td>70</td>
</tr>
<tr>
<td>Being in Poverty</td>
<td>71</td>
</tr>
<tr>
<td>Background Gap/Overlap</td>
<td>78</td>
</tr>
<tr>
<td>Reflection Points</td>
<td>89</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>90</td>
</tr>
<tr>
<td>Reaffirmation</td>
<td>93</td>
</tr>
<tr>
<td>Reframing</td>
<td>96</td>
</tr>
<tr>
<td>Research Questions</td>
<td>103</td>
</tr>
<tr>
<td>Summary</td>
<td>106</td>
</tr>
<tr>
<td>V. Discussion</td>
<td>108</td>
</tr>
<tr>
<td>Discussion</td>
<td>110</td>
</tr>
<tr>
<td>Limitations</td>
<td>113</td>
</tr>
<tr>
<td>Implications for Research</td>
<td>114</td>
</tr>
<tr>
<td>Implications for Theory</td>
<td>116</td>
</tr>
<tr>
<td>Implications for Practice</td>
<td>119</td>
</tr>
<tr>
<td>Conclusion</td>
<td>121</td>
</tr>
</tbody>
</table>
References.................................................................................................................................124

Appendices

A. Informed Consent Form........................................................................................................140

B. Interview Guide ..................................................................................................................142

C. IRB Approval......................................................................................................................144
### List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Visual Representation of Essential Themes</td>
<td>102</td>
</tr>
</tbody>
</table>
Chapter I: Introduction

The profession of nursing has traditionally embraced an ethos of compassion expressed through care that honors the dignity of all individuals and promotes social justice for vulnerable populations (American Nurse Association [ANA], 1926, 1968, 1976, 2001, 2015; Winland-Brown, Lachman & O’Conner Swanson, 2015). It is the job of faculty members teaching in professional nursing programs to promote the tradition of compassionate care by preparing graduates who prioritize patient dignity, culturally sensitive care, and equitable health services for all populations. (American Association of the Colleges of Nursing [AACN], 2008).

The ANA (2015), Code of Ethics has been used as a foundational text in professional nursing education programs when introducing students to a variety of concepts surrounding health equity, social justice and cultural competency. Cultural competency refers to an ongoing process of increasing one’s awareness, knowledge, and skill related to providing care that meets the unique needs of diverse cultural groups (Giger et al, 2007; Campinha-Bacote, 2011). The importance of compassionate, holistic, and equitable care was prominently articulated by the ANA (2015) as part of the first provision in the organization’s Code of Ethics, “The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 3). Nurse educators are required to continually, and creatively, present concepts related to care for patients from diverse backgrounds in hopes of instilling these ideals in their nursing students.

The focus on health equity, highlighted by the nursing code of ethics, has repeatedly intersected with the concepts of cultural competency because patients from diverse populations have been found to be more likely to experience health disparities (Chevarley, 2011; Robert
Wood Johnson Foundation [RWJF], 2014; Kaiser Family Foundation [KFF], 2016). Health disparities have been defined as unequal distributions of disease burdens resulting from social and economic obstacles to health care experienced by vulnerable populations (Center for Disease Control [CDC], 2014). The National Healthcare Quality and Disparities Report, published in 2014, demonstrated the persistence of numerous health disparities in the United States based on low socioeconomic status (SES), educational level, race, and gender (Agency for Healthcare, Research and Quality [AHRQ], 2014). Low SES refers to a comparison of economic and social status indicators such as occupation and income, level of education, and material security (Pampel, Krueger, & Denney, 2010). Findings in the National Healthcare Quality and Disparities Report (2014) demonstrated that low-income individuals experience a greater number of barriers when accessing healthcare and that once care was received, it was of poorer quality than care provided to middle and high-income individuals (AHRQ, 2014). The reported lack of equity in access and care is antithetical to the foundational values of the nursing profession (ANA, 2015) and prompted professional nursing organizations to address the issue (AACN, 2008).

In an effort to better prepare nurses to address inequalities in the U.S. healthcare system, the American Association of Colleges of Nursing (2008) outlined specific competencies as, “essential for baccalaureate nursing graduates to provide culturally competent care” (p. 2). These competencies included working to achieve “safe and quality outcomes” for all patients, including those from diverse populations and “advocating for social justice” within the healthcare system (AACN, 2008, p. 2). Prior to the AACN’s increased attention to healthcare inequities, the Institute of Medicine (IOM, 2006) had developed their own “essential objectives” focused on providing recommendations to healthcare organizations and institutions of higher
learning. The IOM’s (2006) objectives illuminated the importance of preparing practitioners who would have an increased awareness of the needs of diverse patient populations and the skills to appropriately adjust care to meet those needs.

A consensus was reached among professional healthcare organizations (IOM, 2006; AACN, 2008; ANA, 2015) that U.S. providers should strive for increased levels of cultural competency as one method of ameliorating the impact of health disparities. Nurse faculty members were compelled to identify and implement teaching methods designed to produce positive student outcomes in this area. One teaching strategy initiated in an effort to address health disparities was the creative use of simulation techniques as a means of raising awareness of, and increasing compassion toward, people living in poverty (Patterson & Hulton, 2012; Yang, Woomer, Agbemenu & Williams, 2014). The Missouri Association for Community Action (MACA) created a simulation entitled, “Welcome to the State of Poverty” to produce a unique, live action learning event (MACA, 2010). This simulation was created to accommodate 40 to 100 people and has been used on college campuses across the U.S. (Browne & Roll, 2016). Students who have taken part in this simulation were required to role-play the lives of families living in poverty. They attempted to maintain self-sufficiency with limited resources for one simulated month. Simulation activities included obtaining employment, paying household bills and caring for minor children. The entire learning event is approximately three hours which includes an introduction with directions, the role play, and a debriefing period. Simulation techniques in nursing programs had previously focused on the advancement of technical skills while the students assumed the roles of practicing nurses. The new poverty simulation activity did not place students in the role of service provider but required them to role play in a scenario
intended to simulate life situations complicated by the burden of limited economic resources (Missouri Association for Community Action [MACA], 2010).

The use of poverty simulations with nursing students has been the subject of research for over a decade. Reported findings of poverty simulation research have demonstrated an increase in participant knowledge, levels of empathy, and scores on cultural competency scales (Noone, Siders, Gubrud-Howe, Voss, & Mathews, 2012; Patterson & Hulton, 2012; Menzel, Willson, & Doolen, 2014). Upon increased scrutiny these research findings, the bulk of which were generated by quantitative research methods, have been called into question due to issues with establishing validity and reliability with measurement tools, inconsistent findings, and concerns that the activity might increase negative stereotypes (Drevdahl, 2013; Work, Hensel & Decker, 2014; Ruetter, Sword, Meagher-Stuart & Rideout, 2004; Shen, 2015; Reid & Evanson, 2016).

Quantitative approaches have struggled to provide a trustworthy method of assessing such complex, multifaceted concepts as attitudes surrounding poverty or cultural competency levels. Lepianka, Oorschot, & Gelisson (2009) found that,

a considerable part of the research on the social construction of poverty seems conceptually and/or methodologically flawed. Of the two dominant empirical approaches to studying lay poverty explanations – factor analytical approach and forced-choice-question approach – neither succeeds in determining the actual types of poverty attributions nor gives justice to the complexity of public perceptions. (p. 433)

Research focused on the profession of nursing has generated a number of instruments intended to assess measures of cultural competency, however, there continues to be unresolved reliability and validity concerns with those instruments (Shen, 2015, p. 309). Issues with instrumentation and measurement have compromised the generalizability and trustworthiness of research findings. In
addition to the identified problems with measuring such social constructs as cultural sensitivity or poverty, investigating the impact of learning activities designed to address cultural awareness, compassion and social justice has proven equally difficult.

Difficulties in accurately measuring student nurse perceptions of poverty have been attributed to the complex and dynamic influences of ongoing social and cultural messages and the highly individualized nature of interpreting these messages (Reutter, Sword, Meagher-Stewart, & Rideout, 2004; Vandsburger, Duncan-Daston, Akerson & Dillon, 2010). The influence of multiple sociocultural factors and experiences on student perceptions has complicated the research process and prompted the consideration of alternative approaches. A professor from the University of New England, Huy P. Phan (2012), reviewed research from the fields of education and psychology that investigated traditional approaches to studying complex questions regarding knowledge acquisition. Phan found that there have been long-standing design issues for research attempting to adequately address sociocultural influences on the learning process. Phan explained that traditional methods do not meet research needs, “Unlike scientific testing where empirical evidence may be ascertained, this alternative positioning is more non-scientific and inquires more anthropological insight” (p. 4).

Researchers have called for a more “diverse inquiry” into the true nature of how learning activities focused on sociocultural concepts, such as a poverty simulation, may impact students (Drevdahl, 2013; Reid & Evanston, 2016; Browne & Roll, 2016). The importance of establishing evidence that accurately examines the impact of participating in a poverty simulation was expressed in a recent article published in the Journal of Experiential Education when authors addressed learning outcomes, “…it is possible that poverty simulations, when used without critical attention, might actually perpetuate the systems of oppression they are designed
to address” (Browne & Roll, 2016, p. 255). Qualitative methods such as case studies, in-depth interviews, and focus group reviews hold the promise of having increased capabilities to assess the true breadth and depth of the impact of using simulation techniques to address the complex topic of how learners develop attitudes towards poverty. The scant availability of qualitative literature regarding poverty simulations was not the only gap noted while reviewing research.

A review of literature revealed numerous studies investigating the use of poverty simulations in undergraduate nursing programs (Nickols & Nielsen, 2011; Patterson & Hulton, 2012; Noone, 2012; Menzel, Willson, Doolen, 2014). Research was also found that examined use of the poverty simulation with undergraduate students in health-related majors such as sociology, psychology, pharmacology and public health (Steck, L. W., Engler, J., Lygon, M., Druin, P., & Cosgrove, E., 2011; Vandsburger, Duncan-Daston, Akerson, & Dillon, 2010; Strasser, Smith, Pendrick, Jackson & Buckmaster, 2013). One gap identified in the research surrounding poverty simulation was the use of this strategy with Registered Nurse (RN) to bachelor’s (BS) degree students. An extensive search for representation of the subset of undergraduate students that hold nursing licensure revealed no studies directly examining RN to BS student participation in poverty simulations and very few studies examining attitudes toward vulnerable populations (Jones & Smith, 2014). A study published in The Journal of Professional Nursing reviewed tools to simulate poverty used in nursing education and associated research (Reid & Evason, 2016). The authors found eight studies investigating three learning tools. All of the studies involved students in higher education programs, however, none were enrolled in RN to BS programs of study.

The gap in information regarding the poverty simulation and RN to BS students provided an opportunity to uncover valuable information from a unique group of learners. A review of RN
to BS student demographics revealed increased diversity in age, race and socioeconomic status as compared to traditional baccalaureate nursing students (National Center for Education Statistics [NCES], 2011). In addition to increased diversity, the RN to BS students have a history of professional experiences not found with traditional undergraduates. Investigating RN to BS student experiences allows for unique aspects of inquiry to be explored such as reflection upon workplace culture, past patient interactions, and ways in which a practicing nurse might be motivated to engage in future education about the topic.

**Statement of the Problem**

There were numerous layers of social, educational, and professional problems to be considered when this research study was developed. First, there was the problem of the persistent existence of health disparities experienced by vulnerable populations in the United States and the fact that the situation of inequality was identified as incongruent with the ethical foundations of the nursing profession (AHRQ, 2014; ANA, 2015; KFF, 2016). Second, there was need to consider the wide-spread belief that nursing personnel may mitigate the impact of health disparities through an informed practice shaped by the concepts of cultural competency (AHRQ, 2014; RWJF, 2014). Next, there was the fact that nurse faculty and nursing programs have made a commitment to producing graduates that are prepared to meet the ethical standards of providing equitable, culturally competent care to all individuals (Mixer, 2011; AACN, 2008). A variety of competing tactics and strategies have been developed and implemented for the purpose of reaching the goal of promoting cultural competency in undergraduate nursing students. One particular strategy designed to increase cultural awareness in the area of socioeconomic disadvantages was the use of a simulation entitled, “Life in the State of Poverty” (MACA, 2010). The evidence supporting use of a poverty simulation in nursing education has been characterized
as weak or incomplete (Reid & Evanson, 2016) while others have questioned the possibility that it may perpetuate negative stereotypes (Drevdahl, 2013; Browne & Roll, 2016). Unreliable instruments for measuring sociocultural perceptions also contributed to increased difficulties in producing consistent, reliable research findings (Lepianka, 2009; Shen, 2015). Finally, the lack of studies examining the impact of a poverty simulation with RN to BS students represented a problem and potential connection to the professional world that deserved exploration.

The previously outlined problems all contribute to the backdrop of the primary problem addressed by this study which was identified as the lack of data or information available to inform educators on the impact of using the poverty simulation with RN to BS nursing students. Some studies, through use of quantitative methods, have documented an increase in student’s knowledge regarding poverty, however, these studies have difficulty providing information about more complex considerations and lack the ability to explain inconsistent findings. Some simulation experience studies have yielded mixed outcomes on measurements such as pre and post testing of student attitudes. For example, in one study, students were less likely to agree with stigmatizing statements, however, they were more likely to express a belief that, “poverty is related to a personal character deficiency” (Work, Hensel & Decker, 2014. p 329). Furthermore, studies of attitudes and perceptions regarding poverty have shown that a simple change in the wording of survey questions produced markedly different results (Will, 1993).

Poverty simulations require financial resources and time commitments, which could displace the delivery of other content in the nursing curriculum (Patterson & Hulton, 2012). It was considered a high priority of this study to increase understanding of how the simulation, “Welcome to the State of Poverty” (MACA, 2010) either moves students toward or away from the intended goals of nursing educators, and to understand the extent of the impact. Some
quantitative research has demonstrated an increase in knowledge and favorable attitudes towards those living in poverty (Nickols & Nielsen, 2011; Patterson & Hulton, 2012; Noone, Sideras, Gubrud-Howe, Voss & Mathews, 2012) while limited qualitative research has provided us with a glimpse into the dynamic and complex nature of attitudes of undergraduate students toward those living in poverty (Browne & Roll, 2016). Uncovering deeper meaning of the experience of students and understanding what did or did not prompt a shift in attitude as well as how this change might be connected to future nursing practice was considered to be an essential next step in gaining a richer insight into the value of a poverty simulation.

**Purpose and Significance of the Study**

The purpose of this study was to employ qualitative research strategies, specifically hermeneutic phenomenology, to explore how RN to BS students perceive and make meaning of the experience of participating in a poverty simulation. The exploration of the lived experience of RN to BS students participating in a poverty simulation including how they *construct* meaning, *assimilate* new information, *reflect* upon past interactions with impoverished patients, and *shape* intentions toward future personal and professional advocacy activities, was the heart of this inquiry.

The increasing popularity of simulation activities designed to promote the development of cultural competence prompted researchers to question the practice and call for more in-depth investigation (Noone et al. 2012, Patterson & Hulton 2012, Wittenauer, Ludwick, Baughman & Fishbein, 2014; Shen, 2015; Reid & Evanston, 2016). Nurse educators and administrators often turn to evidence generated by research as they make decisions about resource allocation. This is especially true for labor-intensive learning activities like a poverty simulation that carry both a time and financial cost (Patterson & Hulton 2012). The purpose of gathering more complete
information about student experiences and learning outcomes was to inform decisions about whether or not nursing departments want to begin or continue to use the activity. Increasingly descriptive data, it was hoped, would prove to be beneficial for educators as they plan specific components of the simulation, such as debriefing sessions or complimentary learning assignments. A richer understanding of student perceptions of the experience was also believed to be potentially helpful for curriculum decisions such as which semester and course would house the activity. This inquiry was also a starting point for the gap in research done with RN to BS students and was thought to have the potential to uncover connections to the professional world of nursing. A final consideration of the research was the possibility of uncovering negative, unanticipated or unintended consequences of the simulation.

In a broader picture of the significance of this study, reaching beyond the field of nursing education, it was noted that finding effective, evidence-based strategies to produce culturally competent nurses was recommended by professional organizations as this would likely have positive effects on patient care and partially address the ongoing problem of health disparities (AACN, 2008). The Office of Minority Health (2013) referred to the delivery of culturally competent as a “powerful tool” for disrupting the ongoing trend of health disparities in the U.S.

**Description and Scope of the Research**

To address the previously discussed problem of gaps in the overall understanding of how RN to BS students experience and were impacted by their participation in a poverty simulation and to uncover reasons for conflicting research results, I proposed a qualitative study using the techniques of hermeneutic phenomenology. The study involved a purposive sample of eight, RN to BS students, who had participated in a poverty simulation within the last six months. The students were currently enrolled in an RN to BS program at a Midwestern university. The
participants, all English speaking, were invited to take part in one to two semi-structured interviews designed to gather in-depth information regarding their experiences and perceptions related to the poverty simulation.

Nurse educators have been charged with structuring programs that promote the development of cultural competency in nursing students. Evidence based teaching strategies are an integral part of curriculum planning. Nurse educators must have a complete picture of the impact of a poverty simulation in order to make informed decisions regarding the use of poverty simulations as a part of the learning platform. Conducting a deeper inquiry was proposed as a means of gathering information to assist faculty in determining if the poverty simulation activity produced an increase in knowledge which could be achieved through less time-consuming methods, or if the simulation impacted deeper cognitive processes such as perceptions and assumptions made about people living in poverty. It was an additional hope that finding a deeper meaning through research could entice the development of more simulation experiences perhaps tackling other cultural issues such as race relations.

The theoretical framework for this study included the use of two theories, Campinha-Bacote’s Process of Developing Cultural Competence and Constructivism, which fulfilled a dual role as both a guiding philosophy and a learning theory. Constructivism as a guiding philosophy or paradigm shaped this inquiry from beginning to end. According to Guba and Lincoln (1994) when considering how a paradigm might guide a qualitative inquiry it is critically important to acknowledge the interplay between one’s ontological viewpoint, epistemological perspective, and the method of inquiry (p. 108). The constructivist paradigm includes the ontological perspective that “reality is relative” and takes form within an individual as they create mental constructions of concepts based on their experience in the world. Constructivist researchers
believe that these mental constructions can be understood, in an epistemological sense, through interactions between the investigator and the subject. Inquiry methods consist of standard hermeneutical techniques with the goal being, “... to distill a consensus construction that is more informed and sophisticated than any of the predecessor constructions...” (Guba & Lincoln, 1994, p. 111). These principals were expressed in my research questions, approach to data collection, data analysis, and ultimate goal of producing a rich description of the experience of participating in a poverty simulation and how it impacts RN to BS students.

The use of Constructivist learning theory in nursing education has become more prevalent in the last fifteen years. Constructivist learning approaches in the education of nursing students has been recommended by some scholars as a more effective alternative to traditional pedagogies, especially for adult learners (Peters, 2000). In contrast to popular methods of instruction whereby the educator imparts information while the learner passively receives, constructivist methods engage the learner in activity-based, hands-on instruction while encouraging students to use their own observations and ideas to solve problems (Bruner, 1996). This type of instruction resembles learning in a lab or clinical setting for nursing students and on-the-job education for novice nurses. Peters (2000) described the goal of nursing education as creating “reflective practitioners” with skills in evaluating situations, motivation for self-directed learning, and a high degree of awareness (p. 166).

Constructivism was selected as part of the theoretical framework for this study because of the philosophical standpoint that knowledge is that people acquire knowledge through experiencing things and reflecting on those experiences. This guiding philosophy provides a foundation for the techniques of interpretive phenomenology as a research method (Lincoln & Guba, 1985). It is also foundational for the Constructivist Learning Theory, which is also part of
the theoretical framework for this study. Constructivist Learning Theory views the acquisition of knowledge as an active undertaking on the part of the learner. The learner does not passively receive knowledge but rather, actively makes meaning and constructs knowledge through experience (Vygotsky, 1978; Bruner, 1996). The constructivist approach to learning was an appropriate complement to principles of nursing education and because it provided particular insight into the relationship between learning and social interaction. The reaction of students who have participated, and later reflected upon, a poverty simulation experience has been found to be dependent upon the ideas and knowledge they bring to the activity. Poverty represents a concept that confronts individuals in a social atmosphere long before they enter a classroom. Constructivist learning theory proved helpful in examining reactions to the poverty simulation, in large part, because of the emphasis placed on learning from social interactions. Numerous authorities on constructivism subscribe to the belief that learners build knowledge and arrive at perceptions largely through social interactions (Vygotsky, 1978; Bruner, 1996; Merriam, 2009). Acknowledging that students come with a history of social interactions between themselves and people from different socioeconomic backgrounds was a crucial part of understanding student reactions to learning activities designed to increase awareness and self-reflection in this area.

Campinha-Bacote’s Process of Cultural Competence (2011) provided a foundation for understanding issues related to how nurses care for patients from diverse backgrounds including those from socioeconomically disadvantaged backgrounds. This theory, from the discipline of nursing, views the development of cultural competence as an ongoing process with no endpoint and emphasizes cultural humility and self-reflection (Campinha-Bacote, 2002, 2009, 2011). Nurse educators have looked to this theory to increase their understanding of how student nurses
engage in the process of becoming increasingly culturally competent and to inform decisions on curriculum and teaching strategies that effectively stimulate that development.

The research questions were concerned with finding the deeper meaning for students that comes from their poverty simulation experience in the hopes of finding themes that will inform researchers on the process students go through in assimilating new knowledge and shaping future patient interactions.

Research Questions

This study was guided by one central research question and two supporting questions:

1. What is the lived experience of RN to BS students as they participate in a poverty simulation?
2. How do RN to BS students construct meaning and assimilate new information after participation in a poverty simulation?
3. How might reflecting on the poverty simulation shape RN to BS students’ ideas of what it means to provide culturally competent nursing?

Summary

Chapter 1 presented the idea that the nursing profession prioritizes high quality, equitable care for all patients and populations (ANA, 2015) and considers the existence and ongoing persistence of health disparities in the U.S. to be a serious problem. Nurse faculty have searched for strategies to address these concerns as it was shown that students may become professionals that either mitigate or perpetuate inequities depending on their educational preparation (AACN, 2008; AHRQ, 2014). Professional organizations have called for student nurses to be prepared to adequately meet the needs of increasingly complex patient populations, a challenge that has
required engagement in the process of becoming culturally competent (IOM, 2006; Campinha-Bacote, 2011; AHRQ, 2014; CDC, 2014). Creative teaching methods, such as the simulation activity, “Welcome to the State of Poverty” have been used to help nursing students internalize recommended knowledge, gain new skills, and shift attitudes that promote high quality care for vulnerable and diverse patient groups including those living in poverty.

Nursing professionals have viewed it as being of paramount importance that the effects of the teaching strategies used in undergraduate nursing curriculum be tested to ensure that the intended results are produced (Patterson & Hulton 2012; Drevdahl, 2013). Given the complex nature of examining knowledge, skills and attitudes surrounding an issue like poverty, it was deemed essential that sound research methods be employed to produce trustworthy and applicable results (Will, 1993; Lepianka, 2009; Phan, 2012; Shen, 2015, Browne & Roll, 2016). Quantitative research served to document an increase in knowledge and began the initial steps to understanding attitude changes in students (Reid & Evanson, 2016). Qualitative methods were identified as the best hope to fill the gaps in understanding of the ways in which RN to BS nursing students construct meaning from the experience.

Chapter 2 will document the nature of healthcare inequities related to poverty and review research investigating the influence of provider attitudes on patient care. Research examining the impact of educational programming as well as the unique perspective of RN to BS students will be presented including the lack of existing research with this group. Finally, theories used to establish a framework for this study will be identified.
Chapter II: Literature Review

This review begins with a summary of literature intended to provide background information on the current state of poverty in the U.S. and the progress, or lack thereof, made by healthcare organizations in reducing health disparities. The second section presents an overview of research examining the attitudes of healthcare providers and how these attitudes have been measured and shaped. The third section explores the ways in which nurse educators have incorporated the broad concept of cultural competency into higher education programs specifically focusing on providing care to patients from, or with, low SES. This section also scrutinized teaching strategies being employed to address the attitudes and abilities of student nurses to effectively care for patients living in poverty. Finally, this review includes literature considering the theoretical frameworks used for this study and how these theories are connected to a phenomenological inquiry.

The State of Poverty in the U.S. and Associated Health Consequences

The review of information surrounding socioeconomic population trends in the U.S. and associated health consequences, provided a background and demonstrated the greater significance of the importance of educating nurses about providing care to patients from impoverished backgrounds. This section was intended to shed light on the likelihood of healthcare providers encountering these patients and illuminate the seriousness of the issue of health disparities as related to socioeconomic status.

Registered nurses practicing in the U.S. have been, and are expected to increasingly be, faced with caring for patients from diverse backgrounds as population trends in the U.S. demonstrate growing diversity in a number of areas, including ethnicity, age and socioeconomic status. It is expected that by the year 2020, more than half of the nation’s children will be part of
a minority race and by 2060, Caucasian children will be in the minority at 36 percent, compared with 52 percent today (U.S. Census Bureau, 2015). The Census Bureau (2015) projects that by 2030, one in five U.S. citizens will be 65 years of age or older. Increases in ethnic and generational diversity are associated with a larger potential for economic vulnerability. This economic vulnerability was evident in the most recent U.S. statistics that showed a poverty rate of 13.5 percent or approximately 43 million Americans (U.S. Census Bureau, 2015).

Changing patient demographics are expected to have a significant impact on healthcare services and have raised concerns regarding the ability of providers to meet the challenge of delivering quality healthcare for all U.S. citizens. The Commission to Build a Healthier America, established by the Robert Wood Johnson Foundation (RWJF), published a 2014 report entitled, A Time to Act: Investing in the Health of Our Children and Communities, which synthesized population trends, poverty rates and health disparities, culminating in a call to action for public and private sector leaders:

By 2043, the majority of U.S. residents will be people of color, who are disproportionately low-income and living in disadvantaged communities. In the U.S., low-income people and people of color generally experience the worst health for reasons that are preventable and that require actions beyond health care alone.” (RWJF, 2014, p.10)

The report called for an infrastructure overhaul, which would significantly impact the practice, education, and placement of nurses. Most notably the profession of nursing was called upon to increase the number of RN’s capable of working in settings other than acute care, or hospitals. Community based nursing and nurses with expertise in population health would be expected to lead community assessments and structure programming designed to serve populations from a
perspective that focuses on health prevention rather than intervention. Skill sets rooted in
cultural competency would be a necessity for nurses to fulfill these duties. The economic vitality
of the shift in approach to healthcare is also highlighted in this report as preventative care has
been repeatedly shown to be far superior in cost-effectiveness (RWJF, 2014).

In 2016 the Kaiser Family Foundation (KFF) published, Disparities in Health and
Healthcare: Five Key Questions and Answers, a report that outlined the number of impoverished
households in the U.S. and the impact of poverty on health. The report clearly demonstrated the
fact that differences between wealthy, middle, and poor households in the U.S., has continued to
widen. In 2014 the top 20% had an average income of $194,053, compared with an average of
$11,676 for the bottom 20% (KFF, 2016, para.12). Low-income households must make choices
regarding necessities and often health insurance is not a priority (RWJF, 2014). In addition to the
fact that low-income individuals have a higher chance of being uninsured and experience more
access barriers, the KFF (2016) report confirmed earlier findings (AHRQ, 2014) that
economically disadvantaged individuals were more often the recipients of lesser quality care
which in turn leads to worse health outcomes and lower life expectancies than those with higher
incomes (para. 3).

Prior to the KFF (2016) report, the Agency for Healthcare Research and Quality (2014),
prepared an executive summary of findings of an investigation focusing on health disparities.
Using an exhaustive number of 250 different quality measures, it was found that low-income
individuals experience more barriers to care and receive poorer quality care than high-income
individuals. The report outlined specific examples of diagnosis, treatment and service pattern
differences that demonstrated some of the contributing conditions that fuel disparities. For
example, they found that only about half of people in vulnerable groups who were diagnosed
with hypertension have it well controlled and recommendations from providers for ongoing treatment are completed only 70% of the time. In evaluating services for more acute issues, such as hospice care and chronic disease management, the findings revealed that disparities worsen under these conditions.

The investigations into changing demographics, healthcare access, quality, and disparities have revealed time and again that the issues surrounding healthcare equity in the United States are real, persistent and likely to impact the practice of nurses in the coming decades (AHRQ, 2014; KFF, 2016). Ensuring effective, high quality, equitable care depends on the providers’ awareness of, willingness and ability to engage in culturally competent care practices (RWJF, 2014).

**Healthcare Provider Attitudes Toward Diverse Patients**

Healthcare provider attitudes toward patients in regard to race, ethnicity and low SES have been found to impact the quality and safety of care (AACN, 2012). Healthcare providers with a lack of cultural awareness may engage in stereotyping and hold overt or subconscious biases which contribute to health disparities (IOM, 2006; Chevarley, 2011; AACN, 2012). Discrepancies in care often begin with culturally insensitive communication patterns (Chevarley, 2011) and can include preferential behavior towards one patient group over another or alterations in treatment plan decisions (Teal, Gill, Green & Crandall, 2012). Conducting a review of studies investigating healthcare provider and student attitudes regarding individuals with socioeconomic vulnerabilities was an important step in the identification of patterns and social conditions that facilitate either positive or negative attitudes.

Research seeking information about the attitudes that providers hold towards those living in poverty has often been approached with the initial goal of understanding underlying belief
systems, which typically fall into two main causes for poverty, namely behavioral and structural (Lepianka et al., 2009). The ‘behavioral’ or ‘personal deficiency’ category, sometimes called ‘individualistic,’ refers to the belief that the causes of poverty are related to poor behavior, poor choices or unflattering characteristics such as ‘laziness’ (Feagin, 1972; Kovarna, 2006; Yun & Weaver, 2010). The ‘structural’ perspective typically represents a less biased, perhaps more compassionate view towards those living in poverty as it includes the consideration of societal contributions to poverty such as unequal distribution of resources and barriers to opportunities such as higher education (Feagin, 1972; Yun & Weaver, 2010; Work, Hensel & Decker, 2014).

A number of instruments have been developed to assess attitudes held toward poor people and communities (MacDonald, 1971; Rubin & Peplau, 1975; Atherton & Gemmel, 1993; Yun & Weaver, 2010). These instruments, typically scales, have often assisted researchers in determining if a respondent has a behavioral or structural belief in poverty or related descriptors. The popular, Attitudes Toward Poverty (ATP) scale (Atherton & Gemmel, 1993) appears regularly in research examining healthcare provider beliefs and attitudes. The ATP, developed for use in the field of social work, consists of a 37-item survey that generates a score indicating more positive, higher scores, or negative attitudes toward poverty (Atherton & Gemmel, 1993). Yun and Weaver (2010) produced a shortened form (21 items) of the Attitudes Toward Poverty Scale (ATP-SF) to help increase survey response rates and organize results into three dimensions: personal deficiency, stigma and structural perspective. The authors explain that the ATP-SF is beneficial as the, “multidimensionality” allows for a more “comprehensive” and “accurate” measurement of attitudes (Yun & Weaver, 2010, p 184). Researchers continue to use both scales depending on their own preference.
A number of Likert-type scales exist for measurement of attitudes towards poverty, albeit less popular than the ATP or ATP-SF. The MacDonald’s Poverty Scale (MacDonald, 1971) is a 12-item scale intended to measure a combination of perceptions about poor people, causes of poverty, and public policies (p. 118). Similarly, the Attribution for Poverty Scale developed by Feagin (1972) consists of an 11-item scale that includes three dimensions: *individualistic explanations*, *structural explanations*, and *fatalistic* causes of poverty. Building on prior survey designs, Golding and Middleton (1982) developed a scale that measured beliefs about the causes of poverty. The authors identified *prodigality*, *injustice*, *ascribed deprivation*, and *fatalism* as four dimensions describing respondent belief systems. To illustrate the Golding and Middleton’s approach consider that “prodigality” refers to a dimension described as encompassing negative perspectives toward people living in poverty such as, “the wasteful spending patterns, financial ineptitude, imprudent breeding habits and sheer fecklessness or lack of motivation of the poor” (p. 197). The ability to categorize belief systems into complex dimensions based on surveys with sometimes as few as eleven items deserves close scrutiny. Demonstration of the validity of survey instruments and scales through rigorous statistical analysis and repetition of results is incumbent upon researchers if they expect broad scale use in research (Polit & Beck, 2014).

Researchers who have demonstrated an instruments’ construct validity, such as the ATP scale’s Cronbach alpha, an important measure of internal consistency (Polit & Beck, 2014), calculation of .93 (Atherton & Gemmel, 1993) or Yun and Weaver’s report of a Cronbach alpha of .87 for the ATP-SF (Yun & Weaver, 1993) provide greater assurance of the trustworthiness of their research results (Polit & Beck, 2014). Numerous studies have been conducted using newly created scales to assess individual perceptions and attitudes toward poverty. These scales often have little to no evidence in the way of validity and reliability. Authors may refer to an existing
scale and describe ‘modifications’ made. These altered scales should provide convergent validity to establish correlations between the original and the modified scale, however, this type of rigor is often neglected (Polit & Beck, 2014).

Quantitative studies in the field of nursing have tended to favor scales that provide evidence of their trustworthiness. The ATP (1993) for example, has been used as an instrument in a variety of studies conducted in the nursing field (Sword, Reutter, Meagher-Stewart, & Rideout, 2004; Kovarna, 2006; Menzel, Wilson & Doolen, 2014) to assess such things as provider attitudes toward poverty or the impact of a learning activity done with nursing students. Similarly, Yun and Weaver’s ATP-SF (2010) has been employed in the pre/post evaluation of poverty simulations with nursing and counseling students (Menzel et al., 2014; Noone et al., 2012; Patterson & Hulton, 2011; Vliem, 2015; Wittenhauer, Ludwick, Baughman, & Fishbein, 2014).

Reutter, Sword, Meagher-Stewart, & Rideout (2004) used the Attitudes Toward Poverty Scale (1993) to learn about the attitudes of nursing students towards those living in poverty. Their study also included examination of the students’ beliefs about the relationship between poverty and health. The researchers used a cross-sectional design to survey a large sample (n=740) of randomly selected students from three Canadian universities. The survey was completed during class time resulting in a high response rate of 90%.

Ruetter et al. (2004) compared students’ ATP scores with socio-demographic characteristics, levels of personal exposure to poverty, and student beliefs about the relationship between poverty and health. Data analysis began with descriptive statistics reflecting a predominantly female (92%) sample under the age of 25 (77%). The study participants had limited personal exposure to poverty determined by responses reflecting that only 13% had lived
in a ‘poor neighborhood’ and 6% had ever received social assistance. The participants also reported their main source of information about poverty, which for most respondents was found to be the news media at 33% (Ruetter et al., 2004).

Ruetter et al. (2004) used one-way analysis of variance (ANOVA) to explore relationships between demographic variables, ATP scores, and personal exposure and attitudes toward poverty and health. Group differences in support of structural explanations over behavioral explanations for poor health and poverty were found. Students who reflected their main source of information about poverty was through academic courses rather than the media, were more likely to choose statements reflecting structural explanations such as, “Poor people are unhealthy because of living circumstances” (p 303). Regression analysis was performed to identify the strength of predictor variables on the explanations students held on the relationship between poverty and health. Students who supported behavioral explanations, reflected in statements like, “poor people are unhealthy because their behavior makes them unhealthy” (p 303), were older and in the earlier years of their program with scores on the ATP reflecting less positive attitudes towards those living in poverty (Ruetter et al., 2004).

A unique aspect of the Ruetter et al. (2004) study was the performance of group interviews as a follow-up to the surveys. The students provided a number of insights into their survey answers. They acknowledged that social desirability did have some influence on survey responses. “Students in the group interviews said that their ‘personal’ beliefs were more negative than what they perceived to be appropriate responses in their roles as ‘student nurses’ (p. 306). Students also shed light on unexpected findings such as the positive correlation between higher course exposure to poverty and a higher likelihood of agreeing with explanations of poverty that people experience poor health and “drift” into poverty. The students suggested that this finding
was a result of the nature of the course exposure, specifically clinical experiences at mental health sites. This type of exposure may lead students to believe that a person has an illness and then experiences poverty rather than the idea that structural barriers or living circumstances precede ill health (Ruetter et al., 2004).

The final revelation to come from the group interviews performed by Ruetter et al. (2004) was the identification of confusing survey items. Survey questions requesting students to characterize their “interaction with the poor” or use of “social assistance” were confusing and consequently identified by the authors as needing to be “refined” especially because, “different types of exposures have differential effects on beliefs” (Ruetter et al., 2004, p. 306).

The Ruetter et al. (2004) study explains that student experiences with those living in poverty can produce a variety of effects and therefore should be planned for carefully with an emphasis on providing coursework and classroom activities that highlight the structural factors contributing to poverty and its negative health consequences. The researchers also found that clinical placements should serve as a ‘complement’ to the classroom with opportunities that go beyond simply working with families in poverty and into a thorough examination of the causes of poverty at community and systems levels (Ruetter et al., 2004).

The use of an instrument to assess attitudes towards the poor and the layering of the ATP, socio-demographic factors and beliefs about health and poverty made the Ruetter et al. (2004) study rich with data to explore. The large sample size and use of a well-tested instrument add confidence to the authors’ conclusions. The modified and created survey items, however, prompt some skepticism given the complex nature of the topic and the reports of some confusion by students during group interviews (Ruetter et al., 2004).

The Ruetter et al. study (2004) examined student attitudes towards those living in poverty
and the impact of personal and educational exposure. In a more recent study the authors were similarly interested in factors that might influence the attitudes of nursing students towards the poor. Jarell et al. (2013) explored the impact of a service learning program by administering the Attitudes about Poverty Scale (1993) and the Belief in a Just World Scale (Reubin & Peplau, 1975) before and after participating in a community health clinical. Students were randomly assigned to study (n=40) and control (n=130) groups. The ‘treatment’ group performed basic public health nursing functions such as health education and promotion, screenings and physical and risk assessments in a homeless shelter and at a low-income housing complex for elderly and disabled persons (Jarell et al., 2013).

The researchers hypothesized that students participating in the clinical with individuals living in poverty would demonstrate changes on each scale indicating more favorable perceptions of poverty than the control group. Data analysis, consisting of independent t-tests, showed that the treatment group did show a change in scores that was higher than the control group on both scales. The changes signified a move toward the direction authors anticipated, however, these results were not statistically significant (Jarell et al., 2013).

The lack of statistical significance found in the Jarell et al. (2013) study may have been a product of the low number of participants related to a high rate of attrition. Participant numbers were decreased through logistical issues such as not completing their unique identifier to maintain anonymity or not being present on data collection days. The small number of students in the treatment condition who completed both pre and post-tests negatively impacted statistical power and interfered with the researchers’ ability to identify attitude changes related to the learning activity, although some statistically significant correlations on the JWS were identified.

Jarell et al. (2013) used bivariate correlations to identify personal factors impacting
attitudes towards poverty and two statistically significant correlations were identified. Having a family member who has experienced poverty was positively correlated with belief in a just world while student work experiences with poor individuals were negatively correlated. To interpret scores on the Belief in a Just World scale, it should be noted that correlation between those who have strong beliefs that the world is ‘just’ hold negative beliefs about the poor (Cozzarelli, Wilkinson & Tagler, 2001).

Jarell et al. (2013) calculated subscale scores for students in the service-learning group to look further into perceptual changes. The reason for this inquiry was described in their report, “…we considered if attitudes may improve in some areas while growing more judgmental in others” (p 302). Changes in both negative and positive directions were identified. Although students were more likely to believe that society has a responsibility to help the poor they indicated more “superficial perceptions” such as the poor are "dirty" and "act differently" after their service-learning activity. The authors acknowledge the importance of considering the nature of student experiences in programming as exposure to “stark poverty” can perpetuate the belief that the poor are “different from other members of society” (Jarell et al., 2013, p. 303).

Despite the lack of statistical significance Jarell et al. (2013) results supported the Ruetter et al. (2004) study that uncovered the possibility that exposure to poor people during a mental health placement may have altered the students’ perception of the relationship between poverty and health. It is noteworthy that the authors of the Jarell et al. (2013) study do not offer suggestions for addressing this concern.

In the discussion of findings for the Jarell et al. (2013) study much attention was given to anecdotal evidence for student perception changes after the service-learning program. Student comments and journal entries reflected a revelation that clients’ who did not comply with
medical treatments did so because of lack of resources rather than knowledge deficit. The authors report, “It became evident to the students that people who are poor may be financially unable to maintain a healthy lifestyle” (Jarell et al., 2013, p. 302). This supplemental anecdotal evidence was not presented with details of how the information was obtained and appeared to lack a structured analysis. It does seem to point out the possibility that a change in design may have allowed researchers to glean more from the study.

The bulk of research found assessing nurse attitudes towards patients from diverse backgrounds has employed survey methods as the primary means of gathering data. Important considerations with survey methods include the idea that respondents may not always clearly interpret the questions (Will, 1993; Ruetter et al., 2004), may provide socially desirable responses (Ruetter et al., 2004), and self-report methods are likely to miss unconscious bias (Wittenauer, Ludwick, Baughman & Fishbein, 2014). Understanding the presence and impact of unconscious bias is important as nurse educators must find teaching strategies to increase student awareness of their personal bias in order to provide a foundation for increasing cultural competency (Campinha-Bacote, 2002). A closer look at studies examining healthcare provider attitudes towards the poor provided more understanding of unconscious bias.

When nurses care for patients with backgrounds that differ culturally from the dominant group they are confronted with a variety of complex barriers such as communication issues, alternative healthcare beliefs and the patients’ increased likelihood of economic disadvantage (Leininger, 2002; Campinha-Bacote, 2011). Reviewing research focused on understanding the attitudes of nurses as they provide care for diverse patients provided greater insight into the specific challenges nurses may face and how negative attitudes may take shape.
Latin American researchers Murcia and Lopez (2016) conducted a meta-synthesis of qualitative studies in an attempt to understand the experience of nurses when providing care for culturally diverse patients. The authors conducted a literature search for qualitative studies in English, Spanish and Portuguese on topics related to caring for diverse patients.

The authors used the Critical Appraisal Skills Programme (CASP) to determine the quality of fourteen selected studies. While employing CASP methods the authors engaged in an assessment of the methodological rigor of each study. The selected studies were qualitative in nature and for this reason the authors opted not to use conventional systematic review methodologies and engaged in an alternative process termed interpretive synthesis (Dixon-Woods et al., 2006; Murcia & Lopez, 2016).

The interpretive synthesis data analysis process required Murcia & Lopez (2016) to complete a coding and ranking process during data review for the purpose of finding patterns of meaning in the studies. The authors' commitment to the lengthy process of recognizing, re-contextualizing and interpreting the data increased the credibility of their conclusions (Dixon-Woods et al., 2006).

Murcia & Lopez (2016) expressed their meta-theme in analogous terms, “Taking Care of a Culturally Diverse Family, the Experience of Crossing a Tightrope” (p. 5). The “tightrope” analogy was also used to describe each of four identified categories. In the first category the authors provided an explanation of how the nurse feels during the initial encounter with a patient who presents with a diverse set of needs. This category illuminated “internal barriers” which arise from the, “cultural shock nurses experience as they are confronted with values and cultural beliefs that significantly differ from their own” (p. 6). The second category was characterized by the nurses’ focus on barriers and difficulties in providing care, which caused a negative
perception of the experience, likened to “gusts of wind” that might cause one to fall from the
tightrope. The authors explain, “Consequently, care for the family is perceived as an obligation
or a requirement that is difficult to respond to” (p. 8). The third category expressed the potential
positive change in attitude that can occur if the nurse pauses to consider new ways to approach
the patient and family. Finally, the fourth category explained ways in which the nurse, through
understanding, flexibility and recursiveness, may begin to reshape their perception to a more
positive outlook expressed as mastery of the experience of walking the tightrope (Murcia &
Lopez, 2016).

In keeping with the goals of qualitative research, Murcia & Lopez (2016) provided rich
descriptions of how pessimistic views towards providing care for diverse families may be
manifested. The nurse may take on a “negative image of the family,” considering their presence
a “nuisance.” The nurse may also experience strong emotional reactions to the situation such as,
“anguish, stress, tension, uncertainty and frustration,” all of which may contribute to a “distant
and superficial relation with the family” (p. 6).

Murcia & Lopez (2016) provided an overall description of the nurse experience:

The meaning of the nurses' experience in care delivery to culturally diverse families is
dynamic and can move from a positive to a negative perception or vice-versa, according
to the interaction with the family, the factors in the care context and the tools of cultural
competency.” (p. 6)

Additionally, the authors underscored the importance of resource availability in terms of
linguistic services, provisions made for family space and workload adjustments for nurses to
allow for the increased time needed to provide culturally competent care (Murcia & Lopez,
2016).
The focus of an interpretive review is the development of concepts and theories that integrate concepts (Dixon-Woods et al., 2006). Murcia & Lopez’s (2016) meta-synthesis used the technique of interpretive synthesis to generate a unique view of the perception of nurses’ in caring for diverse patients, drawing upon numerous studies. The authors’ rich descriptions provided readers with a fuller understanding of the phenomenon, which is expected of a well-conducted qualitative meta-synthesis (Polit & Beck, 2014).

Murcia & Lopez (2016) provided a summary of the state of the research on this topic and determined similarities in research approaches and limitations as well as identified patterns in results. This meta-synthesis included hearty design techniques that increased the credibility of results. For example, all studies underwent quality appraisal by more than one person and the authors used a well-validated scale (CASP) to rate the studies (Polit & Beck, 2014). The expression of perceptions through an analogy may increase the ease of comprehension for readers but the use of an analogy comes with the risk of adjusting findings to fit a preconceived idea (Polit & Beck, 2014). Overall the insights provided by the authors into the things that shape nurses’ attitudes in caring for patients from diverse backgrounds proved to be helpful in understanding the nurses’ attitudes on an international scale.

The Murcia and Lopez (2016) study provided an increased understanding of attitudes from the point of view of the provider. To increase understanding of how healthcare providers influence care, one must also consider the point of view of the patients. It is important to understand whether patients feel their healthcare providers have a negative attitude toward them as this significantly impacts the patient provider relationship (Wittenauer et al., 2015). In 1999, the United States Congress mandated that ongoing, comprehensive audits be completed and used to generate reports that would provide updates regarding disparities in care experienced by
vulnerable groups (AHRQ, 1999). The reports were intended to identify the strengths and weaknesses in the U.S. healthcare system with three specific focus areas: access to health care, quality of health care and priorities of the National Quality Strategy. The specific agency charged with reporting on the three focus areas is the Agency for Healthcare Research and Quality (AHRQ). Since 1999, the AHRQ has conducted annual investigations including an assessment of care from the patient perspective. Patient surveys of various ethnic groups such as Black, Hispanic and Asian, have uncovered differences between reports of their interactions with providers and reports from those indicating “White” ethnicity. Patient surveys have repeatedly revealed that all racial groups, other than White, are more likely to rate their communication with nurses as “poor.” The AHRQ also considers educational level and economic status in their surveys and found that between the years of 2009 and 2012 patients with lower educational levels and those with lower economic status were less likely than those with any college education to be asked to take part in treatment decisions (AHRQ, 2015).

Important considerations about the data from the AHRQ reports include the fact that it comes from the patient perspective and is one avenue to give voice to the vulnerable. It should also be noted that no significant trend changes were identified in the years between 2009 and 2012 despite increased awareness of the problem of health disparities in the U.S. and persistent calls for change. The AHRQ patient surveys are unique in their ability to give the patient perspective as the bulk of research on healthcare provider attitudes has been generated from assessments regarding the provider perspective.

Increased levels of education have been correlated with less negative attitudes towards poverty (Ruetter et al., 2004; Brathwaite & Majumdar, 2006; Wittenauer et al., 2014; Moreno & Hart, 2014). Ruetter et al. (2004) found that as nursing students learn about causes of poverty
and advance in their program, they are more likely to attribute the state of poverty to structural explanations. Conversely, those whose main source of information about poverty was the media were less likely to agree with structural explanations. Other studies have shown a correlation between education level and cultural knowledge (Moreno & Hart, 2014), yet those with advanced nursing degrees still indicate feeling a need for further training and overwhelmingly report that they would attend such training (Waite, Nardi & Killian, 2014; Sanchez Elminowski, 2015).

Personal experience and background related to poverty has been shown to have a strong influence on the attitudes of student nurses (Kovarna, 2006; Jarrell et al, 2013). In a study of predominantly young, female, nursing students, one-third of whom had received social assistance and lived in impoverished communities, it was found that the students had either neutral or positive attitudes towards those living in poverty. Students above the age of 30 were found to have more positive attitudes than younger students (Kovarna, 2006).

Biased behavior in healthcare providers has proved difficult to assess which may be attributed, in part, to the fact that it is often not a result of conscious, intentional discrimination but rather a result of unconscious forces (Wittenauer et al., 2015). In a research study designed to understand provider bias and eliminate provider contribution to health disparities, researchers found that even those who were motivated to avoid bias engaged in these behaviors on some level, particularly when experiencing fatigue or stress (Burgess, Fu, & van Ryn, 2004).

Research conducted by Burgess et al. (2004) explored the idea that the ways in which healthcare providers process information are influenced by an unintentional disconnect between their desire to provide equitable care and their clinical decision making, which is altered by underlying perceptions of race, ethnicity, socioeconomic status and other factors. An
understanding of the origins of negative attitudes towards marginalized populations and appropriate measurements are required in order to accurately assess the amount to which these beliefs or feelings exist among health care providers. One mechanism for revealing unconscious bias and raising provider awareness is increasing education levels and exposure to various cultures (Ruetter et al., 2004; Brathwaite & Majumdar, 2006; Wittenauer et al., 2014; Moreno & Hart, 2014).

Existing research has confirmed that a knowledge deficit and overt and subconscious bias exists among healthcare providers, even among those with a desire to provide high quality, equitable care (Ruetter et al., 2004; Kovarna, 2006; Brathwaite & Majumdar, 2006; Wittenauer et al., 2014; Moreno & Hart, 2014). As nurse leaders begin to understand the origins of bias, the scope of existence in healthcare, and the impact on health disparities, they are inevitably pointed toward finding solutions. A logical starting point for increasing cultural competency is in the educational preparation of nurses. Nursing faculty must be cognizant of preparing students to enter the workforce who demonstrate appropriate technical skills and sound clinical judgment as well as having cultural humility, awareness and desire for competency in that area. The identification of effective teaching strategies is of primary concern in this venture.

Teaching Strategies

Nurse educators turn to research to assist them in curriculum decision making processes. Researchers Reid and Evanson (2016) hoped to increase their understanding of the usefulness of poverty-focused teaching strategies by conducting a review of pertinent literature. The authors gathered information on the current poverty-simulation tools being used and presented their findings and recommendations for further inquiry in the Journal of Professional Nursing (Reid & Evanson, 2016). They summarized seven tools that faculty reported using. They found that
overall, when examining research on tools and strategies designed to assess student outcomes, the student’s attitudes toward those living in poverty improved and they were less likely to express disapproval of programs designed to assist impoverished families. There were less promising results when it came to motivation to engage in community actions. A fact that led them to recommend that simulations be used in conjunction with other strategies such as service learning experiences or travel studies (Reid & Evanson, 2016).

The Reid and Evanson (2016) study was strong in providing specific information on available tools such as the cost, minimum and maximum number of participants, setting, and a listing of studies performed on each tool. Limitations include the fact that they label all of the tools as, “simulation” which was not entirely accurate. Some of the tools reviewed would be better described as “online learning modules” or even “games.” The authors also failed to distinguish between studies involving nursing students from other disciplines such as social work or law enforcement. Finally, the authors give broad suggestions for use of tools in nursing curricula, however given their in-depth investigation of the tools it would have been helpful if they had given more specific ideas on how to use the tools to meet standards set by the American Association of Colleges of Nursing (AACN). Overall this study proved helpful in assembling knowledge about tools currently being used for poverty-focused curriculum. It was also important in terms of identifying the sparse research that does exist, however, increased efforts to capitalize on the information gathered by increasing the detail of the report would have increased the usefulness of their review (Reid & Evanson, 2016).

In a study of the use of a poverty simulation with nursing students (Yang, Woomer, Agbemu & Williams, 2014), researchers found that students had increased understanding of stress and financial pressures as well as frustration and emotional distress faced by individuals
dealing with the social services system. Statistical significance was reached in terms of students changing their attitudes toward poverty in a more positive direction, however, poorly described research methods, especially in their description of data analysis, detracts from the trustworthiness of the authors’ conclusions (Yang et al., 2014).

Research methods testing the use of teaching strategies often suffer due to the difficulty of assessing the complex nature of attitudes and knowledge surrounding poverty. Mixed method design has sometimes been used, however, these studies often suffer from poorly explained frameworks. For example, Yang et al. began with quantitative methods intending to have students rate their attitudes on a “Likert-Type” scale as well as rating the overall experience from one to ten. The analysis of these ratings were reported in terms of statistical methods such as “paired t-tests.” The researchers also included open-ended, qualitative-style questions, but did not give explanation of their analysis. They reported on “four main themes” including: understanding people with low SES, understanding barriers to healthcare, changing attitudes and changing nursing practice. It is difficult to know how to interpret this thematic summary without any information on how the data was analyzed (Yang et al., 2014).

In another mixed-method approach to evaluating the use of a poverty simulation, created by the Missouri Community Action Partnership, with nursing students, Patterson and Hulton (2012) used a pre and post experience design gathering data with the Attitudes about Poverty and Poor Populations Scale (APPPS). The measurement included open-ended questions with responses analyzed through the constant comparative method (Patterson & Hulton, 2012).

The researchers found that overall the mean scores for attitude moved in a positive direction but it should be noted that only the individual factor of “stigma” had statistically significant results (Patterson & Hulton, 2012, p. 146). The authors then report on emerging
themes from the textual data after having engaged in a line-by-line examination and subsequent coding of responses. The themes consisted of the following: (1) experiencing the reality of poverty; (2) frustrations with timing and long lines; and (3) understanding the need for services for the poor. (p. 147). The respondents also provided feedback on the quality of the learning experience with 91% giving a positive recommendation (Patterson & Hulton, 2012). These findings align with other research on poverty simulation in terms of reducing stigma but failing to produce statistically significant changes in other areas (Yang et al., 2014).

The participants for the Patterson and Hulton (2012) study were obtained through nonprobability, convenience sampling, a common method for research surrounding cultural competence and attitudes related to poverty. Despite a healthy response from volunteers willing to complete the web-based survey (72%), the possible presence of self-selection bias must be noted. Participant diversity, as in many other studies involving nursing students, was limited with over 90% being Caucasian females, which does not mirror the overall nursing profession demographic picture which is approximately 70% Caucasian (Patterson & Hulton, 2012).

Overall the research surrounding nursing students’ participation in a poverty simulation has produced some evidence for increased levels of participant knowledge and a shift in attitude in a more positive direction. These findings must be investigated further as persistent problems with research design and methods, have created questions regarding reliability and generalizability. There is a gap in research surrounding the full impact of the use of a poverty simulation and the meaning it has to students. This gap includes studies done with existing RN’s enrolled in professional programs of study to complete their bachelor’s degree.

**RN to BS Nursing Students**

In the United States there are two types of nursing students seeking a bachelor’s degree in
nursing. The most common is the traditional undergraduate student who has no prior education as a professional nurse. The second is the student who has already graduated with an associate degree in nursing and is completing a bachelor’s degree in nursing, referred to as the RN to BS student. Examining literature regarding the differences in educational preparation for nurses can reveal important differences that may guide nurse educators working in RN to BS programs.

Currently, of the 2.8 million nurses in the U.S., approximately 55% have a bachelor’s degree (or higher) with many of those beginning their education in an associate degree program (HRSA, 2013; IOM, 2011). Data from the Health Resources and Services Agency (HRSA) reflect trends from the last decade showing increases in associate degree nurse (ADN) graduates which have continually outpaced BSN increases, making it likely that the predominant point of entry into the profession will continue to be an associate degree (HRSA, 2013; IOM, 2011).

ADN’s are highly encouraged to continue their education as professional organizations such as the American Nurses’ Association recommend that the minimum preparation for entry into the nursing profession be a BSN (ANA, 1965; ANA, 2008). Many ADN’s will enroll in a BS program to extend their education. Nursing faculty are required to be aware of best practices for nursing students of both the traditional and RN to BS categories.

The RN to BS student perception of participating in a poverty simulation may significantly differ from traditional undergraduate perceptions as they have professional experiences to reflect upon. The simulation can prompt a re-examination of their personal approach to caring for patients who have a background of socioeconomic vulnerability. This aligns nicely with the reasons for advancing educational preparation which include acquiring the ability to comprehend healthcare practices at the systems level, understanding the concepts of public and environmental health, and increased leadership skills, all of which expand the nurses’
ability to care for patients from culturally diverse backgrounds (IOM, 2010; AACN, 2008; NACNEP, 2013).

Increased capacity to care for diverse patient groups is central to the goals and intended student outcomes of a poverty simulation. Research demonstrates a connection between how adult learners, such as RN to BS students, acquire and process knowledge and learning activities such as a poverty simulation. In 2010, Patricia E. Benner was the lead author of a book titled, *Educating Nurses: A Call for Radical Transformation* which was written to bring attention to the fact that as students partake in learning experiences, educators must understand that the student brings with them their past experiences and often deeply ingrained personal perceptions that have often gone unchallenged (Benner, Sutphen, Leonard, & Day, 2010). Learning experiences impact deeper cognitive processes, which are the product of experiences and knowledge that upon deeper examination and reflection can be reformed (Benner et al., 2010). When participating in a poverty simulation, RN to BS students, are encouraged to confront new information that may challenge existing attitudes and perceptions of populations existing in poverty.

In designing educational programs for RN to BS students, nurse educators can draw upon guidelines from professional organizations such as the American Nurse Association (2015) and the American Association for the Colleges of Nursing (2008), however, specific research informing best practices is limited. The paucity of literature regarding the use of a poverty simulation activity with RN to BS students represents a gap in the resources available to nurse educators as they search for evidence with which to guide their educational practices (Reid & Evanson, 2016; Noone et al. 2012, Patterson & Hulton 2012; Drevdahl, 2013).
Theoretical Framework

Two theories provided a foundation for my research, constructivism and Campinha-Bacote’s (2011) theory of cultural competency in healthcare delivery. I will begin with an overview of constructivism as the term can be used in a number of ways and requires clarification. First and foremost, constructivism served as a guiding framework for this study. Secondly, it functioned as a learning theory which was useful in understanding the students’ reactions to the learning event. Once I have detailed the two different aspects of constructivism I will provide an explanation of the theory, or model, of cultural competency in healthcare delivery which served to connect the learning outcomes of the poverty simulation with the profession of nursing and the issue of providing equitable, high quality nursing care for patients from socioeconomically disadvantaged backgrounds.

The ontological perspective, which refers to the form and nature of reality (Guba & Lincoln, 1994), that guided my theoretical framework asserts that reality is subjective and must be interpreted through the experiences of individuals. The complimentary epistemological viewpoint to this, which refers to one’s relationship to knowledge (Guba & Lincoln, 1994), posits that knowledge of our world will always be filtered through human minds and social constructions. I required a research paradigm that allowed for the construction of multiple realities and honored the idea that what can be known about a topic is not necessarily generated by objective, scientific inquiry but discovered through diverse methods with varying degrees of accuracy and certainty. This pointed my inquiry toward constructivism which asserts that there is no single reality and the discovery of underlying meaning of events requires interpretation (Crotty, 1998).

Constructivism, as a research paradigm, closely relates to the philosophical tradition of
phenomenology. The use of hermeneutic phenomenology for this inquiry grew from foundations provided by both constructivism and phenomenology. Hermeneutics also called ‘interpretive phenomenology’ is a recommended method for researchers who approach inquiry through the constructivist paradigm (Lincoln & Guba, 1985). An interpretive or hermeneutic phenomenological approach within the qualitative method of inquiry allowed for exploration of multiple factors and influences on each student’s perception of their experience (Merriam, 2009); a necessary view that has proved difficult for quantitative methods to fully capture.

Edmund Husserl, regarded as the father of the philosophical tradition of phenomenology, spoke to the very heart of the intention behind researching the ways in which students might create meaning from a poverty simulation through his explanation of the difference, and importance of, the “pre-phenomenal being of experience” which is what exists prior to the post reflective meaning of a phenomenon (Husserl, 1929). Teaching strategies that use engaging experiences, such as the poverty simulation, endeavor to stimulate increased student awareness of life in poverty and prompt student reflection. “When we turn toward the experience attentively and grasp it, it takes on a new mode of being: it becomes "differentiated," "singly out.” (Husserl, 1991, p. 132). The increased awareness that educators hope to produce, through learning activities like a poverty simulation, is parallel to the increased awareness or understanding of student experiences, which is the goal of this study.

Phenomenology as envisioned by Husserl aimed to describe things as they appear in the consciousness. The approach created by Husserl, descriptive phenomenology, stressed the fact that “extraneous factors such as religious or cultural thoughts and beliefs can influence how phenomenon are understood” and therefore actions must be taken by the researcher to minimize these influences (Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013, p. 18). Martin
Heidegger, a student of Husserl, acknowledged the influence of extraneous factors, however, he did not believe that these could ever realistically be minimized (Stanford Encyclopedia of Philosophy, 2011). Heidegger believed that merely describing a phenomenon did not go far enough to produce understanding. Heidegger endorsed an interpretive approach that aimed to, “describe, understand and interpret participant experiences” (Tuohy et al., 2013). Heidegger broadened the original techniques of hermeneutics, which simply referred to interpretation of the meaning of an object, to allow for the study of human science and ‘*being in the world*’ rather than simply ‘*knowing the world*’ (Reiners, 2012). This relates back to the constructivist approach as both interpretive phenomenology and the constructivist paradigm center on the *meaning* of a phenomenon as related to those who experience it. This paradigm and approach to the acquisition of knowledge provide a foundation for the theoretical concepts that make up the constructivist learning theory.

Constructivism learning theory honors the individual experience of the learner and takes into account previous experiences and exposures to social situations (Vygotsky, 1978; Bruner, 1996). This provided a helpful guide to use when attempting to understand the ways in which adult learners assimilate information from a learning even like the poverty simulation. Constructivism learning theory provides an argument for providing the learner with opportunities for discovery rather than encouraging passive learning techniques such as reading assignments or instructor guided lectures. Learners are encouraged to observe, engage, and analyze experiences on an individual basis and in cooperation with their peers and educators. Learning is described as an active process whereby the learner forms new ideas from situations and scenarios that often challenge previous knowledge and stimulate new perspectives (Vygotsky, 1978; Bruner, 1996, Merriam, 2009).
The use of engaging, hands-on, interactive learning techniques is not new to nursing educators. Constructivist learning approaches abound in clinical, lab, and simulation settings. In recent years nurse educators have been challenged to incorporate constructivist learning approaches in classroom and theory presentations in addition to the clinical and lab settings. This has been particularly emphasized as appropriate for nontraditional nursing students who appear to benefit greatly from the deviation from traditional pedagogies (Peters, 2000; Benner, 2012). The use of constructivism learning theory was particularly useful for the understanding of the adult learning needs of the RN to BS students as they experienced and made meaning of the interactive learning opportunity provided by the poverty simulation activity.

In addition to the paradigm and learning theory of constructivism, the framework for this study also consisted of Campinha-Bacote’s *The Process of Cultural Competence in the Delivery of Healthcare Services*. This theory describes the nurse or healthcare provider as working ceaselessly to achieve the ability to provide service to patients within their cultural context. It stresses the idea that providers do not achieve cultural competence as an endpoint but rather, engage in a continual quest to learn culturally competent ways of providing care. Each patient encounter serves as an experience to modify existing beliefs and inform new ways of understanding different cultures (Campinha-Bacote, 2002; 2011).

The theory of *The Process of Cultural Competence in the Delivery of Healthcare Services* describes five constructs that comprise cultural competence: (a) cultural awareness, (b) cultural knowledge, (c) cultural skill, (d) cultural encounters, and (e) desire (Campinha-Bacote, 2002; 2011). Cultural awareness involves examining one’s own cultural background and identification of personal biases towards other cultures. This awareness also includes acknowledging the existence of bias in the delivery of healthcare services. Cultural knowledge is addressed when a
provider seeks out information to inform culturally appropriate care for a given group. The knowledge acquired should include the beliefs, practices and values of the investigated culture as well as disease incidence and prevalence specific to the group. Cultural skill involves the ability to appropriately assess health issues impacting a culture as well as individual members. Cultural encounters occur when a healthcare professional interacts with individuals from culturally diverse backgrounds with the express purpose of modifying existing beliefs and confront potential stereotypes. Finally, cultural desire can be viewed as the foundation of Campinha-Bacote’s theory and refers to a nurse’s motivation to learn about cultural differences and interact with culturally diverse individuals. Cultural Desire is described as a “pivotal spiritual construct that provides the energy source and foundation for one’s journey towards cultural competency" (Campinha-Bacote, 2002, p. 244). Cultural Desire provides the foundation for the other constructs including cultural awareness, knowledge, skills, and encounters (Campinha-Bacote, 2002, 2011).

Campinha-Bacote’s theory of The Process of Cultural Competence in the Delivery of Healthcare Services is accompanied by a model that helps explain the concepts and their relationship to each other by using the metaphor of an erupting volcano. The volcano symbolizes the nurse’s willingness to take part in the process of becoming culturally competent. Cultural desire erupts from the volcano initiating steps in the process of cultural competence such as increasing cultural awareness or seeking cultural encounters (Campinha-Bacote, 2002; 2011).

Each theory is part of a framework that builds a case for the use of qualitative methods in reaching a deeper understanding of the phenomenon of using a simulation activity to address the issue of poverty with RN to BS students. The research questions are concerned with finding the
comprehensive meaning in the experience and with understanding the extent to which the new knowledge may shape the participants’ understanding of culturally competent patient care.

Summary

Chapter 2 reviewed existing research in a number of areas pertinent to the study of how RN to BS students experience a poverty simulation. The persistence of disparities in the U.S. healthcare system was documented as well as research related to attitudes of current and future healthcare providers towards patients living in poverty. Research focused on factors that influence provider attitudes, both in and out of the classroom, was detailed. A critical examination of the complexities researchers must face when attempting to measure attitudes and perceptions surrounding a social construct, such as poverty, was also presented. The state of research on the use of a poverty simulation with nursing students was shown to have conflicting findings and some flawed methodology in terms of measuring outcomes. It was also found that existing research lacks attention to the group of learners known as RN to BS students. Theoretical frameworks providing a basis for the research design and outlining guiding concepts for gathering and analyzing data were also included in this review of literature. Chapter 3 will detail selected methodology and provide rationale for design choices and techniques within interpretive phenomenology.
Chapter III: Methodology

This chapter provides a detailed description of the methodology used in this research by expanding on the theoretical concepts identified in chapters 1 and 2 and explaining connections between the conceptual framework and my research design choices.

Research Design

To discover how RN to BS students experience and make meaning of a poverty simulation, I used qualitative research methods, specifically hermeneutic phenomenology informed by van Manen’s (1997) recommendations for conducting research activities within this method. The research design for this investigation originated with my propensity to approach the act of inquiry through the constructivist paradigm. My ontological perspective posits that the nature of reality can be expressed in multiple accounts based on human constructions and these constructions are dynamic and capable of evolving based on expanding experiences. Guba and Lincoln (1994) use the phrase “reality is relative” to describe the ontological perspective of constructivists who believe that reality takes form within an individual as they create mental constructions of concepts based on their experience in the world. There were a number of research traditions that allowed exploration of the mental constructions of individuals considered for this project, however, the phenomenological method was found to align closely with the constructivist paradigm (Guba & Lincoln, 1994).

Educators have chosen to use the poverty simulation as a strategy to increase student awareness of the challenges faced by families existing in poverty (MACA, 2010; Patterson & Hulton, 2012), however, there is limited understanding of how students make meaning of the experience (Drevdahl, 2013; Browne & Roll, 2016; Reid & Evanson, 2016). This study used phenomenological methods to further develop understanding of the experience, how RN to BS
students make meaning of new information, and what impact it may have on student perceptions of cultural competence. As Merriam (2009) noted, “From the philosophy of phenomenology comes a focus on the experience itself and how experiencing something is transformed into consciousness” (p. 24). The process of transforming previously unexamined aspects of patient-nurse interactions into a concept that has heightened awareness is complex and not well understood. Phenomenological techniques provided an avenue to fully examine the cognitive and perceptual reconstructive mechanisms at work, which often included subtle nuances, as the RN students engaged in the learning activity, assimilated new information into their belief systems and reflected upon their history of patient interactions with those living in poverty. The importance of heightening student awareness, or consciousness, of the value of attending to the unique healthcare barriers experienced by patients and families living in poverty, has been identified as an essential step in increasing the cultural competency of nurses and improving patient outcomes for vulnerable populations (IOM, 2006; Campinha-Bacote, 2011).

Phenomenology as a discipline can be traced back to the early 20th century and a man named Edmund Husserl. Husserl developed an approach to epistemology, the study of knowledge, that broke from the traditional empirical focus of his day by honoring human consciousness as the primary means of generating knowledge (Benner, 1994). Husserl’s focus on looking at phenomenon in the “first person” parallels the constructivist view that one can understand the truth of a phenomenon through exploration of personal realities (Husserl, 1929; Polit & Beck, 2008; Creswell, 2014). Husserl’s ‘descriptive phenomenology’ focused on describing the ordinary, conscious experience of everyday life. Husserl believed that as researchers consider a phenomenon they should strive to eliminate personal bias through the act of ‘bracketing.’ “Bracketing refers to the process of identifying and holding in abeyance
preconceived beliefs and opinions about the phenomenon under study” (Polit & Beck, 2008, p 228).

Husserl’s (1929; 1991) ideas provided a foundation for phenomenological research, however evolutions of the method brought significant changes. Martin Heidegger, a student of Husserl, disagreed with the idea that we can separate our research from our own being in the world (Polit & Beck, 2008; Reiners, 2012; Morris, 2013). Heidegger moved beyond simply describing a phenomenon and “stressed interpreting and understanding---not just describing---human experience. His premise is that the lived experience is inherently an interpretive process and argued that hermeneutics is a basic characteristic of human existence” (Polit & Beck, 2008, p. 229). Heidegger broadened the original techniques of hermeneutics, which simply referred to interpretation of the meaning of an object, to allow for the study of human science and being in the world rather than simply knowing the world (Reiners, 2012). Questioning RN students regarding their participation in a poverty simulation using hermeneutics served to expand the focus of this research from simply describing the core concepts of the experience to interpreting and understanding the lived experience of RN students (Polit & Beck, 2008).

The decision to use interpretive phenomenology over descriptive phenomenology for my inquiry was based on three considerations. First, I viewed the nature of my research questions as going beyond what descriptive techniques could provide. I wanted more than participant descriptions of the experience, I hoped to uncover personal and professional meaning in the experience. Second, I did not believe I could ‘bracket’ or set-aside my preconceived opinions and, in fact, I believed that my experiences with the teaching strategy might serve to enhance the dialogue with participants. My final reason for choosing interpretive phenomenology was a desire to be part of the research in a way that would allow open interaction between myself and
the participants and facilitate mutual understanding of the phenomenon, a tenet of interpretive techniques (Guba & Lincoln, 1994; Reiners, 2012). In addition to these three considerations, I noted that it was recommended by research experts that those using a constructivist approach employ interpretive phenomenological methods. In their explanation of the ways in which constructivism is expressed through the techniques of interpretive phenomenology, Guba and Lincoln, (1994) addressed both the researcher role and the goals of this type of inquiry:

The variable and personal nature of social constructions suggests that individual constructions can be elicited and refined only through interactions between and among investigator and respondents. These varying constructions are interpreted using conventional hermeneutical techniques and are compared and contrasted through a dialectical interchange. (p 111)

The methods recommended for interpretive phenomenology differ from other forms of inquiry in that the steps of the process are not strict or rigid, relating to the fact that discovering the lived experience requires ongoing adaptations of approach. Van Manen (1990) explained, “This is a method that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques, and concepts that would rule-govern the research project” (p. 29). Van Manen (1990) identified six research activities that I used to shape my phenomenologic inquiry. They are:

1. Turning to a phenomenon, which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on essential themes, which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon;
6. Balancing the research context by considering the parts ad the whole. (p. 30-31)

With regard to the first activity, I became interested personally and professionally in the experience of participating in a poverty simulation through my work as an undergraduate professor of nursing. Upon review of existing information available to inform educators of the impact of the simulation activity it became clear that more information was needed to augment the knowledge generated from existing research. Van Manen’s (1990) second step encourages the investigation of an experience as it is “lived” rather than as it is “conceptualized”. Quantitative research has predominantly used surveys to question respondents about their attitudes related to poverty. Surveys focused on attitudes regarding poverty inherently require the participant to conceptualize the experience and quantify beliefs. Alternatively, an investigation that allowed participants to tell their story provided opportunity for any number of insights to be discovered. This leads to the third activity suggested by van Manen (1990), “reflecting on essential themes”. The discovery of themes relating to the lived experience of RN to BS students as they experience and are impacted by the poverty simulation provided a new approach to answering some of the lingering questions brought forth by quantitative results such as the true nature of how attitude changes occur and whether the changes will impact patient care and advocacy. Steps four through six of van Manen’s guide are addressed in subsequent chapters.

The purpose of engaging in an in-depth dialogue with participants was to increase insight into their lived experience and to create a depth of meaning for both the participant and researcher. Interpretive phenomenology allowed for exploration of multiple factors and influences on each student’s perception of their experience; a necessary view that quantitative methods have been unable to fully capture (Merriam, 2009). Increased understanding of the student experience was useful in identifying ways in which these experiences aligned with and
diverged from the goals and intended outcomes nurse educators expected when using the poverty simulation.

A hermeneutic phenomenological approach to inquiry guided by van Manen’s (1990) suggestions for discovering the ‘lived experience’ provided direction when constructing the following three research questions:

1. What is the lived experience of RN to BS students as they participate in a poverty simulation?
2. How do RN to BS students construct meaning and assimilate new information after participation in a poverty simulation?
3. How might reflecting on the poverty simulation shape RN to BS students’ ideas of what it means to provide culturally competent nursing care?

**Population/Sample**

The goal of sampling for this qualitative study was not to ultimately produce statistical inferences or generalize data (Lincoln & Guba, 1985) rather, the intention was to gain an in-depth insight into the lived experience of RN to BS students participating in a poverty simulation and to allow them the time and space to tell their story. For this study purposive sampling techniques were used to recruit eight nursing students completing their final year of an RN to BS program at a university in the Midwestern region of the USA. Merriam (2009) described purposive sampling as having been “based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (p.77). To be considered for this study, participants were required to be RN to BS students enrolled in a senior level community health course that included the poverty
simulation as a learning activity. Further sampling criteria included expressing an interest in the topic of poverty as related to healthcare and being willing to participate in one or more face to face interviews where they would be expected to share their story and perceptions regarding the experience of participating in the poverty simulation, “Welcome to the State of Poverty.” Finally, participants needed to be willing to allow audio recording of their interview.

Creswell (2014) explained that purposive sampling allows the researcher to begin the process of creating shared awareness by alerting participants to the focus of the inquiry. The initial contact between the participants and researcher was introduction of the researcher by the participants’ community health course instructor. The students were given an overview of the study including the phenomenon of interest. This was a critical step in the beginning stages of conducting a hermeneutic interview as explained by Vandermause and Fleming (2011), “During the recruitment process, the researcher discusses with the potential participant the phenomenon that is the focus of the research. This allows time for the participant to think about the experience more deeply” (p. 370). Students interested in learning more about the study were invited to share their contact information with the researcher. The researcher’s contact information was made available to all students in the course in the event that a potential participant was not comfortable sharing contact information in the classroom setting. Students were informed of the role of the researcher as an instructor in the undergraduate nursing program and reassured that participation in the research project was voluntary and anonymous to instructors in their RN to BS program of study.

The determination of sample size for any research project differs significantly depending on the nature of the research. The qualitative researcher seeks not to answer the question of “how many” when determining sample size but rather seeks, “knowledge of the content of the
experience, often in depth, to seek the meaning of a phenomenon not ‘how many’ people have experienced such phenomenon” (Englander, 2012, p. 21). Creswell (2014) further explained that, “sample size depends on the qualitative design being used” (p. 239). Appropriate sample size for a phenomenological study ranges from three to ten (Creswell, 2014, p. 239). Data saturation is an additional consideration when choosing participant numbers. ‘Saturation’ refers to the point in data collection at which discussions or interviews with participants no longer bring forth new contributions or are needed to clarify an understanding of specific parts of the experience (Cohen, Kahn & Steeves, 2000; Creswell, 2014). Given expert recommendations for phenomenological inquiry and my goal of reaching data saturation, I chose to aim toward the higher end of Creswell’s range and set a goal of recruiting seven to ten RN to BS students. Eight participants were ultimately included in the study.

**Data Collection**

Interviews are typically the primary source of data for phenomenological studies (Creswell, 2014; Polit & Beck, 2014). The unique aspects of hermeneutic interviewing were central to the data collection process for my study. Vandermause and Fleming (2011) explained that in hermeneutic interviewing, “the interviewer seeks to uncover what it means to be as it shows up or reveals itself through story. As the stories are elicited, the interpretation begins” (p. 369). To elicit stories and create the give and take process required for an open exchange I prepared a semi-structured interview guide. My interview guide was purposefully designed to be flexible (Merrium, 2009) and encourage a ‘fusion of ideas’ (Vandermause & Fleming, 2011) between myself and the participants.

My original guide (Appendix B) consisted of seven semi-structured, open-ended questions, designed to be easily adjusted to individual responses, interests, and allow for
investigation of emerging issues (Merriam, 2009). To increase reliability the interview guide was critiqued by a nursing educator and researcher with studies published in the hermeneutic phenomenological tradition (Scheckel & Ironside, 2006; Scheckel et al., 2012). The interview critique prompted a decrease from seven to five open-ended questions with the inclusion of prompts to be referenced as needed. General demographic questions followed by broad opening questions were used to allow the participant time to feel at ease.

Additionally, I used recommendations from van Manen (1990) to shape my interview techniques such as continuous ‘clarification’ which was done throughout the interview by posing similar questions in slightly different ways in an effort to ensure that the researcher and the participant had a mutual understanding of the ideas being discussed. This technique was a valuable tool for this research because the complexity of the concept of poverty increases the potential for misunderstanding during the interview process. Additionally, topics such as attitudes towards poverty are subject to the issue of participants desiring to provide socially acceptable responses, which may be mitigated through van Manen’s (1990) approach.

The interviews lasted between 50 and 80 minutes with the goal being to provide adequate time to obtain in-depth data consistent with phenomenological methods (Creswell, 2014). The length along with the fact that follow-up interviews were an option contributed to credibility as ‘prolonged engagement’ with the participants and the topic was an additional goal during data collection (Lincoln & Guba, 1985). A journal-audit trail was maintained and submitted for periodic review by committee members throughout the research process as a means of increasing credibility. The journal detailed reduction activities, field notes entered immediately after conducting a participant interview, and additional insights and concerns regarding the research process (van Manen, 1997).
The interviews were conducted face to face in places selected by participants to increase their comfort level. One participant asked to meet at her university, one at her place of employment and the rest chose private rooms in coffee houses. Two recorders were used for audio recording to ensure that no errors in technology interfered with the collection process. Recorded interviews were transcribed verbatim with identifying information removed. Once transcribed, recordings were stored in a digital repository along with transcribed interviews labeled with pseudonyms in an individual file for each interview along with field notes taken on the day of the interview, analytic memos, and journal entries of hermeneutic phenomenological writing.

**Data Analysis**

My data analysis was structured using guidelines for engaging in interpretive phenomenological analysis described by Pietkiewicz and Smith (2012) and steps three through six of van Manen’s (1990) recommended research activities. Pietkiewicz and Smith (2012) advise that interpretive phenomenological analysis guidelines are meant to be flexible and “should not be treated as a recipe” so as not to inhibit creativity (p. 367). I organized my activities into four phases: (a) reading and re-reading transcripts and note-taking; (b) identifying units of meaning/emergent themes through coding; (c) seeking relationships and clustering themes; (d) distinguishing essential themes. It should be noted that these phases were part of an ongoing, nonlinear, recursive process that actually began during the first interview, prior to what would be considered the official data analysis phase (Cohen et al., 2000).

The reading and re-reading phase of my data analysis allowed me to “immerse” myself in the data through “multiple readings of transcripts,” return to audio recordings and review of original field notes (Pietkiewicz & Smith, 2012, p. 368). During this activity I recorded my
reflections, impressions and new insights in the form of ‘analytic memos’ that I attached to a word or phrase in each transcript using the ‘new comment’ function in the review pane of Microsoft Word. Memos can be described as, “conversations with oneself about what has occurred in the search process, what has been learned and the insights this provides, and the leads these suggest for future action” (Ely, Anzul, Friedman, Garner & Steinmetz, 1991, p. 80).

My reading, re-reading, field note review, and analytic memoing activities initially focused on understanding each participant account as a whole experience and subsequently moved to considering smaller parts as familiarity with the data increased. This expressed van Manen’s (1990) step six in the overall research process as it was intended to balance research context by, “considering parts and whole” (p. 31). Returning to the audio recordings to “recall the atmosphere of the interview” was an additional strategy I used in my analysis process as a means of bringing forth “new insights” (Pietkiewicz & Smith, 2012, p. 368) regarding such things as the setting or the participant’s emotional state. While engaging in these activities van Manen (1990) urges researchers to maintain a strong orientation to the phenomenon (step three) while allowing essential meanings from words, sentences or pieces of text to come forward.

The next phase of analysis involved disassembling each transcript so I could consider smaller units or ‘parts’ of each interview. I performed a line-by-line reading of each interview, highlighted meaningful statements and placed codes in the margins. The goal of considering data in smaller units was to help me uncover the meaning of events between individual interviews and to begin identifying phenomenological themes (van Manen, 1990). Once I identified a unit as meaningful, I highlighted it and assigned a preliminary code. My highlighted statements were then recorded in a separate word document, along with a transcript identifier and line number to provide ease in returning to the text for context as needed. I evaluated the separate word
document and each recorded “unit” or piece of data as part of the coding process and thematic discovery. I continually revised my set of codes and created a rubric to explain the meaning of each code and track revisions. Eventually I chunked codes together as a way of identifying my initial themes. A *theme* is meant to unify qualitative raw data through grouping all or part of the data under a symbolic phrase (Polit & Beck, 2012). Van Manen (1990) explained that, “Phenomenological themes may be understood as the structures of experience. When we analyze a phenomenon, we are trying to determine what the themes are, the experiential structures that make up that experience” (p. 79). Once I highlighted, coded and began to identify thematic statements I shared observations and textual examples with a dissertation committee member who provided feedback on themes and subthemes as well as the associated evidentiary statements identified.

My next phase consisted of searching for connections and relationships among themes and placing them in clusters. Pietkiewicz and Smith (2012) advise compiling or clustering themes within each individual transcript prior to looking at connections across interviews. I clustered my initial themes which resulted in an exhaustive list of coding categories that represented all possible themes and subthemes. I continually winnowed themes to exclude those with a “weak evidential base” and those that did not have a place in stronger emerging themes (Pietkiewicz & Smith, 2012, p. 369). I referenced my coding schema to assign descriptive labels to all of the theme clusters. My descriptive theme labels denoted their contextually similar content. I engaged in continual reflection and hermeneutic writing regarding my theme relationships. I periodically requested that one of my dissertation committee members review and provide feedback on clustering decisions.

I engaged in the technique of hermeneutic phenomenological writing during all phases of
data analysis. This type of writing calls researchers to write about themes as they take shape. Van Manen’s (1990) recommendations for phenomenological research (step four) encouraged me to describe the phenomenon of interest, “through the art of writing and rewriting” (p. 79). During my phenomenological writing activities I performed periodic literature searches to locate additional research to inform my findings and contribute to my understanding of participant experiences. My phenomenological writing and thematic analysis was further enhanced by continuation of the sixth step in van Manen’s guide, which encouraged a back and forth movement between consideration of the data in units or “parts” and returning to a global view of the data.

Hermeneutic phenomenological writing served to assist me in my final phase of data analysis, a process known as identifying ‘essential meanings’ (van Manen, 1990). Essential meanings for my research are those concepts that are special and unique to the phenomenon of RN to BS students engaging in a poverty simulation. It was expected that other themes or patterns would emerge during data analysis, however, van Manen (1990) explained that it is the ‘essential themes’ that must be distinguished as these are the themes that are required to be present for the phenomenon to exist. Essential meanings are closely related to the more abstract term, ‘essences’. The ‘essence’ of an experience is arrived at when a researcher engages in the process of intuiting which involves going beyond the basic level of comprehension of text and reaching for a deeper, more thorough understanding of what the participant is expressing (van Manen, 1990).

My goal in identifying essential meanings and searching for the essence of the phenomenon being studied was ultimately to be able to provide a new way of understanding and describing the lived experience of an RN to BS student participating in and reflecting upon a
poverty simulation. “A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way” (van Manen, 1990, p. 39).

I accomplished activities for each of the four phases through handwritten notes and use of Microsoft Word and available functions. I chose not to use qualitative data software as this continues to be a point of debate among qualitative researchers. Some qualitative researchers examining the use of data analysis software programs warn that novice researchers in particular can fall victim to problems becoming immersed in the data when software is new to them (Goble, Austin, Larsen, Kreitzer & Britnell, 2012; van Manen, 2014). As a novice researcher, some pitfalls I intended to avoid by foregoing the benefits of software included having blind spots in data interpretation, misuse or overuse of default functions (Goble et al., 2012) and as Cross (2011) describes “an overall instrumentalization of a process meant to be artful and intuitive” (p.127).

I attended to study rigor, or trustworthiness as it is sometimes referred to in qualitative inquiry, by taking steps to meet the following four criteria: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). During my data analysis process, I was specifically concerned with credibility, dependability, and confirmability. To increase confidence in the truth of the data, also referred to as, ‘credibility’ (Polit & Beck, 2008) I provided research participants with a copy of their interview transcripts and invited them to add to their stories or clarify meaning. None of the participants indicated that they would like to add or revise their commentary. In reviewing the rich, descriptive accounts given by participants and in light of the fact that none of them requested an opportunity to provide additional information,
I did not request follow-up interviews. To establish a trail of evidence and increase ‘dependability’, I frequently engaged in reflexive writing to maintain a journal-audit trail throughout the research process. I also performed analytic memoing as a means of documenting observations and insights. I addressed ‘confirmability’ by submitting my journal-audit trail and an overview of my decisions for review by two of my dissertation committee members who also provided feedback on my thematic analysis and decision-making process.

Data analysis within the hermeneutic phenomenological research tradition involves uncovering themes, distinguishing essential meanings and using this information to produce rich, detailed descriptions of a phenomenon that inspires unique thought and a sense of wonder in regard to the experience. I moved through my four data analysis phases while performing recommended activities designed to assist me in discerning meaning from collected data.

Trustworthiness is an important concept in qualitative research. I have outlined my activities to demonstrate my attention to rigor during data analysis. I will address the topic of researcher positioning in the next section as this is an additional concern when using phenomenological methods with unique aspects relating specifically to hermeneutics.

**Researcher Positioning**

In preparing to interview participants I acknowledged the fact that when employing phenomenological methods researchers must consider ways in which they can make the interview the most effective. It was paramount that as the researcher, I had an understanding of my role as an instrument of data collection. Martin Heidegger argued that we are part of that which we attempt to understand and as researchers we cannot separate ourselves, or our research from our own being in the world (Tuohy et al., 2013).

A study using hermeneutic phenomenological methods does not require ‘bracketing’ as
endorsed by Husserl, however, the process of ‘reduction’ is recommended as a means of recognizing and highlighting unique aspects of the phenomenon that are of interest to the researcher (van Manen, 1990; Heinonen, 2015). According to Van Manen, a researcher practices hermeneutic reduction, also referred to as ‘openness’, by examining their biases and background in understanding the phenomenon to be studied (van Manen & Adams, 2010). To identify my personal biases and perceptions I maintained journal entries throughout the research process. The journal served to document my search for an authentic openness in regard to my feelings surrounding such topics as poverty, college student and nurse attitudes towards poverty, health disparities, and the professional responsibilities of both nurses and educators. Heinonen (2015) stated, “Hermeneutic reduction also means to practice a critical self-awareness” (p. 36). Self-awareness is promoted by the process of ‘reduction’, which enhances the researcher’s understanding of how personal perceptions might pull focus away from the participant’s story during the interview process. As the researcher, I was charged with setting a tone for each interview that allowed each individual’s story to come forward in a way that best represented their unique experience. Continually searching my thoughts and feelings through the hermeneutic writing process assisted me in maintaining a clear mind when approaching each interview.

**Ethical Considerations & Human Subject Approval**

Lincoln and Guba (1985) explain ethical considerations for the constructivist research paradigm as, “intrinsic” as the researcher and participant bring their values to the process (p. 115). The researcher does not hide their intentions or viewpoints, as this would disrupt the process of shared uncovering and discovery of uniquely detailed descriptions of the topic. Confidentiality is a high priority due to the likelihood that conversations during the interview
process may be of an intimate nature. Prior to each interview, I informed the participants of the steps taken to protect privacy, which included assignment of a pseudonym to be used in all research documents and removal of identifying factors in final transcription.

In order to protect the rights of human subjects and ensure adherence to the highest possible ethical standards during this research project, I submitted my proposal for review by the institutional review board (IRB) and obtained approval prior to activities. I completed training and testing on the human subject module prior to presenting my methods to the IRB. Per IRB requirements, I asked participants to review and sign a consent form and gave them the option of receiving a hard copy. Finally, I obtained permission to audio record each interview.

**Procedures and Timelines**

I completed interviews during the fall semester of 2017 following IRB approval of my proposal. All interviews were transcribed within two weeks of each meeting. I provided a copy of each transcription to the participants with an invitation to expand upon or clarify comments. I was able to meet my goals for this research project which included completing the interviews in a two-month time frame and completing thematic analysis and writing of the results within four months of having finished the data collection phase.

**Summary**

This chapter provided a background for my methodological choices which were based on my theoretical framework for this study and existing research associated with the phenomenon of how RN to BS students perceive and make meaning of the experience of a poverty simulation. The steps of participant recruitment, data collection and analysis were carried out as described as well as steps taken to protect participant rights. Chapter 4 will provide a detailed breakdown of the results obtained from my data collection and analysis.
Chapter IV: Findings

I chose to use methods of interpretive phenomenology in conducting this research to describe and interpret the lived experience of RN to BS students participating in a poverty simulation and to increase the understanding of the ways in which participants make meaning from the event. I analyzed the transcripts of eight participants in order to discover essential themes. The process of interpretive phenomenology, also referred to as hermeneutics, involves examining the spoken word, or text, for themes that reflect participant experiences, perceptions, and belief systems (Reiners, 2012). I found it helpful to occasionally return to the audio recordings as a supplement to transcription review, and to intermittently return to my field notes in order to maximize insight into the conversational tone and reinforce the evidence for my interpretation of participant accounts. The information presented in this chapter synthesizes the data collected and organizes it into essential themes. A description of each theme and subtheme is presented in this chapter to enhance understanding of the participant accounts.

Van Manen (1997) described essential themes as those containing elements that cannot be removed from an experience without altering the meaning of that experience. The essential themes presented in this chapter are those I identified as being critical to the meaning of RN students’ experience of participating and making meaning of a poverty simulation. I identified three essential themes: being in poverty, background gap/overlap, and reflection points. The final theme, reflection points, contains three sub-themes: reaffirmation, reconsideration, and reframing. The remainder of this chapter will provide an in-depth explanation of the themes and subthemes as well as evidence for each theme in the form of participant statements. I have provided a model to expand upon the description of essential themes and to demonstrate the
relationship the themes have to one another. Information on the demographic background of the participants was included to further develop a picture of the participants.

**Demographics**

A total of eight RN to BS students participated in the study. They were all part of a bachelor’s degree completion program for associate degree nurses located in the Midwest. They represented a variety of backgrounds in both years of experience and employment areas as Registered Nurses. The participants ranged from having just over one year to more than 15 years of RN experience and reported employment backgrounds that included geriatric care, labor and delivery, transitional care, and medical-surgical nursing. All of the participants were Caucasian females ranging in age from 23 to 45. Participants were asked about their past and current socioeconomic status. Two participants reported that they viewed their childhood socioeconomic status to be “poverty” while six responded that they had been raised in “middle class” families. All of the participants reported that they were currently part of the “middle class.”

**Themes**

The following sections were designed to present the three essential themes in an order that demonstrates the progression of participants as they move through the process of participating in, and making meaning of, the poverty simulation learning activity. The first theme, *being* in poverty, could also be called *existing* in poverty and captures the physical or in-the-moment experiences as well as the emotional reactions generated by the learning event. The second theme, background gap/overlap, expands upon the understanding of the participants’ initial physical and emotional responses by considering how this was influenced by their socioeconomic background. The third theme, reflection points, provides insight into the ways in which participants’ make meaning of the experience and integrate new thoughts and ideas into
previously constructed belief systems. The reflection points theme collects participant accounts that demonstrate shifting perceptions and are further delineated into subthemes that represent the process of making meaning. The first subtheme, reaffirmation, reflects the idea that some of the situations present in the poverty simulation increase commitment to a previously held belief or existing perception. The second subtheme is reconsideration which represents the idea that the simulation presented the participant with new information or a new awareness that has prompted a re-examination of previously held beliefs. The final subtheme, reframing, refers to a shift in the comprehension of situations related to socioeconomic vulnerabilities, reconstructed belief systems, or significantly altered perceptions of issues related to poverty.

**Being in poverty.** The first theme, “being in poverty” emerged from the participants’ descriptions of how they felt emotionally and physically as they existed in a simulated life designed to represent the experiences of impoverished individuals and families. In addition to their physical and emotional experiences, participants provided insights regarding the use of a simulation to address the topic of poverty.

The participant interviews prompted them to relay information about their assigned family roles as a starting point for recalling their simulation experience. Participants provided a mixture of descriptions detailing the environment, expected daily activities, and their emotional reactions. The three-hour simulation event was a brief existence in poverty that participants expressed as causing “anxiety” and being “chaotic” and “stressful.” Sally’s comments demonstrate how uncomfortable the experience was for her.

It was stressful. I felt all four of us [referring to simulated family members] had our own ideas about what we were going to do to make sure we survived and got through the simulation in general. We didn’t always agree, and it was hard to make a plan as a
family. …You could really see trends like at the beginning of the week you could see people like sprinting to go to the bank. It was kind of dangerous. You know, like I thought there was a high sense of urgency that you could feel from everybody.

The feeling of stress was expressed in multiple interviews regarding the simulation experience as well as a sense of urgency. Participant statements, such as those made by Selena, reflected a desire to successfully complete tasks related to successfully managing their simulated household such as paying bills, maintaining employment, and caring for dependents.

I remember feeling very stressed out, like, I’m never gonna be able to get ahead. Like, I can’t, I can’t do what I need to do. And I, I just started feeling, well, I would say there’s an element of feeling demoralized because I like to be successful. And I just always do my best and I couldn’t.

For Penny, feelings of stress were accompanied by a sense of being overwhelmed by the expectations of managing everyday life when faced with economic shortfalls.

I was one of five people in my family. I had a sixteen-year-old daughter who was pregnant. A ten-year-old son and an eight-year-old son. Both in school, or, all three in school. My daughter was seven or eight months pregnant. I had a husband who was a computer programmer, but he was out of work and I was a working mother that made $9.50 an hour at a hospital. I can’t remember if it was food service or if it was nursing but one of those two. I was involved in that. I have worked a job like that for about that wage when I was in my 20’s. Now you throw on the fact that somebody in their late 30’s who has a full family on the same wage. I couldn’t imagine, it was very hard to fathom where to start.
An exchange with Lori, as she outlines the pressures of paying for necessities, reveals a feeling of being overwhelmed by the situation.

Just remembering to get groceries and those things. When you have everything else on your plate. Is my child at school? Are the bills paid for? Is my house going to be taken from me because I didn't pay for my house? You know what I mean?

Lori’s comments demonstrated a clear understanding of the potential consequences of being unsuccessful with household management tasks. Other participants, such as Diana, made statements that connected the expected household maintenance tasks and lack of resources to their stress and anxiety.

I think [I felt] some anxiety. Really, because of the fact that you had to pay the light bill or they were going to shut your lights off. You had to pay your house payment or they were going to evict you. You had to get food so you didn’t starve, which I probably would have been dead really because I didn’t eat for two full weeks.

Penny’s comments provided a synthesis of the overall tone of the participants’ descriptions of how they reacted to the role expectations and economic barriers posed by the family scenarios in the simulation.

When you take that situation you think, “oh my goodness, I can’t afford to feed [the family] and keep all these bills paid and go to work for nine dollars an hour.” That was my first thought, “how am I going to do this?” And I think I was probably a little paralyzed with my words at that point because I was trying to think and my wheels were spinning on how I was going to get my…my fight or flight pattern.
Some participants, such as Andrea, expressed less stress and anxiety regarding the roles and required tasks of the simulation and more frustration with logistical or simulation ‘set-up’ details that she felt were implausible and not fully explained.

It was chaotic. I felt like we didn’t have an explanation for everything, for what was going on. …Because it’s not like we just woke up and we were poor. Usually you, you’re born into a poor family. You know, I don’t want to say ‘the system,’ but you kind of know what to expect. Here, we were just tossed in with, ‘good luck.’

When participants were asked to summarize their emotional state at the end of the simulation they relayed a variety of feelings which included exhaustion and hopelessness. Diana recalls her final impressions of the event.

…at the end, you know it’s hard, people are tired. You have been through this whole process and it’s exhausting. Because I think you feel all of those things that are going on in those family situations that you’ve been part of, emotionally you take that on.

Penny expressed thankfulness that the activity had come to an end because of the feelings it induced.

Honestly my first thought was, ‘thank God this is over.’ I thought to myself, it stressed me out. I was stressed out and it’s not even my situation!

The participants’ statements related to what the future might hold for their simulated families reflected a belief that the families would eventually end up with less and less of their already limited resources. Lori shared her lack of confidence that the situations would improve for families living in the circumstances demonstrated through the simulation.

If you would have gave us one more week we would have been evicted probably, from our house. …Long term these families are not going to stay out of poverty. You are not
going to get them out of poverty. Evictions and those things are going to occur. It just keeps going downhill. ...And if you do stay afloat the stress on your family is so high that [pause] I just couldn’t even imagine.

In addition to providing details and descriptions about physical elements of the poverty simulation and feelings associated with assigned roles and expectations, the participants expressed opinions on the style of the learning event. They reflected on how it felt to actively engage in a scenario that cast them in the role of a disadvantaged individual. They compared and contrasted the interactive nature of the simulation with other educational activities often used to address socioeconomic issues such as watching a documentary, listening to a speaker, or reading research. When asked about her reaction to the simulation activity as a learning event Diana confirmed a preference for an active approach to learning and underscored the value of being in the world of poverty if even for a brief period of time.

I think for me, I am a doer. I learn by doing, so, I took more away from it. If you would have just shown me a video about it I would have understood it. I would have probably gotten something out of it. But I don’t know if I would have felt how I felt being the person in the simulation. And talking to my neighbors about the struggles they were having. I think it made it more personal.

Sally appears to share Diana’s sentiments regarding the benefits of an interactive learning activity. She considers the strategy in light of her experiences as a nursing student.

I think as nurses we get a lot of lecture material and we read a lot of stuff. And some of it, yeah that’s really good and yeah I remember that, but I think a hands on activity and just involving so many people makes a difference.
Lori spoke to feelings of empathy that can be produced by experiencing life from the
vantage point of someone with economic vulnerabilities. When asked if she felt there was value
in having people “role-play” someone living in poverty she relayed a sense of increased
understanding and empathy.

I think it hits more home when you have to live the life in their shoes. Rather than just
watching on TV. Yeah, ok we know this, but when you have to live a life in poverty and
spend a day at a simulation like that, it makes you realize, ‘Oh my Gosh!’ I actually was
stressed out. It stressed me out! And watching a documentary you don’t have the same
feelings as when you experience it. So, I think a poverty sim is definitely a better
approach than just showing a documentary within our country.

Elaine echoed the idea that a simulation may serve to increase learner engagement and
produce an increased level of understanding and empathy.

…it made you think about everything. Being in that and having those feelings in the
moment. It made you feel how it could actually be in that experience rather than just, this
is how people feel when they have to deal with this.

Andrea differed from other participants when providing feedback on the usefulness of the
simulation as a learning strategy. She relayed feelings of annoyance with the logistics of the
simulation related to the pre-set timing. She commented on using the simulation as part of a
larger set of activities to educate providers and increase awareness of issues related to poverty.

I think it [referring to simulation] helps a little bit. It might get them thinking about it. It
definitely had me thinking about it after I left, but I was more annoyed, like, with the time
situation, and doing the math like, “how long should it be, work should not take that
long.” I think that it would get them thinking about it. Like, as an organization, they should continue to reiterate everything and, maybe, have them watch documentaries.

Andrea’s comments related to an “organization” reflected the idea that the poverty simulation might be a learning activity conducted outside the classroom with practicing healthcare providers. Lori commented on this possibility as well considering its’ potential use as an in-service or continuing education activity.

I think doing a poverty simulation in the hospitals would be a huge benefit. Having it put on as a hospital in-service to get people’s eyes opened. We have all these in-services on pressure ulcers and all those things looking at medical sepsis and all these things. Why aren’t we looking at the whole person? We have patient satisfaction services and all these in-services but there is nothing on that. You know what I mean? …I think we need to open health care workers eyes on this and show them how many people live this lifestyle and how this can really affect their health and how we could maybe help fix some of these things within the hospital system. So, I think that would be awesome to do in our hospitals. …For the average nurse on a med-surg unit I think it would be very eye opening.

In summary the participants described the physical environment during the poverty simulation to be one of great urgency with many people functioning in survival mode. One participant referred to the situation as being potentially “dangerous” as participants rushed from place to place in reaction to the high-pressure atmosphere. Emotionally, participants were overwhelmed by the expectations of their roles and detailed high levels of stress and anxiety throughout the simulation. Upon completion of the simulation the participants reported feeling “exhausted” and expressed a sense of hopelessness when considering the likelihood of their
simulated family achieving economic security. Some participants expressed a sense of failure related to their inability to overcome social and economic barriers to prosperity.

Despite the fact that the participants felt varying degrees of discomfort, they overwhelmingly endorsed the learning experience as meaningful. The participants found the poverty simulation experience to be unique in the way that it compelled them to become emotionally invested in their assigned roles. While one participant found logistical issues to be an annoyance the majority praised the interactive nature of the activity using terms such as “eye-opening,” “personal,” and “meaningful.” They spoke of a desire to share the experience with others, especially co-workers, as a potential avenue for increasing awareness of poverty related issues and producing increased empathy. They made favorable comments surrounding the idea of incorporating a poverty simulation into continuing education or in-service activities. One participant suggested that the simulation would work well as one component of a larger set of experiences designed to bring awareness to the life complications experienced by their socioeconomically struggling patients.

**Background gap/overlap.** The background gap/overlap theme provided another layer to the experiences described in the previously described theme. The second theme collected the stories and ideas related to the socioeconomic background experiences that each participant brought to the activity. The gap/overlap theme demonstrated each participants’ natural tendency to filter simulation experiences through their personal socioeconomic experiences and previously constructed perceptions and belief systems. The participants’ reactions to the simulation were influenced by either a *gap* between their personal backgrounds and what they were experiencing as they role-played life activities, or an *overlap* between the simulation scenarios and their personal observations or struggles with poverty.
Participant statements found at the gap end of the continuum demonstrated a sense of surprise when reviewing simulation scenarios as well as increased awareness of the differences between their life experiences and that of someone living in extreme poverty. Sally pointed out how middle-income individuals might be oblivious to the struggles faced by those living in poverty.

I think you forget about it, you forget that there are people out there that are struggling with these things. We tend to get so wrapped up in our lives and like what we’re struggling with that we forget that there are people that are struggling with basic needs. So, like my struggle with, “oohhh I can’t get the latest I-phone because I don’t have enough money,” but there’s people out there that can’t afford food. But you don’t think about that, I think, if you aren’t exposed to it or if you’re not working with those people.

A strong pattern of statements reflecting an increased awareness of poverty related issues emerged and was often accompanied by somber reflection as participants, like Diana, considered the realities of issues like homelessness.

…I think it’s real. I think in larger communities you probably see a lot more of that than we’re even aware of. And I didn’t realize how many people lived in the homeless shelter that were part of the poverty simulation. They actually didn’t even have a place to go. They lived the whole four weeks in the homeless shelter, if there was space for them.

…People if they don’t know it, it’s because they don’t want to know it. But you know it made me want to be more active in the community and help find those things. Because I didn’t, I guess I didn’t realize how many homeless people we [real life community] really have and we [referring to city where simulation was held] don’t have a homeless shelter.
In another exchange, Diana considered the lack of resources for those working in lower paying, non-professional jobs and how she had taken her own employee benefits, “for granted.” You kind of take it for granted that paid time off is going to be there from your employer and sometimes it’s not. …Or they may not have all of the benefits. They may be working for a temporary agency where they wouldn’t have benefits. They may be working in this temp job because that’s all they could get.

Sally hinted at feelings of guilt for failing to recognize the differences between her life and that of someone living in poverty and acknowledged an increased awareness of patient related issues after participating in the simulation.

I think for me it [referring to the simulation] was extremely meaningful. I really, afterwards, oh my gosh. Of course there is people out there that are struggling with these things. Or you know, God, I could be a whole lot more sensitive with my patients!

Sally’s comments on the increased vulnerability to crime experienced by some living in poverty further demonstrates the gap between her life experiences and those of someone living in poverty.

I thought that was horrible [referring to criminal activity victimizing families in the poverty simulation]. I kind of lead a little bit of a sheltered life apparently. I didn’t know that would really happen. And if it does that’s awful, what kind of people can do that? I mean I think that I’m a little bit, even though I have a working environment. I am a little bit naïve to what goes on in the world apparently. That is just horrible when you are victimizing people who are already victims.
Gaps in health care access and health practices were a point of interest for the RN to BS students as they have a professional relationship with these topics. Lori reflected on the differences between those who enjoy middle class health resources and those living in poverty.

In the middle class, we are not worried about prioritizing that [referring to health care coverage]. We have health insurance and it covers all these things. It covers preventative measures. It covers the flu vaccine and it covers going in and seeing your doctor every year. And what it doesn’t cover we can afford, to an extent. …and if it is more than we can afford then we know we can use a loan or different things and we know we can make it. They can’t even think about that. They can’t get a loan or a credit card and they can’t get those things as they are so far into poverty that is the last thing they are worried about.

Some participants who identified areas of gap were more familiar with economic instability. Selena articulated a difference between temporary experiences with economic limitations, such as being a struggling college student, and families experiencing long-term, generational poverty.

In some ways I think it [the simulation] was very realistic because I wouldn’t say I was in poverty, but when I was in nursing school, I was working like three jobs to make ends meet and going to nursing school. And sleep was always the last thing. And like you seriously felt like you were in this hamster wheel of “I can’t.” You know, like everything. It was just hand to mouth, bill to bill, you know. And so it reminded me a little of that. Just the, you know [pause] but I had the hope of getting out of it. These people don’t.
Stacy verbalized a similar understanding of the differences between her experiences with economic insecurity and those of someone living in long-term poverty.

Even though I make more, I still feel like I live paycheck to paycheck. Just because I have like a different lifestyle now, I guess. And so then going to the poverty simulation was just like, ‘Okay, do I need this brand name shirt just because I can afford it?’ Or I’ll…like, it just makes you realize that, like, I don’t know...that you don’t…like you’re still… I don’t know. Like, I still feel like I…I don’t, I don’t feel like I’m in middle class. I don’t. …But the poverty simulation is just like, yeah. I say I live paycheck to paycheck and realistically I do. But my paycheck to paycheck means I still buy groceries. I’ll still go shopping. And it’s just like I might not have a lot of money in my account or I don’t have a savings account, but my paycheck to paycheck isn’t what their paycheck to paycheck is. …I complain I never have money and I’m paycheck to paycheck, but then it’s just like going to that, it’s just like you need to, you need to stop complaining. Like, you don’t live a bad life. I might not always have money or a savings account. But I still can afford to live.

The participant accounts in the gap portion of this theme demonstrate how those who are not confronted with the daily issues of a life in poverty can be surprised when the struggle is revealed to them. They used phrases like, “you forget about…,” “I didn’t realize,” and “you take it for granted…” when discussing different elements of their simulated lives in poverty. One participant referred to herself as, “naïve” and “sheltered” when processing the new knowledge of what barriers exist for those in poverty. Another participant began to consider the ways in which barriers brought about by poverty make some people’s health care practices different from her own. Even participants who have experienced poverty on some level identified areas of gap
between their more temporary existence in poverty and those struggling with generational poverty. One participant, after revealing that she still feels like she lives “paycheck to paycheck,” emphasized the difference by stating, “but my paycheck to paycheck isn’t what their paycheck to paycheck is!”

The overview of participant reflections that illustrated the gap between one’s personal experience and the life scenario of the role they assumed in the simulation reflected one end of a spectrum. The opposite end of the spectrum was the identification of overlap between one’s personal experience and some scenarios in the poverty simulation. As participants discussing overlap areas shared circumstances that had presented in their own lives they demonstrated a range of reactions. Some were stoic while others relayed emotional reactions that they had not anticipated. In the following exchange Selena emotionally connected a situation she experienced in the simulation to a real-life situation with her sister that evoked feelings of shame related to the stigma of living in poverty.

What kinda struck home for me is my, my sister ended up having, she had a messy situation with her spouse and had to leave and whatever. And she was kinda living in poverty for a while. And I remember, like, going to the Social Services office and going [to] all these government things to try and get aid. And it was, it was a lengthy, tedious process. We ended up going several times to try to get approved for different things. And, I mean I just remember feeling, like with my sister, like how have we come to this? Like, you know? …Like, I remember our situation with paperwork. And I just remember thinking, “wow!” It just reminded me of that with my sister. I, I wasn’t in that situation but my sister was.
Selena added commentary on her feelings regarding the stigma felt by those living in poverty.

You kinda felt, you know, it’s like the stigma attached to poverty. You know? Like, I remember being with my sister and the, that room. And I remember looking around like we don’t fit in here. Like, wow. And it was us. I mean it was my sister, but…yeah.

Selena described another situation that created a strong emotional response during the simulation. She explained that while trying to care for her simulated baby and complete required activities she kept feeling like a “bad mother.” She connected this emotional response to a time in her personal life when she felt others were judging her family and her mother. She described her “horrible feelings” surfacing at this point of overlap.

Growing up, I was raised in a large family and we used like a lot of hand-me-down clothes, a lot of Goodwill, we’ve never shopped anywhere but Goodwill or Salvation Army. And we would get the comments, the stares. And then [pause] just like the comments about my child [referring to her assigned child in the simulation] was like it, it struck back to that, because we would get comments like that all the time. People would comment on our clothes or, like kids would especially. People would, my parents chose to home school all of us, and if we’d be out and about during the day and not in school they’d be like, “Why aren’t you in school?” Like, the whole idea that my mom was a bad mom and they’d immediately make assumptions and stuff. So, that kind of came up [during the simulation] I started to feel like, ‘Nooo,’ like that same horrible feelings that we had people say stuff to us. Like, they had no idea what our life was like but they would feel free to make judgments and make comments, accusatory comments and that’s kinda how I felt [referring to the simulation]. Like, ‘I’m trying to be a good mom.’
Selena’s emotional expressions demonstrate one type of reaction to overlap. Some participants recounted overlap without signs of emotional distress which appeared to belie a resignation to the harsh facts of what life in poverty is like. Stacy recounted an area of overlap that was significant and life-altering, however she exhibited what could be described as a matter of fact tone when discussing the overlap. She described a simulation scenario that required her older brother to use his college tuition check to buy necessities for the family. She considered how financial burdens would likely threaten the sibling’s ability to complete college. She then relayed a personal story that connected the simulation with her own personal educational experience.

The first thing he did [referring to simulated sibling] was go to the bank to cash his tuition check. And then he paid the electricity and something else. …it didn’t say that he had to pay tuition for the month but the check said ‘tuition check’ on it. So, my guess would be that it was his tuition money and he just used it for something else. …Like, so, when I first started school [referring to personal life?]. So, my parents didn’t have like money set away for me to go to college, so it was all like financial aid and stuff like that. So my first year I actually ended up going to xxxx State [four year Midwestern University].

And it was like, I don’t know, $15,000 or $16,000 for the year because I lived in the dorms my first year. And I got financial aid but not nearly enough to cover to go to xxxx State the first year. And so what ended up happening is my mom ended up taking out a Parent Plus loan for like $10,000. So, I actually pay that every month [referring to present time]. That’s something, like I never made my mom pay for it. She’s the one that took it out, but that’s the reason I left xxxx State, was money, and went to a technical
school. I mean, I still went to college and I still got my degree, but I guess it [pause] that’s why I switched to a technical school, was due to money.

Stacy’s resignation to these circumstances sharply contrasted other participants from the gap side, such as Sally, Diana, and Lori, who expressed surprise, sadness, and guilt when discussing scenarios from the simulation that highlighted unjust situations experienced by those in poverty.

Selena and Stacy reflected on personal experiences and connected them to the simulation. They also relayed a sense of understanding and empathy for impoverished families experiencing such scenarios. Andrea relayed similar degrees of understanding, however she demonstrated something else related to her overlapping experiences. Andrea’s story reflected that she possessed what could be deemed a ‘skill set’ that could likely be attributed to her past experiences with limited resources and economic vulnerability. Having grown up in a single parent home with five siblings, Andrea demonstrated skills during the simulation that were not observed in other participants. One example occurred when Andrea went to pawn items during the simulation. The volunteer manning the pawn shop was instructed, as part of the simulation, to short people cash after they pawned items. Andrea reflected on her experience with this in the following exchange.

I thought it was interesting, too, that we had to go to the pawn shop to pawn off items.

We negotiated back and forth. And so I count it [referring to payment from pawn broker] but it wasn’t right. So I called him out on it. He was like, “you were the first person that counted the money.” I was like, oh, maybe that’s because I grew up poor. I don’t know. …I’ve always counted, even at the grocery store.
Andrea also made partial payments for her rent and utilities, a problem-solving strategy not typically considered by other simulation participants.

I was saying [to bill collectors], “as soon as I get money I’ll come pay you,” but they all heard that before. But I kept my word. And I said, next week I’ll come and pay you. A lot of them were really surprised that I kept my word and came back. …One of them was our landlord. I said, “I can’t pay this week but I’ll be there next week to pay.” They were surprised I kept my word. My mom always told me to keep my word, so I remember her, you know, talking to people. She would say, “I can’t pay this week but can come and pay you next week” and she always kept her word to them. It kept a stronger relationship between them; they tried to understand her situation. …My mom did better because she kept her word. She had stronger ties. People were more willing, because they trusted her, and she instilled that in you. So it was able to be a benefit, also to get extensions.

Andrea reflected on other lessons she learned about surviving with limited resources from her mother.

I learned a lot from my mom growing up. If she couldn’t take me [to an activity] one week then I would have to find a friend to take me, you know. She would take us the next week or what not. I guess maybe that’s where I learned it from. …and if it wasn’t my mom problem solving, it was us kids. Like, “so and so has to go here.” We lived in the country; we didn’t have much help there either. So, if the bus could drop us off at this place, for example, then later we can have her [referring to her mother] pick us up, and yeah.
The simulation presented transportation barriers that created another area of overlap for Andrea who had experienced transportation complications in her family. Andrea explained that she did not feel the logistics of the transportation in the simulation were true to life, however, she did identify areas of overlap as shown in the following dialogue.

I could think of times, when I was younger, we’d go to CCD [religious catechism] and my mom worked really early in the mornings. She’d have to leave at like 2:00am in the morning to go to work. She would lay down when we would go to CCD and take a nap in the evening. She would have to pick us up at eight at night, and not wake up to her alarm, and we’d have to sit there for an hour or longer waiting until she woke up, and she was like, “oh my gosh, I have to go pick them up.” Whereas, maybe, if there was another person in the picture, another person at home, they could come get us.

Andrea’s recall of childhood events demonstrated how those on the overlap side of the spectrum are likely to find multiple points of overlap and respond with varying degrees of emotion. Overall the overlap portion of this theme revealed that participants may have a range of emotional responses as some participants expressed strong emotional reactions while others conveyed very nonchalant attitudes. Some personal stories had a very obvious connection to the simulation scenarios such as Selena feeling like a “bad mom” in the simulation and remembering when her own mother was judged negatively while her family shopped for second hand clothes. Stacy provided another obvious example of overlap while recalling her simulation brother using his tuition check to pay for family necessities and her own personal story of having to leave college because of a lack of funding.

Not all participants readily connected their personal socioeconomic background to their simulation responses. The participants showed varying degrees of insight into their own
simulation behaviors, however discussions of their simulation experience typically led them to uncover connections to their socioeconomic background. One example of this was Andrea’s reflection on her strategic approach to solving problems related to limited resources. She had exhibited a skill set that was initially unremarkable to her, however, when prompted to consider her unique skill set closer she readily connected her actions to things she had learned in childhood. Andrea reported observing the variety of ways her single mother expertly managed the family’s scarce economic resources. The participants provided a mixture of responses that ranged from emotional to matter of fact and had varying degrees of insight into their emotional responses. The common experience in overlap was that in some way, all participant reactions to the simulation were influenced in some fashion by their experiences with socioeconomic vulnerability.

The background gap/overlap theme demonstrated the significant differences in background that flavored the responses of each participant during and after the simulation. Those participants who had a gap between their background and their simulation experiences made statements that demonstrated a growing awareness of issues impacting those living in poverty. In addition to raising awareness, some participants on the gap end of the spectrum reflected feelings of guilt for not previously recognizing these issues and expressed a desire to do more to help individuals struggling with poverty. Participants on the overlap side of the spectrum shared life experiences that mirrored simulation scenarios. Despite remarkably similar circumstances in their own lives, some participants pointed out that there were differences between temporary and generational poverty and reflected an understanding that while some may transition out of poverty, others find the barriers too great to overcome.
**Reflection points.** The poverty simulation prompted participants to examine socioeconomic situations present in their personal lives and professional roles. A pattern emerged as participants verbalized the process of reflecting and reviewing their experience and associated thoughts and perceptions. The reflection points theme organizes participant stories and their review process into three related concepts: (a) reconsideration of past belief systems; (b) reaffirmation of existing belief systems; (c) reframing of perceptions, belief systems or interpretations of past experiences.

**Reconsideration.** The reconsideration subtheme arose from participant conversations that revealed the participant’s identification of poverty-related issues that they were compelled to consider more closely. Participants expressed a desire to perform this re-examination after having experienced some level of discourse as a result of new information encountered during the poverty simulation.

Participant conversations in this subtheme are marked by uncertainty as they struggle to reconcile competing ideas. Often this occurred when reviewing workplace practices. The following conversation illustrates Stacy’s difficulty in finding ways to honor her new awareness in her professional role.

I think it, I mean, I definitely, like I’m really glad I went [referring to poverty simulation]. I think it was well worth my time. And, you know, it definitely brought awareness. But then at the same time, I don’t feel like I left knowing any more. Like, I was aware, you know, it made me aware of what’s kind of going on, but then it’s just like, what? As a nurse, I didn’t, like I’m not going to, I guess, I don’t think I’m going to change the way I work. …Well, I mean I think it, I can’t say that. I guess it will, to some extent. Because,
you know when you’re more aware, you might not notice that you’re doing stuff different. But that awareness, you know, you kind of incorporate it.

In a similar exchange Stacy discusses the idea that nurses might include socioeconomic status in patient assessment. She appears to be unsure of how nurses might address socioeconomic issues despite verbalizing that it “should” be addressed.

I definitely think it, like it could be a nursing duty but we don’t do it as much as we should. I mean I definitely hear things like the other day they [coworkers] were talking about somebody not taking their meds and the doctor mentioned would Social Services help or Care Coordination help? So, I definitely think it’s out there, but I don’t think that it’s something that, like, as an RN, when I’m rooming a patient, I talk to them about it. Like, ‘why are you not taking this medicine?’ [patient response] ‘Because I can’t afford it.’ Okay, so I put that in there [patient chart]. I don’t [pause] I don’t do anything else with it.

Lori reconsiders current practices and struggles to visualize changes due to time-related barriers. She describes the issue as “sad” but cannot identify how changes might be made in light of existing barriers.

I feel like sometimes we have so many patients that we have time restraints on even taking care of these issues. As nurses you are just trying to make sure that your patient is stable and making it through the evening and you are giving them their meds and all those things. I feel like that is a barrier to this too. Us nurses we don’t even have time to think about these things. …Physical and some psychological needs as we need to address those too. Then we don’t even think of like their home. It’s really sad, it’s super sad that it comes down to that.
Andrea reconsiders the nursing role in relationship to providing community resources and support to economically vulnerable patients. She identifies a knowledge gap for nurses in this area.

The worst part is that if patients have questions we [the nurses] just refer them to the social worker. Like on the weekends, I think there’s one social worker for the whole hospital. And many elderly patients require social work referral, we don’t have a lot of people from upper class. Nurses just don’t know what’s available, I don’t know what’s available. I don’t expect them to know either. We might know the main resources, but the other resources that are more like a hole in the wall…

The following conversation with Selena reflects a similar strand of thought regarding changes to the nursing role in terms of providing support for economically vulnerable patients. The exchange begins with Selena endorsing the nursing role in connecting patients to resources, however when considering barriers, she becomes less sure of how change might occur.

I feel like there was so many [community] resources that we didn’t know about and didn’t access that would have been so helpful. And I think about in real life, like there’s, there’s probably a lot of resources that even would help our patients. I don’t know. There’s a lot of really cool programs and stuff that probably patients don’t know about. …but that also goes back to time. I’ll say I’m running, running, running, running, trying to get the basics done usually for every shift. And so a lot of times social workers are my best friend, because they know all those little details I don’t know.

The reconsideration theme reflects conversations with participants as they process how their newly heightened awareness or increased knowledge regarding poverty related issues might change their activities. While considering potential areas for change the participants vacillated
between taking on new roles and resolving barriers that would likely complicate the process. They appeared to be in a state of attempting to resolve internal discourse possibly through making a decision that will allow them to settle back into their previous beliefs, which I refer to as reaffirmation, or progressing towards a new way of viewing their roles or responsibilities, which can be called reframing.

**Reaffirmation.** This subtheme represents a renewed confidence in a previously held belief system or perception related to poverty. Reaffirmation was demonstrated by participants who experienced a resurgence of feelings supported by examples that unfolded during their simulation experience. These participants tended to be those who had either lived in poverty or had significant experiences with poverty through loved ones and/or professional activities. In this subtheme they revisited ideas and found an increased commitment to an existing belief system.

Penny discussed her life-long empathetic perspective towards families living in poverty and explained how living in middle class can be insulating. She describes the simulation experience as not necessarily sparking new insights but renewing or solidifying her appreciation of poverty related struggles.

I think it is easy to forget. Once you are in a bubble and you surround yourself with people that are a lot like you. So, let’s say if you are an upper middle-class family and you live in a neighborhood that’s upper middle-class. And those are the only people you associate with it’s very easy to place judgment on somebody else who is not from the area that you are. And it’s not of ill intention, it’s just because you don’t remember or you’re not exposed to that. You might have forgotten that life. I remember that just even in my past positions. People have a tendency to forget about those things when they’re not exposed to them. …So maybe just reminding people that when there is a situation
that is not easily explainable. It is easy to judge. I always say that you have to remember
that this is just a moment in time for you, this has been their entire life.

... My family was very friendly. And though I didn’t experience myself being around a
lot of my parents didn't have a lot of time to take me places like the food shelf. We did
donate things and they did make me aware of other lives besides my own. And they were
from middle class as well so and maybe it was lower middle class that they kind of said,
“hey you’re going to appreciate these things.” That was imbedded in my brain at a very
young age and then being exposed to so many people of circumstance, of privilege, it
probably just solidified the fact that I was very aware of what was going on. ...I felt like
it really drove home for me how important it would be for a lot of people to have that
experience. It just solidifies the fact that you just have to be aware of other people and the
way that they live, and then being grateful. I appreciate everything I’ve had and I work
really hard for what I have but I was also given lots of tools. And that’s why I think as a
nurse and it’s probably what drives me and makes me want to be a nurse because I want
to give somebody else those tools.

Penny speaks to an idea that her belief system, after being renewed by the poverty
simulation, may prompt her to change from being an operating room nurse to working in a public
health related field.

I never thought about it before the poverty simulation [referring to working in a public
health field]. And I know there is a lot of public health teachers at this school and I love
this university and I think it is a wonderful place for learning and I think the community
thrives off of this giant university in the middle of it. ...And then my family of nurses. I
had never thought about it before but it also goes along with my morals and ethics part of nursing.

A conversation with Selena regarding patients labeled “noncompliant” presented how a participant may reaffirm their previous perception of a situation with renewed confidence after participating in a poverty simulation.

A pet peeve of mine is judgmental nurses. Because I feel like it happens a lot in SBAR [SBAR refers to Situation, Background, Assessment, Recommendation, a reporting technique used by nurses] like, ‘this patient is non-complaint.’ And then you come to find out, you know, “frequent flyer” and stuff like that. You know, all those terms we’re not supposed to use. They’re used all the time. And, ‘she’s here all the time.’ And then you come to find out the story that they’re [the patient] living with. Like how can she afford basic medications? How can she, like why would she want to take those medications when they’re causing her to feel like this? And she doesn’t have the resources, you know, like she can’t get to therapy and stuff because she’s struggling. I don’t know. I just feel like, there’s a huge backstory! And I’ve kinda seen the look of powerlessness on patients who are ‘non-compliant.’ You just see them like getting talked to by the doctor and us, and they’re just like, they just look defeated and they probably are thinking ‘yeah that’s great, but how?’

Selena continued to reflect on her past experiences and demonstrated reaffirmation of her disagreement with her coworkers’ approach to caring for a vulnerable female patient with limited resources.

She [older patient] was helping hold up a very shaky support network. One son was in prison and her other son was like helping raise kids for him. So, she was like, there was
no female involved and she was in poor health and trying to just raise a bunch of kids. And then we were telling her, “You gotta exercise. You gotta eat right. You gotta do this.” And she was just like, “How?” Like you, you could see the overwhelming. And if they had more resources maybe they could send the kids to [daycare], or get childcare. It sounded like she was like the primary support, so I think a lot of that kind of thing plays in. She was just [pause] I was told in the report she was non-compliant and I think she was just trying to get by each day.

Reaffirmation gave insight into some of the ways participants were impacted by their background experiences and how these experiences influenced the process of making meaning. Participant statements found in the reaffirmation subtheme were those who had indicated either having lived with socioeconomic vulnerability or having been exposed through the experiences of their loved ones. They re-examined past experiences and perceptions and found that the new information and experience of the poverty simulation did not alter their perceptions but rather re-affirmed previously constructed beliefs.

Reframing. The subtheme of reframing held the collection of stories and exchanges with participants who shared a profound shift in their ideas and perceptions of events or circumstances related to socioeconomic vulnerabilities. This shift in thought was connected to experiences or observations made during the poverty simulation. Reframing went beyond reconsideration and was represented by descriptive phrases such as “eye-opening”, “I never realized…” and expressions such as “oh my gosh.” The participants gave specific examples of past encounters that were initially perceived through one lens and then explained how their approach to understanding the patient or situation had been significantly altered. One example of this was
when Diana reviewed some of her past patient exchanges and reframed her understanding of the patient or family’s point of view.

Even though you may never know exactly what is going on when they [patients] are going through it, I think it makes a difference to at least have the perspective of, “well your life is maybe different than mine.” I think back when I worked on the pediatrics floor and you had parents who had five kids at home and dad works second shift and mom works third shift and so here is the sick baby at the hospital with no parent. You may make an assumption about, “why are these parents never here?” It may be because they have to keep working and someone has to stay with the five kids that are at home. So they can only be there on the weekend but you may not see them on the weekend because you work the night shift. And it really makes you think about things and makes you, I would hope, a little less judgmental and understanding that people have things going on and it’s not just that I am a bad parent and I’m going to drop my kid off at the hospital and let you take care of them. And I think that would have been good [to understand previously], not that I was really judgmental at that time, but I think it gives you the perspective to think about it and say, ‘oh you know what, there may be something else going on there and maybe we need social services to see them.’

Stacy looked back on a repeat admission and considered other reasons why a patient had not followed physician recommendations.

So, I can think of one example we have, you know a couple of patients that continually, like this one has diabetes. He continually comes in, blood sugar is seven to eight hundred, he goes to the ICU, we give him insulin and he gets better. Why don’t you take your insulin at home? It’s like how, how, why are we gonna keep helping you when you
won’t help yourself. But then now, now that I think about it it’s just like… Maybe, like, can he not…like, afford the insulin? Is there a financial reason? And I know there is. Like they don’t have, umm, his, they don’t have, umm, they live in like a mobile home kind of thing. So, I definitely know that’s why, you know, finances are a problem. Like, he probably [pauses, shaking head]. But at the same time, it’s like there’s so many state programs that would probably help you pay for your insulin. And maybe he doesn’t, I guess I don’t know if doesn’t know about them and no one’s told him about them or if he just doesn’t want to take his insulin.

Lori demonstrated a reframing of what she referred to as “tunnel vision” on her part, and her co-workers, related to her previous perception of patients’ healthcare choices.

I don’t think they understand. Like I said, a lot of us have a tunnel vision and it’s not opened up and that’s why these poverty sims would be good in healthcare to get people’s minds thinking about how many other things these families are worried about rather than picking up their medication at Walgreens. Or they go to Walgreens and they say this is going to be $200 for this medication. And they are thinking $200 for that or $200 for my rent or electric bill. I’m going to leave the medication right now and not deal with that and I’m going to pay for this bill. And the nurse goes, “why did you not take your medications?” I feel like sometimes we have an almost like a judgmental [pause] we just assume things rather than realizing that this is their life. Their family, home, they weighed out “what is my best option?” And they couldn’t do both. They can’t.

Lori reframed her ideas about the goals of the admission process at her place of employment and considered ways to incorporate economic information that could impact health maintenance.
The three questions we ask on admissions: “have you lost any weight recently, if so how much?” and “have you ever been fed by a tube?” And, what’s the other one, oh, “have you been placed on TPN [refers to total parenteral nutrition]?” or “have you had a decreased appetite?” We don’t ask, “what kind of diet are you eating at home?” “Are you able to buy the food you need throughout the day?” We don’t look at that. …And that’s what’s going to fire our dietician to come and see them. So, we aren’t looking at that. We are looking more at like weight loss and decreased appetite or if they have been on TPN or tube feeding. We aren’t looking at what kind of foods are they eating at home. How might that *exacerbate* their heart disease?

Diana expressed a desire to find out more about area resources and suggested it be part of a planned simulation. She also exerts the idea that it is a way to help patients or clients help themselves.

One of the things we wanted to talk to people about was the resources that are available. Because if I give you the fishing pole and teach you to fish, you can feed your family.

Andrea turned a critical eye towards her workplace practice of placing the responsibility of teaching patients about community resources on the hospital social worker rather than addressing it as part of nursing duties.

I think it would beneficial to find out resources, as a nurse now, I don’t know many resources for patients. All we really say, right now, is, “oh go to your social worker.” As a nurse, we should know resources. And if we have conversations with patients we could name off more places or be aware of places that can actually help them that they can contact.
Community advocacy was an additional focus for some participants. Diana verbalized intentions to increase involvement in caring for people living in poverty encountered outside of their work settings.

I really wish that I would have done this 5 years ago. I just recently moved from the community and I feel like now I’m gun-ho and I want to be more involved and be a better advocate...

The subtheme of reframing included a number of professional experiences reflected upon that the RN to BS students were seeing with a new set of eyes. They verbalized changes to procedures such as patient assessment and discharge planning in the form of connecting them to resources. Participants demonstrated reframing when they reflected a desire to change their current practices or when they looked back on an encounter with a new way of understanding the situation. Other indications of reframing included a renewed commitment to community advocacy or a desire to increase knowledge about poverty related topics. In terms of relationship to other themes it was noted that the majority of participants who shared reframing stories came from the ‘gap’ background group. One participant that engaged in reframing had experienced significant personal overlap, however, her reframing centered on professional practices and did not involve the revelation style that marked the reframing stories of other participants.

The essential themes identified during data analysis served to highlight the crucial experiences and salient participant statements. I created a model (Figure 1) to provide an additional visual reference to explain the themes and how they relate to one another. The large cube represents, Being in poverty, which expressed the chaotic nature of the physical environment and anxiety filled emotional state of participants as they existed in a state of simulated poverty. The outward facing arrows depict the theme of background gap/overlap.
which provided increased insight into the participants’ reactions to the simulation by considering their socioeconomic backgrounds. Participants living in middle or upper class expressed difficulty in fully comprehending the life experiences of impoverished families. Participants with areas of overlap displayed a range in emotions and insights when recalling simulation scenarios and connecting them to their personal backgrounds. The oval shaped theme of reflection points closely examined some of the ways participants found to make meaning of their experience. The reflection points theme produced a progressive arrow representing the three subthemes. The first point along the progressive arrow was reconsideration which illustrated the decision-making process as participants wrestled with new knowledge or points of view raised by the simulation. Reaffirmation, the next point on the arrow, revealed those areas where participants renewed a commitment to a previously held belief system or perception while the final point on the arrow, reframing, characterized points of reflection that had resulted in a new way of approaching situations, practices or altered perception of poverty.
Figure 1. Visual Representation of Essential Themes
Research Questions

The central research question for this phenomenological study was: What is the lived experience of RN to BS students as they participate in a poverty simulation? I found that the themes of being in poverty and gap/overlap provided the best information to answer the central research question. The participants described their experience as frustrating, anxiety-producing, chaotic, stressful, and uncomfortable yet surprisingly meaningful. They shared the belief that it gave them a connection to the emotional experiences of individuals struggling with poverty and served as a reminder to those who were familiar with the struggle. The role-playing aspect of the simulation gave participants the chance to see the world from a different perspective. For some of the participants this was “eye-opening” and produced a number of new ideas. These participants identified differences from their own lives and the simulation that illustrated a significant “gap” in experiences. Some participants identified areas of “overlap” when recounting their simulation stories. These participants had experienced poverty in their past, however, they still found meaning in the experience. For some it was a reminder of how difficult life used to be and for others it pointed out differences between their own situational poverty and another type of poverty that they described as more enduring and hopeless. The participant stories representing the continuum with a gap in experience on one end and an overlap on the other were collected in the “gap/overlap” theme.

Participant accounts of being in poverty as experienced through a poverty simulation reflected a highly personal and individualized experience that connected directly to past socioeconomic circumstances. They verbalized an emotional component that produced a wide array of feelings including guilt, resignation, stress, sadness, pride, hopelessness and relief, as they filtered scenarios through their constructed perspectives of what had previously formed their
The second research question was: How do RN to BS students construct meaning and assimilate new information after participation in a poverty simulation? Once the experience had been filtered through personal background, the participants were naturally compelled to make decisions on how to categorize or make sense of new pieces of information. The reflection points theme provided examples of the various ways in which participants assimilated their new knowledge and made sense of a newly increased level of awareness of issues related to poverty. The three subthemes within reflection points (reconsideration, reaffirmation, and reframing) served to demonstrate the ways in which the activity may influence perceptions. Participants that were engaged in reconsideration were seeking a resolution to a state of discourse caused by their simulation experience. They were engaged in re-examination of thoughts and perceptions, however, statements reflected difficulties in their ability to settle conflicting ideas. The subtheme of reaffirmation was representative of participant responses that reinforced their previously held ideas. Participants reflecting reaffirmation were more likely to be from the ‘overlap’ group who had personal exposure to poverty. Finally, those participants who identified a significant change in perceptions or who revealed a new understanding of experiences were described by the subtheme titled “reframing.” Reframing was particularly meaningful for participants who recalled events with patients that they had misunderstood or held former judgements about. Diana explaining how she did not understand parents with a hospitalized baby who didn’t visit during the week suddenly considered that they were unable to miss work or to afford to pay someone to watch their other children. Sally expressed thoughts about a mother in labor who brought her toddler to the hospital with no one to help supervise. Initially, the concept of poverty. From the lived experience of the simulation, participants transitioned into a state of mind that allowed them to examine and make sense of new information.
nurses were annoyed by the mother bringing her toddler but, upon reframing, Sally decided it was likely that there was no one to help with the child and the dad could not afford to miss work. These participants were most likely to be from the ‘gap’ group with very limited exposure to poverty in their personal lives. “Reframing” their understanding of past situations demonstrates how participants make meaning of new perceptions after experiencing a poverty simulation.

Making meaning of the poverty simulation showed itself to be a process of participants pulling out specific points to reflect upon and making decisions about how those points might belong in their previously constructed ideas about poverty. While some participants had areas that were still unresolved (reconsideration) others found they could use the experience to reaffirm their ideas. Participants who experienced significant perceptual changes (reframing) shared varying levels of inspiration to find new approaches to their encounters with community members or patients.

The final research question: How might reflecting on the poverty simulation shape RN to BS students’ ideas of what it means to provide culturally competent nursing care? Can be answered by considering two of the themes. First the theme being in poverty provided a collection of participant comments related to the use of learning events similar to the poverty simulation being conducted with the RN to BS students’ coworkers. The participants reflect a strong desire to share the simulation and associated awareness of poverty related issues with their fellow employees. These statements in conjunction with statements found in the subthemes of reaffirmation and reframing that reflected concern regarding areas of healthcare that do not adequately address socioeconomic vulnerabilities were interpreted as evidence that the participants believe that there are segments of care in their own professional lives in need of improvement. The participants shared new ideas about a general approach to patient care that
would better address the impact of socioeconomic difficulties as a part of patient care. They demonstrate varying levels of intentions related to practice change, however, overall the consensus was that if all barriers were removed, high quality patient care would include attention to socioeconomic status as a routine nursing function. A further piece of evidence would be the identification of the tendency on the part of nurses to believe that the social worker bears responsibility for addressing socioeconomic issues. In more than one theme area participants pointed out the common practice of nurses initiating a social worker referral as the singular measure taken when socioeconomic concerns are present. The statements regarding social worker referral acknowledge that this is likely not enough to address the issue and nurses may bear more responsibility in this area than what has been traditionally accepted. This reflects an important starting point for practice change and reflects one way that the poverty simulation may impact the RN to BS students’ ideas about culturally competent care.

Summary

The data analysis involved finding patterns in the data that allowed the true meaning of the experience of RN to BS students participating in a poverty simulation to emerge. The first theme, being in poverty, collected in-the-moment descriptions provided by participants. The interviews brought forth a number of uncomfortable feelings as participants recalled being pushed out of their comfort zones and experienced being “thrown” into a world of poverty. While participants assumed their roles in the simulation and set about performing tasks of daily life they naturally filtered their experiences through their personal background, giving rise to the background gap/overlap theme. Background gap/overlap represented a continuum that existed for participants. The lack of experience or perspective of a life in poverty produced a gap that influenced participant reactions while others found that their life stories held points of overlap,
which also contributed to their response. The experience of being in poverty and understanding areas of gap and overlap led to participants identifying reflection points. The Reflection points of participants settled in one of three subcategories: reaffirmation, reconsideration, and reframing. These categories assisted participants in making sense of ideas and perceptual changes that arose from the activity. Chapter 5 will provide an overview of the study and connect the results of the data analysis to the theoretical framework for the purpose of providing answers to the central and secondary research questions. Additionally, study limitations, ideas for future research, and learning strategy recommendations will be presented.
Chapter V: Discussion

Chapter 1 provided a backdrop for this study by outlining the problem of persistent health disparities in the U.S., concerns of bias in the delivery of healthcare services, and associated calls from professional organizations for increasing the cultural competency of providers. Nurse educators were prompted to respond with curriculum revisions and the inclusion of teaching strategies aimed at producing nursing graduates with increased levels of cultural competency. Conflicting quantitative studies surrounding one teaching strategy, a poverty simulation, and a lack of research done with RN to BS students, left unanswered questions regarding the impact of this strategy on higher education students. Chapter 1 revealed that the purpose of this research project was to use qualitative research methods, specifically interpretive phenomenology, to increase understanding of how participating in a poverty simulation impacts RN to BS students. A central research question and two secondary questions were identified:

1. What is the lived experience of RN to BS students as they participate in a poverty simulation?
2. How do RN to BS students construct meaning and assimilate new information after participation in a poverty simulation?
3. How might reflecting on the poverty simulation shape RN to BS students’ ideas of what it means to provide culturally competent nursing care?

Chapter 2 provided a review of pertinent literature further explaining the concerns with health disparities in the U.S. and how this may be perpetuated by healthcare providers through biased or uninformed approaches to patient care. The literature review also focused on the state of the research surrounding the use of a poverty simulation with nursing students and established
evidence for the previously reviewed concerns. Theoretical frameworks were also outlined in the literature review. Phenomenological research methods, connected to the paradigm of constructivism, and the benefits of employing these methods to research the experience of students participating in a poverty simulation were presented. The idea from constructivism that “reality is relative” and can best be understood through investigation of the unique mental constructs of individuals by way of qualitative research methods, such as phenomenology, was detailed (Guba & Lincoln, 1994). Constructivist learning theory was also part of the theoretical framework for this study and explained in chapter 2. The constructivist approach to learning includes practices that engage learners in hands-on activities like a poverty simulation and are believed to prompt creative problem solving and independent thinking (Bruner, 1996; Peters, 2000). Finally, Campinha-Bacote’s theory, The Process of Cultural Competence in the Delivery of Healthcare Services, was presented along with connections to the process of nursing students’ development of attitudes, skills and a desire to become a more culturally competent healthcare provider.

Chapter 3 detailed the research methods beginning with interpretive phenomenology, sometimes called hermeneutics, as the design. Van Manen’s six steps to guide phenomenological research were included:

1. Turning to a phenomenon, which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on essential themes, which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon;
6. Balancing the research context by considering parts and whole.

Reasons for selecting RN students as participants were presented and included the fact that these students have the capability to connect their simulation experience to their practice and workplace cultures. Data collection was detailed showing that eight participants took part in one to one interviews after having participated in a poverty simulation. The process of data analysis was described reflecting that transcribed interviews were systematically reviewed for the purpose of identifying patterns or themes that could inform the researcher of the participants’ experiences in an in-depth and meaningful way. Research positioning, ethical considerations and timelines were also presented in chapter 3.

Chapter 4 presented the findings of the research activities. It was noted that interpretation of the participants’ language, communication style, and response to questions, assisted in uncovering authentic descriptions of the RN students’ lived experience and associated thoughts both during and after the poverty simulation. Salient themes were described as emerging from participant accounts and included: being in poverty, background gap/overlap, and reflection points. A review of the research questions and how they were answered by the data was also presented.

Discussion

The fields of higher education and professional nursing were identified as being areas of application for my research findings. Nurse educators in the field of higher education have shown a commitment to the appraisal of appropriate research when making curriculum decisions. Strategies for content delivery have been scrutinized for evidence that supports the attainment of intended learning outcomes. This scrutiny was heightened with the poverty simulation as it has
been found to be a labor-intensive activity that requires additional monetary resources. As indicated in the problem statement for my study, nurse educators hoping to use the activity have been confronted with conflicting research findings and lingering questions regarding the true nature of changes in perceptions of issues associated with poverty. Faculty seeking guidance on use of the activity with RN to BS students have had no existing research to review as this specific group of learners have not been studied.

The findings of this qualitative research can be used to increase the confidence of nurse educators that the use of a poverty simulation with RN to BS students can positively impact cultural competency levels and increase student awareness of poverty related issues. This increased awareness may be accompanied by a new sense of empathy and understanding as well as produce insights into ways that professional nursing practice can become more sensitive to the needs of socioeconomically vulnerable patients. The participants in this study described their experience as “meaningful” and having a unique ability to address socioeconomic issues while eliciting an emotional investment. Findings from this study also reveal strategies that nurse educators can use to optimize the learning experience such as providing information about local community resources at the event, preparing for strong emotional reactions, acknowledging that learners come with preexisting belief systems about socioeconomic issues, and structuring debriefing sessions to promote integration of new information into existing belief systems in a meaningful way.

While all participants expressed support for the activity, those from different backgrounds expressed different reactions. Some of these differences were identified in the background gap/overlap theme. The four RN to BS students who had personal experiences with poverty (overlap) found it to be a reminder of a number of poverty related struggles such as
feeling judged by others, navigating transportation difficulties, and facing barriers to opportunities such as education. These participants often found a reaffirmation of previously held belief systems and gave some indication of increased confidence in identifying and confronting negative perceptions associated with poverty. Those participants who had a gap between their experiences and the simulation scenarios expressed a number of revelations that prompted them to reconsider and often reframe previous perceptions. In both cases the outcomes expressed by the participants, reaffirming beliefs or reframing previous perceptions, were highlighted in the final theme (reflection points) and provided evidence that participating in the poverty simulation can increase the awareness of, empathy towards, and knowledge of, issues surrounding socioeconomic vulnerabilities.

The findings of this research hold implications for professional practice as the state of health disparities in the U.S. has been identified as a target for intervention. Professional organizations have directed nurse educators to prioritize cultural competency. Increased levels of cultural competency in nursing have been linked to higher quality care and a decrease in health disparities. The participants were found to have been confronted with their own background as it relates to socioeconomic status as they participated in the simulation. This relates to the concept of cultural awareness as previously outlined in the theoretical framework for this study. Participant statements also reflected increased awareness of community programs and increased attention towards the potential for nurses to make referrals based on socioeconomic status, an activity previously viewed by participants as the sole responsibility of social workers. This reflects increased cultural knowledge and can be viewed as the starting point for increasing cultural skill in caring for individuals living in poverty. Campinha-Bacote’s theory, *The Process of Cultural Competence in the Delivery of Healthcare Services*, identified
the attainment of increased cultural awareness, knowledge, and skill as being crucial to the process of increasing cultural competency.

A final consideration on the importance of my research findings to the arena of professional practice involves new insights from the RN to BS students, who have both academic and professional interests. In terms of patient care they verbalized an increased or renewed understanding of difficulties vulnerable patients and families face while navigating the healthcare system. Paying for medication, accessing care while working full time, completing follow-up care activities, and balancing basic needs, such as food and rent, with paying for ongoing health services or preventative care. These findings are different from the existing research done with traditional undergraduate students. The RN to BS student responses reflected an application-focused perspective that only experienced, practicing nurses could provide. This also initiated a discussion on the use of the simulation with existing professionals. The idea that nurses in practice may benefit from participating in a simulation as part of an in-service or continuing education requirement deserves further exploration.

Limitations

Three main limitations were identified throughout the research process and require mention. The first is acknowledgement that the data collection tool for qualitative interviews is the researcher. Performing high quality hermeneutic interviews is a skill that can take many years to develop. As a novice researcher, it was incumbent upon me to read about interview techniques, watch instructional videos, and study the theoretical underpinnings of the process. These activities provided a solid understanding of the technique but could only take me so far in preparing to conduct a skilled hermeneutic interview. The ability to create a natural, conversational atmosphere while identifying critical topics to explore further requires practice
and experience. Some researchers use a pilot study to increase interview skills unfortunately that was not a logistical possibility with this study.

A second limitation encountered was the extremely busy participant schedules. Interviewing nontraditional students as opposed to traditional undergraduate nursing students brought in a myriad of scheduling issues. In addition to nursing courses, these participants were all employed as Registered Nurses. Some of the participants were married, others had children, and these things complicated the scheduling of initial interviews. Their demanding schedules may have been a factor in the lack of response when asked to clarify or add to interviews after reviewing their transcripts. I did not have any additional interviews and increased interaction could have provided them with more reflection time and elicited additional insights.

Finally, the participants’ desire to be socially appropriate or politically correct during the interviews was considered a limitation. Research conducted on sensitive topics such as perceptions of poverty is often hampered by participant inclinations to give socially desirable answers. The participants, while discussing past perceptions, tended to preface remarks with phrases such as, “well it’s not that I was judgmental at this time but…” or, “I wasn’t being insensitive, however I now see that…” I believe these statements indicate that the participants were acutely aware of political correctness during the interviews. It is also possible that this may have been heightened by my position as an instructor in the undergraduate program. The students had never had me as an instructor, but may have had a desire to make a good impression.

**Implications for Research**

The focus of studies investigating the impact of participating in a poverty simulation has typically been on traditional undergraduate students in the fields of nursing, psychology and social work. The information made available through this study provided a starting point for
exploring the lived experience of RN to BS students as they assumed roles in the poverty simulation. This group of learners had unique insights that blended the professional and academic worlds. More research would help further develop the interesting concepts brought forth in RN to BS student interviews. The unanticipated results of this study which include the idea that poverty simulations could be sponsored by an organization such as a hospital or long-term care facility is one idea that surfaced from the unique perspective of RN to BS students that is deserving of further exploration. Could use of a poverty simulation as an in-service activity be a successful technique for promoting increased equity and quality in the care provided to those living in poverty? An additional advantage to conducting research with students who have professional experience was their ability to immediately use new information and awareness to identify practice areas to target for improvements. Some participants readily identified problems with patient assessment or care planning that suffered from a lack of attention to the impact of socioeconomic vulnerabilities. Research with existing practitioners could prove to be a critical step in capitalizing on the increased awareness created by the simulation. Requesting feedback from care providers who have completed a poverty simulation could identify priority areas for practice change based on their increased cultural knowledge and skill.

The rich and expansive topics covered in the participant interviews gives credibility to the argument that the investigation of complex social issues requires qualitative methods capable of capturing the varied nature of participant responses. The supporting evidence for using a poverty simulation with students to produce increased awareness and higher levels of cultural competency continues to be weak (Reid & Evanson, 2016). The difficulties in producing reliable research have been attributed, in part, to quantitative research methods and the inability of survey instruments to fully measure sociocultural perceptions (Lepianka et al., 2009; Shen, 2015). Even
the most popular measurement instrument in quantitative studies, the Attitudes Toward Poverty Scale (Atherton & Gemmel, 1993) lacks the ability to capture the detail and nuances so crucial to understanding perceptions of poverty. Mixed method research, however, may be promising in terms of resolving issues such as inconsistent findings. One reason for inconsistent findings has been traced to conflicting survey responses that result from the fact that respondents may not always interpret the questions as the researcher intended (Will, 1993; Ruetter et al., 2004), or they feel compelled to provide socially desirable responses (Ruetter et al., 2004). The use of qualitative methods such as one to one interviews or focus groups used in combination with survey methods could produce data that informs researchers of the full range of perceptual changes and increased levels of knowledge produced by the activity.

**Implications for Theory**

The theoretical underpinnings for this research were linked in a number of ways to the findings. This began with a parallel to a crucial component of the theoretical framework for this study, interpretive phenomenology, and the unique approaches to knowledge acquisition written about by Martin Heidegger. The goal for this research was to go beyond simply describing the phenomenon and produce an in-depth understanding of how RN to BS students experience a poverty simulation through interpretation of participant testimony. Heidegger (1926) endorsed the use of hermeneutics, as a means to approach the study of human existence and encouraged scholars to focus on being in the world rather than simply knowing the world (Reiners, 2012). The title, being in poverty, was meant to demonstrate the parallels between the first essential theme of this study and the foundational concepts from Heidegger’s famous work, *Being and Time* (1926). Participants explained their physical and emotional experiences as they existed in the simulated world and assumed the role of an individual living in poverty. Heidegger’s brand
of interpretive phenomenology and the constructivist paradigm center on the meaning of a phenomenon as related to those who experience it. The expressions present in the theme being in poverty represent the detail and understanding that can be produced by approaching an inquiry with techniques of interpretive phenomenology and lend support for use of qualitative methods to enrich understanding of complex social concepts like poverty.

Constructivist learning theory has been strongly connected to the constructivist research paradigm and phenomenologic research methods. Constructivist learning theory provided the foundation for two main ideas expressed in the findings of this study. The first was the overwhelming support and expression of enthusiasm for the interactive nature of the simulation. Constructivism recognizes the strength of a learning process that entices individuals to become active agents in knowledge acquisition. Furthermore, constructivism posits that the ongoing construction of cognitive structures takes place in individuals throughout the lifespan and this construction often results from interactions between the subject and the environment (Vygotsky, 1978, Bruner, 1996). The poverty simulation embodied the main ideas of the constructivist learning theory as it promoted individual knowledge acquisition through active engagement in the environment and creative problem solving. The poverty simulation activity was praised by participants as being memorable, engaging, and having the ability to elicit feelings of empathy.

The second area that was informed by constructivist learning theory was in the consideration of how participant social and economic backgrounds impacted participant responses. Constructivist learning theory honors the past social experiences of the learner (Vygotsky, 1978) which was expressed in the essential theme, background gap/overlap. This theme demonstrated that some participants felt connected to the simulation scenarios, referred to as overlap, because their personal histories included exposure to poverty. Participants whose
past experiences did not include exposure to poverty reacted differently than their peers. Their initial reactions to the simulation included being astonished and shocked at the difficulties impoverished individuals must face. These initial feelings of disbelief were followed by varying degrees of guilt or embarrassment at not having understood the situation previously. Although the participant responses were very different, the common theme was that they were all impacted by past social and economic experiences.

Campinha-Bacote’s *Process of Cultural Competence in the Delivery of Healthcare Services* was also included in the theoretical framework for this study. This theory contains concepts that demonstrate how nurses move towards increasing cultural competency. This was expressed in the themes of background gap/overlap and in reflection points. The theme of background gap/overlap directly relates to one of Campinha-Bacote’s five main theoretical concepts, cultural awareness. Cultural awareness involves the examination of one’s own background for areas that might induce bias. Additionally, within the reflection points theme the subthemes of reaffirmation and reframing relate to cultural knowledge and skill. Participants who engaged in reaffirmation of their previously held beliefs or reframing of perceptions based on newly acquired awareness and knowledge demonstrated an increase in cultural skill and cultural knowledge. Participant stories gathered in reaffirmation and reframing reflected an acknowledgement of barriers faced by patients living in poverty as they attempt to care for their health. Participants gave examples of how patients may experience difficulties in following discharge plans because they may not be able to afford medicine or may not be able to take time off work to attend follow-up appointments. Some participants suggested practice changes in the areas of assessment and discharge planning. The increased awareness of these issues and suggested practice change is indicative of cultural knowledge and skill in the delivery of
healthcare services. This is evidence of increased levels of cultural competency (Campinha-Bacote, 2002, 2011).

**Implications for Practice**

The results of this study can be used to ignite interest in exploring practice changes for those in higher education. Recommendations for nurse educators generated by these findings include ideas on how to structure and plan delivery of a poverty simulation. The specific areas addressed include attention to the emotional impact the activity may have on participants, the use of complimentary learning activities, and the importance of including information about community resources in the debriefing session.

The background gap/overlap theme provided indicators that those students having a background that includes socioeconomic hardships are likely to encounter situations in the simulation that mirror past experiences which could result in feelings of distress. Additionally, students described as having a gap in their experiences may be burdened with feelings of guilt and regret as they process an increased awareness of the struggles faced by individuals living in poverty. Finally, all students expressed a dislike for the chaotic environment and sense of urgency created by the simulation. While this environment is intentional, nurse educators should be mindful that all students react to stress differently and varying levels of tolerance for the activity are to be expected. When planning a simulation, educators should be cognizant of the potential for strong emotional reactions and varying degrees of insight on the part of the students. The findings of this study support the idea that educators should make preparations for a variety of reactions and be prepared to provide resources and referrals as needed.

Participant interviews brought forth the suggestion that in addition to the poverty simulation, students would benefit from complimentary activities. There was strong support for
the hands-on, engaging style of the simulation, however, some interviewees supported other avenues of learning about poverty as well. There is research to suggest that no single teaching strategy has been found to sufficiently address the myriad of issues related to perceptions of poverty (Ruetter et al., 2004). The results of my study supported the idea that the simulation should be part of a larger set of activities imbedded in nursing department curricula. The exact nature of companion activities has been the topic of debate and it appears that research in this area would be a worthwhile endeavor.

The debriefing period can also be an avenue for participants to begin to make meaning of the activity and resolve feelings of discomfort. The findings from this research revealed that the participants overwhelmingly report a range of uncomfortable reactions. The debriefing period served as the initial reflection period which was expressed in the reflection points theme. Providing an open forum for sharing experiences is one avenue for supporting the process of making meaning from things encountered during the event. Half of the participants commented on the benefits they received from the presence of community providers and information on available resources. There are guidelines that recommend that when educators plan a poverty simulation they incorporate volunteers from the community, in particular service providers from agencies such as human services. The inclusion of community resources increases the time educators must spend to coordinate the simulation, however, the confirmation from the participants in my study that this added value to the learning event is an important take-away that supports the added effort it takes to realize this aspect of the simulation.

In addition to the applications of these research findings in the field of higher education, there were indications that the poverty simulation may be helpful for the ongoing professional development of existing providers. Participants repeatedly shared concerns regarding the
knowledge level and attitudes of their co-workers towards patients living in poverty. There were numerous suggestions that the poverty simulation would be a valuable tool in increasing provider compassion towards socioeconomically vulnerable individuals and families. Increased knowledge of community resources attained through this learning activity could strengthen the coordination of services and improve referral practices. The use of the poverty simulation as a continuing education activity for practicing nurses or an in-service sponsored by a clinic, hospital, or other healthcare entity, was an unanticipated finding. This participant suggestion represents an innovative practice application that has the potential to increase the competency of providers in dealing with patients from diverse backgrounds and raise the quality of patient care for vulnerable populations.

Conclusion

The use of interpretive phenomenology to investigate the lived experience of RN to BS students as they participated in and reflected on a poverty simulation provided a new dimension to research surrounding the teaching strategy. The findings, organized into three main themes and three subthemes, were used to answer the central research question regarding how RN to BS students experience and make meaning of a poverty simulation. The goal was to provide a rich, in-depth portrait of the experience which was eventually expressed through participant stories and accounts collected in the theme, being in poverty. Understanding of how participants made meaning and assimilated new information from the activity was increased by information gathered in the themes background gap/overlap and reflection points. The constructivist learning theory informed the connections between the two themes and helped to complete understanding of how making meaning and assimilating information occurred. The influence of the event on how participants perceive culturally competent care was also uncovered and expressed in the
theme reflection points specifically under the subthemes reaffirmation and reframing. Finally, the interpretation of how participant responses related to cultural competency was shaped by Campinha-Bacote’s theory of cultural competency in the delivery of healthcare with a specific focus on the concepts of cultural awareness and cultural knowledge.

This research was focused on one teaching strategy however it addressed the larger social and professional issue of the persistent presence of disparities in the U.S. healthcare system. Professional organizations like the American Nurse Association and the American Association of the Colleges of Nursing have highlighted the importance of increasing cultural competency levels in nurses as a critical part of the strategy to combat healthcare inequities. Nurse educators in higher education have sought evidence-based teaching methods to achieve this goal. As indicated in my review of literature, evidence supporting the use of poverty simulations exists, however it can be described as weak or incomplete. Quantitative research has struggled with measuring perceptions towards poverty and has produced inconsistent findings. More recent qualitative studies have attempted to fill in the gaps and explain the complexities of perceptions surrounding social issues like poverty, however, time is needed to fill in the gaps in research and explore the impact with nontraditional student groups like RN to BS students.

This research provided evidence to support the use of poverty simulations with RN to BS students and resulted in ideas for new recommendations in structuring the event. Nurse educators can use the findings from this study in conjunction with other research to create a poverty simulation event for nursing students that is sensitive to the variety of participant reactions it is likely to induce. The benefits of the simulation may be optimized when educators pair the event with complimentary learning activities and utilize the debriefing period to enhance the participant’s processing of the activity. The unique practice-based perspective of RN
students contributed to the body of knowledge surrounding the poverty simulation by demonstrating the ways it prompted existing providers to reconsider professional activities such as patient assessment and discharge planning. The findings of this study can be used as a starting point for new avenues of research including the impact of a learning event on the culture of an organization and the extent to which it may influence the cultural competency of practicing providers and ultimately the health disparities experienced by vulnerable patient populations.
References


Maren, N., & Hart, P. L. (2014). Cultural Competency Among Nurses with Undergraduate and Graduate Degrees: Implications for Nursing Education. *Nursing Education Perspectives (National League For Nursing)*, 35(2), 83-88. DOI:10.5480/12-834.1


Appendix A: Informed Consent Form

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH

My name is Carrie J. McNamer Spier, and I am a doctoral student in the School of Education at St. Cloud State University. I am conducting research that examines the perceptions of nursing students on the experience of participating in a poverty simulation.

As a participant in this study, you will be asked to allow the researcher to conduct one or more in-depth interviews regarding your perception as a nursing student to the course related activity of participating in a poverty simulation. The purpose of our discussion will be to review your experience as a participant in a poverty simulation and uncover the ways it impacted your perceptions of people living in poverty. Additionally, we will explore ways in which the experience connects to your personal and professional history with regard to socioeconomic status and consider potential changes in future interactions with patients from impoverished backgrounds. The interview will last for approximately one-hour. However, if more time is needed, or additional interviews are required, they can be scheduled at your convenience. Your responses will be recorded on audiotape, but only so the researcher may transcribe your responses as accurately as possible for exact representation of our conversation. The participant, the researcher, and the researcher’s doctoral advisor will be the only person to have privilege to these interviews. The only alternative for which the tapes may be heard by anyone other than those listed is by written permission from you, the participant.

Your responses will be kept strictly confidential. At no point do you have to allow your real name or title to be revealed if you so choose. A fictitious name will be used in the document. During the interview you may refuse to answer any questions. After the completion of the interviews, you will receive your transcribed interviews. At this point, if you wish to make any
clarifications to our discussion, you may. At any time, if you wish to withdrawal from this research project, you have the opportunity.

Risks identified include emotional response related to the topic of discussion. Information for support services in your area will be provided upon request. The benefits would include personal growth for each participant through opportunities for reflection and dialogue about their experience.

This project was reviewed and approved by the Institutional Review Board for the Protection of Human Subjects (IRB) at St. Cloud State University on November 17th, 2017.

I truly appreciate your participation in this project. I want you to be as comfortable as possible. Please feel free to talk to me about any concern you might have. My phone number is (507) XXX-XXXX, my e-mail: cspier@winona.edu.

Your signature indicates that you are at least 18 years of age, you have read the information provided above, and you consent to participate. You may withdraw from the study at any time without penalty after signing this form.

Participant’s Name: ____________________________ Date ________________

Researcher’s Name: Carrie J. Spier McNamer Date ________________
Appendix B: Interview Guide

INTERVIEW GUIDE FOR HERMENEUTIC PHENOMENOLOGICAL STUDY OF RN TO BS STUDENT EXPERIENCE OF PARTICIPATING IN A POVERTY SIMULATION

Demographic Information:

- Age Range: 18-25; 26-34; 35-42; 43-50; 51-58; 59-66; 67 and above
- Gender: ______
- Years as a Registered Nurse: ______
- Current employment field: _______________
- Current status in BS degree completion program: _______________
- Reason for completing BS degree: Required by employer_____; Personal _____
- Socioeconomic background A-growing up; B-current:
  - A Upper Class_____; Middle Class_____; Poverty_____
  - B Upper Class_____; Middle Class_____; Poverty_____

Interview Questions  *Italicized text indicates possible probes, if needed.*

1. What did you know about the poverty simulation prior to the experience?
   a. *Were there course related assignments or activities to be completed prior?*

2. Can you tell me about the role/family assignment?
   a. *Do you remember what age you were? Did you work? Attend school? Did you have other family members?*

3. Were there any situations that triggered an emotional response, either positive or negative?
a. Loss of employment, lack of money for necessities, housing concerns/eviction notice, positive or negative treatment by service workers, pawning personal property; experiencing or witnessing criminal activity?

4. Can you tell me about what experiences, if any, brought up thoughts or feelings about your current or past socioeconomic status?

5. Did the simulation prompt any thoughts on how economic differences play out in healthcare?
Appendix C: IRB Approval

Institutional Review Board (IRB)
720 4th Avenue South AS 210, St. Cloud, MN 56301-4498

Name: Carrie Spier
Email: cspier@stcloudstate.edu

IRB PROTOCOL DETERMINATION:
Expedited Review-2

Project Title: An interpretive Phenomenological Study of How RN to BS Students Make Meaning of Participating in a Poverty Simulation

Advisor: Michael Mills

The Institutional Review Board has reviewed your protocol to conduct research involving human subjects. Your project has been: APPROVED

Please note the following important information concerning IRB projects:
- The principal investigator assumes the responsibilities for the protection of participants in this project. Any adverse events must be reported to the IRB as soon as possible (ex. research related injuries, harmful outcomes, significant withdrawal of subject population, etc.).

- For expedited or full board review, the principal investigator must submit a Continuing Review/Final Report form in advance of the expiration date indicated on this letter to report conclusion of the research or request an extension.

- Exempt review only requires the submission of a Continuing Review/Final Report form in advance of the expiration date indicated in this letter if an extension of time is needed.

- Approved consent forms display the official IRB stamp which documents approval and expiration dates. If a renewal is requested and approved, new consent forms will be officially stamped and reflect the new approval and expiration dates.

- The principal investigator must seek approval for any changes to the study (ex. research design, consent process, survey/interview instruments, funding source, etc.). The IRB reserves the right to review the research at any time.

If we can be of further assistance, feel free to contact the IRB at 320-308-4932 or email ResearchNow@stcloudstate.edu and please reference the SCSU IRB number when corresponding.

IRB Chair: ___________________________ IRB Institutional Official: ___________________________

Dr. Benjamin Wills Dr. Latha Ramakrishnan
Associate Professor- Applied Behavior Analysis Interim Associate Provost for Research
Department of Community Psychology, Counseling, and Family Therapy Dean of Graduate Studies

SCSU IRB# 1744 - 2207

<table>
<thead>
<tr>
<th>Type</th>
<th>Today's Date: 11/17/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Year Approval Date: 11/16/2017</td>
<td>2nd Year Approval Date:</td>
</tr>
<tr>
<td>1st Year Expiration Date: 11/15/2017</td>
<td>2nd Year Expiration Date:</td>
</tr>
</tbody>
</table>

OFFICE USE ONLY