School of Nursing and Midwifery

Culturally and Linguistically Diverse Nursing Student Education:

A Grounded Theory Study

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DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

Signed: ……………………………………….

Date: …………………………..

ABSTRACT

This study set out to examine and describe the experiences of undergraduate students from different cultural backgrounds studying nursing across three Australian states. The researcher chose to use the grounded theory method to analyse data collected from 40 undergraduate student nurses and 32 nurse teachers. Other data resources included field observations of student nurses in clinical practice and classroom settings. All interviews were transcribed verbatim and along with field notes and memos were analysed using the constant comparative method synonymous with grounded theory.

This study was set in a sociopolitical climate of disharmony in which the basic social problem of *sociocultural discord: being different and not fitting in* (SD) was identified and developed as the core category. The basic social psychological problem existed for culturally and linguistically diverse nursing students because they were in some way different to the majority of their White western counterparts. Differences existed in, for example, religion, dress, skin colour, beliefs, behaviours, and ways of communicating. Because these students were different they experienced discord. Discord was characterised as sociocultural because differences causing discord were rooted in either a cultural or social domain or both. Those students who experienced SD lived with feelings of social and professional isolation, discrimination, and low self esteem to name a few.

For the students, experiences of sociocultural discord were largely unpredictable and occurred episodically. The fear of embarrassment, discrimination, or some other form of inequitable treatment prevented students participating actively in classes or on clinical practice. Students, however, were unable to determine when they were likely to experience inequitable treatment and for many when it had been identified it was too late; they were amidst the experience. Others were hesitant to interact with their Australian counterparts for fear of rejection.

This study occurred during a particularly disharmonic climate which permeated all aspects of the students' lives and had the propensity to impact upon individual levels of SD. As such this climate existed as the background in this study. One of the background issues identified as impacting upon students in this study was stereotyping.

In this study stereotyping was often based upon perceived cultural, religious, and/or gender norms. The physical environments, that is, university campuses and clinical practice settings in which the students were required to participate, were also found to impact upon student participants and were therefore also considered as background. In these institutions there was an obvious lack of cultural role models and students' behaviours were often misinterpreted. Whilst some students' families were considered as immensely supportive others were identified as being the cause of much sociocultural discord. The politics of race and culture also acted to permeate the students' existence and these issues were given wide media coverage at the time of this research.

In an effort to deal with, or counter, episodes of sociocultural discord student participants engaged the process of *seeking concord to get in the right track* (SC). Some of these strategies worked to reduce SD whilst others did not. These strategies consisted of saving face, covert deception, and using the "yes syndrome". Other strategies included clustering, trying to form friendships, and trying to interact with members of the dominant group. Many students struggled to suppress their feeling of SD by being quiet and/or ignoring differential treatment and avoiding interaction with others. Some adopted other strategies to strengthen their communication abilities in an effort to reduce discordant episodes. Many of these strategies were learnt from other students or supportive nurse teachers. Other support was attained from student counselling services and supportive family members. These were considered the influencing conditions.

Unlike many grounded theories this study was unable to identify the end of the process, that is, successful outcomes. Irrespective that students implemented strategies to decrease their discord they continued to experience other discordant events throughout their undergraduate degree program. Whilst many of the findings in this research support the existing literature, this study can be considered as one of the first attempts to study student nurses from different cultural backgrounds and their experiences of nursing education in Australian universities.

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CHAPTER 1

Introduction to the Study

Imagine being born and bred in Australia and your parents decide to move to China before you leave high school. You move to China with them. Your chosen career is nursing and once you finish school you are to study nursing at a Chinese-speaking university. Alternatively, imagine being born and growing up in suburban Australia but your parents are from Iraq. Your home life is fairly strict, you are male and a practicing Muslim who has decided to study nursing at the local university. In either case, there would be many challenges to face just as there are for students from different cultures who attend Australian universities to study nursing.

This thesis set out to investigate the experiences that students from different cultural backgrounds had whilst studying undergraduate nursing in Australian universities. The researcher explored what happened to these students who embarked upon their nursing degrees. Student experiences, whether these occur in classrooms on university campuses, in clinical practice settings, or even off campus, were believed to have an impact upon the students' journeys throughout their undergraduate degrees. Whilst there was a wealth of literature that discussed the general educational experiences of minority group students, there was a scarcity of research that specifically explored minority group students' experiences whilst studying nursing in Australia.

Based on numerous informal discussions with experienced academics, and from the researcher's own experiences, minority group nursing students faced what to many, arguably, appeared as insurmountable difficulties, not only during the course of their studies but also throughout their professional careers. These difficulties were thought to be linked to a multiplicity of cultural differences, including language, cultural norms and prohibitions. In nursing these issues may be further impacted by the intimacy of interactions and actions that occur between nurses and patients.

Impetus for the Current Research

The researcher's previous experience of working in the tertiary education sector teaching culturally and linguistically diverse nursing students has been identified as the

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catalyst for pursuing research in this area. The researcher was often approached by colleagues to assist non-English speaking background (NESB) nursing student's progress through their course. Because there was a lack of resources and limited literature evidence available related to this specific student group, it became evident that research was needed. In other words, it was time to discover more about the experiences of culturally and linguistically diverse nursing students studying in Australian universities.

By exploring the experiences of minority group students studying nursing in Australia, it was anticipated that a substantive theory would be developed to increase understanding of these experiences and to provide a foundation for future curricula developments. In addition, as governments continue to call for increased enrolments of students from different cultural backgrounds into nursing, issues of student equity could be more readily addressed.

<u>The Students</u>

From the outset, this study sought to attract NESB student nurses as participants. However, early in the study it became obvious that the phrase NESB was restricting participation of some students who were born in Australia and spoke very good English yet identified cultural issues that made their education process difficult. Consequently, the researcher interviewed all student volunteers who considered themselves as being culturally and linguistically diverse, and changed the phrase NESB to culturally and linguistically diverse nursing students (CLDNSs) as this term more accurately reflected the participants.

This study also sought to attract Australian Aboriginal nursing students as participants because it was recognised that although they may come from an English speaking background, cultural differences and influences could impact upon their experiences of studying for a nursing degree. However, recruitment strategies utilised in this research failed to attract any Aboriginal nursing student participants. This may be reflective of the small number of Indigenous Australians enrolled in undergraduate nursing degree programs. Suffice to report that although recruitment strategies were

unsuccessful in attracting Indigenous nursing students, these students were not purposefully excluded from this study.

Whilst reference is made to CLDNSs as a group, it is recognised that whatever may be ascribed to such a group does not necessarily fit every member (Kaputin, 1993; Passmore, 1993). In other words, groups are made up of individuals and most academic institutions benefit by treating students as individuals.

<div align="center">Prestudy Literature Review</div>

As part of the criteria for candidature and in order to discover what research had previously been conducted in this area, the researcher conducted a literature review. This prestudy literature review was conducted with the aim of examining published works that addressed issues related to tertiary education of NESB student nurses. According to some grounded theorists, conducting more extensive, in depth literature review at this stage of the research had the propensity to impact upon the researcher by creating bias (Strauss & Corbin, 1990). Potential bias, however, was managed by the researcher keeping notes on all preconceptions, beliefs, and personal experiences related to the literature and CLDNSs in a journal. These notes were considered along with all other data during data analysis and measures were taken not to allow these beliefs to influence data collection and analysis. For example, before embarking upon this study the researcher believed that NESB students experienced more difficulties in nursing education than local students. These difficulties were listed and the researcher made notes about what difficulties were expected (see Appendix A). Details of strategies used to avert bias are discussed in chapter 2.

Even though extensive database searches were conducted very few articles were located that focused specifically upon CLDNSs studying nursing degrees in Australian universities. Consequently, the researcher had to broaden the search logic to incorporate other health related disciplines as well as research conducted in other countries. Nearly all of the Australian-based researchers (Ballard, 1987; Burns, 1991; Samuelowicz, 1987; Sealie, Gurry & Quintrell, 1990) had used survey instruments; some incorporated open-ended questions and most emanated from university health, counselling or NESB support services. Most of these articles addressed the negative aspects of NESB student

tertiary education, and did not discuss positive experiences of students, or academics working with these students. Many of those studies reviewed did not incorporate Australian Aboriginal students and lacked comprehensive details of giving meaning to the phenomenon in context with respect to patterning of interactions and actions related to the students' experiences. In essence, there were few major pieces of Australian research related to education of NESB students focusing on the health professions, and even less specifically targeting students from different cultural backgrounds studying nursing. Hence, it became apparent that the experiences of this student group warranted further investigation.

Academics and NESB Students

When governments reduce federal funding and academics report high workloads it is not surprising to find reports of academics being unable to, or disinterested in helping NESB students, particularly when it is anticipated that these students will require extra time and resources (Ballard, 1987). This view was supported by Burns (1991) who reported NESB students perceived Australian academics as not always being interested in helping them with their problems. Ballard (1987) reported that many academics were aware of the educational difficulties NESB students' experience, but did not necessarily modify their teaching style to address the problems. Academics expected NESB students to use surface or rote-learning (Ballard, 1987; Volet, Renshaw & Tietzel, 1994), to possess "ineffective or inappropriate study approaches" (Samuelowicz, 1987, p. 126), and to plagiarise (Ginsburg, 1992). Such learning strategies were characterised as 'spoon feeding' (Burns, 1991, p. 62; Roberts, 1993) and whilst they may be well suited to the traditional education systems found in some overseas countries as reported by Ballard (1987), they do not equip NESB students studying the health professions to apply knowledge in clinical situations where patient interaction is expected.

Ballard (1987) described university learning throughout Australia as valuing, encouraging, and rewarding those students who use questioning, analysis, and criticism. However, few universities were known to teach such methods progressively. Ginsburg (1992) made specific comment on discipline-specific writing conventions and reported

that such conventions are difficult for academics to explain because they are often "tacit" and learned "without conscious attention" (p. 8). Nevertheless, many NESB students often do not have these assertive learning skills or tacit ways of knowing upon enrolment. NESB students too often come from the traditional educational systems of their home countries, have succeeded in obtaining a place at an Australian university because they achieved in a system that valued and rewarded replication, observation, repetition, rote, or memory learning (Burns, 1991), and are often consequently ill-prepared for Australian university teaching and learning styles (Ballard, 1987). Further, Australian universities also expect students to engage in independent study, to accept criticism, participate in seminars and tutorials, and above all else, to argue (Ballard, 1987).

Samuelowicz (1987) reported NESB student respondents, when describing their traditional education systems, as saying "... we are not supposed to make any argument in class" (p. 125). Yet as Ginsburg (1992, p. 7) indicated it is those students who are assertive and willing to speak out in class who are rewarded. Many students from a variety of different cultural backgrounds have been taught to be passive and submissive to those in positions of authority, such as academics (Samuelowicz, 1987) or senior nurses (Williams & Rogers, 1993). Many NESB students will not speak out in class nor challenge lecturers (Burns, 1991; Sealie et al., 1990) as doing so is seen as an attack on the lecturer's competence (Ginsburg, 1992). Others characterised such behaviours as making oneself conspicuous which was believed to show a lack of respect (Ballard, 1987) or a loss of self-control (Passmore, 1993).

There are more specific examples of some of the problems or difficulties NESB students have experienced when studying in Australian universities. According to Gare (1993), upon hearing discourse in English, many NESB students translate the spoken words into their first language. Once translated the student formulates a response to the discourse. The response is then translated into English. Such mental processing is complex and NESB students often experience difficulty, particularly with complex terminology that may not readily translate. Gare (1993) developed this position further and put forward diagrammatic schemata representative of the "trials of terminology" (p. 23). Such complex mental processing can lead to periods of silence or pauses during

conversations with NESB students. This is known as "wait time" (Hall, 1992) and is reported as causing concern when NESB students interact with patients in health care settings (Ladyshewsky, 1996). When intimate procedures are taking place such pauses could be a source of awkwardness for both the student and the patient.

For some of us, establishing and maintaining eye contact is a necessary component of effective communication (Geldard, 1989). Student supervisors may also consider it an essential element of nonverbal communication when they are observing and evaluating student interactions. Depending upon cultural expectations, when eye contact is missing the recipient may be left wondering why the sender has not established and/or maintained eye contact. Yet for some people from different cultures, under some circumstances, eye contact is prohibited. For others it represents a lack of respect when eye contact is made, for example people from some Australian Aboriginal groups and some Asian cultures.

Accented English can add to communication difficulties (Burns, 1991; Kaputin, 1993). Whilst many students report they speak English as their first language, it is not often appreciated that English learnt and spoken in Asian countries is quite different from English spoken in Australia (Burns, 1991). Asian English adheres to the rules of English more rigorously than Australian English, which is spoken with various accents and the addition of idiom, euphemism, and slang. Whilst NESB students may understand some academics, it is important to appreciate they may not understand all academics (Kaputin, 1993). In addition, whilst NESB students speak English they may have trouble with their spoken English being understood.

As previously stated, amongst some academics there is almost an expectation that students from different cultural backgrounds will plagiarise. Ballard (1987) suggested that some NESB students might plagiarise as they could still be working from their traditional educational backgrounds where reproduction and/or shared work are rewarded. Ginsburg (1992) used Chinese students as an example to demonstrate cultural differences. According to Ginsburg, Chinese students often use large chunks of verbatim text and report that by doing so compliments are being paid to the author. Often, when academics identify plagiarism, students are punished by loss of credit points. Academics rarely establish the reasons why plagiarism occurred and few set

aside time to work progressively with NESB students to help them counter their errors (Ginsburg, 1992). Ballard (1987) claimed that plagiarism occurs because NESB students may have little practice in writing essays and lack knowledge of, and practice in, using verbatim quotes, referencing, and paraphrasing correctly. The researcher felt it was important to undertake this research in order to gain further insight and understanding of how, or whether, these aspects impacted on the participants and their educational experiences, and if so how they dealt with such issues.

Prejudice and Racism

Contrary to politically correct thought, prejudice and racial discrimination are both very much a part of university life (Bishop, 1993) and both may even occur in clinical settings (Ladyshewsky, 1996). Sealie et al. (1990) found that racism was likely to be related to cultural misunderstandings. Consequently, it was deemed likely that CLDNSs would be exposed to these issues on and off campus. Hence, it was anticipated that this grounded theory study would reveal whether these aspects, prejudice and racism, emerged as important factors to these CLDNSs in Australian university Schools of Nursing.

Student Support Services

Whilst strategies to assist NESB students were found to exist (Alvarez & Abriam-Yago, 1993; Baldwin & Wold, 1993; Davis-Drice, Hunter & Smith-Williams, 1978), they alone were not enough to attract, retain, or graduate NESB students. Such strategies were frequently referred to as freshman (or first year student) support groups and were reported in American literature as having positive outcomes for participants (Inouye, 1995; Nichols & Lachat, 1994). However, these programs were not always integrated into the curriculum and often existed as extracurricular engagements requiring additional commitment which, for some, was not possible. Further, NESB students were said to go out of their way to avoid confrontation, embarrassment (Ballard, 1987), and/or 'loss of face' (Liston, 1993). So, while much data came from university counselling services, it was reported that many NESB students did not use these services because doing so went against cultural norms (e.g., to keep problems within the family). Burns (1991) supported this notion and stated "it is not the done thing to discuss your problems

with strangers" (p. 73). Passmore (1993) put forward the notion that one way people from different cultural backgrounds handle stress created by studying and living in another culture is to "maintain and revive cultural beliefs and values" (p. 17).

Cost

Australian universities gain financial benefits from enrolling international students who pay considerably more than local students for their education (Armitage, 1996). It has been suggested that the recipient universities should plan to meet these students' needs (Ballard, 1987). However, often the NESB students, not the university, pay for extra tuition or English support to assist their learning. Eddy (1990) reported that the real losses experienced by NESB students are related to family and social support and these come about as the student's cultural background is either ignored or trivialised. Kaputin (1993) supported this notion of loss or cost and she acknowledged that most NESB students do graduate but do so at "great personal cost" (p. 14). At the same time Burns (1991) credited NESB students with better grades than local students, and similarly acknowledged the high price of personal commitment.

Cultural Difference Model

Whilst Samuelowicz's (1987) study at the University of Queensland found academics' perceptions of NESB students' learning difficulties to be due to language problems in line with NESB students' perceptions, disagreement in other areas existed. Academics did not perceive cultural differences as having as much impact upon student learning as NESB students did. Support for the students' perceptions is found in other studies where cultural conflicts between schools and students have been reported as leading to school failure (D'Amato & Tharp, 1990). According to the Cultural Difference Model, persistent educational failure amongst certain minority groups is due not so much to a failure of teaching, but rather a failure of communication, as well as social relationships between teachers and students (D'Amato & Tharp, 1990). This model places an individual somewhere on a scale of least adjusted to final adjustment. Each stage describes the change phases that individuals go through during integration. Similar models act to outline the experiences of people working or studying in a foreign country (Cushner & Trifonovitch, 1989; Williams & Rogers, 1993). To improve this

cultural mismatch these researchers report that teaching should be more in line with the student culture. Ballard (1987) made the point that universities, as well as NESB students, need to make adjustments (i.e., universities need to examine teaching strategies and NESB students need to adapt learning styles). If universities made these changes they should become flexible, more culturally diverse, and perhaps more able to attract, retain, and graduate NESB students.

Health Related Professional Education and NESB Students

In research that has looked at health related professional education Samuelowicz (1987) reported academics as perceiving NESB students as having abrupt approaches, being authoritarian, and as being unable to self-identify these characteristics as problematic to patient interaction. Further, these students were identified as having problems obtaining client histories and as displaying inflexible or rigid attitudes, which led to student difficulties in coping in situations where Australian norms were seen as important (Samuelowicz, 1987).

Medicine has long been recognised for complexities of terminology and nursing too is full of jargon. To succeed in health related disciplines NESB students not only have to be successful in conversational and academic English but they must also master discipline-specific terminology. In addition, such health related disciplines require practitioners who give patients more than simple words of instruction. Farnhill and Hayes (1996) have described such professional work as requiring "accurate and empathic communication" and they further note that much of this communication takes place with native English speakers. Guttman (2004) stated that "the nurse-patient relationship is built on communication; the most important tool of the nurse is the effective use of language" (p. 266) Nursing, as a profession, demands competent and articulate two way communicators who are also capable of picking up nonverbal cues of communication. Such cues are often culturally bound (Ladyshewsky, 1996) and students from different cultural backgrounds may demonstrate difficulty identifying these cues. Also, nursing students, like all health professionals, are required to communicate with specificity (Phillips & Hartley, 1990). To communicate without specificity could, in the worst case scenario, lead to patient death by way of incorrect

communication related to drug prescriptions. Nursing students are expected to be able to communicate in all three categories (i.e., in conversational and academic English, as well as mastering discipline-specific terminology). In addition, nursing students are expected to communicate with empathy and to be able to pick up the subtleties of body language.

<u>Justification for this Study</u>

In the past there have been various investigations related to the experiences of NESB students studying at tertiary institutions (Ballard, 1987; Burns, 1991; Ginsburg, 1992; Ladyshewsky, 1996; Samuelowicz, 1987; Sealie et al. 1990). These investigations have been conducted from a generic perspective and have not focused specifically on NESB student experiences whilst studying nursing. As literature and statistical reports (Ballard & Clanchy, 1991; Burns, 1991; Crosling, 1993; Hall, 1995) indicate, NESB student enrolments are increasing and government reports call for strategies to attract, retain, and graduate NESB nurses (Commonwealth Department of Human Services and Health, 1994, xxi). Thus, in order to gain further insight into the experience of minority students in undergraduate nursing programs it was deemed important to conduct investigations that contribute to improving our understanding of the issues from the student's perspective.

This grounded theory will attempt to explain the phenomenon of CLDNS education in Australian university Schools of Nursing from the students' perspective. Attention will be given to causal conditions, how phenomena are managed, (i.e., actions and interactions), how the phenomena are mediated by intervening conditions and with what consequences. Such research findings will inform academics of the detailed phenomenon and experiences of CLDNSs undertaking studies in Australia. The findings may also provide the foundations to develop inclusive curricula, meaning curricula that provides for the needs of student nurses from diverse cultural backgrounds. Such advancement of knowledge in this area could facilitate tangible equity for CLDNSs during the course of their undergraduate degree studies and in so doing assist in the attraction of CLDNSs to nursing studies in Australian universities. Further, the provision of contextual support for minority nursing students may become an informed reality and contribute to recruitment and retention of minority students.

Purpose of this Study

The purpose of this study was to use grounded theory methodology to develop a substantive theory explaining the phenomenon of CLDNSs studying undergraduate degree courses in tertiary institutions in three Australian states.

Objectives of this Study

This research aimed to achieve the following objectives:

- To identify, explore, and describe experiences of undergraduate CLDNSs in Australian universities in three Australian states, from the student's perspective;

- To observe and describe CLDNSs' interactions with patients, patients' significant others, other students, academic and clinical teachers, and other health care staff (anyone working in the health care organisation where the student undertakes clinical experience);

- To identify and explain contextual, perceived causal and intervening conditions, actions and interactions, and consequences, which impact on the phenomenon of CLDNSs' educational experiences;

- To develop a substantive theory to explain the phenomenon of CLDNSs' experiences, in the context of studying an undergraduate nursing degree in Australian universities, and to relate these findings to relevant literature.

Limitations of this Study

All participants in this study were volunteers. This can be viewed as a limitation in as much as those students who had failed their course, or who were no longer studying nursing for whatever reasons, were not approached to volunteer as study participants. Additionally, as data for this study were collected from participants across three Australian states, findings from this study should be considered within those contexts.

Summary

As Australia, and large parts of the world, become increasingly multicultural there will be an ongoing need for health professionals to be representative of all cultures.

It could be argued NESB patients are best cared for by health professionals from the same cultural background. This enables the potential for absolute understanding to exist. Such nurses would better understand the patients' needs and patients would better understand these nurses. However, failing this, it is important that nurses, generally, understand the impact of cultural differences among their colleagues and patients.

Because there is a global shortage of nurses and international travel is readily accessible, nurses from all different countries are providing nursing care to patients from just as great a diversity of backgrounds. Jackson (2003) stated that

> In a climate of persistent international volatility and instability, and with ever diminishing resources, we are challenged to provide increasingly complex care to incredibly diverse and/or fractured communities. We are further challenged to provide inclusive, sensitive, accessible and user friendly services that defy entrenched, cumbersome sometimes inflexible health care cultures. (p. 347)

Therefore, it is not surprising that Australian patients, especially the elderly, often have difficulty understanding instructions given to them by foreign, accented nurses and that nurses do not always understand what their patients tell them. This situation is no different for student nurses from different cultural backgrounds.

The focus of this research was on student nurses from different cultural backgrounds and their experiences of nursing education across three Australian states. The findings present a substantive theory based on this group of students' experiences. This theory provides academics, as well as nurses and others, with greater understanding of the experiences of student nurses from different cultural backgrounds.

<u>Overview of this Thesis</u>

This thesis is presented in seven chapters. Chapter 1 provides the reader with an introduction to the thesis. Chapter 2 introduces qualitative research and discusses grounded theory methodology. The philosophical roots of grounded theory methodology (i.e., symbolic interactionism) are also identified. All information related to data are detailed in this chapter.

The sociopolitical climate in which this theory was developed is discussed in chapter 3. Of specific relevance, chapter 3 also covers issues such as cultural diversity, stereotyping and nursing education in Australia. Chapter 4 addresses the core category,

the shared, basic social psychological problem experienced by CLDNS participants, brought about by being different and not fitting in. This core category was labelled 'sociocultural discord: being different and not fitting in' (SD).

Chapter 5, titled 'Seeking Concord to get in the Right Track' (SC) presents the basic social process that participants used in an effort to reduce their experiences of SD. Chapter 6 presents an overview of the substantive theory of SC and overcoming SD, and compares this with existing literature. Implications of the findings and recommendations from this study are presented in chapter 7.

Abbreviations and Definition of Terms and Phrases used in this Research

Anglo-Saxon: refers to a person or people whose native tongue is English and whose culture is strongly influenced by English culture. Student nurses belonging to this group formed the dominant group in this study.

Australian: in this study when a person was described as being 'Australian' it meant that they were born in Australia. The terms Anglo-Saxon and Australian were used interchangeably to add clarity where required.

CLDNS: refers to culturally and linguistically diverse nursing students who are otherwise not of Anglo-Saxon descent. These nursing students formed the non-dominant group, while Anglo-Saxon nursing students formed the dominant group. For all intents and purposes Anglo-Saxon students in this study were also Australian students.

CLDNSs: is culturally and linguistically diverse nursing students (plural of CLDNS).

Dominant group: refers to nursing students of Anglo-Saxon or Australian descent. In this study these students were seen to have the ability to influence the non-dominant group, that is, CLDNSs.

F.N.: Field note

NESB: refers to a person's background as being non-English speaking. NESB is the most commonly used acronym denoting an individual from a non-English speaking background.

Other health care staff: is anyone working in a health care organisation where a student undertakes clinical experience.

Patient: is the term that has been used in preference to client to reflect Australian nursing culture.

Preceptor: is a registered nurse who works with a student in a clinical practice setting.

RN: is registered nurse.

SD: is sociocultural discord: being different and not fitting in

SC: is seeking concord to get in the right track

A: academic participant

S: student participant

CHAPTER 2
Methodology

This chapter describes the research methodology used in development of a substantive theory related to experiences of students from culturally and linguistically diverse backgrounds studying nursing in Australian universities in New South Wales (NSW), Victoria (VIC) and Western Australia (WA). In this chapter qualitative research is discussed briefly in an effort to position the researcher's choice of grounded theory methodology. The philosophical underpinnings of grounded theory, that is, symbolic interactionism, are explained and are followed by a description of grounded theory method. The application of grounded theory method in this study is also described. Data collection and management methods are detailed, along with data analysis. Strengths and weaknesses of the grounded theory method are presented, and limitations of this study are discussed. The issues of validity and reliability are examined in the realm of qualitative research. This chapter will also address the ethical considerations associated with this research and finally an overview of the findings will be presented.

Qualitative Research

Qualitative research does not use statistical analysis, mathematics, measurement, experiments or any of the other foundations of quantitative research and thus has been viewed as by some researchers as less meaningful (Glaser & Strauss, 1967). In fact, qualitative, or interpretive methods are sometimes "regarded as unreliable, impressionistic, and not objective" (Denzin & Lincoln, 1994). However, qualitative research explores peoples experiences and as such has gained increased popularity and acceptance in health related disciplines such as nursing (Burns & Grove, 1999). This is not surprising because nursing, as a caring profession, needs to know how people feel, and what they think about the delivery of nursing care. As nursing seeks to strengthen its acceptance amongst the health care professions and base everyday practices upon evidence, quantitative methods have gained increased popularity. However, qualitative research does more; it tries to make sense of people's experiences whether by, for example, phenomenology, ethnography, or grounded theory.

The goal of this study, along with other forms of qualitative inquiry was "to add insight and understanding and to create theory that provides explanation and even prediction" (Morse & Richards, 2002, p. 60). Having worked with student nurses from different cultural backgrounds and having learnt so much from them, the researcher wanted to explore and develop a clearer understanding of the experience of this unique group of nursing students.

The researcher was aware that a qualitative approach was needed to investigate this subject area. This awareness existed because the researcher's previous work in this same area (Brown, 1995; Brown, 1996a; Brown, 1996b; Brown, 1997; Brown, Mannion, and Thomson, 1996; Brown, Thomson & Kulski, 1997; Brown, Thomson, Kulski, Palmer, & Goldie, 1997; Kulski and Brown, 1997) had indicated a need to explore this particular group of undergraduate students' experiences in greater detail. Grounded theory method would allow the depth of investigation needed to understand the experiences of student nurses from different cultural backgrounds from their perspectives. Further, this method allowed a substantive theory to be generated from the findings of the current Australian-based study. Development of such a theory that would be directly relevant in the Australian context was considered important, rather then generating results to support existing theories generated overseas. Morse (1994) suggests "If the question concerns an experience and the phenomenon in question is a process, the method of choice for addressing the question is grounded theory" (p. 223). The students were known to have the experience of nursing education and it was suspected they would undergo particular processes and experience specific problems. Clearly, an holistic narrative would be discovered and as recommended by Miller and Crabtree (1994) a qualitative method of research was selected. Qualitative research methods have the potential to facilitate "a deeper understanding of participants' experiences … [and] has [have] the potential for influencing nursing practice in similar situations" (Pleog, 1999). Nursing practice is encompassing of nursing education.

Having attended qualitative research classes and investigating qualitative methods the researcher was attracted to grounded theory methodology because it

promised that the participants' stories would be told and that the substantive theory would be driven by data from the participants in real life situations. Furthermore, the use of the grounded theory method would likely expose social psychological problems from the participants' perspective along with details of basic processes the participants used to deal with their central issues of concern. Because this study focused on the experiences of nursing students from diverse cultural backgrounds, it was important that this research told their stories. A gap in the published literature was identified, this being a lack of research on the experiences of culturally diverse nursing students studying for undergraduate nursing degrees in Australian universities. Thus, the current project using a grounded theory approach was proposed.

Nursing students are perhaps more vulnerable than students from other degrees whose practical experiences may see them working in other areas such as in the business sector. Student nurses work in health care settings, with people, arguably at their most vulnerable. Student nurses are there, at the bedside, through stages of life from birth to death. University based support classes for non-English speaking students cannot provide the specific support needed by student nurses.

CLDNSs' experiences were thought to be fairly unique, but in this uniqueness shared meaning could be discovered. Grounded theory research investigates human experiences to identify shared meaning and patterns of behaviour in the development of a substantive theory. The aim of this grounded theory research was to investigate those experiences of CLDNSs, to identify shared meaning where it existed and to develop a substantive theory that was driven by and encompassed these experiences. This methodology enabled the researcher to discover those circumstances or conditions under which problems were identified and dealt with. As such this method facilitated the generation of rich, complex and dense theory. Further, by exploration and analysis of these experiences and social processes, the researcher was able to develop a substantive theory that met the basic aim of grounded theory.

The philosophical anchor of grounded theory is symbolic interactionism. Symbolic interaction works with grounded theory studies because the grounded theorist necessarily has a desire to "gain a thorough understanding of particular phenomena within certain contexts" (Grbich, 1998, p. 28). "Most qualitative researchers believe that

'truth' lies in gaining an understanding of the action, beliefs and values of others, from within the participant's frame of reference" (Grbich, 1998, p. 16). To understand this frame of reference symbolic interactionism must be explored.

Symbolic Interactionism

The philosophical foundations of grounded theory are rooted amongst scholastic, social psychology and are based in what is known as the symbolic interactionist theory (Chenitz & Swanson, 1986). Broadly speaking, symbolic interactionism is "about human behaviour, … conduct … and group life" (Chenitz & Swanson, 1986, p. 4). Herbert Mead, a renowned anthropologist, began work on symbolic interactionism but it was Blumer (1969) who furthered the original works and proposed the following tenants of symbolic interactionism. The first "is that human beings act towards things on the basis of the meaning that the things have for them" (p. 2). These things could be, for example, "physical objects, other human beings, … institutions … guiding ideals … activities of others, and … situations an individual encounters in his daily life" (Blumer, 1969, p. 2). For the student nurse physical objects could be the hospital bed, needle and syringe; other human beings could be other student nurses, Registered Nurses, patients, and doctors. Institutions could be represented by the hospital or the university and guiding ideals covered by expected professional behaviour, patient care, and advocacy. Activities of others could be acceptance or rejection of the student nurse by Registered Nurses and situations the individual student encounters on a daily basis could be nursing handover or intimate nursing care. However, to distinguish symbolic interactionist theory from others one has to acknowledge that the human "indicates to himself the things toward which he acts; he has to point out to himself the things that have meaning" (Blumer, 1969, p. 5). Humans have to interact and communicate with themselves. Furthermore, we engage a formative process considering our situation and possible behaviours (Blumer, 1969).

"The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows" (Blumer, 1969, p. 2). In other words, meanings arise "in the processes of interactions between people" (Blumer, 1969, p. 4). "Symbolic interactionism sees meanings as social products, as creations that

are formed in and through the defining activities of people as they interact" (Blumer, 1969, p. 5). The concept of self is central to symbolic interactionism (Chenitz & Swanson, 1986). Humans act and interact with themselves as they do towards other people. It is these actions and interactions with the self and others that enable us to form meanings and to live in the world and to develop a concept of self. Because humans live in groups, individuals more often than not align their definitions and meanings to others around them. In other words, as Chenitz and Swanson (1986) state "meaning must be shared" (p. 5). Shared meaning occurs via channels of communication, both verbal and nonverbal. Because group members share the meanings of objects, events and situations they understand each other (Chenitz & Swanson, 1986).

The third premise is that "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (Blumer, 1969, p. 2). Human behaviour occurs because of a "vast interpretive process in which people, singly and collectively, guide themselves by defining the objects, events and situations they encounter" (Blumer, 1969, p. 132). To have global application symbolic interactionism has to incorporate the peoples of the world. Culture has to be considered when studying the individual, his or her family, their social interactions and the community in which they work and live. In other words, culture is important and of relevance to this research. To date studies of cultural aspects in nursing education have been emphasised largely from the patients' perspective (Barbee & Gibson, 2001; Weaver, 2001).

"All phenomena and people are subject to redefinition and new meanings through interaction. Since meaning is created through the self, new definitions of phenomena create new self-definitions" (Chenitz & Swanson, 1986, p. 6). Experiences can change the self and as a corollary can also change behaviour (Blumer, 1969). In some ways humans can therefore redefine themselves.

Grounded theory method has been reported by qualitative researchers as being appropriate and particularly useful in studying human behaviour and interaction in complex situations especially those in which little work has been done previously (Chenitz & Swanson, 1986, p. 7; Hutchinson, 1986). This study meets the criteria espoused by these authors. There has been little research in the area of CLDNS

education in Australia. The decision to use grounded theory method for this research was based largely on the philosophical foundation of grounded theory method in symbolic interaction.

Grounded Theory Method

Grounded theory methodology was developed by American sociologists Barney Glaser and Anselm Strauss in the 1960s. To Glaser and Strauss (1967), grounded theory is the "discovery of theory from data" (p. 1). It differs from other methodologies as those doing the research are obligated to allow theory and hypotheses to emerge by their own analysis of data rather than trying to impose other, preexisting theories and hypotheses onto their work (Dick, 2002). Grounded theory has been described by research scholars as an analytic, inductive research method (Burns & Grove, 1993; Grbich, 1998; Sheldon, 1998; Strauss & Corbin, 1990) that generates substantive or middle range theories (Speziale & Carpenter, 2003; Strauss & Corbin, 1990). Furthermore, it is the research method of choice when examining processes of change and social construction (Morse & Richards, 2002), and therefore it is an appropriate research method to enable the researcher to learn more about CLDNSs' experiences of nursing education.

Grounded theory is a widely used qualitative research methodology that aims to discover the social problems of selected groups in society as well as the processes implemented by group members to deal with these problems. Problems and processes are never examined exclusively; consideration must be given to the context and other aspects surrounding problems and processes. Because problems do not exist in isolation the conditions that coexist must be identified and examined. As a research method, grounded theory explores basic social processes (Glaser & Strauss, 1967; Speziale & Carpenter, 2003) with the explicit goal of developing theory derived from, and grounded in, the data (Glaser & Strauss, 1967; Morse & Richards, 2002; Strauss & Corbin, 1990). In other words, the researcher uses grounded theory method to discover the basic social psychological problem of the participants. Raw data are constantly compared and analysed and eventually conceptualised into one higher order core category which may be indicative of either the participants' central issue of concern, or the basic social

process used by the participants to deal with the social problem. All other categories must relate and have relevance to the core category. According to Glaser (1978) basic social processes remain fairly constant over time, what does change is the relevance. This comment relates directly to the philosophical underpinnings of grounded theory methodology (i.e., symbolic interactionism).

It is the researcher's role to discover and conceptualise by grounded theory methods, what, if any, processes the participants use to deal with the core problem. In this way the researcher is able to generate a substantive theory in a particular area. The theory, once developed, is demonstrated, or as Glaser and Strauss (1967) state, it is "illustrated by characteristic examples of data" (p. 5). Where relevant in this study the researcher has used characteristic examples of data throughout the written report to give richness to, and to demonstrate the complexity of the developing theory. The substantive area in this research project was the experience of nursing education in Australia through the eyes of CLDNSs. Because the researcher had worked with students from different cultural backgrounds for some years, a genuine interest to facilitate their journey through their nursing studies had developed. The researcher was interested in exploring "the social processes that present within human interactions" (Speziale & Carpenter, 2003, p.107) specifically those that occurred for student nurses from different cultural backgrounds whilst they were studying for their initial nursing degrees.

Application of Grounded Theory Method

Over time there has been much academic discussion and several publications related to the seeming divergence of Strauss in methodological application of the grounded theory from his original discovery works with Glaser (Glaser & Strauss, 1967). This had come about largely because of a coauthored publication entitled "Basics of Qualitative Research: Grounded Theory Procedures and Techniques" by Strauss and Corbin (1990). Essentially, Glaser believed divergence had occurred because this publication advocated data analysis using an imposed paradigm in preference to allowing concepts to emerge from the data. Glaser (1992) went on and published the textbook entitled "Basics of Grounded Theory Analysis" in which he

emphasised divergence and reiterated concepts of the original application of grounded theory method.

In this study the researcher was largely influenced by discussions held in postgraduate grounded theory classes facilitated by Irurita (1997 - 2002). In these classes grounded theory method was thoroughly explored and differences between Glaserian and Straussian applications of the method discussed. Colleagues claimed to be using one method over the other and so, as a novice, the researcher felt compelled to read the original text by Glaser and Strauss(1967) "Discovery of Grounded Theory", as well as Strauss and Corbin's (1990) "Basics of Qualitative Research: Grounded Theory Procedures and Techniques. In addition the researcher read Glaser's (1992) Emergence vs. Forcing: Basics of Grounded Theory Analysis, and Glaser's (1998) Doing Grounded Theory: Issues and Discussions. Initially Strauss and Corbin's work appealed to the researcher primarily because it supplied a step-by-step guide on how to conduct research using grounded theory and it was less encumbered with complex academic concepts. However, with further exploration and the supervisor's guidance this research draws more on Glaser and Strauss's original work (1967).

Data Collection

In this study data were collected from student nurses who self-identified as having a culturally and linguistically diverse background, as well as those nurse teachers who worked with them. Because this study aimed to tell the story of the CLDNSs, the students remained the primary informant group. However, formal and informal interviews were conducted with both groups. Clinical and classroom field observations acted as a further source of data. In addition, the body of knowledge in print form was accessed. The researcher's journals, full of memos recorded during the course of this research, were also used in construction of this thesis.

Access and Sampling Strategies

Network and purposive sampling were used to access prospective participants in this study. Initially, snowballing, a form of network sampling, had to be used because access to prospective participants was difficult (Burns & Grove, 1993). Simplified,

snowballing occurs when the researcher accesses one participant and that participant tells the researcher of other possible participants. Figuratively, the snowball continues to get bigger as more and more people act as participants. In this study there were occasions when CLDNSs, as well as their teachers, suggested contacts they believed would be willing and able to contribute.

Towards the end of the study, purposive sampling was used because these strategies had been reported as a successful method for "selecting the best informant who is able to meet the informational needs of the study" (Morse, 1994, p. 117). Furthermore, Morse suggested that a good informant is a person who is "articulate, reflective, and willing to share with the interviewer". Purposive sampling was used as recommended by Guba (1981) "to maximize the range of information uncovered" (p. 86). According to Grbich (1998, p. 69) qualitative researchers use "non-probability techniques" for sampling because these lead the researcher to experienced participants who can usually provide thick and rich information on the phenomenon selected for study. When participants are able to give thick and rich descriptive data there is greater likelihood that comparisons to other contexts is possible (Geertz, 1973).

These two sampling strategies allowed access to a total of 72 participants with whom formal interviews were conducted, 40 with student nurses and 32 with their teachers. The cohort of teachers consisted of two groups. The first group being those who worked with students in clinical practice settings and were employed by the university. The second group, those academics who taught in lectures, tutorials and nursing laboratories on university campuses. The majority of interviews were conducted with CLDNSs.

Recruitment and Accessing the Sample

Advice from Australian Heads of Schools of Nursing in the eastern states was used in deciding which universities to approach for recruitment of undergraduate CLDNSs. In total nine university campuses were visited, that is, two in WA, four in NSW and three in Victoria. Some of the universities had more than one campus offering nursing studies; the most appropriate campuses in relation to numbers of CLDNS numbers were accessed for recruitment.

Due to travel and financial restrictions there was limited time available to establish quality rapport with CLDNSs. The researcher had to work at creating an interest in her research topic and building a bridge to connect with CLDNSs in recruitment sessions. The researcher adopted a number of strategies to build rapport in a limited time period. For example, in the recruitment process the researcher entered students' classrooms and introduced herself and the research topic. At all times the researcher allowed herself to speak passionately about her work and demonstrated a genuine interest in the experiences of CLDNSs. Mentioning previous work involving CLDNSs was also thought to be helpful. In addition, support was given by academics in whose classes the researcher had entered for recruitment purposes. On occasion, the researcher's presence in lectures for recruitment demonstrated aspects of nursing research, the same topic students were studying. As well, the researcher spent time on university campuses in Schools of Nursing being seen by prospective participants.

Profile of Participants

In this study the researcher did not identify or classify students according to traditional definitions, for example, international students. This action was taken since traditional definitions were deemed inappropriate because they tended to exclude CLDNSs who had difficulties studying towards their undergraduate degrees.

Interviews commenced in August, 1997. The bulk of data collection was completed by April 1998, however, some interviews were conducted in 2004. Classroom and clinical field observations were conducted at the beginning of this same time period. Biographical, or demographic data sheets were completed by all participants facilitating collection of the following data. Forty students participated; their ages ranged from 19 to 43 years. Only one student was monolingual, meaning this student only spoke English. All of the other student participants spoke two languages as a minimum: English plus one other. Many of the students spoke three or four languages, and one student spoke five languages. The majority of students were female, seven were male. One student was born in Australia; the remainder were born overseas. This particular student was born to immigrant parents. She had self-identified as having a culturally and linguistically diverse background and thought of herself as second

generation Italian. There was one American student who self-identified and volunteered for this study. Both of these students who self-identified and were willing contributors were not excluded from this study; they were considered as negative cases, expanding the range of experiences studied.

The 40 student participants (see Table 1), represented 18 different countries including Australia, Fiji, Afghanistan, Taiwan, China, Iran, Israel, Sri Lanka, Greece, South Africa, The Philippines, Chile, East Timor, Lebanon, Italy, Vietnam, and Scotland. A total of 14 languages other than English were identified as the main language spoken in the student's home. Identified languages were Tagalog, Italian, Cantonese, Spanish, Fijian, Portuguese, Arabic, Vietnamese, Lebanese, Turkish, Indian, Chinese, Mandarin, and Sinhalese.

Table 1: Number of student nurses interviewed by year of study.

Year of study	Number of student nurses interviewed
1st	01
2nd	21
3rd	18
TOTAL	40

Thirty two nurse educator interviews were transcribed verbatim and analysed. Positions held by this group of participants were Associate Professor, Senior Lecturers, Lecturers, Associate Lecturers, Clinical Coordinators, and clinical teachers. Twenty nine interviews were conducted with female nurse teachers and three with their male counterparts. Ages ranged from 30 to 59 years. Twelve nurse teachers had been born overseas and came to Australia from New Zealand, England, India and Malaysia. Eleven of these 12 came from English speaking homes. Six of the nurse teachers were fluent in languages other than English. Eleven had attended formal courses specifically developed for teaching people from NESBs. These nurse teachers had worked in tertiary institutions ranging from 1.5 to 15 years.

The Interviews

As previously indicated, two participant groups took part in this study. These were CLDNSs and nurse teachers. The participants of interest were the CLDNSs. Forty CLDNSs volunteered to act as participants in this study. All 40 participated in interviews that were recorded. Of these, nine also participated in clinical field observations and seven in classroom field observations. Undergraduate student nurses met entry criteria if they volunteered and self-identified as having a culturally and linguistically diverse background (i.e., believed they had a different cultural background to members of the dominant group). There were no other entry requirements or restrictions placed upon possible participants. Of interest, no Australian Aboriginal nursing students volunteered to participate in this study, which was thought by academics to be reflective of the number of Indigenous students studying nursing.

Student nurse volunteers were enrolled in Australian universities across three states of the country. Twelve were enrolled in WA universities, 18 in universities in NSW, and 10 in VIC universities. All students were enrolled in undergraduate nursing studies with the aim of degree completion leading to either a Bachelor of Nursing or a Bachelor of Applied Science (Nursing).

All interviews with nurse teachers were made at a mutually agreed time and place and were conducted by the researcher and tape recorded with expressed permission of every participant. The same was true of interviews with students except, because the researcher aimed to build rapport before the interviews these were arranged with greater flexibility for the student. Specifically, the researcher made herself available to the student; the times and places that suited the students were the times and places where and when interviews were conducted. Also, students were given the time they needed to complete consent forms and demographical data sheets. Before students signed documents the researcher made a point of inquiring whether there was anything on the forms the student needed clarified. The researcher reminded the participants if at any time they chose to withdraw from the study they could do so without penalty. In addition, the forms were written in lay person's English minus academic research jargon (see Appendix C). At completion of interviews students were thanked and told "You are

a unique person. Nursing needs people like you. Because you are from a different culture and because you have different experiences you can offer the nursing profession something Australians can not. Nursing is lucky to have you."

In many respects the initial period of meeting and greeting the student not only allowed the researcher to collect demographic data and ensure the student was aware of aspects of their participation, it also enabled the researcher to establish rapport with individual students. In some respects this period of time was similar to 'ice breaking' and facilitated a comfort zone for the researcher as well as the participant.

All interviews were transcribed verbatim. Interviews lasted from 20 to 80 minutes. An alpha-numeric code was allocated to all interviews and field observations. The researcher was the only person with access to the alphanumeric coding system and all tape recorded interviews were kept in locked storage.

At interview the majority of students were willing to tell of their experiences. They spoke freely but there were many times when the researcher had to seek clarification. At the beginning of most interviews a period of adjustment was required to enable the researcher to adjust to individual accents. After many interviews this adjustment period decreased in length. Also, the researcher learnt to spend a considerable time chatting with the participant before commencing the formal interview to establish rapport and to adapt to each individual's accent and speech pattern.

Because the primary informant group of this research were student nurses from culturally and linguistically diverse backgrounds for whom English was a second language, specific limitations were identified. There were times during some interviews where participants were not especially articulate or reflective. This may have occurred for many reasons, such as a lack of rapport between the researcher and the participant and English language difficulties. In fact, there were times when the researcher did not understand what had been said by some participants. In seeking clarification by asking for repetition, the researcher may have reduced the comfort level of the participant, thus reducing articulation or reflection.

Most interviews began with general comments of thanks and a brief explanation of the researcher's interest in CLDNSs. This was followed by a period in which the participant was invited to read and ask questions related to the informed consent.

Students were then asked to complete the demographic data form. Once these formalities were concluded interviews began with a statement similar to the following: "Can you tell me what it has been like for you as a student nurse?" or, "Can you describe to me your experiences of studying nursing?" or, "What is it like for you studying nursing?"

There were numerous times during interviews when the researcher had to use probes in an effort to maintain students' verbal accounts of their experiences. For example, "What do you mean you looked after a man who committed suicide?" "Can you tell me what it was like for you looking after the patient from Lebanon?" "How did you feel being asked to act as an interpreter for that patient?" Not all probes were successful and there were occasions when the researcher had to refer back to the original question albeit rephrased. For example, "OK, so you can't tell me any more about that incident, but can you think of other situations that you might like to talk about?"; or, "What else can you tell me about your experiences when that kind of thing happens for you?" As time progressed the researcher was able to follow various leads gleaned from data analysis of previous interviews and questions asked were more focused and related to the emergent theory.

There were only a few occasions when the participant requested the tape recorder be turned off due to the personal and sensitive nature of the conversation, or because a participant expressed he/she had not understood a question(s). Several times it was the researcher who turned the tape recorder off to allow the participant time to recompose when necessary. On occasion students seemed to be grateful that someone had listened to their experiences of studying nursing in an Australian university.

In summary, postmodern interviewing techniques described by Grbich (1998, p. 88) were used throughout this research. Passive listening rather than active questioning techniques aimed to keep participants positioned as the central focus and avoided investigation of nonemergent issues. Essentially, introductory type questions were all that were asked of the students. Their answers were probed and basically the students led the interviews. They were allowed to discuss those issues that were important to them. In this way the researcher allowed the participants' perspectives to be heard and

as a result the substantive theory presented remained grounded. In effect unstructured formal interviews have been used (Swanson, 1986).

When the researcher travelled from WA to the eastern states for data collection she found it difficult to recruit student volunteers without having first established rapport. Following discussion, the researcher's supervisor recommended the inclusion of interviews with nurse teachers, meaning those people who worked directly with undergraduate student nurses. Nurse teachers working with CLDNSs did so in classroom settings as well as in clinical practice settings. These interviews were conducted in two states of Australia and analysis of interview content from this secondary participant group shed light upon CLDNSs' in-class as well as clinical experiences and behaviours. In addition, statements from this cohort acted to support many of the students' comments.

Participant Observation

Participant observations used in this research project have been described by Grbich (1998) as:

> A technique of unobtrusive, shared or overtly subjective data collection, which involves a researcher spending time in an environment observing behaviour, action and interaction, so that he/she can understand the meanings constructed in that environment and can make sense of everyday life experiences. These understandings are used to generate conceptual/theoretical explanations of what is being observed. (pp. 123-124)

CLDNSs were observed in classrooms, nursing laboratories and tutorials on university campuses. In addition, some were followed into clinical practice areas in hospital settings.

According to the literature there are certain advantages to be gained by using participant observation (Glaser & Strauss, 1967, p. 226; Grbich, 1998). For example, the researcher can get close to data as it is happening. This positioning allows the researcher to seek clarification when necessary, as was the case in this study. Issues observed in clinical practice that required further clarification were discussed with participants during non-observation times. Participant observation also allowed the researcher to add specific examples to some categories which facilitated category labelling.

Clinical field observations

Clinical field observations were conducted in clinical practice settings where students had been allocated by their home university. Both public and private hospitals were represented. Prior to student observations, four metropolitan hospitals, along with one outer metropolitan hospital, were visited regularly in an effort to desensitise regular staff to the presence of the researcher. This was done in an effort to allow the researcher to come and go as necessary and so that field observations could to be conducted as unobtrusively as possible. Desensitisation means the researcher exposes themselves to the exact environment into which the participant will work. During this time the researcher met with nursing staff, for example, nurse managers, staff development, and clinical nurses as well as less experienced Registered Nurses. The researcher introduced herself and gave a brief overview the research. Emphasis was placed upon clinical field observations and an undertaking was given that efforts would be made to ensure that field observations would not impact directly on the Registered Nurse, their work, or their patients.

The remainder of desensitisation time was used to enable the researcher to observe and become familiar with routines. This meant that when the researcher returned, regular ward staff were accustomed to seeing her. Desensitisation acted to diminish behaviour alteration between the participant and those with whom the participant worked when the researcher was present. This desensitising took place in most cases one week prior to clinical field observations. In summary, "participant observation … involves the researcher in prolonged immersion in the life of a group … in order to discern people's habits and thoughts …" (Punch, 1994, p. 84).

The researcher used spot observation techniques when following student participants in clinical settings. Students were observed for the duration of two shifts each. Because of the intensity associated with following participants around in clinical practice settings the researcher took breaks to diminish the possibility of stress felt by the participant. Field observations were recorded during these breaks on a handheld microcassette recorder. These recordings were transcribed and used as data.

A total of nine students allowed the researcher to observe them in clinical practice. Research and Ethics clearance was obtained from the universities where these

nine students were enrolled. Research and Ethics clearance was similarly obtained from the hospitals into which students had been allocated. Students had been allocated to general medical and surgical wards, coronary care, paediatrics, maternity, oncology and palliative care areas.

Classroom field observations

Field observations were also conducted in classrooms and nursing laboratories on two university campuses. Students gave written consent and teachers' permission was gained via Heads of Schools. Students were informed that their teachers and respective Heads of Schools would also have to approve the researcher's presence in their classroom. In this respect their teachers knew of their participation in this research. Thus, student participants were made aware that their Head of School and specific teachers would need to be briefed about the research before individual students were asked to consent. Students were understanding and consented irrespective of their lack of anonymity.

Due to time constraints and cost prohibition classroom field observations were not conducted outside of WA. Seven students had volunteered as participants for classroom field observations. During this time the researcher sat silently, towards the back of the participant's class. A total of 14 hours were spent in classroom field observations. Observation records were made during the time spent in classes or laboratories with the participants. Summary comments and sketches were made in the immediate timeframe following observation periods.

Field Notes

Traditionally field notes are written accounts of observations made by researchers whilst immersed in an area of study. The act of writing the field notes may indeed take place following short observation periods. These days, many researchers use microcassette recorders to record their observations in the research field. Tapes were made away from the general area of observation to allow focused input, privacy, and reflection. Tapes were later transcribed and analysed as data. Tape recorded field notes were often supplemented as suggested by Morse and Richards (2002) with diagrams or drawings indicating critical pieces of contextual information, for example,

informant seating in classrooms (see Appendix B). The field notes in this study were tape recorded and transcribed as soon as possible following immersion. In addition, the researcher spent time writing memos reflecting her thoughts about what seemed to be happening in the clinical practice settings and classroom situations as recommended by Davis (1986). These reflections were compared to earlier journal entries accounting for personal biases as well as other memos.

<center>Management of Data</center>

To facilitate interview transcription the researcher used voice activated software. Whilst a novelty at the time, voice activated software did not expedite the transcription process. All interviews and field observations were transcribed verbatim. The researcher ensured omission of all identifying characteristics. Data management was facilitated using Non-numerical Unstructured Indexing Searching and Theorising (QSR NUD*IST) software (Qualitative Solutions and Research, 1997) allowing data storage, manipulation, and retrieval. Data were presented to facilitate line-by-line analysis and coding.

Transcribing

Because most of the student participants in this study spoke with heavy accents the researcher herself transcribed all but one of the interview tapes, which was transcribed by a research assistant. This process, although lengthy, ensured researcher familiarity with interview content. Voice activated software was used in the transcribing process with the aim of reducing the amount of time spent word processing. Unfortunately, time reduction did not occur but the use of voice activated software created a novel approach to word processing verbatim interviews. The researcher listened to each tape and wrote some out by hand. These notes were simply read to the computer and word processing was completed. Alternatively the researcher used a microcassette and played interviews line by line and transcribed each line. There were many times when tapes were played and replayed allowing the researcher to transcribe verbatim conversations. This was time consuming and arduous because of the student participants' accents. Although this process may sound easy, the researcher spent hours

training the computer in voice recognition. Many words and phrases could not be recognised by the computer software and the researcher had no alternative but to type these words phonetically. This is reflected in the data extracts throughout the thesis. Additionally, there was no attempt to correct or omit mispronunciation, pronunciation approximation, or other speech errors. In consultation with the supervisor, the researcher also decided to omit indicating when errors occurred in verbatim quotations from research participants, meaning the researcher purposefully omitted using [*sic*] whenever errors occurred. The aim of this omission was two fold. Firstly, the researcher wanted to demonstrate communication difficulties experienced by the CLDNSs and secondly, the researcher wanted to maintain flow for readers when reading quotations.

QRS NUD*IST

Following verbatim transcription each interview was printed and labelled with its own unique code. Hard copies of interview transcripts were filed for later use. Electronic interview transcripts were imported into QRS NUD*IST software (Qualitative Solutions and Research, 1997). QRS NUD*IST software not only stored the interview transcripts, it also allowed the researcher to explore each interview, create codes and record definitions for each code, search for similar data, collect similar data, and relocate that data. QRS NUD*IST software provided a tool with which to organise and manage the data (Minichiello, Sullivan, Greenwood & Axford, 2004). In addition the researcher used QRS NUD*IST software to write and record some memos. Memo construction occurred simultaneous to coding and contributed to the audit trail. Code expansion or collapse and consolidation were managed using QRS NUD*IST software which also allowed compilation of an audit trail.

Constant Comparative Method of Analysis

One of the aspects of grounded theory that helps to situate this methodology amongst qualitative research is the use of constant comparisons. The constant comparative method of analysis was diligently applied to this study. This method requires that each piece of data is compared to all other data. Constant comparison of

data facilitates coding of like data together (Glaser, 1992). New data are compared to old. Groups of data can be moved around into codes of best fit and in this way categories and subcategories can be constructed and altered as indicated by ongoing data collection (Glaser & Strauss, 1967).

Battersby and Hemmings (1980) asserted that "the kernel of this strategy is the ongoing analysis and comparison of data collected from similar and different sources, which then leads to the identification of significant factors relating to the problem under investigation" (p. 162). Because the researcher becomes close to data and is engaged in all types of coding simultaneously, constant comparison is not as tedious as it may seem at first. Initially, much of the open coding does indeed compare incident to incident and is completed by reading and comparing line by line of data. However, as time moves on, the researcher is more likely to compare incidents to properties within categories or "accumulated knowledge" (Glaser & Strauss, 1967, p. 106). In essence constant comparison is as Glaser claimed; "a meaning making activity" (1992, p. 140).

During this ongoing process the researcher is also able to identify many other aspects of each category. In grounded theory it is critical that memos be constructed that document these other aspects as they emerge during constant comparison. By adhering faithfully to the constant comparative method of analysis researchers will discover what Glaser and Strauss (1967) referred to as the full range of dimensions or properties for each category. By development of this skill researchers look at categories holistically. Researchers using this method should be able to identify under which conditions particular incidents took place and in what contexts. As well, strategies the participants used to deal with incidents should emerge from the data as should outcomes (Strauss & Corbin, 1990). This process accompanied by memo writing and higher level conceptualisation allows the substantive theory to develop. Categories tend to collapse or integrate and so data are put back together which forces "the analyst to make some related theoretical sense of each comparison" (Glaser & Strauss, 1967, p. 109).

It is also the process of constant comparison that enables the theory to become emergent. If the researcher adheres to this ongoing process the theory will self-generate. This is because categories will become repetitive, incidents will cross code, and categories will eventually be collapsed. If the researcher is in touch with data, or is

theoretically sensitive, and provided they trust in emergence, the theory will develop by conceptual analysis of categories and their linkages (Glaser, 1992; Glaser & Strauss, 1967). Indeed it is by the process of constant comparison that grounded theory method works to develop a theory that is suited to its intended purpose (Glaser & Strauss, 1967). Application of this method culminated in the development of the substantive theory presented in this thesis.

Theoretical Sensitivity and Bias

Theoretical sensitivity is a term associated with grounded theory studies. It describes the characteristic of being sensitive towards one's research subject area (Glaser & Strauss, 1967). Researchers who, through whatever means, for example, being well-read or having personal or professional experiences in the same area being investigated, have developed sensitivity towards their subject of inquiry. Glaser and Strauss (1967) describe theoretical sensitivity as "forever in continual development" (p. 46). Accordingly, grounded theorists are able to tune into, or pick up "the subtleties of meaning of data" (Strauss & Corbin, 1990, p. 41). Clearly, there is a need to write memos to keep track of this continual development and insights as they occur. This sensitivity can work for or against the researcher throughout their work. When theoretical sensitivity is used favourably and the researcher allows meaning to emerge from their data, that is, without forcing (e.g., along the lines of one's own preconceptions or the literature), then it should lead to development of "a theory that is grounded, conceptually dense, and well integrated" (Strauss & Corbin, 1990, p. 42).

Ideally, theoretical sensitivity and bias should be considered conjointly because theoretical sensitivity could lead to bias. To counter bias stemming from theoretical sensitivity the researcher wrote memos detailing her thoughts and opinions related to her expectations about CLDNSs studying nursing before data collection commenced. Other researchers refer to this process as 'bracketing' (Oiler, 1982). Journal entries continued throughout data collection and analysis and efforts were made not to allow personal views to influence interviews or analysis of data. These journal entries were revisited from time to time and suggested movement away from initial biases towards neutral grounds (Guba, 1981), but occasionally the researcher's bias had been confirmed. There

were other occasions, however, when the researcher's preconceived ideas were incorrect and there was much to learn from the student group.

There are other aspects of bias and researchers have discussed risks of, for example, elite bias (Sandlewoski, 1986, p. 32) existing in qualitative studies. Elite bias occurs when participants volunteer to take part in research. Volunteer participants are thought to be the "most articulate, accessible, or high status members of their group" (Sandlewoski, 1986, p. 32). As such they can "bury the experiences of other group members" (Sandlewoski, 1986, p. 32) because their opinions and views dominate. Qualitative research methodologies guard against elite bias by looking for negative cases. According to Morse (1989, p. 125) negative case investigation and follow through enables "all sides of an issue" to be represented." In this study both negative cases were analysed and participants were not viewed as representative of members of CLDNS groups.

Theoretical Sampling

According to Sandelwoski (1986) "Qualitative studies use theoretical sampling in which subjects are initially selected because they can illuminate the phenomenon being studied, but the continued selection of subjects is related to the findings that emerge in the course of the study" (p. 31). Effectively, "data is gathered according to its relevance to data which has already been collected" (Battersby & Hemmings, 1980, p. 158). Constant comparison, or analysis of data is necessary to facilitate theoretical sampling because the emergent findings direct further collection of data. Theoretical sampling, as suggested by Glaser and Strauss (1967), also acts to delimit the amount of data the researcher needs to code. Data collection is similarly delimited because the researcher should only access participants who can direct the study. Theoretical sampling also allowed issues to be clarified and expanded in subsequent interviews or observations, thus facilitating theory development.

Coding Data

In grounded theory methodology there are three types of coding that occur simultaneously. These are open, axial or theoretical, and selective coding. Memo

construction coinciding with coding is imperative. As suggested by Glaser and Strauss (1967) it is these memos that inform the researcher. For example, memos related to coding will help recall the reasons for certain codes being constructed and others being collapsed. As a process, coding enabled the researcher to develop more fully the hypotheses related to the research. Although initial hypotheses began as hunches or biases which had already been committed to the researcher's journal in the form of memos, coding facilitated nonbiased hypotheses to emerge from the data.

Open Coding

Most texts on grounded theory describe the beginning of open coding as taking place after data transcription. However, in this research open coding began as taped data were being transcribed. Handwritten contextual memos related to interviews or field observations were also considered as data. To keep track of these initial open codes and how they came about the researcher had written memos. Once tapes had been transcribed the researcher read and reread interview transcripts set out in QRS NUD*IST whilst listening to tape recorded interviews. Data were examined and reexamined and dialogue was broken down into lines, and then incidents, and coded depending upon what seemed to be going on in each incident.

Open coding requires that the researcher identify what was happening in the data. The researcher has to decide how each incident will be labelled. Later on the researcher asks "What category or property of a category does this incident indicate?" (Glaser, 1992, p. 39). By asking these questions and seeking the answers from the data, open coding remained grounded and relevant concepts were emergent in the data from the participants' perspectives.

Following analysis of the first transcript all other transcripts were dealt with in the same way. Specifically, each new piece of data was examined and broken down into concepts. Similar concepts were coded together and in this way each piece of data was compared with data already labelled or coded. When dissimilar data were identified a new category was initiated accompanied by a definition and an explanatory memo. During this phase it was important that the researcher remained aware of her own preconceived ideas, expectations or biases. As previously stated, these biases were

acknowledged by formalised thinking and documentation in the form of memos. Previously written memos were revisited and elaborated as the need arose as suggested by Glaser (1992, p. 38).

It was also necessary to immerse oneself in the data, to read it, think about it and to try to put oneself in the position of the student nurses. These strategies consumed a great deal of time; however, they were considered essential by the researcher to bring about conceptualisation. The researcher asked a series of questions of the data. Some of these questions follow: What was going on in the data? What does this mean to me? What does this mean to the participants? Are these meanings the same? How many other students had similar experiences? What effects, if any, did these incidents have upon the CLDNSs and what happened after these incidents? Can I report this from the participant's perspective? Eventually, all incidents from all interview transcripts were examined, compared and coded for both similarities and differences.

The comparison of many coded incidents allowed the researcher to look for and identify patterns. This patterning could, for example, be related to possible causes of events, behaviours, contexts, or even outcomes. Glaser (1992) encourages all like patterns to be grouped and labelled conceptually as a category. In QRS NUD*IST these categories are grouped together as nodes. Categories can be named in two ways. First, the researcher can use in vivo words (i.e., the exact words used by the participants) (Glaser, 1992), or words that "have been abstracted from the language of the research situation" (Glaser & Strauss, 1967, p. 106). An example of the former is "to get or getting in the right track". In reality though, the researcher can name the categories however he/she wishes. Researchers are advised that naming of categories should not be too abstract as to alienate the intended users. Instead, category names should be "sensitizing [*sic*] and meaningful [and] …. provide a bridge between theoretical thinking … [of the researcher] and practical thinking of people concerned with the substantive area …" (Glaser & Strauss, 1967, p.241). The overall aim was to make the research findings usable by as a wide a group of interested people as was possible.

Theoretical Coding

The process of constant comparison assists the researcher in theoretical coding. By having to compare concepts and determine what is going on in the data the researcher is in effect putting the fractured data back together but in a different way. Like concepts get grouped together to form a category and individual categories, like all the others, contribute to the developing theory. Construction of categories is putting the data back together.

In addition, the researcher must identify links between categories such as cause and effect. For example, when a student nurse (from a different cultural background) was not understood by the patient the researcher looked for explanatory reasons. There were many reasons identified amongst the data, for example, the student may have been speaking quietly or softly, the patient may have been deaf or semiconscious, the student's accent may have been strong and indecipherable or the student may have been using medical jargon that the patient could not comprehend. Perhaps there was a combination of reasons as to why the student had not been understood. The researcher also looked for other contextual factors that may have affected specific interactions. As in all the other stages of grounded theory methodology the researcher must allow concepts from the data to emerge with the participants' view dominant. The participants' stories must be uppermost and it remains the responsibility of the researcher to articulate these stories.

Theoretical coding, sometimes referred to as axial coding, facilitates more abstract or conceptual ways of looking at and linking the data. According to Stern (1980) theoretical coding helps the researcher theorise about descriptive data. Although actual management of coding of data was assisted by software, it was the researcher who had to make sense of the cumulative data and interpret what was happening. Grounded theory processing of data, that is, open and theoretical coding is the essence of category construction. Data linkages were made on the basis of knowledge gained throughout the research, reading related literature as well as professional and, experiential knowledge. The researcher aimed to use Glaser's (1978) six C's to guide conceptual analysis;

however, linkages were allowed to emerge from the substantive codes. Where evident the researcher analysed the data identifying the causes, contexts, contingencies, consequences, covariances and conditions of each event. In this way, linkages between categories were identified. Codes were collapsed and new categories developed whilst others were expanded. All the while memos were written and added as journal entries to keep the audit trail alive. Memos acted to guide the researcher in future data collection and analysis because new ways of seeing the data had evolved or had been discovered.

As more data were collected and compared newer insights were confirmed. Similarities were identified across categories and hypotheses were able to be tested. Larger categories were named and renamed until the best label had been decided (Glaser, 1998). As linkages became clear and smaller subcategories were incorporated under the broader category codes the core category, the basic social psychological problem, sociocultural discord: being different and not fitting in (SD) was being identified. Through this same process the basic social process of seeking concord to get in the right track (SC) was discovered. The main concern for the participants was their experiences of SD and their behaviours or actions were aimed at how they resolved their main concern, that is, by SC.

Selective coding is the strategy used to code for the core. As data chunks were being coded and questions asked and hypotheses constructed the researcher began to see linkages between larger codes. For example, code labels of discrimination, isolation, communication differences, and discomfort were layered with negative feelings. Should these codes be placed under a larger, more encompassing code? If they could, were there other codes that belonged too? Eventually the basic social psychological problem of the CLDNSs emerged as the core category. All problems, or areas of difference and 'not fitting in', everything the students had spoken about that caused them pain or fear or suffering linked to SD. To get to this point the researcher had to determine whether all other categories related to SD and whether this category had most explanatory power. In selective coding all categories were examined and links to the core, if evident, were identified. Memos were written to keep track of how each code linked to the social psychological problem and core category of SD. In this way identification of the social

process was also possible. The researcher was able to see how the participants worked to resolve their main issue and memos detailing these links were also written.

<u>Core Categories</u>

In grounded theory research the core category is allowed to emerge from the data. The researcher makes links between codes and categories to assist identification of the core category. Core categories are identified when each concept or piece of data can be linked or connected to the core. The label for the core category is often conceptualised by the researcher. Almost every piece of data can be connected to the core category. In this research the core category of SD was allowed to emerge from the data. Codes and categories were examined and reexamined and the researcher identified that CLDNSs' experiences of their nurse education were often problematic. The overarching theme of every participant's story was the same. Every CLDNS in this study experienced SD in one way or another throughout their undergraduate nursing degree.

Basic Social Psychological Problem

The grounded theory method led the researcher to the hypothesis that every student interviewed had struggled in some way throughout their nursing degree program because they experienced being different and not fitting in. This difference was related to having different cultural influences and these cultural influences affected the student nurses in everyday life at university and in clinical practice settings. Every category discovered in this research connected to the fact that the participants were different and these differences were related to culture. These differences impacted upon the students social interactions with people whom they came into contact. The basic social psychological problem identified in this research was labelled 'SD' and reflected CLDNSs who were experiencing discord related to social interactions based on cultural differences. SD was the core category in this study.

Basic Social Process

Using the same method the researcher was also able to identify a shared basic social process used to deal with the identified core problem. All students engaged in behaviours or practices that aimed to facilitate their acceptance into the dominant group. The CLDNSs behaviours, or the basic social processes, were labelled collectively as 'SC'. Again the basic social process was allowed to emerge from the data. The process of constant comparison enabled the researcher to label this process conceptually and to identify subprocesses.

Memo Writing and Diagrams

Throughout all phases of this study the researcher maintained a series of journals as recommended by Glaser and Strauss (1967), Strauss and Corbin, (1990) and Glaser (1998). As previously discussed, one of the initial purposes of journaling was to facilitate identification and delineation of researcher biases, but as the research progressed all memos related to the study were kept in these journals.

Memos or journal entries should detail "initial underlying assumptions and biases that are likely to skew results and to uncover biases that may emerge as the research progresses" (Silverman, Ricci & Gunter, 1990, p. 71). Grbich (1998) suggests research rigor can be strengthened by use of ongoing self-reflexivity. This process involves the researcher developing an awareness of their own social influences impinging upon interaction with participants as well as their interpretation of the data. To become actively involved in self-reflexivity researchers are encouraged to keep journals or memos documenting their own biases and assumptions related to the study. This writing should reflect the researcher's beliefs, values as well as prejudices related to the area of study. Researchers should also document, if, when and how their biases, values, prejudices and assumptions changed during the course of study.

The process of keeping a journal of memos assists researchers to look at their works in progress in a reflexive manner. Researchers can document introspective ideas along with their own biases (Spradley, 1979). However, there are other researchers who argue that it is not possible to eliminate all bias from research (Silverman et al., 1990). To counter the effects of bias there are a few techniques well documented in qualitative

research textbooks that guide researchers to "reduce the level of bias and redress its negative impact on research findings" (Silverman et al., 1990 p. 71). Sandelwoski (1986, p.30) suggests that "a major threat to the truth value of a qualitative study lies in the closeness of the investigator-subject relationship". This is countered by researchers keeping journals or writing memos documenting their known biases, along with their "behaviour and experiences as researchers in relation to the behaviour and experiences of subjects" (Sandelwoski, 1986, p. 30).

Analytical and theoretical insights, along with speculations related to the data were documented as memos and used throughout this study in data analysis. Rodgers and Cowles (1993) suggest that to ensure a rigorous analysis the researcher "must maintain consistent and clear documentation regarding all phases of the analysis" (p. 222). In real terms, this meant that memos formalising the researcher's thoughts about the data were written, as well as clear examples from data to demonstrate meanings assigned to them.

In grounded theory method, writing starts at the very beginning of the research process and is "continuous throughout the study" (Strauss & Corbin, 1990, p. 8). Each piece of writing is kept as a memo acting to inform the researcher of ideas related to the data. Memos are sorted and resorted and act to lay the structure for writing the thesis. Additionally, memo writing assists the researcher to justify and clarify coding decisions and to "tap the initial freshness of the analyst's theoretical notions and to relieve the conflict in … thoughts" (Glaser & Strauss, 1967, p. 107). In this study memos were collated in lever arch files as a series of journals (see example in Appendix A).

Glaser (1992) recommends that memos be kept flowing. To this end he particularly advises against trying to write different types of memos and suggests all memos be treated equal until emergence is clear. More importantly Glaser (1992) infers to do anything else with memos constitutes forcing. Forcing occurs when the researcher identifies the core prematurely and attempts to link all other data to the prematurely identified core. This may work for a while but unless the core proper is identified many categories and codes will remain outside. In other words they do not relate to the core category. This leaves the researcher in one position, which is forcing the data into an unmatched core.

Memos from classroom and clinical field observations were written. To remain unobtrusive in the process of conducting field observations in clinical settings these memos were made immediately following observation time slots. Because these were recorded as soon as possible following observation periods the researcher's initial thoughts were captured and were available for the study duration. Memos were able to be written in classroom observation time periods but elaboration was required immediately following immersion.

Most grounded theory studies demonstrate the use of diagrams to facilitate analysis of data. In this study there was a preference to write memos over diagram construction.

<div align="center">Saturation of Categories and Theoretical Saturation</div>

Qualitative researchers espouse that data saturation exists when the researcher continues data collection but analysis reveals nothing new. Once saturation has been recognised there is little point continuing to collect data because no new information will be revealed; the effort to gather the data outweighs the product of data gathering (Speziale & Carpenter, 2003; Strauss & Corbin, 1990). Data saturation is considered when researchers "have enough data to build a comprehensive and convincing theory" (Morse, 1995, p. 148). When the researcher recognised repetition amongst the data it was acknowledged that data had begun to saturate. Data collection and analysis was ongoing for a further period to make sure no new information could be collected. Analysis of this data acted to confirm the shared experience articulated previously by the other participants.

Morse (1995) does have other thoughts about data saturation. For example, she puts forward the notion that saturation is project specific. If data were collected from another cohort then new information may indeed be revealed. Ultimately, the decision to cease collecting data due to data saturation rests with the researcher(s). In this study data saturation was recognised when nothing new emerged from the analysis of participant transcripts; instead repetition of existent themes predominated. Glaser and Strauss (1967) had an alternative, but similar, view on saturation referring to "theoretical saturation" (p. 111) in place of data saturation per se. In the same way as data saturation

delimits data collection so too does theoretical saturation. In the latter, incidents are coded only if they add a new property to the category.

Writing the Theory

Once data was believed saturated and no new codes or concepts were developed and the researcher was sure the social psychological problem and process had been identified correctly it was time to present the data as a substantive theory. Although much writing related to codes had occurred throughout this study writing of the theory continued to the conclusion of the research. As with all qualitative studies the researcher has used verbatim quotes from both groups of participants with the aim of adding richness and thickness to the study. Where necessary square brackets [ ] have been used by the researcher in quotes from the student cohort to add clarity to content. Code numbers have been used for all participants.

Use of the Literature

Glaser (1992) discourages in depth literature reviews at the beginning of grounded theory studies. He claims "there is a need not to review any of the literature in the substantive area under study" (p. 31). Instead, he encourages the researcher to develop their own concepts from the data rather than be biased by what they have read. In other words he suggests that by not reading the related literature the researcher becomes dependent upon allowing concepts to emerge from collected data. Glaser (1992) explains "grounded theory is for the discovery of concepts and hypotheses, not for testing or replicating them" (p.32). However, he does not intend that the researcher negate the literature altogether. Instead, following conceptual identification of the core category, and ensuring all categories and the developing theory seem to fit as evidenced by matching of categories, then it is time to read and link the literature to the study (Glaser, 1992, p. 32; Glaser & Strauss, 1967, p. 37). Literature is used for the purposes of comparison and as data to add to research findings and as such relevant works can be woven into the researcher's developing theory (Morse & Richards, 2002, p. 60).

The findings from this study were compared with existing theories in the final stages of analysis. Glaser (1978) encourages comparison of this nature towards the

completion of new grounded theory research so as to avoid influence of what is known upon the new area of research. When relevant theory exists it is to be examined and compared.

<div align="center">Strengths and Weaknesses of Grounded Theory Method</div>

Irrespective of criticism having been directed towards grounded theory because of divergence away from the original method as first proposed by Glaser and Strauss (1967) the methodology remains and has been used extensively not only in the field of sociology but also in nursing and other health related areas. Grounded theory allows for theoretical interpretation of data analysis whilst remaining grounded in the data. This aspect is of importance in research using grounded theory because it assists people to gain an understanding of the participants' world from the participants' perspective. The researcher must be able to view the world as do the study's participants. An added strength of using grounded theory research is that the researcher can build theory at the substantive level, rather that adopt an existing theory and making that fit their own research. For this reason grounded theory is well suited to new areas of investigation in the health sector. Another benefit or strength of grounded theory research is that no matter what the area of investigation, provided the researcher(s) adhere to the method and trust in emergence, a core category will develop, emerge, or become obvious. From here the substantive theory can be developed.

As grounded theory is a qualitative method of research the weaknesses reported in the literature that relate directly to qualitative research can be ascribed to grounded theory. Noticeably, grounded theory consumes time, not only for the researcher but also for the participants of the research. Time is consumed by interviews, verbatim transcription of interviews and field observation. Peck and Secker (1999) noted problems associated with the amount of time needed to complete research using qualitative methods in the health care arena. They discussed these problems in terms of whether qualitative research fits the health care setting largely because the latter is as they described 'fast-moving'. By extrapolation, slow moving research is not a good fit with a fast moving setting. Another weakness, which adds to the extended time element of grounded theory, is that data initially thought of as dross could later in time become

useful in the developing theory. This problem is partly countered by the process inherent in grounded theory (i.e., the constant comparison). Battersby and Hemmings (1980) also support this thought; however, these authors also discussed the impossibility of researchers ever excluding all biases in totality. Other known weaknesses of qualitative research in general and grounded theory in particular are discussed in the following section. In particular, validity and reliability issues, credibility, transferability and limitations of the study are presented. When grounded theory is used especially with people from different cultural backgrounds, the researcher must adhere to the tenants of the method.

Validity and Reliability Issues

The validity and reliability of qualitative research should not be judged by the same criteria used in quantitative research. Over time, well known qualitative researchers have argued the case for credibility, transferability, dependability, and confirmability to take the place of validity and reliability in qualitative research. This change does not detract from the qualitative researcher's need to search for and report the truth and in so doing present humanistic research meeting the rigorous requirements of any qualitative work.

Research Group

Throughout the majority of this work the researcher belonged to a qualitative research group at the researcher's home university. Novice grounded theory researchers met with experienced grounded theory researchers regularly and discussed all aspects of grounded theory research. From the broadest perspective the experienced researchers mentored novice researchers throughout their research works. More specifically, finite aspects, such as memo construction and diagramming were discussed and demonstrated. Coding checks, where colleagues were given pages of interview transcripts to code and come back to discuss for validation were carried out regularly. Also, novices presented their developing theories and nonthreatening feedback and critiques were offered. Other aspects of doing grounded theory were addressed and mentoring relationships were established and maintained.

Credibility

In this research there were a number of strategies used to ensure credibility. Credibility is similar to internal validity. In other words, research findings have to be real or true for the participants. "A qualitative study is credible when it presents faithful descriptions or interpretations of a human experience that people having that experience would recognise immediately from those descriptions or interpretations as their own …" (Sandelowski, 1986, 30).

Credibility was given to this work as there were many times when people hearing of the researcher's analysis claimed for example, "That's how we all felt when our family lived in Washington". There were others too who recognised the uncovered in this research. When questions were asked in the researcher's grounded theory classes, learned colleagues who had travelled, lived and worked overseas echoed these sentiments. For example, an English-speaking Canadian colleague remarked "That's how I feel every time I open my mouth because I speak with an accent". These volunteered comments, and others like them, demonstrated credibility because truth value had been recognised. In addition, collegial transcript analysis had been encouraged in the researcher's grounded theory classes. During these classes doctoral students shared transcripts and spent time coding each others data. These exercises provided opportunities to question, discuss, and confirm data coding and analysis. Regular presentation of research findings and analysis similarly provided the needed forum to demonstrate adherence to the research process and to ensure credibility of research findings.

Other strategies which added to credibility or truth value were, negative case investigation, the audit trail, and following the guidance of a qualified and experienced grounded theorist supervisor. The latter added to credibility because experienced supervision helped to develop a systematic approach to the rigorous steps of grounded theory methodology. Furthermore, CLDNSs who had similar experiences of nursing education agreed with the findings.

One of the benefits of using triangulation, which is built into grounded theory studies, is identification and pursuit of the negative case. A negative case exists when

data from that participant is inconsistent with all other data collected. In respect to the negative case "triangulation does not necessarily result in outcomes that converge. Often data may be contradictory or inconsistent" (Mathison, 1988, p. 15). When the researcher comes across data that seem incongruent it is worth following as a negative case. In this respect "more and better evidence from which researchers can construct meaningful propositions about the social world" (Mathison, 1988, p. 15) are accessed and in this study there were two negative cases.

<p align="center">Negative Cases</p>

The two negative cases were identified early on because both students had a comprehensive understanding of English and were for that reason more fluent in their use of the English language. This fluency was evident at interview and during field observations. In fact, both negative cases self-identified as being from a different cultural background, however, one was born in Australia and the other was born in an English speaking country. Both were investigated thoroughly as negative cases because as suggested by Strauss and Corbin (1990, p. 109) they added "density and variation" to the development of the substantive theory. As well, these negative cases contributed to data saturation and data diversity (Battersby & Hemmings, 1980). They helped to clarify conditions which influenced the experience of the core problem and basic social process.

<p align="center">Audit Trail</p>

Many qualitative research scholars espouse the importance of developing an ongoing audit trail as it is able to contribute to the rigor of the research (Lincoln & Guba, 1985; Rodgers & Cowles, 1993; Sandlewoski, 1986). "Auditibility is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end" (Sandlewoski, 1986, p. 34). In other words the decisions and directions taken throughout the research are transparent. Audit trails add to qualitative research rigor because they make it possible for anyone else to "examine the processes whereby data were collected and analysed, and interpreted …" (Guba, 1981, p. 87). In this study the decision making trail, or audit trail was facilitated by using Non-numerical Unstructured

Indexing Searching and Theorising (QSR NUD*IST) software to manage and retrieve data. This software tracked changes made during category, or node, construction and collapse. In addition, memos were written that explained why these changes took place and these became part of the audit trail. In reality, this registration or tracking of the researcher's decisions enables others to follow changes and understand rationales for doing so. In essence, these strategies ensured dependability of the research (LeCompte & Goetz, 1982). Writing memos to track decisions also facilitated discussions with the research supervisors.

According to Rodgers and Cowles (1993) a comprehensive audit trail will include four types of documentation. These are contextual, methodological, analytical, and personal response. Contextual documentation contributed to the trustworthiness of this research because it was considered as research data and was analysed. Documentation of this nature not only described the environments where interviews were conducted but also described the processes of data collection along with nonverbal behaviours of the participants during interview. Data were captured immediately following interviews using a tape recorder. Alternatively, key words were written on interview recording sheets and acted as reminders of nonverbal behaviours that were documented following the interview. Inclusion of data extracts in the write up of the thesis, as well as clear description of the methodology used contributes to the audit trail.

<div align="center">Transferability</div>

Grbich (1998) and others have used the term generalisability instead of transferability but used it to mean the same thing. According to Grbich generalisability of research findings "involves the usefulness of one set of findings in explaining other similar situations" (p. 66). Generalisability is known by other names, for example, applicability, fittingness, and external validity. Glaser (1998) also referred to generalisability when he discussed the applicability or relevance of theory developed with one group, for example, hippies, being applicable to a different group, for example, health care workers.

However, Sandelowski (1986) warns that "generalisability is itself something of an illusion since every research situation is ultimately about a particular researcher in

interaction with a particular subject in a particular context" (p. 31). But qualitative research findings should be applicable to other situations under similar conditions. This aspect is also referred to as fittingness in the literature and implies that "research findings should be able to be applied to contexts outside the study situation" (Sandlewoski, 1986, p. 32) as long as they are similar.

<div align="center">Member Checks</div>

In this study member checks were done at the completion of the study whereby nonparticipant CLDNSs were asked to read sections of chapters that related to SD. These same students were also asked to read parts of the process chapter that is, SC. In this way the data and the researcher's interpretations have been checked or tested with representatives from the primary participant group. Guba (1981) believes member checks to be "the single most important action inquirers can take, for it goes to the heart of the credibility criterion" (p. 85).

<div align="center">Limitations of this Study</div>

This grounded theory study has led to the development of a substantive theory that has a place in the lived history of the participants. In other words this theory is only relevant and applicable to those participants at the time the study was conducted. This theory may or may not be transferable and it may or may not act as the basis for further research. This theory could be modified with collection and analysis of more data perhaps from different settings. The goal of this work was to identify the basic social psychological problem and enacted processes of CLDNSs studying undergraduate nursing education in Australian universities across three different states. In so doing a substantive theory has been posited which may be applicable in other settings, that is, be transferable, where contextual matching exists and participant matching occurs. The fact that this study does have limitations is characteristic of all research.

Grounded theory studies usually caution the reader of standard limitations. This research is no different and clearly there are limitations in the use of findings from this work. Limitations apply because abstraction and conceptualisation of findings from this study have been derived by studying a specific group of diverse people over a prescribed

time period. Other studies would rightfully want to report different findings dependant upon members of a different cohort and a different context of the study. This is because "both the substance and form of the results will emerge from the data and will be idiosyncratic to each study" (Ammon-Gaberson & Piantanida, 1988). However, should contextual matching be demonstrated then conceptual outcomes of this study may prove useful and have wider application. Furthermore, this type of research can "not provide any absolute truth about the world, but they can provide a view of reality as experienced by some subjects [participants] who know some things about the phenomena" (Barnes, 1996, p. 439).

Other limitations of this work relate to the fact that there were times when the researcher did not understand what had been said during interviews and field observations. Not understanding came about because the researcher could not comprehend spoken words or did not understand the actions of the participants. There are two ways to consider these specific limitations. The fact that the researcher could have been limited by singular cultural heritage was important. This was overcome, however, because the researcher had spent time working with student nurses, Registered Nurses, nurse academics, and patients from diverse cultural backgrounds. During this time sensitivity had developed which led to an appreciation of working with people with cultural differences. The other, perhaps more common reference under which the majority of people work in these conditions, is to consider the existent limitations created by cultural variance as the problem of the people with that variance. In other words, people from different cultural backgrounds are treated differently, without sensitivity, as non-English speakers, as minority groups, as inferior or as not belonging.

Ethical Considerations

Specific areas required ethical consideration in this study. The first involved gaining clearance from the Human Research Ethics Committee at the university in which the researcher was enrolled. Second, the researcher had to gain clearance from Hospital Research and Ethics Review Committees in those hospitals where nursing students were placed for clinical practice. Once Human Research Ethics Committee approval was obtained from the researcher's home university the researcher approached

relevant Heads of Schools of Nursing from the nine targeted universities. These Heads of Schools were encouraging and agreed to the researcher contacting relevant Departmental Heads, Unit Coordinators, lecturers, and tutors to facilitate access to nursing students. In addition, the researcher approached various Directors of Nursing Services, Nurse Managers, Clinical, and Registered Nurses at various hospitals demonstrating research approval and seeking entry into their place of work to conduct field observations. In other words, the researcher obtained approval from the academic institutions where the students were enrolled and approval from relevant Hospital Research and Ethics Committees. Once these clearances were obtained the researcher commenced recruiting participants.

Because members of the primary participant group were students from minority groups and many used English as a second language the researcher was mindful of informed consent. Care was taken to ensure participants understood what was being asked of them. Students were given ample opportunities to clarify any issues of concern related to the study and their participation. All participants were informed of their right to withdraw at any stage of their involvement. The researcher obtained written, informed consent from each participant (see Appendix C).

Prior to conducting tape recorded interviews, students completed demographic data information sheets. This period of time was purposeful and aimed at facilitating rapport between the students and the researcher. When asked, the researcher clarified any misunderstandings. Following completion of the introductory phase interviews took place. All interviews were arranged at a mutually agreed time and place. All interviews were taped and transcribed verbatim. In so doing names and other identifying data were replaced with researcher initiated, identifying codes. The researcher kept a log of names and codes securely. Coded transcripts will be kept secure for five years in line with University policy on data storage. At all times care was taken to ensure anonymity. As people may have been identifiable on audiotapes these were erased following study completion.

The purpose of the study was explained to staff working in areas where the field observations were conducted. Those present were not informed of the cultural background of any student participants. They were informed that the researcher would

be conducting field observations on nursing students. This omission was purposeful in an attempt to minimise any alterations of interaction between staff and CLDNSs. In addition, field observations took place with every effort to ensure unobtrusiveness. Nursing staff were also reassured that the results of observed interactions would not affect them or their work in any way.

Overview of Major Findings

The basic psychological social problem identified in this study as emergent from the data was labelled sociocultural discord: being different and not fitting in (SD). Student nurses from different cultural backgrounds experienced SD, in an episodic manner. This characteristic was dependent upon the context in which individual students were located. Causes of SD were many and varied and these are detailed in the following chapters.

Ongoing data analysis also revealed the basic psychological social process the students used to deal with episodic SD. This process was labelled seeking concord to get in the right track (SC). Students implemented many strategies to lessen their experiences of SD. These subprocesses formed the collective process of SC and are discussed in the following chapters.

Summary

The grounded theory approach was used to discover the experiences of CLDNSs studying undergraduate nursing degree programs in three Australian states. Two cohorts were used to collect data from for this research. The primary participant group consisted of CLDNSs and the secondary group of participants was composed of those nurse teachers with whom the CLDNSs worked. The main sources of data were participant interviews and classroom and clinical placement field observations. Data collection continued until data saturation had been realised. Participant interviews along with data from field observations were analysed using the constant comparative method of analysis, a feature of grounded theory. All data were broken down, examined, analysed and compared to all other data and finally positioned with other representative codes. Codes and memos were examined. Memos were analysed and shuffled back and forth and further memos constructed. This was the process until the researcher was able to

identify the best fit, a common connection that linked all codes and reflected the basic social psychological problem of the CLDNSs. In other words the core problem had been identified. The core problem was eventually labelled by the researcher as sociocultural discord: being different and not fitting in (SD).

During this time the researcher had become increasingly aware, from the data, of the ways the students were dealing with SD. As this recognition occurred memos were written and different codes were constructed. Analysis of these data and related memos facilitated the researcher to identify, or discover, the basic social process students used to interact with the core problem. This process was labelled seeking concord to get in the right track (SC).

CHAPTER 3

Contextual Background and Influences – Context of Disharmony

The previous chapters have introduced this study and described the grounded theory methodology. The following chapters detail the basic social psychological problem of sociocultural discord: being different and not fitting in (SD) and the basic social process, seeking concord to get in the right track (SC). In this study CLDNSs experienced SD for many reasons on various fronts. Chapter 3 presents the contextual background for the study. It is important to identify, describe, and examine the contextual background to grounded theory studies because context sets the scene in which the participants live or exist. According to Chenitz (1986, p. 42) "context captures the social world of the individuals engaging in the phenomenon under study". Examination of the social world must include the environment in which the study took place. This includes any global or local, social or political events that may influence or impact upon the participant's social world; it may be symbolic such as the meaning of an event to the individuals involved (Chenitz, 1986). This allows the researcher to identify the conditions under which the phenomenon occurs whilst considering the immediate and broader social contexts. In grounded theory it remains important, however, that the participants' perspectives are kept foremost. Accounting for variation and range of the phenomenon under study are facilitated when the researcher identifies and examines all conditions under which a phenomenon takes place (Chenitz, 1986). Strauss and Corbin (1990) describe context as " … the particular set of conditions within which the action/interaction strategies are taken to manage, handle, carry out and respond to a specific phenomenon" (p. 101). Analysis of student and academic interviews, relevant documents, as well as the popular press and other published resources were used to build the background to this study. Background issues existed for all of the CLDNS participants in this study albeit to varying degrees. As such background issues impacted upon CLDNSs every day of their lives.

Background issues of importance in this study were identified as: stereotyping, the environment in which CLDNSs studied for their nursing degrees including the university as well as clinical practice settings, the sociopolitical climate, the impact of

familial traditions, and the cultural differences specifically related to various roles to which the students were exposed. These aspects of the background formed a context of disharmony.

CLDNSs experienced difficulties related to cultural differences whether they were on or off campus. Off campus referred to being in a clinical practice setting or being at home. Each day the students spent a significant amount of time on campus or in clinical practice settings where they experienced many emotions related to being different and not fitting in. At the end of a shift in clinical practice or at the completion of a day on campus students returned home. These are the environments in which CLDNSs lived and studied. What occurred in these environments had affected the CLDNSs and had been thought worthy of incorporation as background to this study.

Stereotypical images perceived by the majority of people with whom CLDNSs worked and interacted are presented. Because the student participants had various roles to fulfil and because these roles affected their lives it was important to investigate these as background issues too. As such, major familial causes of distress and parental disappointment influencing the students is presented, along with the effects of interacting with other people in various professional roles.

A thumbnail sketch of a typical clinical practice setting has been provided by the researcher along with a discussion of typical interactions of the CLDNSs with Anglo-Saxon Registered Nurses (RNs) and student nurses. Other areas related to student differences have been introduced.

However, before any of these issues are addressed, the researcher has attempted to outline the national political environment existent throughout much of the time of this study. This outline will give the reader a broad and simplistic understanding of the impact of political events that were happening in Australia. In addition to impacting on the participants, these events affected many people living in and visiting Australia, as well as people from overseas planning to travel, study or migrate to Australia and contributed to the context of disharmony which formed the background for this study.

<center>Sociopolitical Climate</center>

Consideration of the sociopolitical climate in this study was important because it impacted upon the study participants, both students and their teachers. Furthermore, the

sociopolitical climate quite possibly impacted upon the people with whom the CLDNSs interacted. Throughout much of this study race-related issues featured in the popular press: Australians were challenged by a new political party using race-related issues as party platform, and America and it's allies went to war with Iraq. From a sociological perspective the students of this study lived and worked in community settings whose members often used stereotypes. In addition, CLDNSs usually came from families that had different ways of living. All of these issues are considered in the following chapter as background to this study because all existed as the environment in which, or the conditions under which, the CLDNSs studied.

The Media and Political Influences

The popular press is known to influence the mass population. Media coverage of tragedies, terrorism, war, and similar negative events far outweighs coverage of issues of celebration or joy. The media also has a demonstrated propensity to sensationalise bad news. Before election time political parties use the popular press, for example newspaper advertising and television commercials, in an attempt to gain the so called swinging vote, to advertise their party platforms and policies, and to denounce opposing would-be governments. But the popular press can also have what could be described as a metastatic effect on communities. In Australia this metastatic effect of the popular press was seen with the advent of a 'new' political party. In coverage of this new political party the press also promoted, and in many respects sanctioned, the racially based, if not discriminatory, beliefs touted by this new political party known as the One Nation Party led by Ms Pauline Hanson.

The "Hanson Factor"

Pauline Hanson's One Nation party was launched in Western Australia in the first half of 1997. Prior to becoming the leader of the One Nation party, Hanson was an Independent Member of Parliament in the Queensland Government. During this time her public comments caused what has become well known, in Australia and other parts of the world, as "the Pauline Hanson debate" (Sheridan, 1996) or the "new racism debate" (Ratnayke cited in Laurie, 1997, p. 15). Stories about reducing the numbers of Asian immigrants accepted into Australia, racism and prejudice, along with

discriminatory treatment of Indigenous and immigrant Australians, had been published not only on the front page of every popular Australian newspaper but had also been published " … on the front pages of foreign newspapers in Malaysia, Singapore and Thailand" (Laurie, 1997, p. 13).

Simply speaking, Hanson's comments caused a media frenzy. She was reported as making statements that "attacked Asian immigration … linked Asian residents to crime … and … called for the withdrawal of funding which allowed immigrants to maintain their ethnic links". She had also made comments such as "Australia was in danger of being swamped by Asians" (Hanson cited in Fagan, 1996a) and she had been quoted as saying "My fear is that if we keep going the way we're going … the yellow race will rule the world" (Hanson cited in Laurie, 1997, p. 14). In a nutshell, Hanson "wants to see multiculturalism stopped in the interests of a single, monocultural Australia" (Laurie, 1997, p. 14). Hanson had also said "… any migrant must already be able to speak English to qualify [for immigration], and no migrant assistance should be offered in the person's native tongue" (Hanson cited in Laurie, 1997, p. 14). The party's platform aimed to abolish the existing network of multicultural health and legal services in parts of Australia (Laurie, 1997, p. 15). "Why should we, the taxpayer, pay for them to maintain their own language? They're coming out here to Australia. Our language is English. That's it!" (Hanson cited in Laurie, 1997, p. 15). She had also made comments related to the number and types of immigrants Australia should accept. The following is a direct quote from Pauline Hanson that appeared in The Weekend Australian newspaper and typifies many of her published comments:

> People out there feel as if they're losing the Australia that they know … People are very tolerant and we don't mind, but what we're frightened of is if we go down that track in 50 to 100 years and what it's [Australia is] going to be is a mini-Asia here. (Fagan, 1996b, p. 23)

Other politicians joined Hanson, so she was not alone in voicing her opinions and beliefs. The popular press had published politicians' comments such as referring to, for example, "citizenship ceremonies as a process of 'dewogging'" (Daley, 1998, p. 11).

These comments and others like them were everyday occurrences in the Australian media at the time most interviews were conducted for this study and they

were seen to have impacted upon everyday multiculturalism. In other words, people in the street were being affected by the media coverage and this was evidenced by the following quote:

> Community leaders, politicians and anti-discrimination commissioners told The Weekend Australian of some of the stories of racial intolerance that have flooded into their offices …. Most suspect the apparent rise in racism stems from the current public debate. (Lyall, 1996, p. 9)

Leaders of ethnic associations commented that "many members … have been deeply hurt by comments that Australia is being 'swamped by Asians' and accusations that they are spreading tuberculosis" (Nguyen cited in Lyall, 1996, p. 9).

In 1998, Pauline Hanson's One Nation party won eleven seats in the Queensland State election. At this time, the popular press, newspapers, television, and talkback radio carried media releases, including parts of Hanson's maiden speech, into households around Australia. Television interviews with Hanson were almost a daily occurrence and national airwaves were blitzed with sensationalist journalism at its worst. Hanson had been described as having "a shock value and [as having] has attracted much attention but … Hanson's support derives not just from the ignorant and racist appeal she embodies, but because she taps into the wider social and economic resentments" (Cochrane cited in "Ending the Politics of Racism," 1996, p. 20). "Her potency rests not only with racism but on a powerful sense of cultural loss – of displacement for the centre of things" ("Ending the Politics of Racism," 1996, p. 20). The effects of immigration in Australia are parallel to immigration in other parts of the world. Immigrants wear the brunt of many social issues such as crime and unemployment (Root, 1996, p. 15) and immigration issues are thought to lead to a situation in which "ordinary middle-class people [Australians] see immigrants … [as being] given special benefits, they feel annoyed that minorities can get something they feel they can't [have]" (Laurie, 1997, p. 15). As Ratnayke (cited in Laurie, 1997, p. 15) states: "The most alarming aspect of Ms Hanson's views is not just that she expresses them but that a significant proportion of Australians claim to support them".

Hanson had been labelled publicly as a racist (Mansell cited in Aplin, 1996, p. 9). Furthermore she had been described as "deliberately setting out to inflame the racist,

prejudiced attitudes of people whom she comes across" (Mansell cited in Aplin, 1996, p. 9). Indeed, One Nation had been labelled a racist political party. The corollary was that many average Australians who held racist type beliefs had these beliefs legitimised publicly by a political party that seemed to be gaining popularity. This is the basis of the metastatic effect. Prior to media hype people may have held these same views; however, they probably kept these views to themselves. Australians, by and large, were usually politically correct, that is, it was not the done thing to express negative opinion related to a person's heritage, race, or any aspect of cultural difference. "Up until the Hanson debate … racial abuse was more disguised, as if people were afraid of showing their prejudice outright" (Ratnayke, cited in Laurie, 1997, p. 16). Overnight this changed. "The pall of censorship has been lifted and what we're seeing as a result is a lot of hate talk" (Briton cited in Lyall, 1996, p. 9). People were publicly vocalising opinions related to a variety of issues that previously they would have rarely shared outside of trusted friends or family. This comment was supported by the West Australian Commissioner for Equal Opportunity when she said "Much of the racism is insidious. People in pubs and clubs and parties feel free to let loose and say things they wouldn't say before" (Williams cited in Lyall, 1996, p. 9).

It was obvious that Hanson had an impact upon Australian politics and everyday multiculturalism. Evidence of the impact on everyday multiculturalism was demonstrated when her speeches in parliament prompted a young Singaporean student, Thomas Chan Hean Boon to write an open letter to his countrymen and women about migrating to Australia (Kerin, 1996, p. 8). At this time the majority of the Australian press published stories about One Nation, Hanson, and people immigrating to Australia. Smaller suburban newspapers had also printed stories which may have impacted upon everyday multiculturalism. The following presents such a headline and opening statement "Student Hep B risk: Perth's Asian students are unwittingly bringing Hepatitis B into the country" (Samarakkody, 1996, p. 7). In effect, Hanson was blamed for "Australia's reputation overseas … taking a dive" (Laurie, 1997, p. 13). People who were of Asian descent became increasingly aware of subtle hostility toward them.

During this time, the Hanson debate and the given media coverage were thought by many to have a devastating impact on Australia's reputation globally. For example,

the Prime Minister of Malaysia was reported to have encouraged Malaysian students who were studying in Australia to return home (Laurie, 1997). The National press published articles linking the Hanson debate to declining numbers of international student enrolments in Australian universities (Illing, 1997, p. 4). Others questioned what impact the current political climate would have upon imports and exports and all other aspects of trade. Lobby groups, leaders of Unions, and other Australian political parties had criticised the Prime Minister of Australia severely, and publicly, for not making his condemnation of Hanson's comments earlier and more clearly.

The average person in Australia was exposed to media coverage of the Hanson debate; everyday multiculturalism in this country had been affected. These political events occurred in Australia at the time that the majority of data were collected for this study and they had impacted upon the experiences of the CLDNSs studying nursing in Australian universities. It was apparent that individual students were affected, as were their families.

Asian people and people of Asian descent were not the only ones to be affected. Since the time that the majority of data were collected for this study the world has changed and changed forever due to the terrorist acts in the United States of America. However, even before the events of September 11, 2001 in the United States, the war in Iraq and subsequent terrorist attacks in Bali, Madrid and London, political and religious wars had set people of different religions and cultures against each other. These differences extend across the globe and affected individuals from opposing groups. This was borne out when CLDNSs spoke of their difficulties in caring for people whose countries were at war against their country.

<div align="center">Cultural Diversity</div>

Students in this study came from a variety of different cultural backgrounds. People from different cultural backgrounds often suffer the ignorance of members of the dominant culture. Typically the latter group use stereotypes upon which to base their interactions with people from different cultural backgrounds. Incidents of stereotyping were often predictable but also surfaced haphazardly and at times quite unexpectedly during data collection. It was deemed important to incorporate these differences as part

of the background chapter because they help to inform the reader of the social world of the students. These differences were sometimes overt, other times covert, often underestimated or worse still, ignored by those people with whom the students interacted. Because student participants hailed from a variety of different cultural backgrounds they were seen as different and were usually treated differently.

Stereotyping

Most people hold standardised ideas or concepts (Delbridge & Bernard, 1998) about other groups of people. Research related to stereotyping puts forward the notion that everybody uses stereotypes and that humans do so consciously and unconsciously. The reasons why we use stereotyping are more complex and more interesting. Bargh (cited in Paul, 1998, p. 23) for example hypothesises:

> … that stereotypes may emerge from what social psychologists call in-group/out-group dynamics. Humans like other species, need to feel they are a part of a group and, as villages, clans and other traditional groups have broken down, our identities have attached themselves to more ambiguous classifications, such as race and class. We want to feel good about the group to which we belong – and one way of doing so is to denigrate all those who aren't in it. While we tend to see members of our group as individuals, we view those in out-groups as an undifferentiated – stereotyped – mass. The categories we use have changed, but it seems stereotyping itself is bred in bone.

In this study, Australian teachers and students held stereotypical views of CLDNSs and CLDNSs held stereotypical views of people from cultures other than their own. Stereotyping had occurred largely in negative ways and assumptions were often made about individual students on the basis of, for example, the way they looked, their country of origin, their traditional or cultural heritage, religion, or gender. People in classrooms and clinical practice settings used stereotypes. CLDNSs and their teachers described numerous ways in which some hospital staff were culturally ignorant or unaware of cultural variants. This meant that these staff demonstrated little or no educated or informed understanding of the CLDNSs' backgrounds. Instead, the majority of RNs who had anything to do with the CLDNSs used stereotypes and made incorrect cultural assumptions about the students. This clearly impacted upon the students. There were also occasions when CLDNSs did not fit the stereotypical images held by members of

the dominant group. When students did not fit these stereotypical images they experienced discomfort as they tried to break away from these stereotypes.

CLDNSs had come across stereotypes in every group of people with whom they had contact. At times, CLDNSs also stereotyped people they had encountered during their nursing course, and Australians were not exempt. Due to the relevance as background to this study these stereotypes and subsequent problems are discussed in the following section.

Australians and Stereotyping

As students in this study were enrolled in undergraduate nursing degrees in Australian universities it was deemed relevant to investigate the stereotype of a typical Australian. The typical stereotype of Australians is that they are "…happy-go-lucky, pleasure-loving, free" Oakes (cited in The Health Report, 1996). She goes on to say that "Australians are quite optimistic people, they expect life to be good and if it's not good they want to know why." Oakes (cited in The Health Report, 1996). Interestingly and in contrast, CLDNSs had articulated stereotypical images labelling Australians (i.e., members of the dominant group) as "ignorant" (S115) and "racist" (S12). Although these more negative stereotypes were articulated specifically by relatively few participants these kinds of images were seen throughout the data collected and analysed in this research. Even if these stereotypes lean more towards characteristics or simple adjectives they had been based upon a perception that Australian people had an inability to demonstrate an appreciation for, or acceptance of, other people's religious and cultural beliefs. However, balanced views were also evident and demonstrated in student data, for example, "I've always felt that Australians aren't racist in a hateful sense … rather they, it's just ignorance, so I've never … been insulted by racist type comments" (S13).

CLDNSs commented that they felt they had been stereotyped negatively by members of the dominant group because of difficulties with the English language, comprehension ability, and their physical appearance. From these judgments, CLDNSs felt they were stereotyped as inferior and believed that members of the dominant group

did not want to work with them because to do so would disadvantage them. In relationship to this stereotype, the following comment was made:

> Don't you think that if you look different from other people, then they assume that your English is not good? Or they'll assume that your ability to write an essays or things like is not as good as others. This is one of the reasons they think this person is not able to do good assignment if we are pairing up or group with them - then they will be more disadvantaged. (S32)

In addition, the Australian public holds a well developed, if not dated, stereotypical image of the nurse. The popular press, particularly television, is largely responsible for this. Every week thousands of households tune in and watch their favourite hospital based drama series. These programs maintain the stereotypical nurse images but interestingly, Black nurses make many appearances in the imported television series but do not reflect the make-up of the Australian nurse work-force. American and British programs are more likely to employ the use of actors who depict a multicultural workforce. The Australian equivalent, however, reflects the reality of the Australian hospital based workforce. In particular, that there is an obvious lack of non-Anglo-Saxon people working the professional roles and an over representation of non-Anglo-Saxon people working the patient care assistant roles. Millions of viewers tune into these television programs and so over time the stereotypical image of the RN is not only manipulated but perpetuated by the popular press.

Students who did not conform to existent stereotypical nurse images were often met by challenging comments. There was evidence in the data that nursing students in Australia were still thought of as predominantly White females and definitely not Black. Such was the case when one Black male student attended university to enrol into an undergraduate nursing degree program. He was met with the following comment "Are you here for nursing?" (S16). Whilst this, in itself, was not unusual, the student, when referring to the enrolments clerk, commented that "She didn't say it to other men" (S16). He felt she had queried his attendance because he was Black and he did not fit her stereotypical image of a nurse. This student had made other comments related to ongoing difficulties he experienced because he felt he did not fit the stereotypical image of a nurse. Such comments included, for example, "It was really difficult … you feel,

you sort of um, seeing new people, new lecturers, new tutors coming in and they all look at me" (S16).

Another Black male nursing student discussed this sense of being different to, or not fitting, the stereotypical nurse image. He was similarly questioned about his attendance in nursing classes. University staff had not pictured him as a nurse as the following quote demonstrated:

> I went into the … nursing computer room and as I was walking in one of the lecturers, I don't know if he was a lecturer for computing studies or technology or what but he wasn't our teacher, and he said "You are not a nursing student are you?" And I said "Yes I am" and all the girls just turned around and looked at him and said "Yes he is" and stuff like that. (MS3)

Those students who did not fit the stereotypical image of a nurse hinted at a persistent sense of being different and not fitting in.

Further, analysis of academic interview transcripts demonstrated covert negative stereotypical images of CLDNSs, as well as of Indigenous Australians. At times, these stereotypes were held by individual academics but there were also occasions when data analysis eluded to a perception of stereotypes being more broadly held beliefs of the wider academic community. When individual academics came across such stereotypical comments made by their colleagues they found it difficult to act. One academic recalled the following experience:

> I can relate you a story about Aboriginal people too, which really surprised me, and that was at a lunch I went to and … admittedly people were stressed, it was early in the year and they [the university] were taking special admissions …. They were fairly senior, Heads of Departments, and … people like that, and we were down at the pub and the conversation first started like, [pause] people [pause], it was really quite a racist little conversation …. It started off making jokes about people who were intellectually, well had low TERs [Tertiary Entrance Rankings] and were trying for special admission. Staff were letting off steam obviously and making jokes about that kind of thing and then it moved on to Asian and English as a second language students and someone said "How can they expect to come to university if they can't even speak English?" And there they are letting off steam about that and I'm being generous in my descriptions …. and a lot of humour and laughter going on as well. And then it moved on to Aboriginal people and the statement very quickly, early on, was said that, "Oh well, all you have to do these days is prove your father's a Boong [Aboriginal] and you're in." At that stage I got up and left and actually I did follow it up and made a complaint about it and things, but I was very surprised that here at XXX

University, in the Faculty of Nursing, that was said loudly with laughter and support [from those around]. The table next door could easily have heard and Heads of Department and senior people, I was really quite horrified, so, I think that that was evidence of quite a, quite a bit of racism … although the individuals involved would deny that completely and just say they're [they were] joking. (A12)

Heads of Departments, lecturers and those people with whom students interacted in clinical practice settings, by and large, held stereotypical images of student nurses from different cultural backgrounds. It appeared that skin colour in nursing in Australia did matter. And it mattered because non-Anglo-Saxon people were the minority students and RNs. From data analysis it became evident that CLDNSs interacted with others who held a variety of stereotypical images of people from different cultural backgrounds. This study enabled the identification of two distinct types of stereotyping which for clarity here have been labelled Level I and Level II stereotyping.

Level I Stereotyping

Level I stereotyping referred to a general form of stereotyping wherein students from different cultural backgrounds were all grouped together without any consideration given to individual cultural background or course of study. At this level CLDNSs were either referred to as Non-English Speaking Background (NESB) students, First Language Other Than English (FLOTE) students or students from different cultural backgrounds.

Asian students had also been grouped together. It did not matter that a student was from Vietnam or Singapore. No consideration was given to individual cultural influences or differences. All Asian students were thought of in the same ways. Level I stereotyping cast culturally and linguistically diverse students in the same light: whatever had been applied to one ethnic group applied to all others.

Teachers' use of Level I stereotyping was relevant in this study because of their critical involvement in student education and learning. During interviews most teachers made use of stereotypical labels when referring to CLDNSs regardless of their awareness of the possible negative effects of doing so. Most academics knew they were using stereotypes and most were also aware that stereotyping of students could lead to

negative outcomes. They were well aware that their comments directed towards NESB or Asian nursing students could not apply to every single NESB student or every Asian student. Nonetheless they still used stereotyping at this level.

At the same time that some teachers stereotyped CLDNSs some also articulated an awareness of the need to treat all students as individuals. For example, many teachers preempted or followed stereotypical remarks with riders indicative of their consciousness of the need to treat CLDNSs individually. For example: "You can't generalise … I don't think you can put them [CLDNSs] all in that category" (A111) and "Not all of them [CLDNSs] and it's awful to talk about them as … yeah, cluster them … because some of them are different" (A16). Areas in which level I stereotyping had been identified have been addressed in this chapter because these areas contribute to setting the scene in which CLDNSs studied and as such will give the reader a sense of context.

Reflective practice

Quite a few academics had stereotyped CLDNSs as being unable to use reflective practice, or as having difficulties when required to engage in reflective practices formally. Teachers had also stereotyped CLDNSs as being "Most reluctant to talk about anything negative" (A24). This reluctance to discuss negative issues led to problems related to reflective practice. According to the College of Nurses of Ontario (2004), "Reflective practice is a formal process that helps nurses maintain their competence in today's rapidly changing health care environment". When used effectively reflective practice enables nurses to "think about and achieve a better knowledge of their practice" (Davis, 2003). To engage in reflective practice nurses, including student nurses, must be able to identify and discuss negative issues or events. Some academics believed CLDNSs did not want to discuss negative issues because it was culturally inappropriate.

Simply speaking, reflective practice requires nurses to look back and think about practice situations that could have improved outcomes had the nurse acted differently. Identification of situations that could have been improved amounted to an admission of imperfection, or error, on the student's part. In reality, individual student's cultural

edicts often encouraged the existence of harmony. From their perspective harmony and reflective practice seemed to work against each other even though it could be argued that reflective practice enhanced harmony even if paradoxically so. Conflict in thought processes clearly existed for some of these students when they were expected to practice reflectively.

A flow on from the stereotypical characteristic of CLDNSs' inability to be reflective was the idea that they performed better in science-based subjects where reflection was not required. One academic commented "Our … non-English speaking [students] do quite well in the sciences because it's just a cut and dried, black and white type of subject … whereas reflective practice takes a bit of thinking … a bit of change" (A13). Another academic had similarly stereotyped Asian students, commenting:

> [They] take more readily to … [the] hard sciences kind of aspect of it. You know, learning Asian in Chinese characters from a very early age gives them an affinity to that sort of, you know, working with numbers sort of um, stuff and they are more comfortable with that. (A22)

From the above examples, it was clear that some academics stereotyped CLDNSs as students who would perform best in science-based subjects and poorly in other subjects. From student interview data this was not always the case and many CLDNSs identified problems with both science and non-science subjects.

Teachers and Level I stereotyping

Teachers had often made comparisons between CLDNSs and members of the dominant group when discussing their experiences of working with the former group. Whilst these comparisons gave insight to some of the differences between CLDNSs and members of the dominant group they had been used in stereotypical fashion. Asian nursing students had been stereotyped as experiencing discomfort when studying aspects of health that included counselling and psychology. This discomfort was thought to exist because Asian students "don't necessarily subscribe to that same humanistic framework that we are trying to teach them" (A22). Australian students (i.e., members of the dominant group) were also reported to be better than CLNDSs in delivering classroom presentations. One academic had commented that:

> Australian students would probably be … more comfortable in putting some points up on an overhead projector and um, giving their presentation in an open kind of a way but … the … international students [CLDNSs] just don't feel that way. (A16)

The stereotypical image here was that CLDNSs do not do as well when giving group presentations and that their presentations were less open. Further, academics believed that when CLDNSs were required to give classroom presentations members of the dominant group became bored, disinterested, and restless. Some CLDNSs were reported to have sensed these behaviours amongst their Australian colleagues and many were embarrassed and self-conscious when giving oral presentations. When Asians students failed in clinical practice settings some academics had expected them to make claims of discrimination as the basis for their failure. An example of this situation, and the accompanying stereotype, was demonstrated in the following academic's quote:

> We do have situations where if you fail Asian students, and especially if we fail them on clinical, they become very assertive and very angry, and this sounds a bit sort of general but it does happen. Very often they will say they were discriminated against by the clinical instructor. (A15)

Academics, clinical teachers, and individual CLDNSs, even Asian students, had all made stereotypical remarks about Asian nursing students. Many of these comments paid no attention to the individual student's country of origin and students were often clumped together as Asians. There were, however, other times when stereotypical comments included the student's country of origin and typically groups of students were referred to as "the Lebanese" or "the Vietnamese". These stereotypes fall into Level II stereotyping and have been discussed under that heading.

Most Asian stereotypical images were negative but there were occasions when clinical teachers held positive stereotypes of Asian nursing students. For example, a clinical teacher reported "They find it hard but they are prepared to work hard at it" (A22). This same teacher added:

> Academically, I find the students are quite bright because to get here and to actually do a degree in another language is extremely difficult … so they have got to be exceptionally bright to be able to come here to do it in the first place. I always take their intelligence levels as being as upper. (A22)

Not all academics formulated, or worked by, such positive stereotypes of Asian nursing students. All teachers interviewed in this study had years of experience and their stereotypes had multiple influences. When teachers had previous negative experiences with one or more Asian nursing students it was likely that these experiences contributed towards the development of negative stereotypes of Asian nursing students. When new Asian students came along teachers were, up to a point, expecting stereotypical behaviours to be demonstrated.

Asian students were also stereotyped as having "a very internal locus of control" (A22) and whilst such locus of control was viewed positively when taking on the responsibility of learning it was seen negatively by other academics as far as seeking support for non-academic problems. For example, an academic had stated "they [Asian nursing students] tend not to seek support on issues outside the realm of academia" (A12). The inferred meaning was that Asian students would seek support and guidance from university counselling services for problems specifically related to academe, for example, writing essays; however, they were not known to seek counselling support for other, more personal issues. Hence the stereotype, Asian students will not discuss their personal problems impacting on their education with their teachers or counsellors. This was an important issue because as discovered, CLDNSs had to deal with layers of problems that fell outside of the realm of academia and experienced an almost insurmountable degree of discomfort.

Throughout teachers' transcripts Asian nursing students were repeatedly stereotyped as being quiet and noncommunicative. Although this stereotype has been addressed in the next chapter as the basic social psychological problem the following comments made by teachers act to introduce the reader to this stereotypical characterisation:

> And that's probably one of the main difficulties that we have … is that the whole cultural background thing, which is … something that I don't generally like doing, is using broad labels of Asians, they do tend to be fairly quiet students. (A17)

Another claimed "Some of them in the Asian cultures, some of them they are very quiet and reserved … very respectful of the work environment" (A115). There were other

comments that hinted towards the quiet Asian nursing student stereotype, such as "I just find that sometimes they [Asians] don't have a warmth, some of the students don't have that same warmth, but I just believe that's part of their culture" (A111). This academic was describing Asian nursing student interactions with patients.

In respect to intimate patient care involving, for example, a female student and a male patient, a clinical teacher remarked that "The Asian students are fine, they don't seem to have a problem with that [intimacy of nursing care]" (A115). This particular clinical teacher had stereotyped Asian students as not experiencing any problems when dealing with patients in an intimate manner, for example, showering patients. Not all stereotypes held by individual academics were reflected in student data and there were indicators that disproved many stereotypes held by teachers. This specific stereotype, that is, Asian students not having any problems when caring intimately for patients of the opposite gender was easily countered by students' comments to the contrary. For example, "When I get to their private part I just wash but I not watch" (S34).

Another academic had developed two other stereotypes of CLDNSs. She believed these students to have come from either very wealthy or very poor families. Those who came from poorer families were stereotyped as being better suited to nursing because they were more likely to have helped look after sick family members. Those from wealthier families were believed not to have had the same opportunities and were therefore believed to be less suited to nursing. The bottom line was that even though some academics knew it was not accepted practice they still interacted with students from their, often ill-informed, perhaps well meaning stereotypical frame of reference.

Level II Stereotyping

The second level of stereotyping that became evident from constant comparison of data had greater specificity and core foci became apparent. Three areas of level II stereotyping that surfaced were race, religion, and gender. These are addressed in the following pages.

Racial

Racial stereotyping in this study patterned into four specific groups. These were the Asians, Australians, Italians, and the Lebanese. The following section discusses

Asian, Italian and Lebanese stereotypes as the Australian stereotype has been addressed previously.

Teachers did not always stereotype Asian students by grouping them all together. There were occasions in which teachers acknowledged the student's country of origin and then grouped all students from that country together. For example:

> They may ask a question; however, I've found that the Vietnamese students will tend to be quiet. They have beliefs about the role of the teacher and the role of the student that may mean that they will remain quiet even when they don't understand. They won't challenge if they disagree, they tend to take our word for what we say. So let's say hypothetically that a student … in my group and she is following a lot of what I am saying but there are issues there that she either disagrees with or does not understand …. It's highly unlikely from my experience that she will speak up, that she'll stop me. And it's also highly unlikely that she will come and see me about any difficulties she is having until it's at the crisis stage where she has failed her first assignment .... (A23)

When analysing data that had stereotyped Asian students it was noted that most comments had been made by teachers and that most of the comments were in some way related to students' communication abilities. Examples of typical comments follow: "At that time the students were almost exclusively Asian, we had some students from Singapore who had Indian backgrounds ... generally their English was better than those that came from Korea or from Taiwan" (A16) and "Yet the Hong Kong students' English is usually very poor … so it is very difficult to understand them" (A24). It is easy to identify the stereotyping in this quote, for example, all students from Hong Kong have poor English skills. And another:

> Often kids from Vietnam in particular, because we probably tend to get more of Vietnamese kids … I'm thinking … than any other country, they like to know what they are saying … so they will sort of hold back until they know what they are talking about …. I also think that their comfort with English is one of their main difficulties. (A17)

Perhaps there was justification for academics' use of stereotyping, for example, when students were seen as being quiet. However, there were other occasions where justification for stereotyping remained elusive. For example:

> I mean the … Vietnamese and the Korean people are sort of quite um, overt, they're ok I think, their English isn't marvellous but … they've just got a different um, a different way of thinking … they feel, I mean, … they're well

made up, made up, lots of jewels, you know, the whole bit … whereas, um, I'm thinking of two in particular who look as if they are straight out of Vogue, whereas the probably Hong Kong, Singapore, they don't. (A13)

Infrequently, non-Asian CLDNSs had made stereotypical comments about RNs from specific Asian countries and had voiced their preference to work with other staff members. The following student data extract illustrated this point and gives examples of the development, as well as perpetuation and negative outcomes, of stereotyping:

I mean I've also got a Filipino friend at school and she is very rude and straight forward, I don't know whether they think they are being rude, I think they think they are just being straight forward …. And also with their accent, it's just the tone of their voice that just makes them really come across as really bitchy and I mean now if you go out on clinical and there is a Filipino nurse … I hope I'm not with her even if she is really, really nice …. I mean you've got this thing and because I also work at XXX hospital, and a lot of the Filipino nurses there too, they are horrible. (S116)

During data analysis it became apparent that female Italian nursing students had also been subject to other people's stereotypical categorisations. The usual stereotypical image of Italian females was that they were meant to be at home, married, with five or six children, and definitely not nursing. Triggers that brought out these types of stereotypical comments from patients were, firstly, the students' names and, secondly, the students' physical appearance. From these triggers, patients assumed students' cultural backgrounds and attempted to talk about all things Italian.

Another series of stereotypes, based upon country of origin, pieced together from interviews, were those placed upon Lebanese nursing students. These stereotypical images portrayed Lebanese nursing students, irrespective of gender, as people who had many problems. Teachers often portrayed Lebanese students as: having problems stepping outside of their own cultural edicts; living under restrictive parental influences; having a different set of problems to other CLDNSs; displaying a reticence to using on campus counselling services; and being capable of emotional expression only when a sense of security was provided. Whilst these stereotypes had been specifically applied to Lebanese nursing students other data indicated equal applicability to other groups of student nurses from other cultural minority student groups.

Female Lebanese students were, however, identified by academics as living under more extreme parental influences than other ethnic student groups. This influence was commonly brought to bear by female students' mothers and was illuminated by the following academic's comment:

> They [their mothers] won't let them go, they are extremely demanding, they don't understand and this student came from [had changed from] someone who was so motivated, so enthusiastic … obviously working hard from the beginning of semester, delightful repertoire with all the other students and really wonderful and then suddenly curtailed by the mother moving in and saying you know "I don't like this …. You are away too long …. Where are you going? … Where else do you go apart from the University? You should know that your place is in the home" and these sorts of things. (A113)

Female Lebanese students' attempts to interact with other nursing students were often thwarted because they could not use the time outside of formal university classes, away from family commitments, to engage in other activities. These restrictions often caused Lebanese students much frustration and at times embarrassment; however, academics reported these students as being reticent in seeking counselling. This reticence was seen in the following academic's quote:

> There is always the 'stand back and I will deal with it myself' and to get over that they really have to be at a degree of frustration and … anguish before they will go [to counselling] and that is with a lot of pushing [encouragement] and many a time I've, they've been in my office and I've said "Look I'm really worried. Can I ring them [counselling] whilst you are here? Can we make an appointment?" And that is the only way I get them in there [to counselling]. (A113)

Religion

Stereotyping can also be based on a person's religion or perceived religious affiliations. People sometimes judge others on their understanding of another person's religion irrespective of accuracy. There was evidence that students had been stereotyped and treated according to perceived beliefs about their religion. Students who were from Muslim or Jewish religions were often stereotyped by those with whom they worked, either in clinical practice or classroom settings. It is worthwhile pointing out that Lebanese nursing students were also Muslim, the corollary being that Lebanese and Muslim stereotypical images were often integrated.

Muslim nursing students were similarly cast into stereotypical images irrespective of individual character. One of the more difficult and salient of these images was female oppression. This proved difficult for the students concerned because they did not see themselves as being oppressed. They were, however, aware that many others around them, on clinical practice and university campuses, thought they were oppressed. Student awareness of such stereotypes came about in a number of ways and the following account depicted a less than pleasant means causing much discomfort for the student concerned:

> There is nothing you can do. I've had the situation like that previously and I think my God ... let me get this straight. What happened was we were in theatre [operating room], me and my friend, and she, the facilitator was waiting outside for us to finish getting dressed [in theatre clothes], and my friend was finished before I did, because I had other things to do, [putting on the scarf] so she, my friend was waiting outside and she heard two RNs plus the facilitator talking about me .... Saying that … people like me are oppressed by men and that you know, just stuff like that …I didn't comment … then we were in half way in theatre … I was so upset that I just walked out of theatre, I just couldn't handle it… anything. Like for about two weeks after that I'd just burst out crying, you know, and um I didn't say anything. (S114)

Muslim nursing students believed that they were simply following their religion, that they had a right to do so, and that it was not their religion that oppressed them, but rather xenophobic comments and beliefs.

In addition, Muslim nursing students believed that members of the dominant group of students had stereotyped them as religious fundamentalists who had no individual opinions or independent thoughts, but instead adhered to strict religious codes. A poignant example of this was borne out at interview when a Muslim student discussed a tutorial session where the issue of euthanasia was discussed. This student commented:

> I feel that people are ignorant in that they stereotype where they think that's, you know, I may not respond to what they say or I have no feelings because I'm blocking out and I am not accepting any other opinion … any other suggestions or opinions. For example, if there is an issue about euthanasia … I have … voiced my opinion it was sort of like "Oh, ok, this isn't this person talking but this is a person who's got a headscarf on the head that's talking … a person that … is probably like from the Middle East" You know? Because of, many people do link the headscarf with the Middle East and so called suppression [oppression]

which … which like equals to whatever … inferiority … of like being a female. Like there's that, those ideas in there as well. That's basically what I see, the ignorance in the relation that … I have my own opinions, yet it's not fixed, it's only an opinion and I'm … open to any other opinion. (S115)

In summary, this student had suggested that other students had stereotyped her as a Muslim fundamentalist who had no real opinions of her own, who lived an oppressed existence and was not capable of having her own beliefs about euthanasia. In reality, this was not true; this student had her opinions on euthanasia, she believed they were not fixed and that she was open to other people's ideas. These are the kinds of situations or contexts that student nurses from different cultural backgrounds study within.

Some academics also held restricted stereotypical images of Muslim students. These images were described as restrictive because some academics believed all Muslim students wore head-scarves. Clearly, not all Muslim students wore head scarves. Firstly, male Muslim students did not and, secondly, not all female Muslim students interviewed in this study wore head scarves. This stereotype, like so many others, was ill-informed; however, the stereotype was evident amongst academics. Additionally, there were teachers who ascribed to the commonly held stereotypical opinion that female Muslim students had problems or difficulties when they had been allocated to care for male patients and that care would involve dealing with naked male anatomy. This stereotypical belief about female Muslim students predominated amongst academics and obscured the fact that other groups of CLDNSs, as well as students from the dominant group, also had difficulties when allocated to care for patients of the opposite gender requiring the same level of nursing care.

Jewish nursing students were also typecast. The stereotypical image of primacy for this student group was based upon assumed fiscal status. One clinical teacher reportedly made the following comment to a Jewish student:

I know about Jewish people, I used to work at XXX hospital [a Jewish hospital] … you've had opportunities other girls haven't had … you are all smart. Why don't you do …something else instead of nursing? Why aren't you studying medicine? (MS5)

The same student believed that clinical teachers thought "If you are Jewish … you have a multimillion dollar mansion and your parents drive BMW's [expensive cars]" (MS5).

The student labelled this stereotypical image the "Little Jewish Princess" (MS5) and felt that clinical teachers who believed in it treated her differently to other students when in clinical practice settings. She was unable to effectively rationalise why clinical teachers treated her differently, what was important was the fact that she felt she was treated differently.

Other Jewish nursing students shared an awareness of stereotypes of the Jewish nurse but they did not discuss these because they had no personal experiences. Discomfort nonetheless existed related to their awareness that others with whom they worked and studied held such stereotypical images.

In summary, Jewish nursing students, Asians, Muslim, Italian and the Lebanese all experienced some form of stereotyping. Their student nurse colleagues, their teachers, patients as well as other hospital workers and people they interacted with, had cast them in a particular image. The environments in which student nurses studied were full of people who held stereotypical images. These environments and the behaviours of people within contributed to the background of this study.

Gender-based

Although infrequent, gender-based stereotypes specifically casting male students were discussed by people at interview thus adding to the contextual background in which CLDNSs studied. The two of any significance were that all male nurses were homosexual and the Middle Eastern male stereotype. Male students from culturally and linguistically diverse backgrounds were aware of the former stereotype and some had discussed it openly, for example:

> That's the thing that I was really worried about, that people won't consider me as a typical nurse because I'm not, I don't know, I mean, a lot of people stereo, this is what I was basically worried about when I first started nursing was that they stereotype male nurses as being gay. I'm not gay, I'm heterosexual. (S212)

Clinical field observations also showed culturally diverse male students' awareness of the gay male nurse stereotype. The following data excerpt from clinical field notes makes reference to this stereotypical image:

> When the student was going to take a male patient's pulse he said to the patient "I'm going to hold your hand now and take your pulse but that does not mean I

am that way inclined". The elderly male patient laughed with the student. It seems obvious their reference is to being gay. The student knows what he has referred to, so too does the patient even though nothing specific has been said. This stereotype seems fairly strong. (F.N)

This particular stereotypical image, that is, all male nurses are gay, cut across cultures. Specifically, the issue of male sexual orientation existed irrespective of cultural background.

Gender-based stereotyping was also discussed by other male student nurses. Each country has social norms dictating gender roles. Gender is referred to as the "socially conditioned characteristics of typical [male or female] behaviour" (Delbridge & Bernard, 1998, p. 463). In other words, there are specific behaviours expected of a person because they were either male or female and these specific behaviours are influenced by cultural backgrounds. Some of these culturally-based, gender-specific roles caused problems for individual students in this study because they prescribed behaviours that the student no longer fully ascribed to. For example, if you were male and Muslim it was unlikely that your family, particularly your father, approved of your nursing. This was because Muslim people did not believe men should be nurses. In fact, male Muslim students' fathers were known to be more disapproving of their sons nursing than any other family members and disapproval often caused these students to experience difficulties in their familial relationships. Fathers did not like their sons studying nursing because it was not seen as masculine work and they had been reported as having asked "How could they [my son] possibly be interested in a female role?" (A113). Additionally, this group of CLDNSs was known by academics to have experienced "a lot of shame and a lot of guilt; they are often ostracised by male members of the family and their fathers won't talk to them" (A113).

Some may believe that all male nurses experience this kind of reaction from their fathers and other male family members and doubt that Muslim family reactions are any different to non-Muslim family reactions. Whilst male nurses from the dominant group may still come across stereotypical comments about males and nursing, male nurses appear to be far more accepted in Australian culture compared to Muslim culture.

Other examples of gender specific, culturally based roles existed for female students. Of primacy were the expectations that some female students would have difficulties providing nursing care for male patients because their cultural backgrounds, plus or minus their religious beliefs, prohibited them from doing so. Where female CLDNSs held such beliefs they discussed the feelings of self consciousness and embarrassment they experienced in caring for male patients. On the whole this did not prevent female student nurses providing care for male patients. Rather these students talked about delivery of nursing care to male patients and their concurrent feelings of discomfort, embarrassment, and self-consciousness. Conversations related to this topic were often stilted and students required encouragement and reassurance of their anonymity.

Female students identified their feelings of self-consciousness when delivering intimate nursing care to male patients. These students also felt embarrassed especially when questioned about this area of care by family members and friends. These feelings stemmed from female students' parents, spouses, or members of their cultural community having expressed their disapproval of them caring for male patients and being involved with intimate nursing care. Disapproval existed because of traditional cultural beliefs in which females were not supposed to provide nursing care for males. Some students tried to help their friends and relatives see their role as a student nurse from a more liberal perspective and engaged in discussions with family members and friends. An example is provided in the following student quote:

> I have had … [friends] say to me 'But how can you do it [nursing] especially when you have to see men naked or when you have to look after men?' And I just turn around and say 'Well … if you're sick and the only people who can look after you is a man what are you going to do?' I mean someone has got to do this job and … I tell them that "It doesn't make any difference". After, it's like "Once you have seen one you have seen them all". (S213)

Most academics and clinical teachers were aware of the discomfort that many female CLDNSs experienced when they were allocated to care for male patients in clinical practice settings. In the extreme, this was highlighted when a small group of teachers mentioned knowing of a handful of CLDNSs who had successfully

completed their undergraduate nursing degrees and graduated without ever caring for male patients. These students were reported as having exchanged patients with other students in clinical practice settings whenever they had been allocated to care for male patients. To prevent reoccurrence of this situation university policies were written and implemented that stated all students were to care for all patients irrespective of religious or cultural beliefs. Staff from other universities knew of similar scenarios and made informal policies informing female CLDNSs that they would not be given "exemption from looking after male patients" (A15).

Furthermore, academics had also talked about female CLDNSs not only having refused to care for male patients, citing religious reasons, but also refusing to buy textbooks with pictures or illustrations of male genitalia. As females in their religion it was against their beliefs to look at such pictures or illustrations. Again these situations had caused problems with the corollary being the development and implementation of specific formal and informal policies directing CLDNSs to use textbooks irrespective of their beliefs.

Some male CLDNSs were perceived as having demonstrated aggressive and domineering behaviours towards females with whom they interacted. Notably these male students were all presumed to be from Middle Eastern backgrounds and these characteristics were thought by teachers to be related to culturally-based gender role expectations. The following data extract supplied part of the description of male nursing students from Middle Eastern backgrounds:

> [His] whole attitude was very aggressive. He used to invade my personal space all the time …. And he was about six foot 10 inches tall or something (laughing) and I just felt that he didn't have any respect for my position in that sense …. I didn't have any specific complaints from the Registered Nurses on the ward about his behaviour. Had I had, it might have been a different story but because I didn't have, they said "Oh no he's co-operative, and he's working reasonably well and … not a problem" but he, oh I don't know, just the whole general attitude was one of … "it doesn't really matter who you are or what you say or anything else I will do what I want to do". Now his interaction with patients was … he'd only do barely enough … to get by, it was like he knew the system. Knew what to do to get through … he wasn't the "sit down by the bedside, you know, let's get to know this person for who they are type of thing". He would just do enough … would work alongside the RNs and just do enough to get through. (A115)

Aside from this description other female teachers had spoken of their own attraction to the physical characteristics of male students from Middle Eastern backgrounds. Simply, some female teachers and female RNs had found themselves charmed by the mystique of the tall, well-built, dark male and some had aligned this group of students to the stereotypical image of a "stud". In this situation the characterisation of these students being studs specifically referred to "young men of obvious sexual prowess" (Delbridge & Bernard, 1998, p. 1160).

These particular stereotypical images, that is, that all male nurses are homosexual and Middle Eastern male nurses are "studs" are somewhat opposing. Whilst these images were not the focus of this study they became evident from data analysis. Clearly, they existed and created the background in which student nurses from different cultural backgrounds studied for their nursing degrees.

Stereotyping in the classroom

A number of CLDNSs had commented on their dislike of some of the negative comments made in lectures, by academics, about people from different cultural backgrounds. These students felt that when academics made sweeping stereotypical comments in class that these could affect the ways other students viewed patients from different cultural backgrounds as well as themselves. For example, an Italian student thought that the comment "Women from Mediterranean backgrounds … are very vocal during childbirth … and yell a lot when they're in pain … you don't worry about it [their vocalisation]" (S13) had the potential of perpetuating stereotypes such as all people from Mediterranean backgrounds will be very expressive of pain under any circumstances. Instead of using stereotypes, this student wanted teachers to emphasize the concept of the individual. Some CLDNSs were incensed when people from their cultural background had been portrayed by negative stereotyping, yet others seemed quite forgiving and made comments such as "I was not insulted … because the academics "really are making an effort to at least include cultural issues in classes" (S13). This particular student, however, went on to say "There can also be a lot of stereotyping … when they [academics] mention cultural aspects and … they [academics] don't go into them in enough detail" (S13).

Analysis of academic transcripts had also shown that, occasionally, academics had used students' names or their physical appearance as a base from which to stereotype. Whilst often these basic indicators were correct, there were times when stereotypical assumptions made on the basis of a student's name or physical appearance belied academics' assumptions and, as one academic, when asked to comment how she knew students were from a different cultural background, stated:

> Just um, by the roll ... and obviously the appearance … however, it's very easy to be … caught up with that when calling out a name and somebody answers in absolutely perfect Australian … because I guess we would get third generation students. (A13)

There were other examples of stereotyping used in classes that were discussed at interview, however, the point of discussing stereotyping in this context was to set the scene in which this study took place. CLDNSs also encountered stereotyping in clinical practice settings.

Stereotyping and the work environment

All student nurses studying in Australian universities are required to spend a specified amount of time working in a variety of clinical practice settings. The amount of time and specific areas depend upon the different State regulating authorities and specific curricula of individual universities. Many students had made reference, although often indirect, to encounters with stereotyping when discussing their experiences in clinical practice settings. For example, one student believed that clinical teachers "think … because … we comes from a different backgrounds maybe we need more time to be told things compared to others" (S24). This student did not offer any opinion regarding whether or not the comment was correct but saw this type of attitude as explaining why RNs had often chosen to work with members of the dominant group instead of her. On this occasion the student identified a common and often true stereotype of CLDNSs as reported by teachers. That is, students whose first language is not English actually did require more time and energy than members of the dominant group.

Stereotypes that were developed and perpetuated in clinical practice settings were often based upon RNs' one-off negative experiences of working with individual CLDNSs. For example, when RNs had worked with Lebanese students and their

experiences were negative they often made requests that the next student they had come from any other background. RNs making these types of requests took much convincing, by clinical teachers, that the next student they had from a Lebanese background would be different. In these situations the stereotype was dominant against the individual student.

In summary, stereotypes of CLDNSs were largely negative. Students had been stereotyped, for example as: being quiet, incompetent at classroom presentations, difficult to work with because of communication problems, nonreflective practitioners, oppressed people, and having strict parents. There were many other stereotypical images portraying students from diverse cultural backgrounds that negated the aspect of individualism. CLDNSs experienced different levels of discomfort or difficulties and problems in relationship to stereotypical images bestowed upon them. As previously mentioned, CLDNSs faced these issues because they did not always fit stereotypical images. When students were expected to behave in certain ways and they did not, they effectively broke the mould. Others around them were unprepared and took time to adjust to unexpected behaviours. Self-consciousness and feelings of not fitting in had also been evident in CLDNSs because they were aware that people around them expected them to act in specific ways. CLDNSs were not only aware of stereotypical images held by others but often disliked such imagery because they simply did not fit. These images, or beliefs, made CLDNSs uncomfortable and were often not true.

For other CLDNSs, the stereotypical images caused difficulties because these images were partially true and the students were unable to change their situation although some wanted to do so. Stereotypical imagery was evident in this study and had influenced those people with whom CLDNSs interacted and the interactions themselves. Clearly, these images impacted upon the student nurses directly and indirectly and so it was deemed relevant that the readers of this study be exposed to the more common stereotypical images held by the many people with whom these CLDNSs interacted.

Nursing Education in Australia

Readers should also have a general overview of the type of education programs students had to complete to become an RN in Australia at the time of this study. Simply

speaking, students attended university for either three or three and a half years. This depended upon which university was attended and, in Australia, most universities offered a three year Bachelor of Nursing or Bachelor of Applied Science (Nursing) degree. During this time, knowledge was gained on university campuses in classrooms or laboratories and this knowledge was consolidated and extended by way of clinical practice. Assessments took place during the course of the undergraduate degree program. These assessments were largely based on theoretical knowledge and took place on campus as formal assessments. In addition, students' application of theory to practice was assessed in clinical practice settings or nursing laboratories. Students were placed into clinical practice areas that exposed them to delivery of nursing care across the life span. In other words, students were placed in diverse clinical practice settings ranging from maternity settings to residential aged or palliative care units. Not all clinical practice occurred in hospital settings; students sometimes travelled to remote area communities or were placed in the local high school to work with the school nurse. Others had unique learning experiences, (e.g., nursing with the Royal Flying Doctor Service or working alongside RNs in state prison services). Theory was usually followed by a period of clinical practice.

Clinical Practice Assessments

Clinical practice assessment in this study referred to the evaluation process that all students underwent during the course of clinical practice. More often than not clinical practice was broken down into two or three different clinical placements attended by students over the course of each semester. Each placement was referred to as a clinical rotation. Clinical rotations may have been undertaken at the same or different health care agencies meaning students may have stayed in the one hospital for three consecutive rotations or they may have been allocated to different hospitals or health care facilities for each. Assessment was necessary to determine whether or not a student had met the objectives set for each clinical rotation. Clinical practice units did not occur in isolation and students' progress through their course was dependent upon passing clinical practice units as well as theoretical units based on campus.

At the time of this study Nursing faculties or Schools of Nursing across Australia based clinical assessment criteria upon the five domains of the Australian Nurse Competencies Incorporated (ANCI). All nursing students were assessed during the course of clinical practice using modified versions of these competencies. Modification existed so assessment matched the different levels at which student nurses were expected to perform depending upon their level of development and education. Variation in these assessment forms also existed because each Nursing faculty or school developed their own clinical assessment forms.

On the whole, clinical teachers commented that the assessment tools they used facilitated objective student assessments. Some clinical teachers, however, believed that the assessment structure could cause some students to fail their entire clinical placement due to substandard performance in one of the five assessment domains. This was viewed as a regular occurrence for students from different cultural backgrounds and failure specifically resulted from poor performance in the domain related to communication.

Assessment in clinical practice caused problems for many CLDNS for various reasons. Most students reported being affected in some way by clinical assessments. By far the majority found the assessment process uncomfortable due to stress. Many students had described these feelings as self-placed, or internal, but there were others who picked up on these feelings from external sources. There were also times when internal and external pressures and tension co-existed. For example, students often felt pressured when being assessed administering patients' medications. Under these circumstances students felt pressures of self-consciousness related to being assessed along with pressures to complete the task expediently because they perceived they were taking too much time and slowing other people down. Students had been told by RNs to "hurry up" during medication administration and during clinical field observations RNs were seen attending to other aspects of patient care whilst the students gave patient medications without focused supervision. The combination of pressure and tension, both internal and external, along with students' inexperience often resulted in nervousness demonstrated by tremulous hands and the students also had a feeling of being dissatisfied with their performance. Under these circumstances and due to the

lack of experiences of medication administration students needed extended periods of time to complete this task.

Whilst some students stated nervous feelings had only occurred on the first occasion they were assessed on newly acquired tasks others reported a constancy of feeling nervous whenever they were working and another person was watching. This meant nervousness was experienced even when the clinical teacher or RN simply accompanied them but were not necessarily engaged in formal assessment. The assessment process had been described as "nerve racking" (S15, S13) and something which made students doubt their own abilities. As one student said "You [are always] think [thinking] that whether you do the right [thing] or not … saying [to yourself] "Is there a small mistake or something that you didn't do right? And it [this] give you a bit of nervous, like a shaking" (S28). The fact that clinical teachers had also observed students' signs of nervousness, such as an inability to do as asked, was indicative of the stress experienced by many students. As one clinical teacher stated "If they are nervous everything [their prior learning] goes out the window!" (A114)

Generally speaking, CLDNSs made comments reflecting their understanding and acceptance that assessment by observation, even though perhaps culturally inappropriate and unfamiliar, was a necessary part of evaluation. Irrespective of this understanding most CLDNSs, not unlike members of the dominant group, found this form of assessment problematic. CLDNSs were thought to be in a more disadvantageous position than their counterparts from the dominant group because, as one student commented:

> Some people [CLDNSs] would find it even more nerve racking [than members of the dominant group] because they're not generally assessed like that. In their own country they've never had to do something like that so it freaks them out. It would be doubly disheartening especially if English isn't their first language and they feel that maybe they haven't understood … the way you accept constructive criticism …. I think you are vulnerable as it is because it's not your own environment, it's not your own cultural environment and to have to live through an experience like that, being observed and then having to take on board the criticism … I think it can be very difficult and … it may lower their self worth. (S13)

Another student's feelings of discomfort related to assessment by observation existed because she felt that being watched by RNs and clinical teachers highlighted to the patient that she was student, a beginner or a learner. And for another student the effects of assessment were described as follows:

> When some of the errors were pointed out I felt really bad…. I felt as though it was a fate worse than death…. I'd put the garbage bag on the wrong side [of the dressing trolley] and crossed over the [sterile] field and I didn't know what it meant … I remember feeling "Oh my God" because the facilitator actually said "If I were a patient I don't know if I wanted someone to do my dressing who crossed over and contaminated the [sterile] field". And I thought "God, it's something deadly … its life or death". But I just didn't know what she meant. (S25)

To compound this nervousness many students in this study described what the researcher has termed 'yo-yo assessments'. Yo-yo assessments occurred when CLDNSs had received a series of clinical assessments where a negative report followed a positive report. In this sense student assessment went up and down like a yo-yo, that is, one report positive, the next negative. From one perspective clinical teachers were incensed whenever they worked with CLDNSs who demonstrated what amounted to substandard communication skills but who had passed their previous clinical rotation without notation of communication deficits. From an opposing perspective other clinical teachers were appalled and saddened by the apparent insensitivity of their colleagues who assessed CLDNSs and subsequently informed the students that they had communication difficulties when they themselves had no trouble communicating with the students. This appeared to be the basis for this type of assessment. That is, one group of clinical teachers viewed the students' communication abilities negatively and another group viewed students' communication abilities positively.

The following teacher's quote illustrated this yo-yo type of assessment when CLDNSs received positive clinical reports: "they were very elated because apparently they had had quite a bit of criticism from their previous clinical [teacher] about their language problems" (A115). And another quote that highlighted this aspect, again from a clinical teacher: "he [the CLDNS] told me 'Last clinical I was told I couldn't speak English'…. I said 'Well I've got no problem with you at all!'" (A116). Yo-yo assessments seemed to create problems for CLDNSs because they did not know who or

what to believe. Students went into their place of clinical practice experience not knowing what type of assessor they would encounter.

Assignments

CLDNSs had reported having to complete written assignments related to clinical practice whilst working as student nurses in a clinical practice setting. Although students acknowledged that such assignments could further their learning they found these demands pervasive and believed these assignments detracted from their clinical learning experiences. This was due to time expenditure required to complete assignments which led to lack of sleep, resulting in tiredness during practicums which detracted from their learning whilst on clinical practice. In addition to being tired on clinical practice they were also tired for assignment completion. Students in this cohort claimed they had to spend a lot more time with their written work compared to English speaking students.

Clinical teachers and academics claimed all students, irrespective of cultural background, were assessed in exactly the same manner whilst on clinical practice. Although these claims seemed to stem from well-meaning, equity-based faculty philosophy they also acted to highlight the degree and unquestioning acceptance of ethnocentrism associated with student nurse assessment. Teachers knew of and talked about the differences they saw during assessments when they had CLDNSs in their clinical groups. They spoke of their awareness of the greater difficulties CLDNSs had when compared to students from the dominant group when they were required to make presentations, for example, in clinical debriefing sessions and they had identified CLDNSs as the student group most likely to have problems engaging in reflective practice.

Clinical Assessment and Assessor Availability

Student nurses' clinical skills were often assessed at the bedside by their clinical teachers who were employed by the universities but who worked with students in

clinical practice settings. Because clinical teachers were responsible for student assessments CLDNSs often experienced difficulties when having to interact. Although most clinical teachers would more than likely argue that they were readily accessible and willing to be involved in student assessment, CLDNSs frequently discussed their perception of clinical teachers being inaccessible or unavailable. Some students commented that the only time they saw a clinical teacher was for assessment purposes. At times CLDNSs seemed to want clinical teachers at their side and at other times they preferred the comparative independence of working with an RN. CLDNSs reported that they were uncomfortable using paging systems and telephones to contact clinical teachers. When CLDNSs were unable to consult with clinical teachers to clarify specific issues they usually went ahead and acted without clarification. CLDNSs blamed clinical teachers for not being present when they wanted them. This situation quite possibly also existed for members of the dominant group; however, the difference was that the most of the of CLDNSs did not seem to have the confidence or courage to make contact with clinical teachers to ask for needed supervision and assessment. Student comments were occasionally backed up by academics when they made statements such as "The sadness is we don't have enough time to spend with each student on clinical" (A118). In summary, when students were unable to access their clinical teachers in clinical practice settings they experienced problems. CLDNSs also had difficulties in the process of having to contact their clinical teachers. These are some of the types of problems CLDNSs faced because of the way their clinical practice was organised. These kinds of situations caused discomfort for CLDNSs in the form of anxiety and frustration.

Clinical Assignments

Most students had to complete one form or another of assignment whilst out in clinical practice settings, for example, physical assessment and patient history. These assignments were set by individual academics and usually had an ample time for completion. Sometimes these assignments were marked and graded whilst other times they were not graded but nonetheless had to be completed to achieve a pass in clinical practice settings. All assignments appeared to be related to the clinical practice setting to which CLDNSs had been allocated.

Interactions with Registered Nurses (RNs)

CLDNSs had experienced episodic difficulties when working with individual RNs in clinical practice settings. Students often disliked the many ways they had been treated by RNs. For example, some felt as if RNs dismissed them, ignored them, or tried to avoid having to work with them. Others indicated that they had lost learning opportunities to RNs because they had taken over and completed specific tasks. Some students believed RNs were too busy to teach them anything and their perceptions of RNs' personalities also affected interactions. Students also believed that some of the RNs with whom they worked were racist and acted in a discriminatory fashion. CLDNSs reported times in clinical practice settings where they felt RNs had dismissed, ignored, or avoided them. There were other times, at interview, when students had talked about their perception of being dismissed by the RNs with whom they had been allocated to work. Students believed RNs did not want them "tagging along" (S15). To make the tag leave, the RNs directed the students to do other tasks. These students commented they felt like "slaves" (S113) as they were often sent to carry out the so-called menial tasks of providing basic nursing care. CLDNSs expressed a desire to learn rather than complete such basic tasks as making beds or washing people. Students also reported feeling as if RNs had ignored them. RNs demonstrated ignoring behaviours towards students in many ways; some were more purposeful than others. CLDNSs had reported feeling as if RNs treated them as if they were not present. Some had perceived this treatment as a message that the RNs wished they would vanish. This perception was discussed in the following student's quote where she had been comparing her own part-time work place to clinical practice. She had said she enjoyed her interactions with RNs in her workplace "whereas on clinical, you know, 'Oh, students, Oh, you know, don't worry we'll just try and ignore them maybe they will get the message and go away'" (S112).

Some claimed RNs ignored them because they were "from a different country or can speak another language" (S10). Because of this they believed the RNs thought they would think differently too. This impression was created by RNs by their choice of words when talking to students and in their use of nonverbal messages. RNs' body

language was described as "closed" (S113) and was interpreted as dismissive. Students picked up similar messages when RNs left them "hanging" (S10) during conversations. When a student was left hanging, the RN did not answer the student. Rationales for RNs' behaviours were offered by academics who believed CLDNSs took up more of the RNs time leading to resentment. Effectively, whilst students were being ignored, or avoided, the RNs did not have to spend time teaching or supervising them.

From data analysis there were two types of avoidance behaviours identified. Firstly, CLDNSs reported RNs' actions to avoid working with them and secondly, the students acted to avoid working with certain RNs. In both sets of circumstances CLDNSs experienced discomfort. Students questioned whether avoidance or ignorance as demonstrated by RN preceptors was racially based. For example, one student spoke about an RN who, once she found out she had been "buddied up" with a CLDNS, changed her own patient allocation so that they did not have to work with the foreign student. On another occasion a student talked about standing at the nurses' station and being told who her patients were for that shift. When the RN she had been buddied up with realised she was working with her she said, pointing to another student, "If I have to get stuck with one of the students I want her" (S113). In this case the RN had pointed to the only "Anglo-looking student" (S113) in the group. From the CLDNS's perspective the RN demonstrated a preference to work with the "blonde-headed … like very much Aussie" (S113). Other CLDNSs had talked about their perceptions of RNs' discomfort following student allocation. The perception of racial bias was seen in the following student's comment "I think she wasn't feeling comfortable with me … it could be, I just don't know whether it would be my colour" (S24). Others had thought that RNs did not like working with them because they were stereotyped as having communication problems.

Together work

In this study the phrase 'together work' referred to those occasions in which CLDNSs worked with the RNs to whom they had been allocated. Preceptoring, buddying, and mentoring are other terms that do have specific meaning but are often used interchangeably. All student nurses experience clinical practicums under the supervision of an RN. This supervision may be indirect but usually occurs directly. In

other words, the student nurse works alongside an RN. Effective 'together work' indicated that RNs and CLDNSs worked collaboratively and co-operatively. Students spoke of different levels of together work. In the extreme, students would follow their RN preceptor everywhere; some even waited for their mentor outside the bathroom. By staying so close to the RN, students felt they got more opportunities to have hands on experiences. CLDNSs reported upon the many tasks they had performed under direct supervision of RNs and the list ranged from transferring patients from bed to chair to performing complex wound dressings.

At times policies existed that aimed to ensure together work. Occasions when CLDNSs were expected to work under the direct supervision of an RN included: during medication administration, performing procedures for the first time, and performing difficult or painful procedures. There are many reasons for the existence of such policies not withstanding patient safety. Together work ensures students receive one on one clinical education from an experienced RN. This acts to consolidate those procedures that have been taught theoretically in a classroom, plus or minus practically in a demonstration laboratory.

Lost opportunities and taking over

There were many incidents seen during clinical field observations and discussed at interview indicative of students losing learning opportunities because RNs took over. Basically, taking over was the phrase used in the following section to refer to those occasions where RNs or clinical teachers took learning opportunities away from CLDNSs by doing the required work themselves. The following extract from clinical field observations illustrated this concept of taking over:

> The participant attempts to take another patient to have her shower. This patient is to go to radiotherapy in about 40 minutes. He gets a commode chair and wheels it into her room. The RN comes into the room shortly after he arrives with the commode chair. She says to him "this patient walks to the shower". He says "Oh", and he exits pushing the commode. He returns to the room and says to the patient "I'm going to take you to the shower". The RN is still in the room and she takes over the organising. He lets her. After the RN had talked some more to the patient she leaves the room and then he starts to get the patient out of bed. Suddenly this patient (who was admitted with an affective disorder) develops left sided chest pain. He is about to leave the patient and go and find the RN when she returns to the room. He looks really concerned and he says to the RN "She's got chest pain". The RN takes over again. She tells him that this

pain is related to her condition and is not cardiac pain. Then the patient says to him "It's not me heart, there's nothing wrong with me heart". The RN suggests leaving this patient's shower until after she has been to radiotherapy. The student seems relieved and happy about this suggestion. He covers the patient with a blanket as she said she was cold. She seems happy enough sitting up in the bed clutching her painful chest. He seems relieved getting out of the room. (F.N.)

The preceding data extract evidenced how these "taking over" behaviours took learning opportunities from CLDNSs. Whilst members of the dominant group possibly had the same experiences they were thought to be better equipped to interact with the RNs and patients compared to the CLDNSs. There were many occasions when taking over actions of the RNs deprived CLDNSs of not only the physical, hands on experiences that all students need, it simultaneously removed opportunities for interaction with Australian people.

Too busy

Many students in this study had characterised the RNs with whom they worked as being too busy. Students felt the RNs did not have the time to spend with them. When students asked questions they were often told "I'm too busy" (S21) or "Ask me later" (S18); all too often this was not followed up. Patient acuity has increased steadily over a number of years and many would argue that patient to nurse staffing ratios have been too slow in catching up with patient acuity. Simply translated this means it is likely that RNs are busy and have little time to spend with students teaching them at the bedside. When RNs are at the bedside they are often pushed to complete essential nursing care; delivery of holistic nursing care is often impossible.

Interestingly, CLDNSs reported feeling that patients were pleased that they had the time to talk with them because the RNs were too busy. If, as was often claimed by their nurse teachers, CLDNSs required extra time to be spoken to or to be taught skills because of language problems it was obvious that the RNs' busyness impacted upon student learning.

Personalities

When student nurses worked in clinical practice settings and were allocated an RN mentor or preceptor, there were no choices given. Students were allocated to available RNs and student mentor suitability was rarely considered. Suitable matching

was overridden by RNs availability. If students and mentors did not get along very few students were reallocated another mentor. CLDNSs occasionally commented on their perceptions of personalities of the RNs with whom they worked and how these perceptions had affected their clinical learning. This aspect of is presented in the following chapter.

Behaviour misinterpretation

Overall student nurse behaviour varied widely, from those who seemed uninterested in activities happening around them to those who demonstrated initiative and a keenness or willingness to learn. Students from culturally and linguistically different backgrounds were often labelled as belonging to the former group. Some teachers, however, felt this description to be incorrect and instead believed that there was little understanding by many RNs of the cultural norms of students from various different cultural backgrounds. This lack of understanding and behaviour misinterpretation, as well as consequent reactions, are manifest in the following teacher's comments:

> Depending upon the staff member's cultural background because the staff member feels that this [CLDNS] student isn't motivated, doesn't want to be there, so they then switch off and say "Well, I'm not going to show you anything, I'm not going to assist you, you don't want to be here. Whereas actually the student wants desperately to be there but doesn't have the mannerisms that go with our expectations of being motivated and … enthusiastic so the staff get very tired by students all the time. Sometimes this is just enough, they say "Look just go and make beds with that person." They don't have the energy to find out if it is just a cultural difference or if the student is really bored. If the student shows signs of boredom or lack of motivation they [RNs] very quickly switch off and … let them stand and observe. (A113)

CLDNSs had indirectly discussed their reasons for looking as if they lacked initiative in respect to patient care. Sample reasons follow:

> You don't want to go and initiate on your own … care because you think that well they could just turn around and tell you off. That would be just so embarrassing .… it's really scary …you feel intimidated and even if you want to do something you are not going to ask … because you don't want to get your head snapped off. (S112)

Under these and similar circumstance CLDNSs were hesitant, or avoided, initiating patient care because of their judgments of the RNs with whom they had been working.

At other times students were viewed as always seeking permission to attend patient care. Most RNs wanted students to initiate patient care and not ask permission to attend to patients' needs. Yet students from different cultural backgrounds often felt they were obliged to seek permission. This obligation was borne out of respect for the RN, that is, the senior person. Whenever students' and clinical teachers' expectations were mismatched and it appeared that the students did not live up to expectations the students had difficulties. Furthermore, in order to demonstrate the difficulty some students had with this issue it is worthwhile pointing out that at least two students did not comprehend the meaning of the word initiate.

Effects of feedback

Feedback simply meant that CLDNSs had been given some information about how they were performing. Feedback occurred in written form as well as verbally and nonverbally and could be positive or negative. CLDNSs had reported receiving both positive and negative feedback from staff with whom they had worked as well as academics who marked their written assignments or graded their classroom presentations. Naturally, positive feedback made students feel happy and satisfied whilst negative feedback did not have the same effect.

There was a full range of reactions from CLDNSs regarding assessment feedback. At one end of the continuum students were clearly upset when they received negative feedback and at the other end of the continuum students were content with positive feedback. Throughout this range, however, there was an underlying feeling identified in student transcripts where, in some way, students cast doubt over their assessments. Even those students who received positive feedback via assessments evidenced this doubt. One student, for example, saw her reports of being "pleasant and quiet, easy to work with" (S32) as a pass but also viewed these comments as her own inability to "stand up and speak up for herself" (S32). Rather than seeing herself as "quiet" and "easy to work with" she saw herself as compliant, passive, and unable to challenge or critically reflect or analyse. As she said "I don't … analysis [analyse] and critically look at it … and say … maybe this is not right and we should do this and that" (S32).

At other times students felt they had been unfairly assessed, and one student went as far as saying she had been made out to be an "incompetent moron" (S27). Another student reported feeling as if she never achieved anything positive and often felt like a failure because she had never been given positive feedback.

Working with Other Students

Student nurses rarely work in total isolation. They usually work as part of a team, in pairs or in small groups. Working with members of the dominant group had at times created problems. These problems largely occurred due to cultural differences. Students cited incidences that occurred during classes in which they had become upset because of the way they had been treated by members of the dominant group. One student discussed how members of the dominant group would always send her to collect materials they would need to work with during the laboratory session. She had felt left out even though she was assigned to work with these students in a group. This student had discussed her desire to be treated the same as the other students in the group but felt she could not ask for this to happen. The dilemma she experienced was evident in the following quote:

> I can't go and argue with them all the time or I can't come home and be eyes full of tears … some days I was driving and I said to myself "How? Why, why is like that? Why I'm not in a good group? (S32)

Younger Asian students had experienced significant problems when working with older Asian students. This was not the case for all Asian students but enough had brought it up in discussion warranting investigation. On occasion when young Asian students were allocated to work in groups with older Asian students many felt obliged to show the older students respect and a degree of traditional courtesy. In real terms this traditional courtesy and respect meant younger Asian students had to allow the mature aged student to dominate; younger students felt obliged to allow older students to take control. When assignments had to be completed conjointly younger students commented that they did most of the work and felt this was an expectation of the older students. There were also occasions when young Asian students reported having to hold back and allow older Asian students to speak first. If the older student did not speak then it was inappropriate for the younger students to do so. Infrequent lapses of

disrespectful behaviour were quickly identified by the older students and brought to the younger student's attention. For example:

> Every time we do group work we got a very hard time, [I] work with my friend, we always get … argooment [argument] … it's awful …. every time when I, we, we, work and I want to say something … I just feel like friendly, you know, just, OK, I want to talk, I'll jump in and talk, and then she [mature aged Chinese student] said "You can't do that, you can't do that" and I have to say "Excuse me, can I say something". I just have to do that, and when I jump in and I say something and she just ignore my thing and she just continue and afterward I feel very … awful … like you [are] nothing … in that group and then when she get back and ask me what I want to say and I really upset and say "Oh, I think I forgot now". And I don't want to say anything … she just yell at me. (S21)

According to younger students interviewed, older Asian students not only did less work, they commanded parental type respect. No academics or clinical teachers discussed this issue or anything similar during interview; in fact they seemed unaware of these types of situations.

<div align="center">Other Differences</div>

CLDNSs had talked about and demonstrated many other ways of being different to, and not fitting in with the local student group. Most of these ways have been collapsed and conceptualised as the basic social psychological problem and labelled as sociocultural discord and will be presented in the next chapter. By far the major difficulties for CLDNSs were differences related to communication; however, the description of the environment in which CLDNSs studied as described above was also relevant. There were other elements that impacted upon CLDNSs from a broad perspective and these were: the multiplicity of learning, methodological speed, and taboos. All three are part of cultural background that need to be considered when working with student nurses from different cultural backgrounds.

Multiplicity of Learning

CLDNSs had spoken of the many differences between themselves and others and the problems that existed because of these differences. These have been addressed elsewhere. However, the gestalt, or the multiplicity of learning, also needs to be considered. Students had a whole range of issues which they dealt with on a daily basis,

for example, looking different, accented English, studying in another language, and mixing with new people. The cumulative effect of being different and not fitting in, of experiencing difficulty or discomfort on social and cultural fronts clearly impacted upon CLDNSs.

CLDNSs spoke of the many aspects or multiplicity of their learning, including for example, how to act as a student nurse, new terms and phrases, professional culture, how to study at university level, how to integrate with student nurses from the dominant group and how to interact with patients and other health care professionals. This multiplicity of learning was seen in the following student's data extract:

> Coming from a different background with a different educational system … as well and coming here is a totally different thing. I find it's like learning, at the same time while you [are] learning … the … educational system and learning the way to do things and learning how my class mate sort of interact with … each other like, learning that culture and learning that educational system at the same time while I trying to integrate … like learning everything, basically yeah …. It's a huge (pause) you know, it's like overwhelming. (S22)

Multiplicity of learning impacted upon CLDNSs. They had to learn how the education system works as well as get through the required study for their course. They had to learn about new cultures and the profession of nursing as well as how to survive these, all the while being considered as being different.

Methodical Speed

In addition to the multiplicity of learning, CLDNSs were perceived by teachers as being methodical in their approach to their work, especially in comparison to members of the dominant group. Teachers held this belief because they had observed CLDNSs at work, taking time to go through procedures step by step. Working methodically amounted to taking more time and CLDNSs were often labelled as being too slow. Teachers believed CLDNSs worked methodically because they were unable to make assumptions or take anything for granted about any stage of their work. In comparison, members of the dominant student group worked with the benefits of cultural knowledge or worked within a framework of cultural congruence. In other words, they already knew and were comfortable with the environment in which learning

took place. By not having this same frame of reference CLDNSs were bound to be slower than members of the dominant group. This slowness inevitably led to problems for CLDNSs because the people with whom they worked had other expectations.

The following example will help clarify this notion of methodical behaviour. Members of the dominant group quite possibly have all used Paracetamol, that is, tablets, capsules or liquid. Paracetamol is better known as Panadol and it is a simple 'Over the Counter' analgesic. It is also widely used in Australian health care settings. Yet CLDNSs may well have come from other countries where Panadol is either not available or better known by another name. Local students will have processed this information more quickly while CLDNSs are faced with another new concept. In other words, step by step learning had caused problems for some CLDNSs because it took them longer than others to complete procedures and understand new concepts. Students from the dominant group were able to take a lot more for granted compared to the CLDNSs. In clinical practice settings slow students were often treated by RNs with disdain. This treatment led to issues for CLDNSs and these will be discussed in the following chapter.

Taboos

The term taboo refers to "the system or practice, or an act, whereby things are set apart as sacred, forbidden to general use, or placed under a prohibition or interdiction…" (Delbridge & Bernard, 1998, p. 1190). Few CLDNSs actually referred to taboos per se; however, there were indications amongst student data that specific subjects were not easily discussed, almost as if there was an existent taboo. Example subjects included: issues related to females caring for males, looking after patients who had tried to commit suicide, discussing failure, verbalising dissatisfaction with poor teaching standards, and discussing anything that students considered of a negative nature. When these issues arose during interviews CLDNSs used extended pauses, a lot of sighing, and their otherwise relative comfortable demeanour changed. When students demonstrated these changes they were encouraged to shed light on these issues and reminded of their anonymity. Of these uncomfortable situations shared by CLDNSs the most poignant issue was raised when a student recollected her experiences of caring for a young man

who had attempted to take his own life. The following student data extract demonstrated discomfort evidenced by the content and stilted dialogue:

> This guy, who came to me was …admitted there and he'd (pause – extended pause), he had actually committed suicide and (pause)… sorry, attempted suicide and he was (student pauses), I (extended pause), like we had to care for him and after, during one of my breaks after caring for him (student pauses) I sat there and I thought … if he was in my country no one would come and help him. He would be like the lowest of the low because like (pause), attempting to take your own life is just taboo. That kind of thing, is just a bad thing. A bad thing to do because it's like (student pauses) … very religious … at home … it's, it's, it's, for something to be taboo, you can not do and if somebody else actually does it, you can't associate with them either. (S18)

Clearly, these types of situations had the propensity to lead to culturally based dilemmas. Culturally, students knew they were working in prohibited areas yet to get through their clinical placement and pass they were aware they had to care for all patients irrespective of their own beliefs. Although rare, taboos and other cultural beliefs impacted upon individual students from different cultural backgrounds.

Families

Many of the CLDNSs interviewed for this study came from close-knit families and whilst such family structures were often supportive there were other occasions when the students' families were the root of much emotional turmoil. This turmoil and a whole range of other emotions existed for CLDNSs because of strong issues related to family history, parental expectations, and commitments that were different to those of the student nurse from the dominant culture. Nguyen (cited in Pryor, 1998, p. 32) supports this when he states "Language barriers between parents and children, different education levels and high parental expectations combine to place strain on children in migrant families". Problems occurred as students' family members went through processes of adaptation, often one or two steps following the student. Others described situations in which family members were unable to adapt. Participants from families who were slow to adapt or non-adaptive experienced more problems than those students whose families adapted easily. Vasta (cited in Pryor, 1998, p. 32) stated:

> It's pretty scary when they go to a new country. They find there are all these cultural traditions that are alien to them … the children have probably integrated

> a lot quicker than the parents … picked up the language a lot more quickly and
> are well on their way

There were quite a few families represented in this study where the participant was the first, in an often extended family, to attend university. Many parents were known to want opportunities for their children that they did not have. The following student's quote demonstrated this uniqueness of being one of the first, if not the first family member to study at university:

> Perhaps [I have] … different expectations, like I was saying out in the corridor my sister and I are the first from both sides to go, of the first generation to go to university because it wasn't expected of either really and especially because we are women and so I guess because I don't just accept this as being, I've had to, more things have been different for me than opposed to other people say … because I don't just accept everything as cut and dry, or as a given to me because nothing has been handed to me on a plate. In a way, I guess, I think more about things which affects my nursing and I am likely to analyse more things and not just accept that's just the way things are. (S17)

Students from this type of background felt a constancy of pressure to succeed and they did not want to disappoint their parents and other family members. Some were also aware they were role modelling, in a positive way, for cousins and siblings.

From a different viewpoint other CLDNSs spoke of their parents not being particularly happy with their choice to study nursing at university because as far as their parents were concerned nursing was an occupation of little status and little pay. They did not believe nurses needed to study at university to gain a degree. Parents held these types of opinions about nursing because in their home countries nursing was considered a lowly job and certainly not a profession. Parental opinions related to the nursing profession were similar to those portrayed in the following student's quote:

> In Turkey its [nursing is] basically like, pardon my language but, cleaning up shit and you know looking at people with nothing on … and just being ordered by doctors. You're not being, you know, this self-directed, you are not being the actual manager of what you are doing. (S115)

Other parents had contributed to CLDNSs' discomfort by expressing their desire for their children to have studied something else aside from nursing at university. As one student said:

> My Dad thought I would be like a teacher … because my sister went teaching …
> I never thought I was going to do nursing until the last minute …. I thought … I
> was going to be doing teaching, primary school teaching. (S14)

When discussing parental reaction to career choices another student had said "It's more like um, ok, if you get into education that's a very good choice but nursing mmm, that causes a bit of a fuss" (S214). Law and medicine were also considered good career choices by many parents, but not nursing. Many students' parents had expectations that their children would study other professions and not nursing. Noticeably, those professions that have a greater earning capacity and perceived social standing in the Australian community were preferred by parents.

Some of the Jewish nursing students interviewed in this study spoke about parental and Jewish community pressures to study so called "high status jobs" (S214) in preference to nursing because a position of higher status drew a better income. According to one Jewish student, when Jews studied nursing, community members were inclined to question "Well couldn't you get enough marks for medicine or law?" (S214). CLDNSs also experienced a degree of pressure and discomfort related to the expectations of relatives aside from their parents. For example, a student had said: "My Uncle … he comes up to me and he goes "So you're doing nursing?" and I go "Yeah" and he goes "Couldn't you find a better job?" (S14). Whilst these comments could be seen to reflect a wide-spread view of the nursing profession and a view that was not exclusively held by members of the Jewish community many other people do believe nursing to be a profession and a rewarding and satisfying job.

Familial expectations were not all negative. There were other students in this study who talked about wanting to become nurses because they viewed nursing as a positive part of their family history. Many of their relatives either had been or were still nursing. This familial tradition of nursing was demonstrated by the following student's comment:

> I love it [nursing] because a lot of my Aunties are nurses, they all trained in
> places like South Africa … and they are really happy with me doing nursing,
> they were really overjoyed … a lot of my Aunties back home that do it as well …
> because it's a very common thing for coloured nurses. (S212)

Yet for some CLDNSs the fact that other people in their family either had been or were nurses created pressure in the form of expectations that they too would become a nurse when in reality they would have preferred to have chosen a different career altogether. An example of this type of situation follows:

> You see my Mum's a nurse and my … most of my family like other cousins they're all nurses and … my Uncle is a lab technician and well my parents also wanted me to become a nurse … I wanted to take a psychology course but here I am doing nursing. (S19)

Parental expectations were also evident when a father had accepted his daughter's decision to study nursing but he wanted her to become a midwife because as he said "It will be good for … the Lebanese community" (S14). This student experienced conflict between her desires and her father's expectations because she had developed an interest in surgical nursing and thought she would never become a midwife or work in the Lebanese community.

Academics were also aware, and had discussed examples, of familial pressures that some overseas students had to bear whilst studying nursing in Australia. These comments were related to students who felt an enormous amount of pressure to pass their examinations because their families back home had to do without many of the comforts they were used to in order to pay the student's university and course related fees. These students were thought by academics and clinical teachers to have experienced more pressure to pass, irrespective of personal cost, than most because of their family's situation back home.

CLDNSs experienced familial pressures amidst cumulative pressures of studying. As one student said:

> I, I, I just go home and I stress on my family, on my mum and sister … and I go home and I said well I'm, I'm, I, I, I'm the only one that that, that, that dummy, the most dummy girl in the family (laughing) … as well … as … you know because everyone is expecting me too much [too much of me]. (S12)

Older female students discussed parenting school aged children and their commitment to childcare and running a smooth family home. As one student commented "I don't mix [with the other students] a huge amount … I've got heavy domestic commitments, I've got two children … a husband and a house … it's a big domestic commitment" (S111).

Others said they had no time to attend English language classes or study support classes because they had young children in daycare centres. When they were not attending formal university classes they wanted to spend time with their children or wanted to be at home with their families.

Individual CLDNSs, who lived at home with their parents, spoke of the difficulties they experienced when family members pressured them to maintain traditional beliefs and values and to behave in specific ways. For example, some parents wanted their children to do as they were told; they wanted them to adhere to traditional beliefs, which for many meant that female students were expected to adhere to strict roles. Some were expected to be at home whenever they were not in formal university classes or on clinical practice. Academics had reported that under these living conditions students endured many problems that often prohibited them from mixing with their peers, as the following data extract showed:

> The mothers can be extremely protective which frustrates the students tremendously. They don't have any time to unwind after class with peers, they can't go to the library because mother … will be waiting out the front. One of the students I had last year, had the most horrendous time …. (A113)

This academic went on to say this student was:

> Terribly distressed, no matter what she could do, what she did was never right because she should not have been looking after herself, she should have been at home with the family, or going out with good Lebanese boys, or looking for Lebanese husbands. (A113)

In some families nursing studies came third after tradition and family. Under these circumstances students experienced many problems related to conflicting values.

Others lived with different types of familial expectations that also caused what seemed like insurmountable problems. Some students were obligated to care for aging family members and to contribute to family earnings. This led to varying dilemmas or difficulties for students because, even though most felt they lived up to expectations, they believed they really did not have the time to get involved in the family business on top of their university studies, nor did they have time to care for elderly relatives. Academics felt that CLDNSs living and studying under these circumstances were "Very, very disadvantaged". One academic went on to cite an example of "This little

Vietnamese student … working in her parent's take-away food shop until the early hours of the morning" (A111). The academic was concerned for this particular student because she often fell asleep in classes. Students who came from business families who chose not to work in the business discussed being aware of the covert pressures they felt from their parents to do so. Additionally, there were expectations placed upon some students to eventually take over the family business even though they had no interest in doing so and were studying nursing.

Aside from having to care for elderly family members and work in the family business, when there was one, CLDNSs mentioned other problematic familial expectations. Students spoke of having to spend time with their families. This meant they were expected to do things together as a family or just be at home as part of the family. This 'spending time with the family' not only detracted from valuable study time causing stress but also acted to prevent students' involvement in other university based activities or prevented them mixing socially with their friends. Familial expectations and the resultant pressures were evidenced in the following student's comment related to attending language support classes.

> It's [I] find [it] difficult because you know we don't have time …. I find the nursing course is very stressful because I have not just the knowledge also have to cope with the language … and I have to still be with my family. (S20)

Further, some female CLDNSs spoke of strict paternal expectations to not mix with males. This caused problems for female students because firstly, they had male colleagues, secondly, male teachers, thirdly, they worked with male RNs and of course male patients. During interviews, students discussed knowing of these types of parental expectations even though for some students these expectations had not been discussed openly at home. For example, a student spoke of her father's disapproval of her mixing with male students because it was "not done" in his culture and went against his traditional beliefs. Such parental beliefs and expectations had led this student to experience discomfort because she did mix with male nursing students. In fact, at the time of interview she had recently completed making a video, for assessment purposes, with a male colleague. Once the tape had been graded and returned, she had to get home, before her father came home from work, to record over the tape so her father

could never see evidence of her mixing with a male student nurse from the university. The video tape had to be returned home because her father had made the purchase and she knew he would check for the return of the tape.

Another female student expressed discordant feelings she experienced by having to refuse a lift to and from clinical practice repeatedly. This student could not accept the lift because it meant she would have to travel in a car with a male. This student faced a number of dilemmas related to being different and not fitting in. First, she was worried that her father would find out she had been offered the lift. Secondly, she had to decline the offer on a daily basis, and thirdly, she had to decline the offer even though she would have preferred to accept the ride to clinical practice instead of using public transport. There was another issue at stake for this student too. The male student offering the lift to and from clinical practice was also from a non-English speaking background and because he did not understand the reasons for not accepting his offers he asked her every day. In the end she believed he felt offended by her regular refusal. This had impacted upon their developing friendship.

CLDNSs also experienced problems when they returned home after mixing with members of the dominant group and tried out, or practiced, new ways of interacting with family members; so called Australian ways. Students had told academics that it was "A really tough juggling act … if we go home and we sort of behave like our Anglo-friends then we get into trouble because that is not the way we do it in our family"(A17).

Many of the participants in this study spoke languages other than English as their first language. Students came form many different types of families. Some parents and extended family members actually encouraged students to use English at home. The aim of using English at home was to help the student to improve their English. Such encouragement and support had occurred in some homes where English had not been used previously. In contrast, other students spoke of intentionally using English at home, irrespective of their parental wishes, because they knew this to be the only way they could improve their English language skills. These types of situations caused many dilemmas for students because their parents often could not understand English. Students reported feeling sad for themselves as well as their parents because there was a

concurrent and mutual sense of loss, or a moving away from tradition and culture. This situation was exemplified in the following student comment:

> Sometime I just feel very sad to my Mum because sometimes I just speak it out in English. But I wasn't like, I wasn't mean it. And she is very sad about it because my Mum, she can't speak English … so you [I] feel sad about speaking English to Mum, to my Mum … but with my Mum it's different and she also get, she also feel, [it's] tough for her too because her own daughter's speaking English to her and she don't know what it talking about … so you start to get further, even more further away from your parents. (S12)

Another aspect of familial related problems occurred when students had to help their parents understand aspects of Australian nursing culture. Parents were known to have disapproved of, or expressed their dislike for, specific nursing interventions such as females showering males. Female students reported their fathers as reacting negatively and some fathers had told their daughters "you are not to be doing those kinds of things" (S115). A small number of fathers were reported to have backed down from their original stance over time and made inquiries as to whether gender-opposite nursing care was the norm in Australia. These kinds of incidents had caused frustration amongst CLDNSs because initially they were told not to have these types of interactions with male patients. Then their fathers seemed to make adjustments but the frustration existed due to the father's slow process of change and their need to revisit this issue regularly.

Academics too had discussed familial adaptation processes or family changes that they knew had occurred. These participants spoke of "good family relationships" (A112) in which a lot of "give and take" (A25) had occurred. Parents, nevertheless, were reported by academics, as well as by students, as being the cause of much emotional trauma for CLDNSs, especially in the first twelve months of their course.

During their undergraduate nursing degrees CLDNS worked through many difficulties stemming from moving away from familial and cultural norms. Students had often come from families with long and sometimes harsh histories in which family members held nursing in low esteem. Parents were usually open and honest about their disapproval of their children studying nursing and most of these students lived at home facing this disapproval on a daily basis. Those living in the family home were usually expected to abide by family traditions and customs leading to further discomfort or

discord for students who were trying to make their own way through university. From an outsider's view, students in this situation seemed to straddle two cultures, that is, their parent's culture, which may have originally been their own, and Australian culture. Discomfort existed for these students at home and at university. Further, students did not purposefully set out to disappoint their parents but many course requirements and student outcomes met with parental disapproval. Some students were able to avoid parental disapproval by not telling their parents about issues or situations they knew would be met with discontent. However, this omission, whilst aimed at avoiding parental argument really acted to cause more discomfort because it was not shared at home and the students felt they were being deceitful.

Whilst members of the dominant group may have experienced similar problematic episodes by trying to meet family expectations, CLDNSs had more difficulty due to co-existing problems. For example, language barriers, cultural differences, parental expectations to adhere to the 'old ways', and stereotypes that were used by many of those whom the CLDNSs had contact.

Roles

CLDNSs were exposed to the many and various roles that the RN assumes during the course of his or her workday. Students also had plenty of roles they too needed to fulfil on a daily basis. As background, these also need consideration. Because dedicated roles exist in universities as well as health care settings they become part of the background to the study, forming part of the conditions under which CLDNSs studied. CLDNSs were exposed to many different roles during the course of their undergraduate nursing degrees. The lack of familiarity with many of these roles caused problems for CLDNSs initially because they did not know how to interact with members of the dominant group in these roles. Instead, students acted and interacted as their culture and traditions dictated. In other words, they acted in ways to which they were accustomed, often inappropriate in Australian universities and health care settings, leading to difficulties for those concerned. The following section looks at these various roles and subsequent issues as experienced by CLDNSs. In this sense 'roles' becomes part of the background to the study.

Student Roles

All students interviewed for this research had attended universities where curricula addressed the role of the student nurse. Students had the opportunity to expose themselves to learning this role and most knew what their role entailed. However, culturally-based problems were uncovered indicating that not all students could fulfil their student nurse role. Many of these culturally based problems have been identified previously, for example, interaction with authority figures or not speaking in classes.

Others thought they were meant to do everything they had been told and when they were told to do something with which they disagreed they had to do it anyway. Because of these beliefs many CLDNSs never tried to enter negotiation with their teachers or the RNs with whom they worked in clinical practice settings. At times, to avoid challenging the RN, students simply did not do as they had been told. Others did as they had been told but experienced difficulties because what they were doing was different to what they had been taught at university.

Problems had also been experienced by CLDNSs in clinical practice settings when they watched RNs give medications to patients without first checking the patient's medical record number via their identity band with the patient's medication chart. Students had experienced difficulties on these occasions because they believed it was not their role to tell the RNs they were meant to check the patients' identification before they administered medications. In fact, the majority of CLDNSs believed they were meant to act passively in clinical practice settings and do whatever the RNs told them to do. On the odd occasion, when they did question how things were done, RNs made comments along the following lines: "This is how we do it here" (S23) or "You're in the real world now" (S31). Those who received these types of comments never entered further discussion; instead they did what they were told, or they did nothing. Whilst it could be argued that local students may well have similar experiences those from culturally diverse backgrounds were known to be less assertive from the outset.

There were exceptions to this characterisation, for example and as previously discussed, male nursing students who came from Middle Eastern backgrounds. These students had tried to usurp the role of female teachers and often questioned her authority.

Furthermore, female clinical teachers commented that male student nurses from the Middle East seemed to have problems accepting being told what to do irrespective that they were told by an RN. These clinical teachers felt that this probably had something to do with differences in cultural backgrounds, specifically men from the Middle-East being dominant, powerful, and aggressive. Under these circumstances it was not believed possible that female clinical teachers or RNs could act as role models.

Teachers as Role Models

Teachers from academic settings occasionally talked about themselves, and their colleagues, as being positive role models for CLDNSs; however, there was little evidence from analysis of student data that students aspired to be like their teachers. Regardless that the CLDNSs did not visualize themselves as ever becoming an academic they had commented about RN role models. Whilst few could articulate their aspiration of becoming a good RN many had strongly identified the type of RN they did not want to become. In clinical practice settings where positive role modelling took place some CLDNSs experienced difficulties because they anticipated problems acting in similar ways. When negative role modelling had occurred students experienced dilemmas because they recognised that they had not been taught what they had seen but felt pressured to carry out procedures in the same manner.

Negative role modelling took place whenever RNs and teachers acted inappropriately or out of line with the students' expectations related to professionalism. The issue of negative role modelling was not only discussed during interviews with CLDNSs and teachers, it had also been observed during clinical field observations. Participants spoke directly and indirectly of times of negative role modelling. Indirect reference of negative role modelling was demonstrated by the following teacher's quote:

> I think there are people who are just cut and dried, besides um, black and white and um, the rules are this and that's all there is to it and I believe they [my colleagues] don't treat people [students] as individuals. I mean we try to tell that to our students. We tell them that the patients are individuals but they don't always get a lot of examples along the way. (A13)

Other indirect references to negative role modelling were more subtle and only uncovered by comparative data analysis, for example, one CLDNS had discussed her

disappointment of an omission of cultural issues being addressed during a mental health lecture because the academic had run out of time. The student believed that this sent a clear message to all students "when things had to be trimmed, cultural issues were the first to go" (S17). All of these incidents and many more, caused confusion for CLDNSs because they sent subtle, mixed messages. For example, students were led to believe that cultural issues were less important than other issues because they could be left out of lectures and that it was acceptable practice to take short cuts during medication administration.

Cultural Role Models

In this study a person was looked upon as being a cultural role model for CLDNSs when they were non-Anglo-Saxon and worked either as an RN in clinical practice settings or as a teacher of university nursing students. There was a common belief amongst academics and clinical teachers that very few cultural role models existed in university settings as well as the workplace. This belief was supported by the small number of teachers interviewed who were born outside of Australia. Most of these teachers were from English-speaking countries and relatively few came from countries where English was not the dominant, or first, language. Teachers also believed that the current lack of RNs from different cultural backgrounds sent negative messages to CLDNSs in clinical practice settings. Whenever CLDNSs entered clinical practice settings they were aware of being a minority and that they had few people who could truly be empathic towards their situation. Essentially, they had a limited number of role models or mentors.

Interacting with Teachers

It is not uncommon for CLDNSs to treat academics with more respect and regard than students from the dominant group. It is a well-held and documented belief that Asian students, more than any other cultural minority group, regard the role of the teacher highly (Kaputin, 1993). Teachers were perceived as the learned and were therefore the authority figures. People in authority commanded and were given respect and they were not approached for anything, especially not asking of questions. Most

CLDNSs appeared to hold this belief and interacted with academics and clinical teachers accordingly. There were positive and negative effects of these beliefs for both students and their teachers; however, it was the negative effects for students that were of interest in this study.

Differences had affected interaction and communication between students and teachers. As this study investigated culturally and linguistically diverse nursing students' experiences of studying nursing, readers are guided to consider teachers or academics in a traditional sense and to include those nurse teachers who worked with student nurses in clinical practice settings. Many CLDNSs were too intimidated to approach those they held in esteemed positions. Others believed they could not ask questions and when they had approached teachers they became nervous, tongue-tied and made speech errors; they felt self-conscious and embarrassed. These students were more inclined to ask other students questions or they would try to approach teachers after formal class time. However, when CLDNSs approached teachers after classes, teachers were often busy with other commitments. Many students chose to avoid feeling self-conscious and embarrassed by not interacting with their teachers.

Some believed that speaking in class was a form of showing one's disrespect for the teacher. Other students believed if you spoke in class you were challenging the teacher therefore they refrained from speaking. To demonstrate one's respect students were meant to be silent. Interaction, attempted interaction, as well as avoidance of interactions with teachers all led to difficulties for these students. Problems existed for those who avoided interaction with teachers because they studied in an environment in which the majority did interact with teachers. Because they did not interact, they were different.

Female CLDNSs were believed by teachers to have experienced greater amounts of discomfort when the teacher was a mature aged male because older men were also viewed as father figures. Female students who held this belief were reported as having great difficulties in communicating with mature aged, male teachers. A male teacher, fitting this description, had described female students as being shocked when he first met them in clinical practice settings. This layering of role upon role created barriers

between female CLDNSs and male teachers further obstructing student interaction and learning.

Academics reported feeling awkward when CLDNSs behaved in traditional ways. There were occasions when academics did not know how to deal with culturally specific behaviours and they admitted to feeling uncomfortable when confronted with these behaviours. In these types of situations a certain irony existed because both students and their teachers were inhibited by each other's behaviours and they tended to avoid each other. Teachers had identified specific parts of their work with CLDNSs as problematic because, for example, they were not sure whether or not to encourage students to participate in class or let them sit in silence. CLDNSs could easily have been considered disadvantaged when they were in classes in which teachers were unsure of how to interact with them. Where student learning took place in small groups and input was expected from every student, teachers were inclined to want to see, and, more to the point, hear all students contributing. Many, having encouraged CLDNSs to participate in classes by asking them to contribute, reported being aware that direct as well as indirect questioning placed CLDNSs in a position where they experienced discomfort. Academics found themselves being unsure of what they should do, that is, leave the students alone and allow them to be silent or ask them direct questions with the aim of getting them to contribute.

Furthermore, academics spoke of being attracted to members of the dominant group in classes because they were the student body contributing and interacting. The behaviour of these students appeared to be more conducive to learning, so it seemed natural for academics to be drawn to this group. The downside, however, was that the quieter CLDNS group was often ignored or left out. Whilst these situations caused dilemmas for some teachers they were also seen as leading to problems for CLDNSs because they were aware that they were left out of classroom interaction. Those who were bothered by being left out of classroom interaction experienced other forms of discomfort and self-consciousness when they attempted to participate in classroom interactions. Basically, CLDNSs had experienced problems whether they participated or not. These will be discussed in the following chapter.

Summary

This chapter has identified and described aspects considered important as the contextual background of this study. These included the sociopolitical climate at the time of the study, the effects of the popular media, cultural diversity, stereotyping, nursing education, working with RNs and other student nurses in clinical practice settings, studying nursing on an Australian university campus, being different, familial issues, and various roles. These aspects of background to this study were considered important because they impacted upon CLDNSs experiences of nursing education. They described a context of disharmony that formed the world of the CLDNSs. It was this world in which CLDNSs lived and studied and as such background issues affected the students' actions, interactions and reactions not only in clinical practice settings and at university, but also within their own homes.

Chapter 4 identifies, defines, details, and conceptualises the difficulties the CLDNSs had being in this world. As such these difficulties are known collectively as the basic social psychological problem, SD, that is, sociocultural discord: being different and not fitting in.

CHAPTER 4

Sociocultural Discord: Being Different and Not Fitting In (SD): The Basic Social Psychological Problem

Any basic social psychological problem identified in grounded theory research refers to the main concern or problem shared, but not necessarily articulated, by the primary participants. Individual participants experienced the basic social psychological problem in a variety of ways and tended to discuss it in much the same manner. There were, however, other participants who referred to their experiences in a less direct way but, nonetheless, their discussions were reflective of the basic social psychological problem. In addition, there were other participants who spoke about the same issues but from a different perspective, because of differing influencing conditions. These individuals are referred to as negative cases and their information and perspectives are also considered in this grounded theory research because they add richness and completeness to the study.

All students in this study self-identified as being different to members of the dominant group. They saw themselves, and were seen by others with whom they interacted, as being different. These differences caused experiences of discomfort. These experiences of discomfort have been referred to in the previous chapter, which described a context of disharmony, by words or phrases, for example, as being self-conscious, upset, or worried. In this study discomfort caused by being different and not fitting in, along with the consequences, was labelled as sociocultural discord: being different and not fitting in (SD). Discomfort was identified by such feelings as fear, hesitation, self-consciousness, embarrassment, having to try harder, frustration, needing to be quiet, wanting to disappear, having to wait until told to do something. As well as feelings of stupidity, not knowing or understanding, isolation, moving away from one's family and cultural traditions, confusion, feeling dumb, not being able to communicate effectively with patients, worrying, being left behind, feelings of being pressured for time, stressed, being slower than everyone else, feeling disadvantaged, singled out, ridiculed, distressed, and disorientated.

SD was experienced by student nurses in this study in an ongoing but episodic manner. The dictionary defines episodic as "an incident in the course of a series of events, in a person's life or experience …" (Delbridge & Bernard, 1998, p. 372). This is exactly the way CLDNSs experienced SD. Although episodic in nature, it was also evident that CLDNSs experienced SD, in an ongoing and often cumulative, fashion. The intensity of the feelings of discomfort altered, depending upon the individuals and the type of encounter. But those students who looked different or spoke differently to members of the dominant group always experienced episodes of SD because they were seen as being different and not fitting in. The full meaning of this basic social psychological problem will become clear as the following sections unfold.

There were many issues that led to episodes of SD, for example, looking different, physical differences, and clothing differences; however, ongoing analysis of transcripts and the process of constant comparison revealed that most of the discordant feelings experienced by CLDNSs related in some way to communication differences. Communication differences were split into two forms; verbal and nonverbal and these are addressed in this chapter along with other culturally based differences that led to SD. From the outset, however, it is important to note that the majority of CLDNSs believed that their communication abilities were under constant scrutiny.

<div align="center">Being Different: Constancy of Scrutiny</div>

Those students who looked different to the members of the dominant group believed that teachers assumed automatically that they would have communication problems. This concept was most evident in clinical practice settings and was conveyed by the following quotes:

> They think because you are from different place that you can not speak English. We can speak it … we just a bit slower. They're always on the look out for you to make mistake … just one and you can fail the whole clinical. (S33)

And:

> With Asian students … the people that I know … when I talk to them … most of them were so preoccupied with their own ability of whether they could pass the unit or not because all the time they're thinking about … "My English is not good, maybe the preceptor not able to understand me" and things like that. (S32)

In addition, those CLDNSs who looked no different to members of the dominant group, but who spoke with an accent, commented that as soon as they spoke teachers became aware of the possibility they too would have communication problems. These students sensed they had been branded as needing close supervision whilst on clinical practice and also felt that not only their verbal communication but also their written communication was under constant scrutiny. Anyone who spoke differently or who looked different to the average student was scrutinised and the scrutiny felt constant. Because students felt as if they were always being assessed they experienced varying levels and continua of SD. This was demonstrated in the following quote: "It feels like when I talka that they wait for me to make the mistake" (S32). These students felt they were over evaluated or over assessed in respect to communicating and whilst being over assessed might well have been acceptable if support was offered to those found to have communication deficits, this was not always the case.

It was rare for CLDNSs to have experienced SD related to one single aspect of communication. It was more likely that a number of communication differences coexisted. For example, CLDNSs may have misunderstood communication sent to them because of the use of slang and the rapid pace at which the message was spoken. Whilst recognising that problems related to differences in communication coexisted, the researcher has dealt with each aspect of communication identified by data analysis separately in an effort to lend clarity.

<div align="center">Communication Differences</div>

The term communication has been used in an encompassing manner to incorporate all modes of sending and receiving messages. The act of communication took place both verbally and nonverbally and there were numerous occasions wherein CLDNSs demonstrated differences or had problems or difficulties in sending and receiving messages. Because of the many differences in communication CLDNSs were seen as not fitting in with the dominant group and experienced varying degrees of SD. It is a well accepted concept that only a small percentage of communication actually occurs via speech, and that the majority of communication takes place via unspoken messages (Balzer-Riley, 1996; Pease & Pease, 2004). This concept was considered

essential because SD experienced by CLDNSs related to verbal as well as nonverbal forms of communication.

Verbal – Sounding Different

All members of the student cohort, except one, spoke English with an accent. Accented speech meant CLDNSs sounded different and as mentioned previously this difference drew much unwanted attention to students inevitably leading to episodes of SD. Many of the students interviewed had spoken of feeling embarrassed, or referred to a loss of face, associated with sounding different to members of the dominant group. Several of the CLDNSs interviewed reported their discomfort of having to join small groups or work in pairs with students from the dominant group because they felt they would make speech errors in front of others. Even more discord was anticipated, and had been experienced, by CLDNSs when they were required to stand in front of their colleagues and give tutorial presentations. In fact, the majority of CLDNSs held a preference not to speak in classes.

However, there was more to speaking English than speaking with an accent. The mechanical aspects of verbal communication were also considered, that is, pronunciation, tone of speech, and pace of speech delivery. In addition, Australian slang, colloquialism and parochial speech, along with medical jargon, and abbreviations caused episodes of SD that warranted investigation. Students who used translation skills to assist comprehension of English also communicated differently due to resultant pauses associated with 'wait time' and 'word fishing'.

Pronunciation

In general terms pronunciation refers to the way humans speak, how we say words, the use of accent and the tone of our speech. Specifically, pronunciation relates to "the act … of producing the sounds of speech … (Delbridge & Bernard, 1998, p. 924). Accent, inflection, pace of speech delivery, and intonation are some of the mechanisms of speech that affect pronunciation.

Due to the complexity of nursing jargon and the lack of familiarity with nursing terms and phrases most students starting out in their nursing careers experiencing difficulties with pronunciation irrespective of cultural background. Many CLDNSs,

however, also had difficulties pronouncing everyday English words. Those CLDNSs who had difficulties with pronunciation made speech errors. These errors highlighted differences and caused CLDNSs considerable discomfort or discord because they had made mistakes and did not speak as members from the dominant group did. Because they spoke differently, or whenever they made speech errors, they drew unwanted attention to themselves and were either considered by others as being different or considered themselves to be different and not fitting in with the dominant group.

Many CLDNSs reported knowing that they had difficulties related to pronunciation but, as previously stated, these difficulties rarely occurred in isolation. When discussing pronunciation, students also spoke of other facets of communication that they had found problematic. The effects of mispronunciation were cumulative and could be seen in the following student's quote when she spoke about reactions from students in the dominant group to her speech:

> I just, saw they [were] … laughing [at me] and I just … say [said] nothing, do something … maybe, like I get very nervous, red face or I'm shaking so much and they see it and they laughing and things like that and maybe (pause) and then I start to get worse because … how we had to speak English and some word is very hard to pronunciation [pronounce] and when you [are] nervous it sort of (pause) I've [I] tend to get more wobbly. (S12)

Clearly, this student experienced SD, manifested by silence, feeling of wanting to do something to change the situation, nervousness, embarrassment, facial flushing, tremor, self-consciousness, and awareness of decline in personal performance.

CLDNSs spoke of the efforts they felt they expended when trying to pronounce words in order to be understood. Irrespective of such efforts, CLDNSs remained prone to pronunciation errors and resultant discord. An example of this perceived effort and making of errors follows:

> And I consider I try my best to pronounce a word and to be understood in English and sometimes I just can't help it if I got an accent. I might think … I want to pronounce this and I want it to come out right but … once I speak, it come out (pause), it come out completely different. (S10)

Clinical teachers had also acknowledged the problems that CLDNSs experienced regarding pronunciation. Some teachers reported that CLDNSs often knew what they wanted to say but did not know how to pronounce specific words. There were some

occasions when CLDNSs had no idea how to pronounce specific words because they had little previous exposure to these words. The following student quote further demonstrated CLDNSs' problems related to pronunciation:

> The patients … one of them in the room I'm looking after and it was one of her operation, very long word and I couldn't read it, like, it was in her file and I'm trying to say … and I sort of look at her and then she say, she looks at me and she give me a smile and then she went "You can't pronounce the word" and I say "No". And then she pronounced it out for me. (S15)

Although the preceding quote was used to show pronunciation difficulties, it also demonstrated rapport development between the student and the patient. In fact, the rapport may have been partially developed on the basis of pronunciation difficulties, but irrespective of the basis of rapport development the student expressed discord because he was embarrassed that he could not say the name of the patient's operation.

Teachers had also reported that some CLDNSs misplaced word emphases resulting in mispronunciation or misapproximation of pronunciation. Interestingly, this misplaced emphasis was also seen to create differences between English spoken with non-Australian accents and that spoken with Australian accents. On occasion, teachers reported non-American CLDNSs as pronouncing words with American accents. Teachers believed that these CLDNSs pronounced words with American accents because they had been taught to speak English by Americans. Examples of such words were "kaaaaath-air-terr" instead of "kath-e-ta" (catheter) and "kap-ill-air-eee" rather than "kap-pilli-r-ee" (capillary). Even when these students pronounced nursing terms with American accents they drew attention to themselves because they sounded different. Sounding different led to experiences of SD.

Problems associated with students' accents and pronunciation were also seen in clinical field observations, for example, an American-accented student was seen to consult with RNs prior to calling patients into treatment rooms in an outpatient's clinic. The student had asked the RNs how to pronounce patients' names the 'Australian way' so patients would respond to her call. Pronunciation of names had also caused problems, notably for Asian students, when patients' last names began with 'Mc' or 'Mac'. Each time the students used the patients' last names, errors in pronunciation were made. These occasions drew unwanted attention to students who subsequently

looked embarrassed. The patients would say their names repeatedly to the students who made several unsuccessful attempts to correct their mispronunciations. Because students could not say some patients' names they experienced SD; clearly they were self-conscious and embarrassed. Furthermore, when Asian students could not say the patients' last names it was quite probable that they had no way of referring to patients aside from room or bed numbers. This was particularly so for those students whose cultural beliefs of respect of elders prohibited them from referring to their patients by their first names. Occasionally patients were referred to, for example, as "Mr. Bob".

CLDNSs also had the propensity to add or omit word endings thus affecting word pronunciation. For example, students often added or omitted 'ey' or the letter 's'. These additions and omissions acted to change word pronunciation and sometimes meaning, but teachers were unlikely to pay attention to such errors. As one teacher said "I don't think it causes … huge problems" (A115). Such errors may not have caused problems for teachers; however, CLDNSs discussed having been laughed at by members of the dominant group, which often resulted in a loss of self-esteem, embarrassment and a belief that members of the dominant group thought they were "stupid" (A23). These feelings contributed to CLDNSs belief that they were different and that they did not fit in.

Accents

Throughout data collection and ongoing analysis it became obvious that those CLDNSs who had stronger accents had experienced more problems, or SD, than those CLDNSs who spoke with only a hint of accent. Accent in this study referred to the "characteristic style of pronunciation … distinctive character or tone" (Delbridge & Bernard, 1998, p. 6) of a specific language. Communication difficulties related to accented speech were reported by all groups of participants. For example, "It's really … difficult to … fit into Australian society … just because of having an accent" (S10). Speaking with an accent made some CLDNSs acutely aware that they were different to dominant group members and many had felt as if they did not fit in or were not accepted. At times CLDNSs detailed the problems they had encountered whilst attempting to talk to others specifically because their accent prevented understanding.

Some students even stopped themselves from speaking in class because they believed members of the dominant group would not understand their accent.

Whilst most reports in this study were of others not understanding CLDNSs, there were occasions in which academics, and infrequently the students, acknowledged the difficulties of understanding English because of variance in accents. As one academic noted, "What I found was that we were their problem, we don't speak English, we speak Australian" (A23).

Those CLDNSs whose physical appearance aligned them with members of the dominant culture, and who had managed to avoid being identified as having a different cultural background, were as previously stated unable to avoid the attention they attracted when they spoke with a non-Australian accent. As one student stated "I would probably feel more comfortable speaking in a Scottish class than I do speaking here because as soon as I open my mouth I sound different to everybody else" (S111). By sounding different to everyone else CLDNSs drew attention to themselves. Such attention created a focus which highlighted speech content, errors, and differences. Because of their accent, many CLDNSs experienced discord in the form of discomfort, self-consciousness, or embarrassment by being the centre of attention whenever they spoke.

From analysis of student interview transcripts it became apparent that, whilst some students were cognisant of the problems their accents had caused in communication, others were not. Students from the former group discussed their thoughts and feelings of having an accent along with the efforts they made to be understood. One student from the former group was clearly frustrated by the apparent lack of sensitivity he experienced during communications with members of the dominant group. He explained "I don't think they [members of the dominant group] understand that you actually, you have been speaking a different language most of your life and it is quite difficult to pick up an Australian accent, the rhythm" (S10).

Teachers and CLDNSs had described members of the dominant group as being rude in respect to the way that some of them treated CLDNSs in classes because of speech differences. This characterisation seemed justifiable in the following student's quote:

They [members of the dominant group] don't really bother with you and some of them can be quite rude … they completely ignore you or others will just … say "It's amazing you've been living here for ten years and you still got that strong accent". (S10)

A small number of CLDNSs reported having developed an awareness of teachers who had difficulty understanding them because of their accents. Those students who reported this awareness spoke of their concerns of being graded unfavourably in assessments. These CLDNSs also discussed their reticence in approaching the same academics to discuss their concerns about not being understood. Clearly, in these situations SD existed and CLDNSs felt they were in a 'no-win' situation. Students knew teachers had problems understanding them because of their accents but at the same time they would not discuss their concerns with teachers.

Tone

In this study tone of speech referred to "a particular quality, way of sounding, modulation, or intonation of the voice as expressive of some meaning" (Delbridge & Bernard, 1998, p. 1233). Teachers regularly described CLDNSs' speech as being laden with negative tones. Students' tone of speech was problematic because teachers had used it to determine individual student's mood and attitude and, often, subsequent interaction was based upon these culturally skewed suppositions. On many of these occasions there was no evidence that teachers had given thought to the effects of the students' first language, for example, accent or sense of syntax, upon tone of spoken English. At times, teachers made assumptions based upon their interpretations of the students' tone of speech labelling them as "pushy" (A23), "rude" (A112), "disinterested" (A25), or "arrogant" (A11). It was often the case that when CLDNSs' tone of speech had been misinterpreted their interactions with teachers were less than positive.

CLDNSs had made similar comments on their interpretation of other people's tone of speech. For example, one student had said "I don't know if they [the Philippine RNs] are really horrible but it's just the way they speak, like even if they're telling you something nice it's sort of like … in a really barking sort of way" (S112). Because the student was unfamiliar with this group of RNs' speech tones and accents she felt that everything said, even positive comments, were negative.

For most CLDNSs, pronunciation, accent, and tone of their speech acted to set them apart from the dominant group. CLDNSs were seen to be different, in part,

because they spoke differently to members of the dominant group. Because of these differences in speech CLDNSs experienced various types of SD. This discord was discussed throughout student transcripts and was manifest, for example, by feelings of embarrassment, self-consciousness, and of loss of self-esteem. In addition, feelings of discord were experienced when CLDNSs became the focus of other people's attention because of communication differences and by not being understood.

Rapid pace of speech

Interview transcript analysis revealed awareness, amongst both CLDNSs and their teachers, of communication problems caused by rapid pace of speech. Most of these problems stemmed from miscommunication (i.e., people not understanding each other). As previously stated, miscommunication was multifactorial; however, rapid paced speech caused problems for some CLDNSs in two ways. Firstly, their own use of English was too fast to be understood by members of the dominant group and secondly, these individuals spoke too fast for CLDNSs to understand. Furthermore, rapid paced speech resulted in miscommunication with patients and hospital staff in clinical practice settings.

When students spoke too fast, patient comprehension was often devoid. An example of this lack of understanding was seen during clinical field observations when a CLDNS, whilst feeling a patient's pulse, instructed the patient to 'move over'. The patient, being semiconscious, from an Italian background, and unfamiliar with the student's accent, thought the student had asked about her mother. The patient started to call out 'Mamma, Mamma'. When this student gave the patient the instruction to 'move over' she spoke too fast which acted to compound the existing communication difficulties. The student stood with a bewildered look upon her face and asked the patient "Are you talking about your mother"? The patient responded in the affirmative but she did not move over simply because she had not understood the student's request. The outcome in this situation may have been different had the student spoken slowly.

Teachers had also expressed their concerns regarding rapid speech and CLDNSs' ability to understand instructions in emergency situations. These situations often meant life or death to patients and outcomes usually depended upon a few people, doctors and RNs, over the duration of a few minutes. Under these circumstances, instructions or

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orders are often spoken in what may seem an abrupt manner, quickly and loudly. Teachers' concerns were related to CLDNSs not comprehending doctors' or RNs' instructions correctly thus impacting upon their ability to participate in an emergency situation.

Some teachers only became aware of student problems related to pace of speech retrospectively. This was demonstrated by the teacher who realised that student difficulties existed after having read students' summative evaluation sheets. She said "They didn't tell me that I was talking too quickly, they didn't tell me that they didn't understand particular words that I'd used" (A16).

Although there was a distinct awareness amongst CLDNSs of communication problems related to pace of speech, they were reluctant to report such problems when they occurred. As a corollary, many carried on without understanding what had been said to them. They experienced SD because not only had they not understood; they were too embarrassed to seek clarification. For many students asking for clarity acted to draw unwanted attention and was an admission of error.

Repetition

Having to repeat oneself "most of the time" (EI2) or "quite often" (S26) had a tendency to wear away at self-confidence related to communication skills. The undermining of students' self-confidence was discussed, for example, by one student who previously believed his English language skills to be satisfactory but who questioned this satisfactory skill level because on clinical practice people he worked with had asked him so often to repeat himself. As he had said "Some people I talk to they kept saying 'I beg your pardon, I beg your pardon' and I feel that maybe they doesn't understand what I'm saying" (S16). Many students who had been asked to repeat themselves did just that. They said exactly the words that had not been understood initially and it was not uncommon for the recipient to have to ask the speaker to repeat themselves yet again. These types of scenarios caused SD for students who became increasingly frustrated at their seeming inability to communicate. Students also experienced frustration and embarrassment when they spent time trying to understand what had been said to them or when they searched for a particular word they wanted to make use of to facilitate their communication.

Translation

In an attempt to improve comprehension students who had difficulties understanding English would translate spoken words into their first language. Translation in this study meant "to turn (something written or spoken) from one language into another" (Delbridge & Bernard, 1998, p.1247). Although translation could be seen as a strategy which CLDNSs used to decrease discord, many experienced SD associated with the act of translation. Students talked about receiving messages in English, translating these messages into their first language, formulating a response in their first language, translating that response into English then speaking the response in English. Obviously this five-step process took time and students made comments such as "You've got to find the wording that's correct …. I'm very ashamed … I'm embarrassed, like, OK, I'm taking some time to tell them what I want to say" (S13). Other problems were depicted in the following quote:

> I've got a problem of thinking of what I'm supposed to say beforehand because I'm thinking in Spanish and then trying to translate it to English and make them understand. Spanish, we speak backwards to you. It's a bit hard because having been taught Spanish all through your life, well spoken to at home, I haven't lost it now, it's like, it's always there. It takes me far more time to write up an assignment than anyone else. I think because I've got to write it out in Spanish … and then put it in English and sometimes I might just do it all in English because I've got written statements [quotes]. But my views, I've got to write them in Spanish and then translate them and make sure they're translated correctly. (S113)

Aside from issues related to translation, the preceding quote and others like it drew attention to the issue of syntax problems. Whilst CLDNSs may complete the translation process and use the right terms or phrases and pronounce words correctly, if syntax was disordered they were often misunderstood.

Another student had described the process of translation as a "rotating circle" (S28). Upon hearing something he did not understand he translated the words into his first language and then used his first language dictionary to ascertain word meanings. When word meaning was understood he translated that back into English. Translation had been described as circular in nature because he felt as if he had gone around an entire circle. His use of the adjective 'rotating' was indicative of the frequency and ongoing nature of his use of translation.

Many CLDNSs perceived the process of translating from English to their first language and back again as placing them in a disadvantaged position particularly in learning situations that involved discussions. Under these circumstances student participation was limited because of perceived risks associated with making errors during translation and experiencing the resultant ridicule from others when errors were made. Besides, because the process of translation took time other students often answered questions before CLDNSs could complete translation and answer in English. Furthermore, English words did not always translate into the students' first language, leading to confusion and distress. As one student said:

> I don't understand where I am … like even I have to translate back into my own language and learn it in my own word or [when it won't translate] then I have to just learn [it in] straight forward English. (S12)

Another CLDNS had spoken of having to translate behaviours and concepts into his first language as well as into his culture before he could fully understand what was going on. He would try to identify a similar behaviour or aspect of his culture with which to align a newly taught concept. Alternatively he said "I probably can just accept and learn as it is" (S10). In other words, he would take on what he had been taught; he would learn concepts as new, without making any reference or connection to his previous knowledge.

Occasionally, academics had discussed their experiences of working with CLDNSs who used translation processes. There were reports of pairs of CLDNSs approaching academics at the end of lectures where one student would ask a question. The academic would answer the question and one student would translate the given answer to the other. Academics were accepting of this use of translation but were worried about the difficulties some students may have encountered during examinations if they could not understand English. For example, one academic had commented: "I don't have a problem with that [translation of my answers], it's fine but I don't know how they can possibly pass an exam … I don't know what they are going to do [in the exam]" (A22).

Translating English into another language was not always viewed negatively. Students reported advantages and benefits when they had been allocated to care for

patients who spoke the same language or a similar dialect. Under these circumstances CLDNSs were able to translate conversations for patients, facilitating their understanding of nursing procedures and other care. Situations in which CLDNSs could talk to non-English speaking patients were reported as one of the highlights of these students' clinical practice.

The processes of translation and interpretation used time which has been referred to in the literature as "wait time" (Hall, 1992). Hall referred to wait time as the periods of silence in conversation between people communicating when one or both engaged in translation. In this study, periods of silence had occurred because of translation as well as 'word fishing', that is, searching for specific English words. Periods of silence had also occurred when CLDNSs were practising pronunciation of English words to themselves silently before use. During interviews, and in field observations, there were clear indications that CLDNSs were experiencing episodes of wait time and word fishing. For example, during patient interaction when a CLDNS was completing a patient history the student had asked the patient why she had been admitted to hospital. The patient replied and in doing so explained her reason for admission in lay person's terms. Initially the student stood silently, directing a look of concentration towards the patient. Eventually the student wrote the patient's reason for admission onto the admitting form.

Other students described the similar discord they felt in the form of frustration when they had used wait time. This frustration was seen in the following student's quote in which reference to class interaction was made:

> "I just see when I speak … it always late, it's [I am] always the one, the last one … compared to the other … Australian girl. Teachers just pop out a question and straight away they [members of the dominant group] answer". (S12)

When CLDNSs used 'word fishing' they would try to find words they perceived as correct, enabling them to speak and be understood. Word fishing caused students to be hesitant in speech which contributed to periods of silence and led to episodes of SD. The following data extract from a student's interview demonstrated typical use of word fishing. On this occasion the student was waiting with other students, in line, to ask an academic a question at the end of a lecture.

I just went there [joined the line] and I practice and I said "Oh, which word I said for that question, oh, what was the word? What's the word, what's the word?" And then suddenly I say "Forget about it". And [then] I'll go and ask someone else. I'll go and ask one of my friends. (EI1)

From this extract the negative effects of being unsuccessful in word fishing were obvious. The student avoided asking the lecturer a question because she could not identify specific words. Other students referred to these types of situations as "Get [getting] stuck" (S20) and as "not having the right words" (S113). Students reported similar experiences when they had been asked to answer questions in class and on various other occasions when they had to speak in front of other people. During such occasions students described getting stuck in the following manner: "I can't express myself with the right words, it just doesn't come. So it's a bit hard for me and I'm cold and sweaty when I'm going to tell something" (S24). Another student explained how word fishing caused her to lose concentration, invariably stopping her from participating in classes. As she had said:

Something stops … my um (pause) … my sort of um (pause) my just vocabulary, sort of limited at [that] time. When I say things I just sort of don't want to, I can't think of the way I want to say it. I sort of lose the flow, the flow of my idea and I can't join [the] discussion. (S22)

Whilst the period of silence that occurred for CLDNSs who used word fishing was the same as the period of silence that took place when they used translation, student activity was different. Irrespective of these differences, CLDNSs clearly experienced SD. Not only did others speak on their behalf but by being silent members of the dominant group developed negative perceptions or stereotypes of them. CLDNSs were seen as being hesitant, lacking in confidence or were viewed as being unsure of what they were doing. As a corollary, some members of the dominant group would act to help students understanding; however, these acts often served as interruptions to translation or word fishing. CLDNSs who hesitated when using translation or word fishing processes were communicating, perhaps unknowingly, to others around them. They were using nonverbal messaging.

Jargon

The use of medical jargon was found to cause SD for most CLDNSs. This fact was expressed not only by the students but also by their teachers who described the amount of jargon associated with nursing studies as "voluminous" (A114). The term jargon refers to "the language peculiar to a … profession …" (Delbridge & Bernard, 1998, p. 606), in this case, nursing. In this study the phrases nursing jargon and medical terminology have been used interchangeably.

CLDNSs experienced discord because they had problems or difficulties understanding medical terminology used by others with whom they interacted, for example, fellow students, RNs, teachers, doctors, and sometimes patients. Jargon had caused problems for many CLDNSs not only in clinical practice settings but also in classes. In the former, most problems were reported as having occurred during nursing handover. Nursing handover referred to the time period when staff from an oncoming shift met with staff from the off going shift and information about patients was passed from one group to the other. Handovers may or may not have occurred live, that is, information about patients that was relayed may have occurred face-to-face or have been tape recorded. Whatever the transmission mode, information about patients was passed from one group of nurses to another.

The first thing that became evident from analysis of student interview transcripts was whilst all students acknowledged they had attended handover, or listened to handover, not all students had given formal handover. Those few students who had been observed by the researcher giving handover face-to-face did so with much hesitation and a great deal of self-consciousness. Self-consciousness was evidenced by the students' body language consisting of tremulous hands as well as staccato speech and a tendency to read verbatim from handwritten notes. When asked how they felt about giving handovers students made comments such as "I [am] … very scare [scared] … to speak in front of a lot of people" (S11).

At nursing handover CLDNSs reported not understanding patient diagnoses, treatments, or planned nursing care because they had not understood what had been said. In respect to nursing handover, one student had commented "Usually I don't get what they're [RNs] saying because of the terms that they [RNs] use" (S19). Another student

said "I'm unfamiliar with all those conditions and stuff like that. It's a bit hard to understand … what's wrong with the patient" (S14). Whilst it is recognised that this situation may well have existed for all nursing students, irrespective of cultural background, many CLDNSs were seen to be affected more adversely because, for example, some had only been learning English for a few years prior to commencing university studies. These students had struggled to understand ordinary English words used throughout handover, as well as specialist terminology.

Data from clinical field observations also demonstrated other situations in which CLDNSs had not understood jargon, for example, having read a patient's medical record a student turned to another health care worker and asked "What is this words corset and TENS [Transcutaneous Electrical Nerve Stimulation] machine"? The following data extract from a memo written during field observations further demonstrated some of the problems CLDNSs had understanding terminology:

> Another incident occurred when the student was doing a central line dressing. The RN said to her "hold it by the flange". The student was not holding anything by the flange. She was not holding the lines at all. The RN repeated herself at least twice, if not three times, using this same word: flange. The student did not follow. The student did not hold the line by the flange which acted to connect the triple lumen. When she was cleaning under the flange her task was made more difficult because she could not lift the lines to clean under them. Instead the lines were cleaned; the skin around the flange as well as the flange surface was cleaned. Later I asked the student if she knew the meaning of the word flange. The student asked me to repeat myself so I say "flange". I wrote it down for her, but her face is demonstrating that she still does not get the word or the meaning. She says, "No, I don't understand what the word flange is". (F.N.)

Because this student failed to understand the terms used by the RN during a dressing change she experienced SD. She did not understand the instructions given to her by the RN nor did she ask the RN to explain the meaning of words she did not understand. Consequently, instructions were not followed. A similar example of noncomprehension was recounted by a clinical teacher, who discussed instructing a student to "pick up a couple of gauze squares with the forceps" (A114). On this occasion the student could not follow instructions because she did not understand the meaning of the word couple.

Another student went to some length outlining her predicament of not understanding medical terminology. She had tried to explain that whilst she probably

understood certain medical terms in her first language she did not understand the same terms in English. This student used the word 'coma' as an example. She explained that she had a basic understanding of what it meant to be in a coma and that she had a mental image of a person in a coma in her first language. However, because she had not heard the English term, when she first came across the word coma, she had no idea of what had been discussed. SD existed because this student could not relate the word coma to her existing knowledge. She was unable to follow the discussion as it unfolded and she felt left out.

Jargon also caused communication problems between CLDNSs and patients. There was evidence seen in clinical practice settings where CLDNSs had actually used jargon when talking to patients. For example, students had asked patients when they last voided (passed urine). On another occasion a student had asked whether or not the patient had their dentures insitu (inside their mouth). There were numerous times when students had problems differentiating medical terms from words used by members of the dominant group in everyday conversations.

Discord that occurred in clinical practice settings due to a lack of understanding jargon extended into classroom settings. One student commented:

> I don't understand anything when they [the teacher is] speaking, when they teach me. Like if I don't, is the problem with the teacher? She have a lot of knowledge, I know that. She talk so clearly, she has overheads [and] everything but it's just that, like, I just put it down [write what is on the overhead]. Last week I had to like, I don't understand the main point, what is it in there? (S12)

Specifically, this student could not comprehend terms associated with nursing research such as "para-dig-im [paradigm]" and "critic [critique]" (S12). Another student had no understanding of assignment requirements that specified essays had to be submitted in size 12 font. This student experienced episodic SD because she worried that she would not pass assignments because she could not do what she had been asked. If she did not understand instructions she could not adhere to them.

As stated previously, whilst problems associated with understanding jargon may exist for all nursing students the plight of the CLDNSs seemed worse because they also

had difficulty understanding everyday words such as summary. This was seen in the following data extract:

> They [members of the dominant group] don't realise [that] the few times I [have] ask [asked] them and they speak, explain very fast … I said look, "I don't understand". And they still, maybe they don't realise, not because they don't want to help, they don't realise your feeling. They [have] never been in another country. Maybe … they don't know how that feels. They don't even … believe that maybe, the little word I don't understand. Like I go and ask "Do you know what assignment [summary] mean? What [does] that mean?" [The word] Summary? You know, it was the [a] simple question, the [a] simple thing but … when I said, "How do you have to sort of gather information or something? How you make summary from the book?" They just [said] "summary, summarise it, summarise it". But they didn't even realise I don't even know what [the word] summary is [meant]. (S32)

Another student commented "Every day is so very difficult and then everyone in the lecture they talk very fast and I … couldn't follow … the lecture" (S36). In addition to not understanding lecturers because of the rapid pace of speech delivery, as discussed previously, this same student had found lectures challenging because she failed to understand much of the associated discourse. As she stated "I'll sit in the classroom without understanding anything … I might just take in a few words but I don't understand them all" (S36). Other students occasionally found parts of lecture content unfamiliar because specific issues were not recognised in their culture, for example, the female menopause, the concept of teenage rebellion, and placement of elderly relatives into nursing homes. When these or other unfamiliar subjects were discussed individual CLDNSs were lost. They experienced SD because they did not understand the issues or associated discussions. Essentially they felt as if they did not fit in with the dominant group of students.

Students cited multiple demands upon their time as preventing them from learning specific terminology related to nursing. This lack of understanding jargon, however, often acted to hinder CLDNSs' active participation, for example, in patient care or classroom settings. Students reported not wanting to answer questions in class because they worried about pronouncing medical terms incorrectly. These students were trying to save face, trying to avoid the SD that they would have experienced should they

have mispronounced words. In addition to problems related to nursing jargon CLDNSs reported difficulties understanding words that had been abbreviated.

Nursing terms were often abbreviated by use of acronyms, for example, "NUM" meaning Nurse Unit Manager or by use of letters, for example, "ICU" meaning Intensive Care Unit. At times abbreviations existed that deviated from these rules, for example, "cabbages" indicative of coronary artery bypass graft surgery. There were other times when the same set of letters had more than one meaning. Abbreviations caused problems for all students especially in clinical practice settings during nursing handovers because they did not understand what the abbreviations meant. As stated previously many CLDNSs were considered more disadvantaged than members of the dominant group because they had difficulties understanding English, jargon, and abbreviations. CLDNSs experienced varying degrees of stress because they found it impossible to keep up, understand, and follow the handover. Under these circumstances students experienced much discord because they simply had no idea what had been said. As a corollary, they had little understanding of the nursing care that they were meant to give patients following handover.

Australian speech

Communication for CLDNSs seemed fraught with numerous problems or difficulties associated specifically with Australian speech. In this study, the term slang refers to "language differing from standard or written speech … involving extensive metaphor … [and] humorous usage … [it is also] less conservative and more informal than standard speech" (Delbridge & Bernard, 1998, p. 1089). CLDNSs also had problems understanding when they interacted with members of the dominant group who used colloquialisms and parochial speech. CLDNSs often engaged in literal interpretation resulting in a failure to comprehend the intended meaning. Because students' reactions indicated that they had failed to comprehend meaning, they were seen as being different and experienced considerable SD.

There was evidence, nevertheless, to suggest that not all CLDNSs had problems related to the use of slang. A couple of academics had acknowledged some CLDNSs spoke "the vernacular very well" (A24). Clearly, academics had referred to a minority of CLDNSs when they made such comments and by far the majority did have

difficulties related to understanding slang, colloquialisms, and parochial speech. These problems were perhaps best illustrated in clinical practice settings when CLDNSs simply did not understand the dialogue of those with whom they interacted. For example, during clinical field observations, a patient had asked a student for a "bib". The patient was an elderly male accustomed to hospital routines due to his many admissions. He knew lunch would be coming soon and that he needed a feeder to protect his clothes when eating. The student did not know what the patient meant by the term. She told him she would get him a "bib" and left his bedside. The student set about finding an RN to ask, "What is bib?"

There were other occasions during clinical field observations wherein CLDNSs did not understand what had been said to them but of greater interest was the regular use of slang by Australian RNs. It also appeared that most RNs were unaware of the problems that their use of slang caused. For example, following venipuncture and withdrawal of blood from a patient an RN instructed a student to discard the used equipment; however, she actually said 'doss it'. When the student did not respond the RN repeated the instruction as if the student had not heard. The student stood hovering over the patient, still holding the used equipment. The third instruction given to the student was 'chuck it'. When asked about this incident the student commented that she had not known what either phrase meant but eventually figured 'chuck it' must have meant to throw the equipment away. She had commented that she thought 'to chuck' meant to vomit. This meaning is indeed an Australian colloquialism (Delbridge & Bernard, 1998, p. 197).

The following data extract from clinical field observations further demonstrated CLDNSs' inability to understand slang terms:

> On occasion I noted the people with whom she interacted had used words or phrases that I thought she would not understand. I waited until these interactions had finished and then clarified with the student if she had understood what had been said to her. On this occasion the phrase was "boo boo" [mistake] as in I've made a bit of a boo boo. The RN had said this to the student. The student did not show any change in facial expression when it was said. Later on, when I asked the student if she knew what it meant she smiled, and said, "No, I don't". (F.N.)

Clinical teachers had also discussed their observations of RNs using slang, parochial speech, and colloquialisms when working with CLDNS. Instructions given by RNs often incorporated slang or parochial terms leaving students confused and unsure of what they were meant to do. These speech patterns were also problematic for CLDNSs in classroom settings, causing the same problems. Some of the words and phrases not understood were "bloody", "paddock", "bong", "give us some slack", "as rare as hens' teeth", "scream blue murder", "lovie", "dearie", "sweetie", "hoy 'em," "chokas", "head sherang", "tranny" and "pelt it". To most Australians these words and phrases make sense and have meaning but to CLDNSs these, and many others, made no sense at all and had no meaning. Furthermore, such words and phrases often could not be translated. When CLDNSs did not understand these expressions they experienced SD. In effect they had no idea what had been said to them and were often left unsure as to what they were meant to do.

Some CLDNSs had discussed being laughed at by members of the dominant group when they openly sought word meaning. Others did not attempt to determine specific meanings because they were afraid of being laughed at by members of the dominant group. Students spoke about feeling as if they should have known the meaning of many more words than they actually did. This feeling existed because of the frequency with which they came across unfamiliar words. Yet others had told the researcher of their belief in the normality related to not knowing slang or colloquial language of a "new country". As one student said "You be in my country in ten years [even for ten years], maybe you don't know the slang we talk" (S32). Irrespective of this feeling of normality this same CLDNS had also commented:

> Maybe [it is] me, I see everything … against me, and I felt like every time they [members of the dominant group] interact together with their slang language and their problem, their private life, I couldn't enter. It's like [a] barrier between me and them and that made me feel terrible. Like if I was a kid, I would run away. (S32)

There was no doubt the use of slang, colloquialism, and parochial speech caused problems for CLDNSs. Many experienced confusion because, for example, they could not understand nursing handover, patients' requests, or instructions given to them by RNs and others. Without understanding, students had difficulties interacting with

members of the dominant group and many were hesitant in seeking clarity because they were afraid of being ridiculed, laughed at and embarrassed. Under these circumstances CLDNSs experienced SD. They perceived that they were different and did not fit in.

Nonverbal Communication

In this study, nonverbal forms of communication referred not only to body language, including eye contact, but also to a sense of being able to detect and interpret unspoken messages. Many teachers had difficulties interpreting CLDNSs' body language and CLDNSs had enormous trouble identifying and interpreting other peoples' nonverbal forms of communication. However, from an altogether different perspective, a lone academic believed that CLDNSs used the same types of nonverbal communication that members of the dominant group used but she believed they did so away from classes and clinical practice settings. She believed CLDNSs used regular forms of nonverbal communication but only when they were amongst friends and felt safe to do so.

Body language and eye contact

Nonverbal communication was recognised as culture dependant in the literature too. For example, according Abu-Saad, Kayser-Jones & Tien (1982) Asian students are brought up believing that to show facial expressions when talking is immature as an adult whilst Americans and Australians rarely talk without using facial expressions. Eye contact can be considered rude, inappropriate, impolite and arrogant in many cultures yet it is widely expected when talking to another person in America (Bola, Driggers, Dunlap & Ebersole, 2003) and Australian cultures. Those students whose cultural backgrounds discouraged eye contact were known to have difficulties engaging in conversation with members of the dominant group. In addition, Bola et al. warned that those with limited cultural competence may well misinterpret the foreign-educated nurses' nonverbal messages incorrectly. They believed that recipients of nonverbal messages may think the foreigners are being disrespectful or inattentive which works against interactions with the dominant group. The same kind of misinterpretation occurred for CLDNSs in the current study.

Typically, eye contact occurs when one person's conscious gaze meets another person's conscious gaze. Many CLDNSs had difficulty establishing and maintaining eye contact because to do so in Australia had different meanings compared to those with which they were accustomed. For these students, eye contact was a specific form of nonverbal communication that was reserved for culturally designated and clearly delineated occasions. To engage eye contact on other occasions, such as, those requested by their nurse teachers in Australia, would have led to SD.

By far, most of the CLDNSs in this study were aware of the cultural expectations of the dominant group regarding eye contact. Students had mentioned formal education and learning about the importance of having eye contact when communicating with people, especially sick people in hospitals. However, classes that addressed the specifics of eye contact were often ineffectual because students were not committed to practise what they had learnt. Many had commented that having eye contact made them feel "uncomfortable" (S36) and it was something they did not like doing. Others had described one-off occasions in which they were unable to have eye contact, for example, practising breast examinations on colleagues. Many CLDNSs were not familiar with practicing breast examinations to detect breast cancer in its early stages. In fact, some students commented that breast examinations would only be performed in their country if it were known that a problem existed and even then, eye contact would not have been made between the woman and the doctor before, during, or after the physical examination.

Not all students discussed their inability to use eye contact. There was one occasion when a student said "It depends on how … serious the conversation is, like if it's a … really … serious … topic that you [are] talking about you'd expect people to have eye contact or at least look at your face" (S113). This type of comment, however, was indeed rare and the student concerned went on to say "because I expect it [eye contact], I give it" (S113).

Although some academics had mentioned the existence of specific cultural edicts affecting particular races engaging or avoiding eye contact the majority discussed CLDNSs' inability to use eye contact from their own, Anglo-Saxon, perspective. In other words, academics knew it was culturally inappropriate for some students to look at

them when they spoke but nonetheless they expected eye contact. Interestingly, many teachers were cognisant of and taught student nurses to respect Australian Aboriginal beliefs related to eye contact. In other words, CLDNSs had been taught to respect their patients' customs related to eye contact without receiving consideration of their own customs.

Facial expressions

Teachers had also commented on the differences and difficulties they had encountered related to nonverbal communication in the form of facial expressions, or more precisely, the lack of facial expressions used by CLDNSs. Their comments focused upon CLDNSs' expressionless faces and many interpreted these blank looks to mean that students had not understood conversations or instructions. Academics had also expressed their frustration with trying to read CLDNS's nonverbal messages because as far as they were concerned they did not exist. The stereotype of the "inscrutable Asian" (A13) had been articulated by one academic but inferred and referred to by many others. Asian students had been characterized as having "very little expression … and mask-like faces" (A13) and these behaviours led academics to believe they were unable to make any kind of connection with Asian students. As one academic had said "They [Asian students] give the same façade to everyone" (A113). From this information many nurse teachers had developed the stereotype that Asians students were quiet whilst RNs in clinical practice settings often made the assumption that being quiet coupled with a lack of facial expressions meant that the student was not interested in learning whilst on clinical practice.

Behavioural differences

There were many times when CLDNSs had used nonverbal forms of communication but were seemingly oblivious of messages they had sent. Students were labelled as being quiet because they failed to participate in classroom activities. They were similarly labelled as lacking initiative in clinical practice setting because they stood back waiting until they were asked to participate. Whilst students believed they were acting appropriately, waiting to be invited to participate or waiting to be told what to do, their nonverbal messages of showing respect for those more senior to them was interpreted by recipients without consideration of the student's culture. In other words,

the students had sent messages that were mismatched and flawed from a cultural perspective.

Interpreting nonverbal messages

CLDNSs' ability to pick up and act upon nonverbal messages sent by members of the dominant group was often questioned by nurse teachers. However, the ability to interpret and act upon nonverbal messages was contextual and depended upon the type of message being sent. Students had been reported by teachers, and sometimes observed during field observations, as failing to react or respond to nonverbal messages. From the teacher's perspective, nonverbal messages sent to CLDNSs by staff and patients were direct and precise. However, it was quite probable that CLDNSs were unable to pick up messages because they were not tuned into all the nuances of nonverbal communication existing in Australian culture.

Contrary to this perception CLDNSs had reported regular receipt of nonverbal messages. The following data extract demonstrated student accuracy in picking up and interpreting dismissive nonverbal messages.

> I don't really know why but … it happens here even with the students. Sometimes we talking about something about, a discussion in the tutorial or some essays we have to write some assignments, some presentations we have to do and as soon as I start speaking, because I have an accent, they just turn away. [They] don't bother with me. They don't really want to listen, they don't really say anything to me but by the fact, eye contact is something really important right. If I direct my attention to you, I keep eye contact with you. That way you know that I'm actually listening to you but if I turn my face away from you, what am I telling you? I'm not really interested in you. I'm not really interested in what you have to say. That's the message I'm getting. (S10)

Other students made similar comments about interpreting dismissive messages from nonverbal interactions with members of the dominant group. For one student whenever she tried to interact with members of the dominant group in laboratories they sent her off to gather equipment or to start the experiments without them. They engaged in social chatter whilst she was off working independently. As she said "You feel it, you get the message … you know when you are not wanted" (S32). Another student had commented that when he spoke and people turned their backs to him, he knew they were not interested in engaging. As he said "It's as if I have no face to talk to. When I say something they didn't listen, they … just talk over me" (S10). Similar behaviours were

also observed by the researcher during clinical field observations. There were occasions where RNs turned their backs to students so as to facilitate social chatter with their colleagues. The students were left out of the group and out of the conversation. Further to this type of treatment students had offered their beliefs that some of their RN preceptors had purposefully dismissed, ignored, and avoided them. Students had interpreted nonverbal messages that their RN preceptors did not want them tagging along. To make the tag leave the RNs directed the students to do other tasks. These students commented they felt like "slaves" as they were often sent off to carry out the tasks that the RNs did not want to complete.

Students also reported feeling as if RNs had ignored them. RNs demonstrated ignoring behaviours towards students in many ways; some were more directed than others. Students claimed RNs ignored them because they were from a different cultural background, spoke other languages, and would hold different beliefs. These impressions were created by RNs in their choice of words when talking to students and in their use of nonverbal messages. RNs' body language had been described by students as closed and was interpreted as dismissive. Students picked up similar messages when RNs left them 'hanging' during conversations. This meant that students asked questions and the RNs did not answer them. Instead they left the students hanging. Rationales for RNs' behaviours towards CLDNSs had been offered by academics believing that CLDNSs took up more of the RNs time causing resentment. Effectively, whilst students were being ignored, or left hanging, the RNs did not spend time teaching or supervising them and the students believed they were being ignored or avoided.

From data analysis there were two types of avoidance behaviours identified. Firstly, CLDNSs reported RNs' actions to avoid working with them and secondly, the students acted to avoid working with certain RNs. In both sets of circumstances CLDNSs experienced SD. Students discussed their thoughts that RNs may have been racist and perhaps this was the reason why they tried to avoid working with them. They had also talked about the RNs' actions that enabled them to avoid working with the students. Once RNs knew they had to preceptor a CLDNS some were reported to have changed their own patient allocation so that they did not have to work with a foreign student. On one occasion, as mentioned previously a student talked about standing at

the nurses' station and being told who her patients were for that shift. When the RN realized she was working with her she said, pointing to another student, "If I have to get stuck with one of the students I want her" (S113). In this case the RN had pointed to the only "Anglo-looking student" (S113) in the group. From the student's perspective the RN demonstrated a preference to work with the "blonde-headed … like very much Aussie" (S113). Other CLDNSs had talked about their perceptions of RNs' discomfort with them following allocation. When RNs acted to avoid working with CLDNSs the students questioned whether the RN's actions were racially based. This was seen in the following student's comment about being preceptored by an RN from the dominant group: "I think she wasn't feeling comfortable with me … it could be, I just don't know whether it would be my colour" (S24). Others had thought that RNs did not like working with them because they were stereotyped as having communication problems.

Students had talked about a feeling of knowing when other people liked or disliked them. This knowing came from the nonverbal messages students had identified and interpreted from others with whom they had worked. As one student stated "I can feel it if someone is … be nice to me or not be nice to me … there is a funny sort of way … you can see it on their face" (S36). Another student had made similar comments about knowing when other people disliked her because of nonverbal messages. As she had said:

> I know that you're supposed to have everything, like statistics backing you up and everything to actually prove your case and all the rest of it but a lot of it really … does rely on senses, it … really does. I mean you can sense if that person hates you … you can really sense it and you know it … but you can't prove it because that person won't say it. I sense it a lot of the time but I can't say this person hates me. I can sense it. People will say, "Well how do you know?" So, I know because I do sense it, like … the little things they do, little things they say like they won't include me in the general conversation, they just act as if I'm not there … it's like you're not here, I'm ignoring you, just stay away sort of thing. (S114)

Similar discordant feelings were discussed by another student who believed members of the dominant group thought less of her because she came from a different country and held different beliefs. She had described dominant group members' body language as "closed" (S113) because whenever she had tried to interact with them they sent out the message that "I'm not really interested in what you are talking about or … they

[members of the dominant group] just leave you hanging there … whilst you're talking to them" (S113). She commented further saying that these students were not inclined to face her whenever she spoke; instead she had observed them looking and facing in other directions or sitting with their arms folded.

When CLDNSs encountered these kinds of reaction from members of the dominant group many felt disappointed and hurt, but they usually allowed this interaction to continue. Even though some had commented that they had felt like confronting people who had treated them in this way none actually engaged in confrontation. Instead they made comments such as "Bugger it, I'm not going to follow up that" (S113). Effectively, they had been ignored, they had been left out, they were not fitting in and they experienced SD. These perceptions made those affected feel unwelcome in spite of the fact that they were keen and eager to learn. In clinical practice settings many felt as if they were in the way and took too much time to complete nursing care.

<center>Impact of Communication Differences</center>

Differences in communication impacted upon all concerned. Students had experienced immeasurable amounts of SD because there were many times they were either not understood or could not understand others. Communication differences occurred in clinical practice settings, on university campuses and in most aspects of the CLDNSs' lives.

Self-Introduction and Rapport Development

Introduction of oneself to hospital staff or patients was seen as an important component of communication in clinical practice settings. Analysis of data had shown self-introduction as being a major inlet to further interaction and subsequent rapport development with patients and staff. Those CLDNSs who were able to introduce themselves and engage in conversations with staff and patients were more successful in the area of communication. The following data extract demonstrated ongoing rapport development between a CLDNS and a patient subsequent to self-introduction.

The first day I had a chat with her, introduce myself and everything. And then the next day the first thing she told me was like "I'm really glad you here because I got to know you better from yesterday". (S34)

Occasionally students believed:

The patients like it [introductions] because a lot …of time they don't know who you are because some time even though you got nursing, … Uni. [university] uniform on they don't know you're from Uni.. They just never thought of it and I think it's good to introduce yourself because then they know. And then they'll ask me "How many years have you got to go?" And they start asking about Uni. and stuff. (S34)

Self-introduction, however, was not easy for all CLDNSs. Those students who looked different to the dominant White health care workers were less comfortable. At interview, for example, a Muslim student, acutely conscious of patients reacting to the headscarf (hijab), commented on her beliefs that self-introduction could "break the ice" (S115) and facilitate meaningful interactions contributing to patient rapport. Typically she would introduce herself in the following manner "Hello, my name is XXX. I'm a student nurse and I'm here to help you" (S115). In developing rapport with patients she had been successful on a number of occasions; however, she felt self-conscious because she wore a headscarf.

In clinical settings it was common practice for most students to be introduced to nursing staff by clinical teachers and introduced to patients by RNs. Following introductions to staff, clinical teachers usually left students with the expectation that they would be able to introduce themselves to whomever else they came across as the need arose. From clinical field observations, however, RNs were seen to take over this role. Students interviewed in this study held the expectation that the RNs with whom they were allocated to work would always introduce them to patients. This expectation was demonstrated in the following student's quote:

Most of the time … the nurse that I'm working with is next to me and she usually [is] the one to explain to the patient and tell them this is [student's name], she's a student nurse from Uni. … she will be doing this for you … so I don't usually have to say anything. (S34)

During clinical field observations, RNs and CLDNSs usually began each shift walking around the ward, from bed to bed, meeting their patients after handover. The purposes

of these "walk-around" sessions apart from, for example, checking their patients' charts, or intravenous fluids was for staff to introduce themselves to the patients. During these times the majority of RNs took it upon themselves to introduce the CLDNS to the patients. Because RNs did this, students hardly ever had to introduce themselves to patients prior to caring for them. The majority of CLDNSs who did not introduce themselves but who were introduced by others had been embarrassed by the introduction simply because they were the subject of conversation and centre of attention.

There were few CLDNSs who had introduced themselves to patients and who did make an effort to engage patients in conversation. Occasionally patients ignored the students' efforts and subsequently the students felt self-conscious and silly. In other words SD existed because of the negative type of responses, or more correctly the lack of responses, students received from patients. On one of these occasions a scarf-wearing, female, Muslim student tried to introduce herself to a patient but the patient all but ignored her. This ignorance was demonstrated by the patient's monosyllabic responses to the student's attempts of introduction and rapport building. However, when another student, not wearing a hijab and obviously a member of the dominant group, joined this student at the bedside, the same patient was reported to become more vocal and engaged in conversations with the 'new' student. Other students experienced SD because they did not introduce themselves but knew via their education that they were meant to do so. Even though the majority of CLDNSs interviewed for this study had acknowledged, by discussion, the importance of practicing self-introduction and subsequent rapport development many experienced difficulties in doing so. As a result, these students often had little interaction with patients and staff and during clinical field observations many were seen to spend lengthy periods of time on their own and in silence.

Patient Conversations

It became apparent from analysis of field observations that not many CLDNSs actually initiated conversations with patients. Plenty of patients, however, initiated conversations, or at least tried to have conversations with CLDNSs. This is not meant to infer that the students never initiated conversations they did, but only occasionally. This

difficulty was admitted freely by some CLDNSs and the following student quote demonstrated this freedom, "I'm a good student … apart from the fact that sometimes I find it hard to actually … start a conversation with patients" (S14).

Conversations between patients and CLDNSs were usually either nursing orientated or in some way related to the students' cultural backgrounds. These types of conversations dominated interactions between CLDNSs and patients at the expense of conversation related to other areas such as family, current affairs, world events, or personal beliefs about health. Typically students asked patients questions from health history forms or checklists. This restriction of conversation was seen in the following student's comment: "I'll ask just the basic things like if they [the patients] want, needed help with anything … but I wouldn't actually sit down and make a conversation with them, really talk to them" (S14).

Conversations orientated towards nursing care differed from those related to the students' cultural backgrounds because in the former the students directed the conversations but in the latter the patients were in control. The style of conversation also differed and shifted from an informal base when students' backgrounds were discussed to a more formal, goal orientated pursuit when conversations were nursing focused. Comments from clinical teachers acted to support these observations and some thought that interaction between CLDNSs and patients depended upon students' English language competency. As one clinical teacher had said "Students that have a problem with English … know that people find it difficult to understand them … so I find that they are apprehensive in initiating speech" (A14). And another teacher had commented that it was more likely that CLDNSs adhered to nursing type areas of conversation "especially if they are unsure about their language" (A115).

The following academic quote cast more light on the issue of conversation initiation:

> I think on the whole the initiation of communication comes from the RN not from the student unless the student has been in Australia a long time and then they might be a little bit more talkative. But if they are a recent arrival, which many of our students are, I think all the initiation comes from the RN. It doesn't mean the student won't respond but they… don't initiate communication. Sometimes they will [initiate conversation with patients] … but, it's minimal … and I think … sometimes to us it looks a little bit rude but I

just think for them too they worry a bit about their language, perhaps if it's not perfect they're not sure … what to say. (A15)

Another clinical teacher felt she couldn't state whether patients or CLDNSs initiated most conversations but she did comment that much depended upon the patients.

If they [the patients] don't feel well and they don't want to talk to anybody … if they find it hard to understand what they [CLDNSs] are saying [or] they haven't got the energy to make the effort, then obviously they wouldn't initiate much conversation. (A14).

Self-introduction and initiation of conversation contributed to the establishment and development of rapport between CLDNSs and patients. Of interest was the fact that some of those students who failed to introduce themselves to patients were often still able to establish rapport by engaging in conversations initiated by patients. On the other hand, those CLDNSs who were unable to introduce themselves or converse with patients were seen as having little or no rapport.

In clinical practice settings CLDNSs employed relatively few strategies, aside from formal clinical questioning to establish patient rapport. Students asked patients about the reasons for their hospitalisation and questions were often read to patients from admission forms, preoperative or preprocedure checklists, or from university assignment proforma. The following data extract, from clinical field observation notes, demonstrated this type of formal questioning. The student involved in this patient interaction had not met the patient prior to completing the preprocedure checklist nor did she introduce herself to the patient prior to asking questions. In fact, the student arrived at the foot of the patient's bed and began asking questions. The RN told the patient what was happening from across the four-bedded room.

The student continues to work her way down the preprocedure checklist. The patient is scheduled to have a series of X-rays later today. She gets to X-rays and asks the patient "Will you be taking your X-rays with you?" The patient looks at the student blankly, the student just stands there and looks back at the patient. The RN explains to the student "If we have X-rays on the ward they are to be sent to the X-ray department with the patient when she goes". The RN tries to explain that this is not the patient's responsibility but the nurse's responsibility. The student's face indicates that she is listening but looks confused. She also looks bewildered as to what her responsibilities are related to completion of the form. She goes on and asks the patient whether or not she

has 'fasted' and when she last 'voided'. The student actually uses these terms and clearly the patient does not understand what has been asked. (F.N.)

On this occasion, the CLDNSs became task-orientated and focused on completing the preprocedure checklist. Questions from the checklist were asked verbatim. Even though the student was in the latter part of her degree she was unable to rephrase the questions into layperson's words from the checklist to secure the information she needed to complete the form. Although CLDNSs did interact with patients when they used formal questioning, development of rapport was often unlikely.

Questions related to the admission process had probed patients' personal lives uncovering issues related to family and living arrangements. Once these types of issues were uncovered patients often mirrored the student's line of questioning. For example, patients began to ask the student about their own family and their country of origin. Clearly, patients were trying to establish rapport with the students and at times they were successful. At other times, irrespective of the amount of effort put in by patients, CLDNSs ignored questions or answered in a monosyllabic fashion. Effectively, they missed opportunities to establish rapport and converse with patients.

In clinical practice settings patients were identified as the primary rapport builders. Much of the conversation that occurred between CLDNSs and patients was related to the students' cultural backgrounds and was instigated by the patients who basically engaged in a guessing game in which they openly verbalised their thoughts of the student's country of origin. Although this strategy paid little attention to differentiate between the students' cultural background, as opposed to country of birth, patients were usually successful using this strategy to engage CLDNSs in conversations. The students' physical appearance, accent or names, that is, length of name or presumed ethnicity of their names, acted as triggers for patients. It was quite likely that whenever ethnicity was suspected, patients played the guessing game. Having established the student's country of birth or cultural identity, where possible, patients reminisced about their own travel adventures to that country. This occurred irrespective of whether or not the students had ever been to that specific place. Having set the scene, the students were invited to join in. From these foundations, relatively strong rapport was developed

between CLDNSs and patients in which conversation content moved on to other subjects such as the student's progress through university.

Students were not always comfortable when patients questioned them. Hijab-wearing female Muslim student nurses spoke of their anticipation of patients' questioning related to their cultural background and clothing which, for some, felt like interrogation. Others reported that over time they grew accustomed to such patient behaviours and often invited questions rather than wait to be asked. These students felt many Australian patients had to ask questions because they were not used to interacting with Muslim people, especially hijab-wearing women.

Students reported a range of feelings from being accepted to not being accepted as a nurse by their patients. Those who did not feel accepted were less likely to engage rapport-building strategies. The feelings of nonacceptance were demonstrated, for example, when a student said:

> Oh these people [the patients] don't see me as a nurse, they look at me as a person from another country and they are probably a bit scared that another person from another country is going to be nursing me. (S16)

First Time Clinical Experiences

One of the most stressful times for any nursing student, irrespective of cultural background, is probably the first time they work in a new clinical practice setting. This time is not only stressful but carries with it many other feelings such as pride and excitement. There is no doubt that at this time most students exist in a state of altered sensitivity. CLDNSs reported an inability to concentrate on their first day in clinical practice settings. Students talked about being consumed by many thoughts in addition to what had been said to them. On occasion this inability to concentrate on conversations led to students being unable to do as they had been asked. The corollary was as stated by one student "In the beginning you don't learn" (S25).

Another stressful time that related to clinical practice identified by all students was the first time they performed newly acquired tasks. Moreover, students had reported that when they performed specific tasks on patients that "Most of the time it's … the first time, the first experience of this or that or whatever" (S34). As it was their

first experience of task performance either a RN or their clinical teacher accompanied them. For some CLDNSs this supervision added to the stress they experienced when they performed tasks for the first time. Students commented "You get a bit nervous" (S34) and this nervousness was discussed by another student when he spoke of giving his first injection to a patient. He stated "I can remember the first go, I was shaking like … Hell" (S15). Whilst the RN said nothing about his physical tremor the patient asked "Is this your first go?" (S115). Upon confirmation of the patient's suspicion the patient told the student "You're doing pretty good!" (S115). This student reported the patient's feedback had made him feel "more confident" (S115).

<center>Cultural and Racial Differences</center>

As stated earlier there were other causes of SD for CLDNSs aside from communication differences. In this study CLDNSs considered themselves to be different and felt as if they did not fit in when their physical appearance or cultural ways set them aside from the dominant group. Physical characteristics of difference included, for example, skin colour, facial features, and for some students, different dress styles. Behavioural differences included, but were not limited to, for example, spending significant amounts of time with parents instead of socialising with colleagues and not eating food from sunrise to sunset during specific religious periods. When CLDNSs looked or behaved differently to members of the dominant group they often experienced inequitable treatment. Many experienced SD because of these differences causing them to feel uncomfortable and self-conscious.

Looking Different

There were many cultural and racial differences between CLDNSs and members of the dominant group. Whilst some CLDNSs looked like members of the dominant group, others who were cosmetically different had often felt as if they did not fit in with the majority of nursing students. Individual students from the latter group looked different because of their physical characteristics, skin colour, and/or clothing differences. When people look different, they have unlike qualities, they are unusual or distinct, unusual and striking (Delbridge & Bernard, 1998, p. 309). When people fit

these characteristics they attract attention. The CLDNSs in this study did not try to attract attention purposefully. During interview one of the participants used a piece of paper and drew a diagram similar to the one that follows. Whilst drawing the picture the student commented "When everyone else around you is White and you are Black, you're different and you stand out like the black spot on this piece of paper. This picture is represented in Figure 1.

And another:

> I don't know, I just have to be like … you have, you still have to be careful with what you [are] doing otherwise they … I don't know. Because we [are] the minority, or like people … stare….Like if something [is] going wrong they [then] someone can remember "Oh that's him who did it", … [I get remembered] because of my skin colour. (S28)

Essentially, this student felt he would be remembered by people with whom he had worked because of his skin colour. He would be easily remembered because he was Asian. In other words he stood out as a minority; he was different and he believed he would be easily identified because of his physical differences not his gender. Student nurses of colour were in the minority and as such they were not only different but often did not fit in. Skin colour difference existed and caused SD. This is demonstrated by comments such as "Sometime I feel very awkward because of my … skin colour" (S18).

Analysis of clinical teachers' interview transcripts revealed comments that supported students' thoughts and feelings of being treated differently because of physical differences. Clinical teachers had discussed incidents from working with CLDNSs and at the forefront of many conversations, almost as a preface, reference to skin colour was made, for example:

> I can think of a very … clear situation. Last year I had a student who was from … Africa, somewhere, now where was it? I'm thinking of a specific country. Well I mean it … certainly wasn't South Africa and they weren't White. Ok. It was a dark-skinned student from you know one of the other, sort of probably Middle African type countries. (A115)

If academics had not referred to skin colour, typically, they made reference to some other distinguishing characteristic, country of origin or language problems, setting CLDNSs aside from the dominant group.
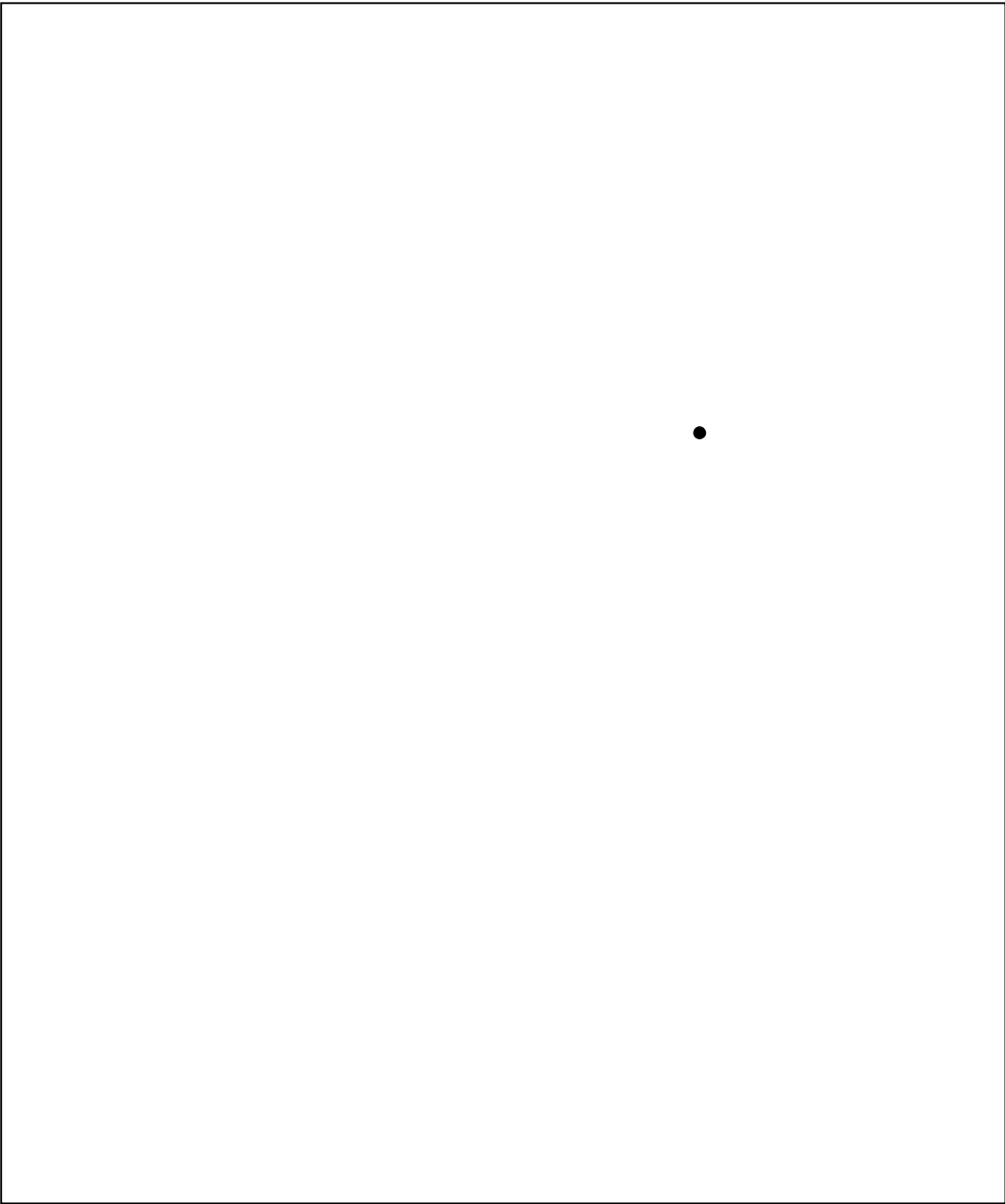
Figure 1: Black spot

Another example of SD that had been revealed and described at interview was student anticipation of patient rejection based on difference in skin colour. For example, "Is this [possibility of rejection because of] the way I am presenting myself or is it because I am Black?" (S18). Whenever Asian and non-Anglo-Saxon students cared for White people they often felt skin colour differences acted as an overt, unavoidable, almost constant reminder of possible cultural differences between themselves and the patients. For some, skin colour differences meant extra work trying to communicate effectively with Whites. CLDNSs reported having to make attempts of understanding and appreciating the patient's culture so they could try to interact. An example of this situation was demonstrated in the following student's quote:

> When I come in [to the patient's room] their culture, the patient's culture, to be able to pick out what their background is and I sort of had to respect it like trying to understand what their background is and respect them. (S15)

From clinical practice experiences some of the non-Anglo-Saxon students interviewed believed clinical teachers as well as RNs took more notice of and paid more attention to White nursing students. They believed that more time was spent educating nursing students who were White. This student-held belief was contradictory to comments made by those clinical teachers who felt they spent more time teaching CLDNSs and, further, that members of the dominant group were often annoyed by this apparent monopolisation of their time.

At the other end of the spectrum there were a few occasions when CLDNSs referred to positive outcomes of being physically different. Firstly, Asian students could easily identify other Asian students simply by their physical characteristics. Asian students had a propensity to group together or to want to be with other Asians. By simple identification, based upon physical appearance, Asian students easily and quickly formed friendly, supportive peer groups.

Clothing differences

Those CLDNSs who dressed differently to the student nurses from the dominant group also experienced SD. Female Muslim students who chose to wear their traditional headscarf (the hijab) seemed to experience the greatest amounts of SD, but not all

students from this group did so. The only other way these students' appearance differed was the fact that they wore long sleeved tops, and skirts with trousers. They covered all of their body except for their hands and faces regardless of ambient temperatures. There were many reasons given as to why Muslim women wore clothing that adhered to their religious edicts. The common thread, however, was that women who were covered were less likely to attract flirtatious interactions with men. In effect, women who were covered by clothing were supposed to be seen as less sexually attractive to men, which was meant to enable men and women to interact equally and with respect.

Nevertheless, those women who wore the hijab had experienced SD particularly when they worked in clinical practice settings. Discord existed because scarf-wearing female nurses were a minority and they stood out as being different. With the exception of specific suburbs, scarf-wearing women largely remain an anomaly in Australian culture and reactions towards these students were unpredictable. Hijab wearers spoke of the poor receptions they had received from RNs when being introduced on clinical practice. Students were met with lengthy stares directed at their clothing. These types of reactions from RNs left students feeling angry, uncomfortable, awkward, and not wanting to work with those who reacted in these ways. They had also reported meeting female RNs who told them that Muslim men oppressed them because they wore scarves. Those students who had this experience felt a great deal of SD, often wondering what they had done to deserve such uninvited comments.

Scarf-wearing Muslim students spoke of the difficulties they had in caring for Australian patients in health care settings because of beliefs about their clothing. From analysis of interview transcripts and clinical field observations it was evident that a number of Anglo-Saxon patients were not at ease when they had a CLDNS caring for them. Student nurses from Middle Eastern backgrounds felt they created more uneasiness than any other group of non-Anglo-Saxon nurses. At times students discussed insurmountable barriers firmly cemented between them and their patients. One student when discussing an example of negative interaction stated:

> Most of the time what you feel like, there is a barrier … because people don't know how to respond … some people have got personal issues that they need to deal with and they take it out on me because I wear a scarf. It's likely that they automatically assume that I'm one of them [Middle Eastern Terrorist] and that I

should be punished for sins or whatever … and that really upsets me because I sort of think I'm in Australia, I'm Lebanese … they are two totally different things and yet because I follow this religion they associate me with them … and I don't think that's fair. (S114)

Another student, also of Muslim religion, stated:

I do get nervous … beforehand, that is, actually meeting patients and their reaction when they see me … I mean they … see that first before seeing this … they see the headscarf before they see my eyes. They look straight at that and they sort of hold back, thinking … "Who are you?" (S115)

Then,

I find that once they know that I'm Arabic or Muslim … they kind of keep away … even if they are talking to you or they want you to do something for them … just to spend time with them or whatever and they find out … you are Muslim … they just don't want to spend as much time with you as they did. (S14)

Very occasionally, female Muslim students described patients as having a genuine curiosity towards their dress, religion, and culture. However, most students were fearful of rejection and negative receptions from patients because they dressed differently. Some believed patients were not relaxed with them until they had proven themselves. The following student's comment exemplified this belief:

They [patients] won't actually engage into conversation with you … until actually … [I] like show them that I'm an easy going person, and I'm only human. Then do they [they do] feel … more relaxed and more comfortable in being … in I don't know, in, in letting me treat them or you know, whether I go for do anything for you …. they see the scarf first and then they see me." (S115).

Some of the female Muslim students from this study discussed making conscious decisions to stop wearing their headscarves whilst on clinical practice. They simply felt more comfortable without their headscarves because they did not draw the extra attention usually given because of the scarf. Another student had stopped wearing her hijab because she believed her chances of gaining employment in a hospital as an RN in the future were better if she did not wear the hijab as a student. Discord reduction had been achieved in one sense; however, there was a different level of discomfort experienced related to not wearing the hijab and having one's head uncovered.

Racism

Students' talked about their individual reactions to comments and treatments received because of differences in physical appearances. Analysis of these individual reactions indicated that most had experienced one or other form of inequitable treatment. They had used words such as prejudice, inequity, discrimination, and/or racism when discussing their experiences. At times students used terms without consideration to true meaning and the corollary was that terms were used incorrectly. Nonetheless, these students had experienced inequitable treatment episodically and as a result experienced varying degrees of SD.

Racism was analysed as having presented in two ways in this study, that is, covertly and overtly. Both presentations caused problems leading to SD for those student nurses who came from different cultural backgrounds. Covert racism was difficult to substantiate; it was illusive and deceptive but nevertheless participants' transcripts indicated the existence of covert racism. CLDNSs reported their experiences of covert racism as having taken place both on and off campus. These feelings of racism had been accompanied by a great deal of doubt. Doubt existed because students were unsure if their perceptions were accurate. This doubt was evidenced regularly by students' comments. For example, during clinical practice, a student had questioned why she felt RNs behaved as if to avoid her. She said "Like I don't know, I'm not sure whether it's my Asian [looks] or whatever, but I don't know" (S34). Another student, having been denied the opportunity to resubmit a failed assignment, felt she had been treated in a racist way because as she said "They have a standard there, a procedure, that if you fail your essay you can redo it .… I wasn't allowed to redo it. I think it was racism involved" (S211).

Other comments were also found throughout students' interview transcripts that supported students' doubts about the existence of covert racism. The following example was identified as a student discussed her feelings related to interacting with teachers:

> I think maybe [teachers are] judging too much on like maybe because I'm Asian, because I am in a different country .… so I don't really know, but sometime when you try so hard you think "What is the problem?" Maybe she [the teacher] doesn't like Asian. (S34)

Another example of covert racism had occurred in a clinical practice setting when a CLDNS, having been told by a RN to participate in skills in which she was inexperienced and undereducated, declined to do so. Subsequently, the RN reported the student to the clinical teacher. The clinical teacher acted as the student's advocate and supported the student's stance; however, the student was left wondering if the RN's actions were racially motivated. As the student had said "That's where I think also the racism has come along, sometimes where they've made complaints" (S113).

Contrary to students' beliefs some academics found it hard to believe that covert racism existed. Others claimed they knew racism existed; however, they could not recount specific examples. For instance, one academic had said "I think there is [racism], but not really, no, no, I couldn't actually pinpoint [it] but I have a feeling that from time to time there is definitely [racism]" (A13). Unlike teachers many CLDNSs were able to cite specific incidents of covert racism as the previous few quotes have demonstrated. Covert racism accompanied by self-doubt led to episodes of SD.

The opposite manifestation of covert racism was overt or direct racism. Overt racism was comparatively easy to identify throughout interview transcripts and was often accompanied by objective examples. Overt racism took on a harsher form and subsequently left no doubt in the students' minds of intended meaning. The following section outlines examples of overt racism as experienced by students and demonstrated the resultant problems or SD.

The most obvious, perhaps unintentional, example of direct racism surfaced unexpectedly during an interview with an academic. Overt racism was clearly identified in the following extract:

> I've got a couple of other little theories too, that most of them [Asians] have unbelievable … teeth. A mouth packed full of teeth and so they can't speak very well…. I mean in … this day and age, in Australia, most kids have their orthodontistry. Their teeth are all straightened up and they can speak. Whereas these, some of these people, I mean, I can look at one girl, … she would have twenty teeth all screwed up and a jaw coming out as well which would have been fixed here, tightened up and she really is, sometimes, she really cannot say some words…. what she thinks she is saying is not coming out. (A13)

This specific example became overt during the course of an interview but it should be pointed out that such theories may, in reality, also present covertly.

Another academic said she thought racism occurred whenever CLDNSs and students from the dominant group separated themselves into culturally discreet groups for class work. She saw these actions as a form of self-imposed segregation signalling racism. She went on to comment that when students were segregated in such groups it was unusual that group membership altered the entire semester. This segregation also extended outside classes where students were seen to mix in exclusively, similarly-cultured groups. CLDNSs also spoke of members of the dominant group treating them in racist ways. Racist treatments were sometimes triggered when CLDNSs spoke in languages other than English and members of the dominant group could not understand dialogue. The following student's comment demonstrated this trigger in action:

> Sometimes they just … [give] … you a dirty look and they [are] racist like … they … [are] just always pick [picking] on you, like they trying to try to look [and find] something about you … that [is] different from others and they … tend to talk, tell you off every time you start to … to speak Vietnamese. I know that [this] is … because we speak Vietnamese [but it] doesn't mean we tell bad thing about them. (S12)

Racist graffiti defacing the toilet walls in nursing departments, on and off university campuses, did not go unnoticed by CLDNSs or academics. Whilst few academics mentioned the existence of racist graffiti, students had not only mentioned it but also discussed their personal reactions. Racist graffiti on toilet walls contributed to students' perceptions of the existence of racism in their immediate environment and as such it was considered a form of overt racism. Many were clearly offended by racial slurs adorning toilet walls even when the message was directed towards other racial minorities, for example:

> There's something I have read in the hospital toilets and there's something's I have read here at the University toilets … racist statements written on the walls in the toilets and it said … like I read this statement the day before yesterday and it said "What is the highest degree for an Aboriginal?" And then you get answer "a cleaner" and I think that's really sad. Or I read this other comment in the toilets "Get all the Latin bastards out of university, they should be out cleaning toilets". That's where they should be do you know? And there's lots of other comments about Asians, mostly Asians … other than anything else but I think it's really sad. (S10)

This anti-Asian genre of graffiti was also reported by other students and one had commented "The graffiti in the toilets is quite disgusting, there is a lot of anti-Asian feeling that I am picking up from that graffiti" (S13).

One student's reaction to racism was demonstrated in the following quote:

> I get rid of it [graffiti] immediately and I think … of … the others from non-English speaking backgrounds … people who actually [are] more conscious about it [racism], that's why, it's really, really upsetting and you think about it (pause). We're here getting an education! (S10)

Clinical practice settings were not free of inequitable or racist treatment and CLDNSs were often the target of racist type comments from patients. There were times when patients were known by nurse teachers and academics to treat CLDNSs differently to members of the dominant group. Disparity during interaction was often demonstrated when patients made demands of the CLDNSs expecting servant like responses. Further, clinical teachers had heard patients "refer to them [Asian students] as slanty-eyed little people" (A13).

Students had also discussed their experiences of racist interactions with patients. For example, a patient had accused two CLDNSs of filling educational places that he believed should have been filled by Australians. Both CLDNSs responded to the patient's claims, one acted as her own advocate by saying "I've been in this country for so long and … I don't think I've wrecked anyone else's chances, I've had to work hard just to get where I am" (S113) and the other responded by "swearing" (S113).

In clinical practice settings female Muslim students had thought they were at times treated inequitably on racial, religious, and/or cultural grounds. Feelings of inequitable treatment had surfaced when male RNs asked and encouraged only non-Muslims to work with them or to perform specific nursing skills under their supervision. Female Muslim students believed that Australian male RNs probably acted in such ways because they were unsure and ignorant of Muslim culture, especially male to female working relationships.

From analysis of CLDNS interview transcript data it also became apparent that students disliked the racist manner in which many Australian RNs interacted with members of their cultural group who happened to be patients. For example, one student

had commented that she felt her mother had been treated "like … dirt" (S114) by Australian RNs because she was from a different cultural background and did not speak much English. Another had spoken about the ways Australian RNs had discussed hospitalisation of overseas travellers saying "They were lucky to get [medical] treatment in Australia in the first place" (S13). Other students had picked up that RNs believed that provision of care for non-Anglo-Saxon patients created extra work and that RNs believed non-Anglo-Saxons had no right to complain about care they received. Furthermore, these patients were labelled as demanding. CLDNSs who came across RNs who vocalised negative attitudes towards non-Anglo-Saxon patients were hesitant to identify themselves as having non-Anglo-Saxon backgrounds. Moreover, they felt uncomfortable and self-conscious working with RNs who made these or similar comments. In other words they had experienced SD.

Other CLDNSs had discussed their experiences of coming face-to-face with cultural "put downs" from RNs in clinical practice settings and being unable to react. For example, one student spoke of being greeted by an RN on clinical practice and after the student had introduced herself the RN made the student aware that she was visually examining her physical appearance by inspecting her from head to toe. Following this nonverbal interaction, which had made the student feel uncomfortable and self-conscious, the RN said to her colleague "The only thing similar to all the students are their uniforms" (S113). This comment, coupled with the preceding visual inspection, was seen as derogatory and racist by the student and consequently she felt intimidated.

Although there were many reports by CLDNSs of being treated negatively or inequitably on the grounds of being different, there were also some reports to the contrary, that is, not every student interviewed for this research felt they had experienced racist type treatment. Although few in number, there were reports of positive clinical working environments in which CLDNSs reported they "haven't come across one [RN] that was racist" (S17).

Clearly both forms of racism, that is, overt and covert, had led to situations in which CLDNSs experienced episodes of SD. Students were made to feel uncomfortable and often doubted the accuracy of their own perceptions of racist treatment. Students also suspected many of their negative interactions with members of the dominant group

to be racially based and triggered because of differences in physical appearances. Student interviews showed variation in beliefs of what actions by others were considered as discriminatory treatment. Whilst some made claims of racism or discrimination under certain circumstances, others, in similar situations held different views, views in which neither racism nor discrimination were considered to exist. Such opposing views suggested that prejudice, inequity, discrimination, or racism, regardless of cause, were essentially interpreted individually. In other words, events that were considered racist by one student may not have been considered in the same way by another student. Examples of such opposing interpretations and labelling of situations as negative or otherwise were seen in the following student's data extract. On this occasion one student discusses her friend's perception of racism.

> I don't know, well, when she does something wrong and they reprimand her … sometimes and I mean, they are not being discriminating. No. But she does [think so]. I don't know why. I tell her it's all right. I means I don't think they're being racist or anything [but] she say "No, no, no, I think they were being racist". (S19)

Behavioural Cultural Differences

There were a number of aspects of CLDNSs' behaviour that were different when compared with the dominant student nurses' behaviours. These differences were thought to be culturally based. For example, CLDNSs families often had greater expectations of them to take on an active role in family engagements and responsibilities. Also, dates of cultural significance impacted upon CLDNSs behaviours.

Family expectations

Family expectations have been detailed in chapter 2, however, it is important to reiterate that family expectations impacted upon CLDNSs behaviours making them experience episodic SD. When CLDNSs engaged in behaviours expected by their families they were seen as being different to members of the dominant group. For example, instead of going out on weekends with their friends from university to engage in social activities, CLDNSs often stayed at home and participated in family functions

which have been described in chapter 2. Essentially CLDNSs often engaged in family expectations which made them different to members of the dominant group. Because they were different they experienced SD.

Dates of cultural significance

Students from different cultural backgrounds were known to experience SD. Many had experiences when dates of cultural significance went unrecognised by university and hospital planners. This type of situation often occurred in clinical practice settings where, for example, Muslim students were required to work during the period of Ramadan. Clinical teachers had problems in clinical practice settings when Muslim students fainted or otherwise felt poorly because they did not eat during the daylight hours. These students were reported as not having the stamina to complete their shift without taking rest periods. An example of problems that occurred in clinical practice settings as discussed by a clinical teacher follows:

> During the Ramadan, normally in hot weather (laughing) they [Muslims adhering to Ramadan] have to have breaks, they feel a little faint because they're not eating, not drinking … and I said to one "You should try to eat before dawn". (A116)

Other students had made comments related to problems their colleagues experienced because dates of cultural and religious significance had been ignored on the university calendar. Because of the lack of recognition of dates of cultural significance some students either took the time off, away from university, or they attended university and missed out on culturally significant events. Either way many experienced SD.

Teaching and Learning Approaches

During interview many of the CLDNSs had expressed their individual preferences for learning environments. Some preferred lectures, some tutorials, others preferred the laboratory learning environment, and others enjoyed learning in clinical practice settings. Those who preferred laboratory settings commented they were able to learn the desired task by copying the demonstrated behaviours without having to read English textbooks.

Whilst some CLDNSs expressed their preference for learning in lectures rather than tutorials and laboratories, there were others who disliked lectures. The most

patterned feature of SD related to learning in lectures was that CLDNSs had problems understanding the lecturer. Problems arose for all the reasons previously mentioned, for example, abbreviations, accents, and pace of speech. Those CLDNSs who could not understand the lecturer found they were unable to keep up in class, they had difficulty with taking lecture notes, and struggled to follow dialogue. Clearly, they were left behind. These students knew they would have to catch up somehow. In the event that they were unable to catch up many believed they would be at risk of failing.

Even though tutorial class sizes were always smaller than lectures, and most CLDNSs had expressed a preference for tutorials over lectures, a degree of SD related to attending tutorials had been reported. Discord that occurred in tutorials was, once again, related to the students' feelings of embarrassment or loss of face associated with the prospects of, or actually making, speech errors in front of other people. Discord was also experienced when CLDNS were shy or afraid of making contributions. This shyness was demonstrated in the following student quotes: "I couldn't understand why I was so shy. I wouldn't open my mouth, I wouldn't make any comment on anything. [And the] Tutorial was such a waste with me because I wouldn't put in my two cents worth" (S24) and "First I wasa … scared and real shy in … tute, but then I said 'Why?' I notice likea 'Who cares?' If I be quiet they think I'm a stupid and I don't know anything" (S32). Again these feelings were directly related to making speech errors. When CLDNSs feared making speech errors they usually avoided speaking; they had a propensity to sit quietly and let others make contributions. By being quiet, however, many CLDNSs drew unwanted attention to themselves.

Some students commented that they were not capable of active tutorial participation. These were unfamiliar behaviours because they went to schools overseas, in educational institutions that used traditional, passive modes of teaching. Consequently, when these students studied in Australian universities and were expected to participate in tutorials they experienced SD. Perhaps the most moving example of this lack of familiarity with tutorial behaviours expected in Australian Universities was demonstrated when a student confided that in the beginning of her degree she sat in tutorials thinking she was in a meeting of students who all sat around chatting. She would sit waiting quietly for the tutorials to start. She commented that it was not until a

number of weeks had passed and a discussion with another student that she realised these chat meetings were in fact the tutorials.

Another example of this lack of familiarity with expected behaviours in Australian universities was seen in the following quote:

> In class I like, in a way it's like, I still find it hard actually because … well this, well I tell why? In the class I find it's a different culture like here or students here are more sort of vocal. As far as education, [I am] certain that it [is] part of the education system here that Australians [are] encouraged to verbalise their idea but in my culture (laughs), well, we not programmed that way. We [have] been given our reading subject and given things to learn and [the] teacher would just tell you what you going to learn for exams. Not like here … it's discussion tutorial and sort of you discuss it with the students but … during discussion I find sort of … feel … hesitant to voice my ideas. It's like because it's foreign to my culture. You not encouraged to voice your idea. We're not encouraged to voice … or explain my idea, so here we got a discussion, but it's not as much as I would like to. I feel like … I sort of am not expressing myself. I sort of feel [I] should have discussed more of myself but I can't do that … so … I sort of routinely doesn't … want to do it. (S22)

SD also occurred in class for some students when students talked simultaneously. Discord was created because the subsequent noise distracted CLDNSs from concentrating on single conversations. When CLDNSs had difficulties with English, this type of environment contributed to and compounded their communication problems. It was culturally inappropriate for most of them to interrupt others and they could not understand conversations when people spoke simultaneously.

CLDNSs had also reported their dislike of being in clinical practice groups in which they were the only non-Anglo-Saxon students. Several reasons existed for this; however, of significance was the notion of not being able to learn from colleagues. CLDNSs believed when they were grouped together for clinical practice that they would learn from each other by sharing their experiences. When they were placed with members of the dominant group they were less likely to share their experiences and found it more difficult to learn from these students.

Some academics had also reported that members of the dominant group disliked working with CLDNSs because they believed that they did little preparation, rendering them incapable of contributing to the group. Consequently, members of the dominant group believed that they carried CLDNSs unfairly. Specifically, they felt as if they did

all the work and the CLDNSs got the same marks. Other academics believed these perceptions to be false. Rather, they thought CLDNSs were prepared for group work but were quiet and unwilling or unable to participate.

When working in culturally mixed groups, members of the dominant group usually took on the role of dividing and allocating the necessary workloads. Work was divided so as to enable members of the dominant group to collate and polish the group's work in preparation for submission or presentation. At times, this meant that CLDNSs did most of the work, that is, they went to the library and gathered the literature, read it, and drafted papers. Dominant group members were reported as doing "the typing … and the checking" (S11). CLDNSs who found themselves in this situation were not altogether comfortable with the division of labour but felt unable to make any changes.

Not fitting in and belonging

There were numerous comments made by CLDNSs indicating that they felt they did not fit in or belong in classes with members of the dominant group. Whilst those attending laboratory and tutorial settings were provided with opportunities to work in comparatively smaller groups, or pair up with members of the dominant group, many expressed a preference to interact with other CLDNSs. When their preferred group of colleagues was unavailable they rarely joined in conversations and they often felt left out. Those who felt left out expressed feelings of despair and frustration because they did not enjoy attending classes under these conditions. Feelings of this nature were demonstrated by the following quote:

> [This] made me upset one day, very badly, because I said to myself "What I'm going [to] do? I can't make them like me. When [are] this [these] lab [laboratories] going to be finished so I don't have to think about it? It wasn't, you know, instead of being pleasurable I suppose … it was really frustrating for me. (S32)

CLDNSs also held the perception that very few members of the dominant group had a genuine interest of interacting with them in tutorials. Some of the CLDNSs felt they had put considerable effort into communicating with members of the dominant group, but believed these efforts to have been largely ignored. As a consequence interaction did not occur. These acts of ignoring were seen in the following CLDNS's transcript extract amongst comments related to interacting with members of the dominant group.

"Sometime they not bother answer my questions … maybe because … maybe …. they don't like … you … don't bother to speak to … me" (S21). Another student felt ignored by members of the dominant group when he said "Some presentations we have to do and as soon as I start speaking, because I have an accent, they [members of the dominant group] just turn away" (S10). Whenever members of the dominant group ignored CLDNSs' attempts to interact they felt rejected and they experienced SD.

In relation to group work, CLDNSs had experienced SD on many fronts. Wherever the term group work appears in this study the reader should consider occasions in which several students were required to attain prescribed learning goals together. Group work had taken place in laboratories and tutorials as well as outside of formal classes. During these latter occasions students were responsible for arranging meeting times and places. For some CLDNSs the very act of getting into a group, as requested by teachers, had caused SD. From the very beginning discord was experienced because CLDNSs were often left out of groups. In other words, they were not included as part of a group when groups were being formed. Instead, they joined smaller formed groups to make up numbers.

Upon reflection about joining student groups one student thought her approach to members of the dominant group might have been too formal. She had said "Good morning, do you want to work with me? I want to work with you today" (S32). Members of the dominant group were reported as having laughed at this and similar attempts made by CLDNSs to become group members. Of those CLDNSs who had secured a place in a group with Australians, many had made comments about feeling left out and uncomfortable within the group. Some reported moving on to other groups hoping a different group would be more receptive of them but those who stayed felt left out because of problems related to communication differences. In other words they were experiencing SD.

CLDNSs felt uncomfortable working with Australians students because they perceived them to be generally unwelcoming and culturally different. Students had made comments reflecting this view, for example:

> If I say something humorous, like … when I go into a group, that I don't even
> know them, so that's also different for me because … they just don't think it's

funny or they have their own views, you know, "We've already got our own group … most of the time I don't fit in". (S113)

CLDNSs had commented that they needed to feel as if they belonged in any group before they could participate in group activities. This need was demonstrated in the following comment: "You want to make sure that you feel wanted. You know, make sure you fit in somehow. Whether you be the smart one or the other one … basically I try to get along with people" (S10). Others had discussed their experiences of working in diverse groups. Students commented, for example:

> If I go into a group where there are [a] few other non-English speaking background students they probably listen to me but if I get into [a group of] … Australian people or White … people maybe one or two out of the group would … bother listening to what I say. (S16)

This student went on to make this comment about working in groups comprised solely of members of the dominant group: "Last year was [a] really bad year for me. I was sort of being properly rejected" (S16). He also discussed the repetitive nature of joining new groups and how much time he spent working through the same negative feelings. His comment "I thought this was going to kill me again" (S16) summed up his feelings of discord. Eventually he came to a point, some 18 months later, when members of the dominant group had grown accustomed to him.

CLDNSs also believed that members of the dominant group did not want to work with them in group situations because stereotypical images portrayed them negatively. These students spoke of being stereotyped as difficult to work with because of their different cultural backgrounds and perceived, or real, language problems. In fact, CLDNSs often commented about communication difficulties causing SD. The following data extracts give examples of how CLDNSs felt about group participation:

> Sometimes … I find that … if I can't get my point across to the others, I sort of like hold back, or I just stay quiet first or I say it again until they actually say "Oh, ok, we understand you". [Sometimes] … they actually respond to it, that's what I wait for. (S115)

And

> Something stops [me]. I don't know (pause). Also because of my accent that's when I (pause), with my accent, my um (pause) and my sort of um, my just, vocabulary, sort of limited. At time [Sometimes] when I say things I just sort

of don't want to. I can't think of the way I want to say it, I sort of lose the flow, the flow of my idea. Sometimes not … like speak to the group. You want to say some things and you just feel threatened or bad … I might give wrong impression and I'd rather just not say it. (S22)

The student who made the latter comment went on to say that most of her culturally and linguistically diverse colleagues felt the same way, that is, "They hold back … someone overpowers them [talks over them], and they can't get their point through, they hold back and they just keep quiet" (S22).

Academics had made similar comments based upon their observations of students in group work situations. Although CLDNSs were physically present it appeared as if they were ostracised within groups. Furthermore, academics felt that some members of the dominant group were "overpowering" (A111), making it less likely that CLDNSs would be active in group activities. This was seen in the following quote:

> I find it really hard to sort of (pause) um (pause) say like (pause) to have [to] say what I want. I tend to become, just you know, to get along with them. Especially too, just to agree with whatever, especially with the um … stronger ones. Sometime if I don't agree I might say one or two things but … that's about it. I don't sort of really make my point clear. (S37)

Academics had made other comments about members of the dominant group not wanting CLDNSs in their groups, for example:

> In problem based situations … they have to form groups … and they get a choice as to what groups they form … it can be difficult sometimes. They [Australians] avoid, they do not want the NESB [non-English speaking background] student in their group because of the difficulties of working with that student. (A117)

As this academic had received formal written feedback about the units in which she taught she knew of the problems members of the dominant group had when working with CLDNSs. Sample comments from these feedback sheets follow:

> [I] couldn't understand the presentations from the overseas students; [I] found it difficult to communicate; [I] had an overseas student in my group and we couldn't … explain to him … exactly what the whole assignment was about. We struggled with that for weeks before we could even get to the topic and start to work. (A117)

When discussing feelings of rejection, most CLDNSs were hesitant; however, some had made comments indicating that they could appreciate the frustration members of the dominant group felt when communicating with people for whom English was their second language. This appreciation of frustration was apparent when CLDNSs talked about the times when they too felt frustrated because they could not understand what was being said to them.

Many CLDNSs felt left out and isolated when they were required to work in groups largely made up of students from the dominant group. This isolation was described in the following quote:

> In tute groups, because I don't know them, all right … [it is] like a party … I mean like with this sort of a big group and they were talking to each other and those kind of stuff, I just isolate myself. (S36).

Much of the discord CLDNSs experienced was in some way related to speaking in front of an audience.

Speaking in front of an audience

Speaking in front of an audience meant CLDNSs spoke under circumstances in which there were more than two people present. By far the majority of students in this study disliked speaking in front of an audience because of their preconceived fears of making speech or content errors. As previously stated these preconceived ideas caused SD for students, due to embarrassment or loss of face. CLDNSs had discussed their preference of giving presentations in front of as few people as possible. An example of this preference was seen in the following quote: "I think it's [if it is] just another one [person in the room] will be ok [to do a presentation] but more than two or three [other people] is no good" (S11).

CLDNSs were often required to give oral presentations in tutorials on campus, but oral presentations were also required in clinical practice settings in the form of nursing handover or case studies. Most CLDNSs in this study were inexperienced in giving nursing handover to hospital staff; however, most had been required to practice giving handover to their fellow students. The fact that most handovers given by CLDNSs were for practice did not alter their experiences of SD. Case study presentations that took place in clinical practice settings often formed part of the

students' course assessment and as such it was necessary that teachers attended so they could allocate grades.

In regard to speaking in front of others, CLDNSs reported that they not only felt embarrassed but "shy", "silly", "nervous" and "self-conscious". Some of the female CLDNSs had never spoken in front of an audience before. This was a totally new experience because it was not the norm in their culture. This newness of experience was portrayed in the following data extract:

> I think I'm very nervous for to speak something because when I was in my country I just, to speak to, some people I know them … I never speak to people, the stranger people, I never meet them. I have no this custom to speak … so I think it's quite different especially for men, if, for when I was in China the men, I never meet them. They [could] speak to me, if just to know, nothing happen, just to speak on something, I think these things is very stranger so I don't like, just for the cultural traditional cultural so it's [I am] very nervous to speak. (S211)

This particular student not only lacked experiences of speaking in front of others, in her culture women were not meant to speak to men unless men initiated the conversation. Compounding this difficulty, she believed she should only ever have spoken to the men she knew.

> Lack of experience and nervousness was also seen in the next quote:

> First time [I had to give a presentation] it [I] was like so scare [scared] … because like in Hong Kong we didn't have like this … presentation because I didn't go to the university in Hong Kong. So probably the others had it in high school or in other study group. We didn't have the like presentations. (S11)

Analysis of academic data supported the finding that some CLDNSs had difficulties giving presentations because they were not used to it. This was seen in the following academic's data extract:

> In large groups, in tutorials I'm very aware that for some … it's a very scary thing to ask them to do, you know, when you're assessing it, … really [it] isn't an equal task, I mean, for Australian, Anglo-Australian students it's just part of what they've done probably a lot of their life, you know, in the classroom and various things and for some Asian students I think it's a very scary thing to ask them to do, they're not at all used to it. They have to do a bit of a case history and a presentation and the presentation is always difficult for them … they have a shyness about doing seminar presentations" (A12).

Others had similarly commented, for example, "I think … presenting in a language which is not your primary language is enormously stressful" (A17).

Academics were also aware of CLDNSs' problems of getting themselves understood by their colleagues, especially when they were required to give formal presentations to the class. As one academic had said "This particular student has a presentation to give in the next couple of weeks and I know that maybe one word in 20 the Australian students are going to understand" (A117). Academics had spoken of other factors that they believed hindered CLDNS's presentation skills. For example:

> They [CLDNSs] will do student presentations together, so … rather than seeking the assistance of Australian students who could really act as a buddy, act as a facilitator, they [CLDNSs] work together and their presentation may be well below standard. (A23)

Sometimes CLDNSs held misguided beliefs in respect to giving presentations to their colleagues in class. This was seen in the following quote:

> But I think because the culture is different, even like my English is not good, even like my presentation probably is not so good but I think the Australian people they don't mind about you, like, language or they don't like look at you, or how you say, how to describe? (Laughs) Um, I think it's different, like in Hong Kong if you doing a presentation so, so many people look at you or they would like pay attention [to] your speaking or [to] your everything. But in here they don't. I mean the Australian people they just don't mind, you can do … what you wanted to, or I mean they listen to us but they don't give like, I think it's judgment. (S11)

This belief, that members of the dominant group did not judge CLDNSs when they gave oral presentations, was incorrect and much of the data coded at this category showed that members of the dominant group did judge CLDNSs especially when they gave presentations.

Academics had also commented about how members of the dominant group reacted when CLDNSs spoke in class. Many members of the dominant group were reported to "hate it because they can't understand what they [CLDNSs] are saying" (A13) because "their language, their descriptions of whatever is … not understandable" (A13). Teachers had characterised members of the dominant group as being rude when CLDNSs gave presentations and these rude behaviours were more noticeable in second

and third year classes. The following academic's quote described the way some members of the dominant group acted towards CLDNSs when they were giving oral presentations in class:

> They [CLDNSs] suffer the unspoken ire of the rest of the group. They [members of the dominant group] may not really pay attention. They don't … particularly first year … the students will be more … accommodating initially … of students with difference but as time goes on … I've noticed they are less accommodating. They get frustrated and irritated and they are likely to talk through the [CLDNSs'] students' presentations … they actively don't … assimilate those students. They leave them where they are, on their own. I think there's … probably lots of reasons for that too, but it's quite difficult talking to people and communicating with people from … another culture whose English is not particularly sound. (A23)

Interestingly, CLDNSs had also made comments about listening to presentations in less than fluent English and offered reasons as to why they believed problems occurred. For example:

> I think also with her it's her nervousness that stuffs it up as well you know. She … can't speak properly as it is and then when she gets all nervous it makes it that much harder [to understand her]. (S112)

Not all CLDNSs avoided speaking in front of others. During interview one CLDNS spoke of the times she had unsuccessfully attempted to speak in class. Basically, her attempts to speak in class were unsuccessful because her voice was never heard. As she had said:

> Like the way I speak or something, it doesn't make the other people get attention compared to the other, like Australian girl …. but when I'm saying it, I don't know why, what's wrong with the way I'm saying, but it never, like, it tend to be never get attention from the lecturer, like the teacher or facilitator. (S12)

Academic transcript analysis also revealed that very few CLDNSs were ever given a choice in respect to speaking in front of an audience. Many student assessments were based upon one form or another of student presentations. CLDNSs had no choice but to speak in front of an audience irrespective of all the reasons why they would have preferred some other form of assessment.

Asking and answering questions

Data analysis also revealed that communication problems causing embarrassment and self-consciousness acted to deterred CLDNSs from asking or answering questions. A typical example of hesitancy in asking questions follows:

> If you ask some question and some student feel … it [it's a] silly question or something you know, even [though teachers] they say "[there are] no silly question in this world", but some student will because they are so criticise [critical] or something they feel "Oh, what a stupid question". Or because the teacher already did answer or something and you couldn't understand and ask again and they go "Oh look, what a stupid. English not good that's why she asked again". (S22)

For others, problems occurred because asking and answering questions meant speaking in front of an audience. Again students were concerned that they may have mispronounced terms or said the wrong words and been laughed at by members of the dominant group. Others commented they lacked confidence and felt unable to speak to ask or answer questions in class. As one CLDNS said "In here (student points to her heart) I can't do that but I can't you know, it will upset myself actually ... upsets, I'm not … like strong enough to stand up and do the asking" (S21).

Irrespective of discomfort and fear most CLDNSs lived with a feeling that others, especially their teachers, expected them to participate in class by asking and answering questions. After all, members of the dominant group were doing both, that is, asking and answering questions, and CLDNSs felt pressured to do likewise. As one student stated "I really can't, I want to ask … I feel … very silly, I should ask … but I don't like it" (S37). Others expected not to have to answer questions in class and appreciated learning from members of the dominant group when they answered questions.

There was also a small number of CLDNSs who believed asking teachers questions was taboo behaviour. In other words there was no way they could approach their teachers to ask anything. To do so was considered disrespectful. This was demonstrated in the following quote:

> I had a student sitting in this room … saying to me she couldn't possibly ask a question because she was 25 years old. She'd never asked a question of a

teacher in her life. It would be too disrespectful and after all a teacher knows everything. (A15)

This student held academics in venerated esteem, as well-respected people who had great knowledge and who should never be questioned.

CLDNSs had made many comparisons between themselves and members of the dominant group. In respect to asking and answering questions in class CLDNSs held the view that members of the dominant group acted with greater speed. Sometimes this left them sitting with their hands up in the air waiting to be invited by the teacher to speak. Members of the dominant group spoke without using the formality of raising their hand. When CLDNSs waited to be asked to speak they made comments such as "You have to wait, wait, wait, it's run out of time and you couldn't have the time to ask anything and to learn from anything" (S12).

There was a small number of CLDNSs who had indicated a desire to ask questions in class but were unable to do so because they were essentially overloaded and pressured just to keep up with the lecture content. This was demonstrated in the following comment: "It's a bit hard for you to think and consider all the question and then later on … you know just [have] so many questions in your brain" (S12). This student had enough to do just keeping up in class without having to formulate questions and find the courage to actually ask the question in front of the whole class. She did, however, have plenty of questions to ask.

Obviously not all CLDNSs avoided answering or asking questions. Some had mentioned their frustration at having to repeat themselves when asking or answering questions because people had not understood them. The following quote demonstrated another student's willingness to ask questions in class:

If it's something, if it's a question really like related to the whole class, I will ask. I raise my hand and ask the question but if it's something personal, like just for myself, I will waits for the lecture to finish and I then approach the lecturer. I ask it later. (S26)

Academics had also commented about how, by the time CLDNSs were in third year classes, they seemed to ask "plenty of questions, probably the same as their Anglo-Australian colleagues" (A22). This latter comment also suggested a maturation process of increasing confidence in communication occurring with the passage of time.

Impact of Cultural and Racial Differences

The impact of cultural and racial differences was significant. These differences often set CLDNSs aside from members of the dominant group and affected interactions especially in clinical practice settings. CLDNSs felt as if members of the dominant group had interacted with them differently because they looked different or dressed differently. Some believed members of the dominant group interacted with them differently because of their religious beliefs and presumed religious affiliations. There were times when cultural clashes occurred meaning individuals from two different cultures met under particular circumstances and problems existed because of cultural differences. There were also occasions when CLDNSs had difficult encounters with elderly patients because they looked different and reminded the elderly patients of their war time experiences. The intimate nature of nursing care had also led to difficult encounters for CLDNSs with patients because of cultural differences.

Impact on interactions with students from the dominant group

Cultural and racial differences impacted upon CLDNSs interactions with their student nurse colleagues. CLDNSs believed members of the dominant group were largely ignorant of cultural differences. One student commented that whilst most members of the dominant group would have heard of Islam very few would have any understanding. Muslim nursing students also felt that members of the dominant group were ill informed of their dress differences. CLDNSs felt members of the dominant group often ignored them rather than attempting to make friendships. CLDNSs feared being laughed at or ridiculed by members of the dominant group causing them to withdraw and adopt a quiet persona. Students from the dominant group had difficulties understanding cultural differences related to family commitments. There were times when CLDNSs reported being teased by members of the dominant group because they had to attend family outings. There were many other occasions in which members of the dominant group avoided contact with CLDNSs. This type of behaviour served to make CLDNSs feel different, unwanted, devalued, isolated, and ostracised; they felt they didn't fit in. In effect they were experiencing SD.

Dissimilar connections

A type of rapport with patients based on cultural differences was evident in this study. This rapport, based on connection by differences, was similar to that reported by Australians who, having spent many months overseas, away from home and all things familiar, came across other people from Australia. Under these circumstances people described a feeling of being connected to complete strangers. This feeling of connectedness had cultural similarity as its base. A comparable feeling of connection had occurred for many CLDNSs when they came across patients, or RNs for that matter, who had a background akin to their own. Backgrounds need not be identical; the fact that both were from minority groups appeared to create a sameness that acted to connect these people. Because this connectedness existed a degree of rapport followed. CLDNSs did not report engaging any actions to establish this type of rapport. Instead, under these circumstances rapport was taken as having a given existence. This phenomenon was illustrated by the following student quote:

> I think there are a lot of positive things for me as well as patients. I think that especially for a non-English speaking background patient whoever they are, wherever they come from, I think there is a lot of benefit because I can relate to them. You see I have a whole culture here of people like them who can not speak English, very good English and whatever nationality they are … I think that because I'm used to it, relating to these people, years and years of interpreting for … family members, the friends … I've just become so used to it that I think I can, even if they [only] speak a couple of words I can tell what they're thinking, what they are feeling, or what they want, so I think it's a great benefit for them … I mean for me too. (MS2)

Teachers who worked with CLDNSs and culturally mixed patient groups were also aware of this phenomenon as seen in the following student's quote:

> The clinical supervisor … asked me to admit her … and she goes "I think it's an advantage that you are Fijian because you, I think other people from different backgrounds other than Australian would feel more comfortable with … another person with a different background other than Australian". (S18)

In the preceding quote the clinical teacher had referred to similarities created by cultural differences. That is, the student had a non-Anglo-Saxon background as did the patient. Whilst neither was identical, neither was Anglo-Saxon. Not being Anglo-Saxon was the common factor. From this common base, patient rapport would develop and put the new patient at greater ease than if she were admitted by an Anglo-Saxon nurse. This

phenomenon of sameness was seen as one of the unique contributions that CLDNSs could make to the Australian nursing profession.

In this case, whilst advantages of a CLDNSs caring for non-Anglo-Saxon patients existed, disadvantages were also apparent. One of these disadvantages was the fact that neither patient nor student had English as their first language. The base of this communication dyad was English, the weaker, second language. With weaker communication dyads communication problems were more likely to have occurred. Examples of these problems were evidenced in the following student data extracts:

> I didn't know what we were supposed to do with a lady in a shower so I went in, she's Italian, she couldn't speak English and I ask her, … and then she keep on shaking her head and then I went in … and … started to ask her like you don't mind if I … given you a shower? And … she keep on shaking her head … and I must assume she's saying "no". (S15)

And:

> I was looking after her so they said "Look you can help her have a shower", which was fine … I was told that I would never leave a patient who needed shower with assistance, I would never leave them alone in the shower … but she was very embarrassed, like she didn't really want me there … she got terribly embarrassed and … again I couldn't explain to her "Look, I appreciate your privacy, I'll leave you alone as long as you do not try to get out of the chair by yourself" …but I couldn't tell her that … I had to stay with her. (S13)

It must, however, be remembered that although this kind of rapport was common it did not always exist for all interactions between students and patients from different cultural backgrounds.

Intimacy and culture

The provision of intimate nursing care often posed problems for many students not just those from different cultural backgrounds. Intimate interaction in this study referred to those occasions when students had to deal in some way with patients' genitals, breasts, buttocks, or anus. As this study investigated the experiences of CLDNSs this next section focused on these students' experiences of intimate nursing care.

Female CLDNSs seemed to experience more discord in respect to intimate nursing care than their male counterparts. Many of the female students interviewed perceived intimate interactions with male patients as problematic because they were

unfamiliar with such encounters. Some female CLDNSs were half way through their course but had never washed or showered male patients. Academics had reported their knowledge of CLDNSs who had completed their course and not cared for male patients at all. Whilst it was recognised that similar situations may have existed for female members of the dominant group they were less likely to have had to come to terms with religious or cultural restrictions related to viewing and touching male bodies, specifically, genitalia. In addition, they were more likely to have the necessary communication skills to enable them to interact comfortably in these situations.

Although analysis of interview transcripts from male CLDNSs did not uncover data related to intimate interactions in the same way, clinical teachers had mentioned scenarios in which males had been embarrassed whilst providing intimate nursing care for female patients. Because analysis of male students' interview transcripts did not reveal provision of intimate nursing care to be problematic the following section refers to culturally and linguistically diverse female students and their interactions in the provision of intimate nursing care for male patients.

Discord was believed to have existed for some students because of direct or indirect sexual innuendo occurring at the time of giving intimate care. Sexual innuendo came directly from patients or alternatively, the students had thought the patient may have been thinking about sexual references when they were providing intimate nursing care. Examples of direct and indirect sexual innuendo were identified in student interview transcripts. Direct sexual innuendo was seen, for example, when one student was assisting an RN to stand a partially paralysed patient to pull up his underpants and trousers. At this time the patient had said to the student "Some other time I might feel like, you know, with, you know pulling my pants that I might feel something … about sex or think like that and he said 'I don't have this anymore'" (S36). This student questioned "If he doesn't have anymore … why is he thinking about it? … why he was talking about it?" (S36).

Another CLDNS encountered numerous interactions with male patients in which she suspected sexual references existed. Such encounters occurred when she was sponging or showering young, male patients. Whilst no direct evidence of the patients making sexual innuendoes existed the student questioned herself about the act of

sponging or showering males and how they may have made sexual connections to what she saw as part of her job. Discord existed because she believed younger male patients may have made sexual connections to her actions as she washed them. These same difficulties did not arise for this student whenever she washed older male patients because as she said "I know that in their minds they wouldn't be thinking of any [anything] bad [sex] … they accept it … they understand that washing them is part of my job" (S34).

There were other occasions when CLDNSs talked about feeling uncomfortable during intimate patient interactions. Students had stated that they were embarrassed "Because he is male and his organ is different" (S11), "It's a bit weird … because I never been in that kind of close to male patients before" (S12). Students discomfort was further evidenced by their avoidance of using correct terminology such as penis, testes, or scrotum. Instead, students referred to male genitalia using obscure terms such as "bits" (S34), "bottom" (S33), "it" (S36) and "parts" (S13).

Every now and again CLDNSs had put themselves into the patient's position and talked about embarrassment related to nudity. These students believed being naked in front of strangers, even nurses, would have been embarrassing or made the patient feel vulnerable. One student had commented that she felt awkward when showering a particular patient because she knew the patient was embarrassed about being nude yet she also knew she could not leave the patient unassisted in the shower. In this situation, irrespective that the patient was female, the patient's embarrassment confounded that of the student's, exacerbating an already uncomfortable situation. The student said "I had to stay with her but I knew she wasn't comfortable … everyone has their own rituals about how they clean themselves … what [body] parts they like to clean first" (S13).

Intimate nursing interactions were known to act as barriers for most female Muslim nursing students. The extent to which female Muslim students perceived caring for male patients as a barrier depended upon individual interpretations of the Koran. In the strictest interpretation this religious doctrine prohibits females from seeing naked males until they are married. Married females should then only see their husbands naked.

In this study, there was one occasion when a student had described her behaviour whilst washing a male patient as "a bit pathetic" (S114). She and a colleague, whilst not only leaving washing the patient's genitalia until the very last minute, also argued from one side of the bed to the other, back and forth, as to who was going to wash his genitalia. This situation came about because the student was working with a colleague and as such the opportunity to avoid this intimate encounter by getting someone else to do it existed. Additionally, it was her first experience at having to wash male genitalia and as a consequence she lacked the necessary skills to communicate with the patient to either instruct him to wash his own genitals or to inform him that she wanted to wash his penis and scrotum.

Cultural clashes

Unexpected and potential disadvantages had become manifest for CLDNSs on some occasions when they cared for people from non-Anglo-Saxon backgrounds. Problems in this area occurred in four ways. First, there were those occasions when students from counties at War with each other were allocated into the same clinical group. Secondly, CLDNSs were disadvantaged when they were allocated to care for patients from cultural groups that clashed historically with their own. This latter situation caused SD for those CLDNSs who found themselves in this situation and was demonstrated in the following data extract:

> She had a really demanding daughter and I thought … I'm out [in] for it. But I didn't allow her to because I would come in and smile … and talk to her like there's nothing going on and I looked after her mother perfectly and gave her a lot of attention and to tell you the truth I did do it deliberately because I didn't want them to go away and say "There was a Muslim nurse and she was uneasy with us … she kept away from us". The word travels and I don't want Jewish clients thinking that [negatively] of me or any other Muslim nurse. (MS2)

Thirdly, CLDNSs had discussed a feeling of having one's time monopolised by individual patients when they cared for people from identical cultural backgrounds as their own. The following student's quote demonstrated this feeling of monopolisation of time:

> I didn't really want to be around her because I found her a bit annoying … because she … they tend to be … well they, we were stuck on something. They

familiarise themselves … and they don't let you go. They just want to hang around you all the time. (S14)

Finally, CLDNSs also reported feeling disadvantaged when a patient of their own cultural background had been admitted to the ward. Discord was experienced under these circumstances when ward staff stereotyped the patient as difficult to care for. Students were hesitant to identify themselves as having the same cultural background as the patient for fear of being similarly labelled.

It is also relevant to emphasise that people born in the same country do not always share the same culture. Black South African students talked about feelings of apprehension when they cared for White South African patients. Student data evidenced this type of apprehension and comments were made along the following lines: "It all depends upon their opinion … I'm the kind of person where I'm, I'll try to forget about the past" (S16).

Students from Asian backgrounds had also found themselves in difficult situations on those occasions when they had to care for older Asian patients. Difficulties existed when the patient expected to be treated with the equivalent to parental respect, meaning the student could only interact via invitation, yet the expectations of clinical teachers were different.

In this study there was another kind of cultural clashing that occurred when CLDNSs used languages other than English in front of members of the dominant group. Although this happened infrequently it created discord for both the CLDNSs and members of the dominant group. Discord existed for the CLDNSs when members of the dominant group became angry with them and they expressed this anger. On some occasions under these circumstances CLDNSs bore the brunt of racial abuse. Students from the dominant group would make derogatory comments in addition to saying that the CLDNSs should speak in English. Academics as well as CLDNSs believed the members of the dominant group became angry under these circumstances because they could not understand whatever was being discussed. CLDNSs added that perhaps members of the dominant group felt they were the topic of conversation. In this way different cultures had clashed and CLDNSs experienced SD. Some could not

understand why members of the dominant group had become angry when they spoke in languages other than English.

Elderly patients and culture

When CLDNSs were allocated to provide nursing care for elderly Australian or Anglo-Saxon patients many issues arose that were unique to this group. Some were positive whilst others were negative. From a positive perspective CLDNSs were reported by some clinical teachers to have been "very respectful towards elderly patients" (A116). On separate occasions a couple of students had been allocated to care for elderly non-English speaking patients. These experiences seemed to have had profound effects on both students, one reporting, from this first-hand encounter, a realization of the difficulties encountered by elderly patients whose first language was not English. So moved by this encounter this student claimed to have a renewed outlook on his Nursing career, began to study with vigour and had realised his desire to work in aged care of Vietnamese people.

Some CLDNSs identified that they preferred to care for elderly people. Vocalisation of this preference was supported by clinical field observations indicating many positive interactions between CLDNSs and older patients. One such example had occurred when a student was taking an elderly patient's blood pressure. The following data extract from clinical field observations evidences such interactions:

> The patient is a bit of a character. He is quite chatty with the staff whenever I've been in his room. He shares a four-bed room. When the student takes his blood pressure he says to the patient "I'll let you guess it. Come on, what do you think it is?" The patient says "Oh no, I don't know that one but I'll tell you it's all right". The student says "Yes, it's OK, you are right". After the student had taken the patient's temperature the patient volunteers his guess. The patient says "And that's 95.4". The student looks at the patient and laughs, he says "No way, it's 36.4". I think the student is not cognisant of the fact that the patient is elderly and that in Australia up until not that long ago we used Farenheight. Perhaps this patient, because of his age, was referring to degrees Farenheight not degrees Celsius. Irrespective the patient smiles at the student and goes back to his crossword. (F.N.)

However, a certain degree of irony existed in the fact that whilst analysis of many CLDNSs' transcripts and clinical field observations demonstrated students' enjoyment in caring for elderly patients, it was people from this same age group who often refused

to accept CLDNSs as nurses. In addition, with an increase in patient's age it became more likely that the patient had some War-time experiences. This fact was supported by teachers' comments along with incidents from clinical field observations. For example, at interview one of the clinical teachers stated "A lot of the elderly … don't like the Asians … because of the Wars" (A116). In clinical field observations patients were heard referring to CLDNSs as, for example, 'nips', 'japs' and 'the enemy'. On one occasion CLDNSs who had thick, curly or coarse hair had been called 'fuzzy-wuzzies'. War-experienced, elderly men often engaged in one-way conversations in which they directed volleys of racially-based insults to non-responding CLDNSs. At other times students tried to respond and engage in conversation but it seemed that derogatory comments were not understood. The following excerpts from clinical field work journals demonstrated two such incidents:

> She helps the patient back into bed after she has showered him and asks if he needs anything. He asks her to turn on his wireless. She does not understand. She has a questioning look on her face and asks him "What is?" He says "Turn my ABC on." He then says "Humph. Doesn't even know what the ABC is! That'd be right." (F.N.)

And another:

> Yeah, I remember escaping from me home [nursing home]. They never know when I go. I get on the bus, it's a CAT [Central Area Transit] bus. They're free you know? And all the China-men get on that bus only because it's free. I go to the newsagent and buy me weekly Lotto. You should see 'em all, they only use it because they don't have to pay. (F.N.)

Those students who were called 'fuzzy-wuzzies' were treated in a kinder manner, but were questioned about their country's involvement in 'the War' and were given miniature history lessons about people who looked like them supporting Australian soldiers.

CLDNSs experienced other problems related to difficulties in the provision of nursing care for elderly patients. Students had identified elderly people as the most likely group of patients to shorten words. This made students' comprehension difficult. One student stated "It's just the terminolology [terminology] they use … usually they just chop words or they say something and they will mean another thing" (S14). Older patients also used words with "tag endings" (A114) often referring to students as, for

example, "lovie, deary, or sweetie" (A114). Students had misunderstood these terms and worried until they consulted with their clinical teacher who was able to reassure students of the friendly nature of such terms.

Analysis of student data also revealed that elderly patients were more likely to have restricted, or dated, views of socially accepted Australian norms and further they held old-fashioned stereotypes. These stereotypical images, held by elderly Australians or Anglo-Saxons were demonstrated when, for example, a CLDNS discussed her clinical placement on a geriatric orthopaedic ward. She commented:

> Patients were generally curious about where I'd come from and why I had such a long name. It was quite a pleasant sort of curiousness … about my name and about where I came from and … given that I was Italian why wasn't I married with six children? (S13)

Although the student had not been offended, the dated, and somewhat sexist, stereotypical imagery of the Italian woman, married with six children, was clearly stamped on this quote.

So although many CLDNSs enjoyed working in clinical practice settings with elderly patients these experiences were not always free from problems associated with communication, negative stereotypes, racism, or sexism. Many of these interactions led to episodes of SD for CLDNSs.

<u>Consequences of Being Different and Not Fitting In</u>

When a person is considered different, or sees themselves as being different and not fitting in, they experience or live through the consequences. CLDNSs had many experiences of being different and not fitting in; and they too lived through the consequences. These consequences occurred on university campuses and in clinical practice settings as well as outside of university life. CLDNSs felt there were times they had been excluded in clinical practice settings as well as their classrooms. They had come across RNs who did not want to work with them, they felt they did not have equitable access to learning opportunities, and worked in clinical practice settings feeling left out of the team.

Together Work – Exclusion

The concept of 'together work' was introduced in the previous chapter outlining the background conditions of this study; however, together work caused issues of concern for some of the CLDNSs in this study. Issues arose when the student and the RN were not able to work together, collaboratively and cooperatively, and the students felt they had been excluded and missed out on practical learning opportunities. For example, students could only gain the experience of medication administration in clinical practice environments with real patients prescribed real medicines. Regardless, there were a number of reports by CLDNSs that they were not allowed to engage in this task. One student had discussed a situation where the RN would not allow her to administer patients' medications because she did not believe university educated nurses had enough experience to do so. This student was clearly frustrated, angry and annoyed, and believed that she had no choice other than to accept the situation. The RN's actions on this occasion blocked the student's learning, impacting on the student's self-esteem. As she said:

> I just thought "Well I mean when am I going to learn? When do I learn this?" If every RN was to say that to me until the end of third year when would I learn it? You know, that's, it's things like that … you just feel like crying. At that time you just want to leave it, you know, just (pause) stuff nursing. (S112)

This student's frustration was extended when she had met this kind of interaction with another RN. The student had negotiated that if she completed the RNs' showers that the RN would supervise her giving patient medications. Unfortunately, only the student kept her end of the bargain. When it was time to administer patients' medications the RN had already completed the medication round.

CLDNSs had reported the benefits of together work and many had enjoyed working alongside RNs. Students talked of having easy access to RNs and seeking their "on-the-spot" advice and being able to learn new things. Others were not so fortunate and could only discuss their perception of the benefits of working closely with RNs and their desires to do so. Students reported being told:

> "These are your patients. These are the patients that you'll be looking after". "You just need to … give them a bath, change their beddings" and all that stuff

and "attend to whatever they need" … that's it. The only time I work with the nurse is when I'm giving the medications to the patients. (S19)

There were other students who experienced similar working conditions and spoke of never having experienced together work with RNs to whom they had been allocated. What they did remember was being told to do specific tasks. For example:

I was told "Go to room number five … do the shower" or do the … whatever, but she's [the RN], [is] never, like we're never together. So she wasn't really helpful…. Then she asked me to shower this lady and this lady she doesn't speak English and she's a very, very, fat (pause) sorry, big lady and I was by myself, I had no help … and I was told, she [the RN] say "Don't … bend her … leg because she just had … whatever [operation], the day … before" and I thought like "How can I? How can I get, I can't get her [out of bed], she's too heavy". (S34)

Even though RNs gave CLDNSs instructions, there were times when the students considered their interactions of little or no help.

Of those students who discussed together work some had mentioned their feeling of having to ask the RN if they could perform specific tasks for their allocated patients. These students believed that if they did not ask permission to do specific tasks that the RN would have completed all the work whilst they stood watching. Occasionally, students' requests had been turned down. Under these circumstances students experienced discord because they had to build up the courage to ask and when they did, they had been declined. Some received the reply "I'm too busy".

Interestingly, RNs had been characterised by many CLDNSs as being "too busy". Basically, students felt RNs did not have the time to spend with them. The following data extract highlighted this sense of the RNs being too busy:

[RNs] don't care about the students … [they] just don't like students … they don't talk to you … [they are] not showing an interest in teaching … if you ask them something … anything … they all say … "I'm too busy". (S34)

When students considered that the RNs were too busy it was unlikely they would ask for assistance.

Personalities

CLDNSs had also talked about their perceptions of individual RNs' personalities and how these had affected their clinical experiences. Some RNs had been described as "abrupt" and "horrible" in their approach to CLDNSs, as one student had commented:

> I'd just like to say I hate clinical only because of the fact that sometimes you get RNs that you are assigned to and they are just horrible and I mean especially when you don't know the place and you're only there for four days. (S112)

Another student had said "Some of the RNs really don't like students, I suppose we slow them down" (S13). Students had also discussed their beliefs that some RNs had negative attitudes towards students and that RNs they had come across thought of themselves as superior. This air of superiority was described in the following students' quotes:

> I hate people [RNs] that … don't want my input … it's basically 'You're still at Uni. you don't know anything. I've been out here for so long [I've been an RN for so long], I know what I am doing. (S113)

And:

> I had a nurse like, I was working with a nurse last week and whenever I talked to her she like, she didn't smile or anything like that, it was like … "I'm the superior, I'm more superior than you because like you know, I'm a fully RN and you're only a student" and all that stuff. (S19)

CLDNSs seemed to pick up verbal as well as nonverbal negative attitudes directed towards them. Some had wondered if their cultural backgrounds influenced RNs' attitudes towards them. This was seen when students described the impressions they felt they created when they first turned up for clinical practice where they were met with lengthy stares and derogatory comments related to their physical appearance.

Feedback

Perception and interpretation of negative feedback was seen in the following student's comment related to feedback:

> Their [the RNs'] facial expression and the tone of their voice … is telling you … "I don't want to … talk to you" or "I'm too busy" … I feel I'm intruding in their work … and I feel like a pest. (S19)

There was little doubt that this CLDNS had experienced SD whilst working under these circumstances. Other students had also discussed situations in which they felt comments passed about them were negative. The following data extract demonstrated these perceptions:

> [On] the last day, when we were leaving, the three of us, myself and the other two students, I went to say "Good bye" to everybody and the other two students were with her, this lady [RN], … and she said, and she went "Oh" and she looked at those two and she said "I know you two will pass with flying colours, I know definitely you two will pass". And she looks at me and she said, "I don't know about you because I haven't worked with you". (S24)

And another:

> "But it's just that nobody supports me and … well I like to get support from like at least they don't, they don't tell me like of course there will be … a … time when she have to tell you what you doing wrong and a time where she tell you, you doing good thing … but not all the time they say you doing that bad thing. (S12)

This student also commented "I am very … stress [stressed] because … all my facilitators say I have a problem with my English, I have problem with understanding other nurses and understanding on the handover" (S12). There was a distinct lack of positive feedback to CLDNSs whilst in clinical practice settings and in its place there seemed to be a constancy of negativism.

Failure

Failure is not easy for any person at any time irrespective of cultural background; however, for many CLDNSs failure was believed to have resulted in extreme embarrassment often not only for the individual student but for their family too. As one CLDNS had said in regard to failing "It's not part of our family way of thinking, we just don't fail" (S32). This embarrassment was referred to as suffering a loss of face. Students who had failed became so embarrassed that they dare not show their face publicly.

In some cultures, higher education carries with it a certain prestigious status and is something to be quietly proud of, something that brings unsolicited admiration from others not just to the individual but to the entire family. Because of this prestige,

academic failure also carried with it a great shame or a public humiliation not only to the student but again to their family members. These effects of failure were seen in the following academic's comment:

> Academic failure is seen as a real failure … it really does affect their [CLDNSs'] self-esteem because their whole status is seen by education … you know, educational failure, I mean so much is expected by the parents … and the families of these students [that is] that they come to Uni. and they succeed. (A111)

There were several outcomes, actual and potential, related to failure in clinical practice settings. Outcomes ranged from students having to repeat delineated pieces of assessment they had failed to reenrolling and repeating the entire unit of study. When talking about students having to repeat whole units of study one academic said "The second time they feel so much better … they even enjoy it … and they do quite well" (A15). Having to repeat entire units of study often resulted in the students' progress being held up because they could not continue in the course as passing one specific unit was a prerequisite for other study units. The corollary being that most students had to continue their studies in a part-time modality thus extending the overall length of their course. This situation caused concern for all CLDNSs so affected but perhaps the hardest hit were those who came from overseas, that is, the international students. These students were concerned about visa extensions and the cost involved by having to stay in Australia for a longer period of time.

Fear of failure

In this study fear of failure meant CLDNSs were scared or frightened of, worried or concerned about failing. For most CLDNSs this fear of failure was fairly constant. As long as they had problems or difficulties related to communication then the fear of failure was present. CLDNSs failed when they did not gain a pass grade in a particular piece of assessment. CLDNSs and teachers had reported failure across all subjects for a variety of reasons but most linked to problems and differences related to communication.

Fear of failure was demonstrated, for example, when students discussed their inability to discriminate between important, and possibly examinable, information and dross in lectures. Students worried if they could not make this distinction that firstly,

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they would have to learn and study everything and secondly, they could fail assessments. One student had commented:

> I was told by people "You should just put down the main points in the lecture" … it all seems important to me! Like at that time I was so worried that I might miss out some point that was being said by the lecturer and then that might affect my knowledge for the exam. Like I won't be able to know what to do and things like that. (S32)

Others spoke about worry related to academic writing and feared that their work was inadequate and would lead to failure. They were concerned because they believed they could not express themselves well enough to pass using English.

Many CLDNSs were aware of failure and subsequent outcomes because these were discussed by academics at the beginning of each semester for every unit of study. When academics introduced study units they usually went on to discuss failure and many used a serious tone of voice that at times frightened CLDNSs. An example of this fear follows:

> They [teachers] tell you "You have to get whatever mark to pass … the unit" and that scares you because you have to pass the unit … every component … all assessments you have to pass to pass the unit. (S34)

Other students had developed an acute awareness of failure and subsequent consequences because they knew of other CLDNSs who had failed or they had failed previously.

> Fear of failure may have existed for all students, irrespective of cultural background, however, some CLDNSs' fear of failure related more to the negative familial consequences, that is, shame and embarrassment of having failed.

Some of the students were anxious about failure because if they did fail it was likely they would have to repeat study units. Repetition of study units automatically extended the length of the student's course. For overseas students this meant having to be away from home for a further period of time and the financial and personal issues related to possible course extension due to failure and the subsequent need to extend visas and other arrangements also threatened CLDNSs who were studying as international students.

A large number of academics and clinical teachers commented about CLDNSs' fear of failure, for example, "That fear I think that's … one of the main issues with these students [CLDNSs], their fear of failure" (A111). Fear of failure was also evident in this comment: "I'm sure they [CLDNSs] worry a great deal about it [failure]" (A19). Negative effects associated with fear of failure were reported by academics as well as students. The former group believed that student anxieties were "directly related to failing" (A12). Such anxiety related to failure was also seen as "building up a barrier to … learning" (A111). When CLDNSs were scared of failing they became anxious and fear and anxiety interfered with their ability to learn, study, and function.

Those students who had previous experiences of failing clinical practice were seen to be more wary or timid than others. Effectively, they were experiencing the fear of failure. They worked with first-hand knowledge of failure and were inclined to act more cautiously than other students who did not have the same experiences. Student cautiousness was demonstrated in the following quote:

> So after that time [clinical failure], like, after that whole time, I, every time I, like, I'm kind of like more reluctant to do things. Instead of saying "Yes I'll do it", every time I you know have an opportunity I, I always clarify whether I'm allowed to do that or not. (S34)

Another issue that surfaced regularly and caused concern related to fear of failure was not being able to attend to specific tasks in a manner acceptable to Registered Nurses in individual clinical practice settings. This problem existed for all students; however, CLDNSs were believed to be more disadvantaged than local students due to the cumulative effects of being different and not fitting in. Students were confused when challenged by RNs expecting them to perform tasks in a manner identical to their own. For example, there were some CLDNSs who demonstrated a lack of confidence in performing patients' wound management or dressings. Although their dressing technique had been assessed and passed in other clinical areas this group of students were concerned that if they could not perform dressings according to ward staff and clinical teachers' preferences they would fail their current clinical rotation. Students in this position experienced discomfort in the form of fear of failure.

Although few in number, some CLDNSs had shared their feelings of anger in relationship to low or fail grades they had received for written assignments because their writing skills were not up to standard. Even though CLDNSs spoke of having put a great deal of effort into writing assignments they often believed their grades never reflected their efforts. Whilst some students accepted this situation as a fact of life others became angry and annoyed. SD was experienced under these circumstances and was demonstrated in the following student's quote:

> Even if I put in a lot of effort … it doesn't matter, I don't … get the good mark because of my language … I know the thing maybe better than some others who do the assignment well. (S36)

Academics also believed that some CLDNSs became angry when they received poor marks for their written work. An example of this kind of reaction follows:

> Some of it is their demeanour, some of it is the way they bark and they behave in ways that if they were with a group of friends in class they never would. They are very defensive [when they fail] and they often express anger. (A24)

Others had stated that some CLDNSs claimed their teachers were racist and their failures or low grades reflected discriminatory treatment.

From a different viewpoint CLDNSs had thought themselves failures because they knew there were times, particularly in clinical practice settings, when they were unable to communicate effectively. CLDNSs worried about failing clinical practice units because of their communication deficits. Some spoke of their earliest clinical practice experiences having caused them more worry and concern than those experienced most recently because in their latter years they had come to understand what was expected of them. As one student had said:

> By now I know that as long as I do my best and … I don't make any mistake with the skill or been unethical with the standard of care, as long as I maintain that, there's no way I'm going to fail my clinical …. because now I understand that so I'm not so worried now. (S32)

The effects of worry, concern, and fear of failure upon CLDNSs could be seen as either positive or negative. The positive effects were that the fear of failure motivated some students to engage not only in study but also in consultation with their teachers. CLDNSs sought consultation to address issues that were of concern to them. The

primary reason CLDNSs sought out, and consulted with, teachers was related to worry associated with the fear of failing assessments due to problems expressing themselves in English.

Students in this study seldom spoke of the negative effects of fear of failure directly. They did, however, discuss endless amounts of time they had to put into their study, for example, transcribing verbatim lecture notes from tape recordings and rewriting lecture notes neatly. By putting a great deal of time, effort, and energy into these largely ineffective study methods students had diminished amounts of time to devote to other activities.

At risk of failure

In this study when the descriptor of being 'at risk' was applied to CLDNSs it meant they were seen to be more likely to fail assessments than all other students. Experienced teachers were capable of predicting which CLDNSs they believed would fail. These predictions were based on experiences gained over many years of working with student nurses during which time academics had built a virtual 'at risk' student profile. When the descriptor of being at risk was applied to CLDNSs it meant that student was seen to be more likely to fail assessments than all other students. Most failures amongst CLDNSs were in some way based upon communication problems and teachers' predictions were rarely incorrect. For example: "I've had students [CLDNSs] who quite clearly have absolutely no idea what I'm saying, they say nothing and do nothing and are unsuccessful" (A15). Other academics thought that students who enrolled in units and then did not attend classes were also at risk of failing. Although CLDNSs as well as members of the dominant group skipped classes it was the former group who were thought by academics to be at greater risk of failure because communication problems usually co-existed.

Just passing

Just passing meant that CLDNSs received low pass marks for assessments. For example, if an assessment was graded out of 100 percent CLDNSs would receive roughly between 50 and 55 percent. Those students from this study who received low pass marks for assessments were divided into two groups depending upon their feelings about receiving just pass marks. One group struggled to accept their low pass marks

whilst the other group was more accepting. Data from interviews with members of the latter group showed not only an acceptance but also an expectation of low pass marks. In addition to acceptance and expectation of low pass marks student discussions connoted a lack of worry or concern about low pass marks. For these students there was no need to worry. They believed as long as they had passed, their numerical grade was irrelevant. As one student said "Once I can pass this all right, I don't care about my … good mark, I just pass … that's all right" (S20). These students also believed that it was unlikely that future employers would be interested in their marks.

Interview data from the former group displayed evidence of dissatisfaction with low pass marks. Students from this group discussed their often unsuccessful attempts of securing re-marks with the aim of improving their grades.

Despite these differences student groups were similar in that low pass marks were, by and large, the result of some form of communication difficulty.

Repeated failure

Repeat failure in this study meant CLDNSs had failed the same study unit or units on more than one occasion. Students rarely broached the subject of repeated failure directly. In fact, most students had only mentioned repeated failure when explaining other issues. In other words, they had referred to repeated failure indirectly. For example, one student had mentioned changing universities and having to repeat specific units because she had failed them at the first university she attended. Those students who had previous experiences of failing clinical practice were seen to be more wary or timid than others. They worked with first-hand knowledge of failure and were inclined to act more cautiously in regard to avoiding errors. They checked and double-checked, they asked permission, they made sure they turned up on time, and made extra efforts to communicate and establish rapport with others with whom they worked. Student cautiousness was demonstrated in the following quote:

> So after that time [clinical failure], like, after that whole time, I, every time I, like, I'm kind of like more reluctant to do things. Instead of saying, "Yes I'll do it", every time I you know have an opportunity I, I always clarify whether I'm allowed to do that or not. (S34)

Throughout the data there were references made to policies associated with student failure and as in most education bureaucracies students as well as teachers cited

such rules as either working for or against them. Such was the case when academics discussed students who had failed assessments repeatedly. Despite the fact that universities had policies in place that terminated students' enrolled status whenever patterns of repeat failure were seen academics in this study demonstrated jovial and somewhat cynical attitudes when talking about this issue. Evidence of these types of attitudes was found amongst academic interview transcripts, for example, "We've got a student in second or third year for what seems to be the 89th time, she's just a student who has been here forever" (A17).

This issue of repeat failure did not occur solely for CLDNSs; members of the dominant group were also known to exhibit repeat failure patterns. Academics, however, believed that CLDNS failed repeatedly because of problems related to communication using English. As one academic had stated:

> It's the language and if there's a problem here it's the language … out on clinical and even with academic writing with these students because I feel that it really inhibits them in all areas of learning. If they don't feel confident with that, they're at risk of failing. They come into classes year after year, if they have made it in one subject there is another they haven't made it, they limp through the course. (A111)

Clearly, this quote was indicative of repeated failure related to communication problems with emphasis upon speaking and writing in English. When CLDNSs were expected to give verbal presentations many experienced episodic SD because they were worried about failing.

Discrimination and failure

At times when students were in receipt of failed grades or border-line just pass marks they had made claims of discrimination or racism. One academic was recorded as having said "They'll [CLDNSs] say 'I was discriminated against by the clinical instructor on racial grounds'" (A15). Another academic had commented "If you fail them they usually claim that you have discriminated against them" (A13). Effectively students' inferred failure had occurred on racial grounds. Of the academics who had talked about failure on racial grounds most clearly did not believe students' claims; nonetheless, students were encouraged to discuss and or formalize their concerns. One academic recalled saying "Look you know you have failed, we've got all the reasons

here, if you want to put in a complaint that's fine" (A15). The eventuality, however, was that students rarely formalised their concerns; nonetheless their experiences were unpleasant.

Discrimination Related to Communication

CLDNSs experienced discrimination, prejudice, inequitable treatment, and racism because they used dissimilar communication modalities with which Australians and Anglo-Saxons were unfamiliar. As a result it was relevant to address differential treatment related to differences in communication.

Whilst CLDNSs had discussed their experiences, or perceptions, of being treated in a discriminatory fashion by some, but not all, of their teachers, teachers rarely acknowledged their own acts of discriminatory treatment towards CLDNSs. There were, however, a few examples in which teachers had acknowledged such discriminatory treatments. Two of these occasions were related to student assessments in which, following years of implementation, teachers realised the format of assessment they had been using had discriminated against CLDNSs. As one academic explained:

> We used to … try and use, (pause) perhaps higher order words and expressions in exams hoping to discriminate with good and bad students and what I found was, it was with the Australian students that we were discriminating between the better students but with the Asians I wasn't. I was just discriminating against them because often there were words they didn't understand and that did not reflect their academic ability. (A15)

This academic went on to say "It really hit me, I said 'My God'. I'm not discriminating against bright students. I'm discriminating against academically perhaps bright Asian students' because … they've never heard those words and they wouldn't in normal conversation" (A15).

Assessment formats were also identified as discriminatory when examination questions were projected onto classroom walls instead of students being in receipt of hard copy examination papers. Discrimination was thought to have existed on these occasions because of the way in which the examination had been presented. Typically, the first set of questions would be projected for a brief period and students were required to write their answers. The next set of questions was presented in the same manner and

this went on until all questions had been projected. Because questions were only projected for a short period of time and had been purposefully formulated so subsequent questions built upon answers to previous questions, concerns were expressed about discrimination against CLDNSs. Teachers felt that those students whose first language was not English would have problems keeping pace with native English speakers. Perhaps CLDNSs needed more time than members of the dominant group to read questions and formulate their answers. Even though under these circumstances it was realised that no students could reaccess those questions that had been projected this situation was believed to have caused much angst for CLDNSs because these students had no way of reviewing their work before submission. In other words, they could not go back to check they had interpreted previous questions correctly. Because these students did not use English as their first language it was thought more likely that they could misinterpret the meaning of some questions. It was not hard to appreciate the SD that many CLDNSs may have experienced in both of these assessment scenarios.

From a different perspective CLDNSs had also expressed concerns related to their perceived communication differences or inadequacies and their career aspirations. These students were concerned not only about their own nursing careers but also for the careers of their fellow CLDNSs and non-Australian RN colleagues. The following student data extract described this personal and extended level of concern fittingly:

> This girl, from Thailand, actually a RN and as I say … I work in the X ward and … she wants to be … a clinical nurse specialist in this specialty. She's got an accent but I think her English is quite good, is even better than mine. Her accent isn't as a strong as my accent and I can see that she's quite clear. But for them, for the rest of the staff, she's still got an accent and she has applied for this position. She has applied to work with the XXX and do this course and she wasn't allowed to. She wasn't allowed to and I heard all the rumours why she wasn't allowed to do it and most of the people been discussing … the Anglo Saxon people, you know … the nursing unit manager couldn't allow her because she can't really speak English very well. I think … we might have an accent but it doesn't mean we can't read and write and it doesn't mean we can't communicate. So I don't quite understand it. I think it's really ridiculous. It does worry me for my future … it does worry me a lot because I think well I've got an accent also and I think I've got all the potential for, after becoming a RN, for doing another course, and same for upgrading my career and I think if I've got people with this small mentality what's going to happen to me? I won't be able to move forward. It's frightening! I don't really know how to take it … as I said before sometimes I think its racism, pure racism. (S10)

Another CLDNS had expressed her concerns echoing precisely those from the preceding student's quote. She had in fact questioned whether the researcher had encountered RNs from non-English speaking backgrounds facing restrictions in their career progress because of their cultural backgrounds or accented speech. Both students discussed their concerns for those colleagues who spoke English with accents suggesting that barriers to career progression were related to communication skills and were more likely imposed upon those who spoke English as a second language.

Misnomer of positive discrimination

Analysis of academic interviews revealed the occasional use of the phrase "positive discrimination" and it became obvious that positive discrimination was something only referred to by academics. Academics believed they discriminated positively towards CLDNSs when they purposefully directed questions to individual students in class with an expectation they would reply. Academics believed such actions afforded CLDNSs an increased opportunity to contribute to class discussions but students largely interpreted these actions as being "picked on" (A25). CLDNSs disliked answering questions in class because they often felt it culturally inappropriate that they give an answer. Additionally, many were self-conscious about making speech errors in front of an audience or feared being laughed at. From their perspective, they were being discriminated against or singled out by members of the dominant group; they were being placed in situations the others were not. From analysis of student transcripts few if any would have termed this form of differential treatment as positive. Certainly many of these so-called incidents of positive discrimination led to feelings of SD for those students involved.

Effects of Inequitable Treatment

CLDNSs' interview transcript data also showed that students were hesitant to report incidents of racism, prejudice, or discrimination from teachers for fear of "rebound effects". From analysis, these rebound effects acted to gag many CLDNSs from formalising their concerns related to inequitable treatment. Specifically, CLDNSs were prepared to put up with most forms of inequitable treatment from teachers because

they were aware that the teachers were the very people conducting their assessments. CLDNSs felt that speaking out about inequitable treatment, such as racism, would effectively jeopardise their progress in the course.

This gagging effect was seen when a student had spoken of her fears of identifying herself as Jewish. This fear had occurred in both classroom and clinical practice settings when teachers had made derogatory remarks about migrants. This student had recollected such derogatory remarks being made on one occasion to a group of students, predominantly from non-English speaking backgrounds, attending a preclinical practice orientation session at an inner-city hospital that had been described to students as a hospital that catered for a lot of migrant patients. This student had been flabbergasted by the clinical teacher's remarks related to migrants and had described how she had looked at all the other students to see if they had reacted similarly. When the teacher had said to the student group "I hope none of you are offended" (S27) the student commented "Like as if we are going to say we are offended, like it might have a rebound effect" (S27). Under these conditions this student did not want any one to know her cultural identity for fear of being thought of similarly. Effectively, she avoided revealing her cultural identity.

Data analysis also revealed worry, apprehension, or dread directly related to fear of inequitable treatment. This was indicated in student transcripts by such comments as: "I've just got this thought running in my head, I am just going to encounter racism" (S18). Another comment that portrayed this worry occurred when the same CLDNS was talking about being in class and the teacher asking class members to split into groups. She always feared she would be left out of student groups because no one would want her in their group because she was different.

Analysis of student data suggested that CLDNSs held concerns about their physical characteristics leading to patients rejecting or not accepting their care. From analysis of non-Anglo-Saxon students' interview transcripts it seemed some were also concerned about their futures in nursing because they expected to be treated differently, even as RNs. For one non-Anglo-Saxon student, this concern was clearly based upon skin colour preference, White preferred to Black. Whilst some felt they could deal with such inequitable treatment, others were already "fed up" (S114) and had considered

leaving Australia, once they were registered, to work in other countries where they felt it more likely that their cultural beliefs would be accepted.

Language and Loss of Cultural Connections

Pittman and Rogers (1990) identified NESB RNs who expressed a degree of loss because they had not been using their first language as much as English. This sense of loss of culture was evidenced by a decreased fluency in their first language. Nonetheless, these RNs were still expected to take on and care for any patients in their immediate workplace who had the same or similar cultural background. This expectation continued irrespective of their own cultural disconnection and need to be exposed to English speaking patients. During interviews students from the current study had also articulated feelings of a sense of loss of culture. In fact, CLDNSs had described their feelings as a sense of disconnection from their culture because they too had been using English more than their first language. It seems somewhat ironic that to become more fluent in English CLDNSs were encouraged to use English yet at the same time they attributed their loneliness to their poor communication skills using English (Abu-Saad, & Kayser-Jones, 1982; Abu-Saad, Kayser-Jones & Gitierrez, 1982; Abu-Saad, Kayser-Jones & Tien, 1982).

Summary

Participants in this study were found to share the basic social psychological problem identified as sociocultural discord: being different and not fitting in (SD). This was experienced in an ongoing, episodic manner with many causal and influencing conditions. CLDNSs experienced the feelings labelled as 'constant scrutiny' because once they had been identified by teachers as having a different cultural background they felt as if they were being monitored constantly. There were many differences between the minority CLDNSs and members of the dominant group studying on university campuses for their undergraduate nursing degrees. By far most CLDNSs experienced episodes of SD because of communication differences. These differences in communication existed in all verbal and nonverbal forms of communication. They were apprehensive in respect to communication with members of the dominant group because

they spoke with an accent, made speech errors related to pronunciation or used disordered syntax. CLDNSs were nervous when introducing themselves to people irrespective that this process usually led to rapport development. They often found themselves in situations where they could not understand communication and where their own communication could not be understood. These differences impacted upon their interactions with patients to whom they had been allocated. Through trial and error they learnt that many of their once familiar cultural norms associated with communication etiquette were no longer applicable. Often when they wanted to interact they discovered they could not communicate effectively even though they could speak English. Some realised they had lost their confidence to speak in front of other people and many were afraid of making mistakes because of the perceived and often real consequences of ridicule. Others had experienced personal or professional failure. They felt physiological and psychological discomforts and they felt afraid and disconnected. Those students who were different and who did not fit in felt unwelcome and as if they did not belong in the settings where nursing education took place.

Other differences that led to episodes of SD, were being Black or Asian along with wearing different clothing or following traditions of another culture. Students also experienced SD because of perceived racism and their interactions with members of the dominant group. In addition, CLDNSs were often unfamiliar with expectations of teachers in Australian university settings. These differences often caused episodes of SD for CLDNSs manifest by, for example, embarrassment, hesitancy, self-doubt, and loss of confidence and self-esteem. Students also experienced shame, fear, worry, anxiety, and self-consciousness to name but a few emotions enmeshed in the concept of SD.

Students experienced SD both on and off campus making it conceivable that discordant episodes could arise at any time throughout the students' professional education. Student had experienced SD in classrooms, lectures, tutorials, nursing practice laboratories, walking around campus, and in clinical practice settings. Essentially, students experienced SD, in every facet of their undergraduate nursing education. Being different and not fitting in took their toll upon CLDNSs, but the students employed strategies to help them deal with episodes of SD. Students referred to

the strategies or processes they used to "get in the right track" and these will be presented in the following chapter on the basic social process of seeking concord to get in the right track (SC).

CHAPTER 5

Seeking Concord to Get in the Right Track (SC): The Basic Social Process

Along with identification, saturation, and conceptualisation of the basic social psychological problem, in this case, sociocultural discord: being different and not fitting in (SD), the researcher using grounded theory method identified the strategies and processes the participants used to manage or deal with their identified problem. CLDNS participants had willingly spoken about the things they did to deal with their episodes of SD. The grounded theory research method dictates that the researcher review all collected data, memos, and codes; use constant comparison; and have trust in their data to be able to identify, or to allow the emergence of strategies and processes used by participants. These strategies were analysed and compared to all other existing pieces of data in an ongoing fashion. Contextual factors had clearly affected the participants' abilities or willingness to enact processes to counter SD. In this work, the basic social process used by the CLDNSs to deal with SD, has been labelled seeking concord to get in the right track (SC); several subprocesses were also identified.

As described and discussed in the preceding chapter all culturally and linguistically diverse nursing students experienced episodes of discomfort related to being different and not fitting in. They did not fit in because of their differences to members of the dominant group, not only from a cultural perspective but also a social perspective. In other words students experienced episodic SD. When CLDNSs experienced episodes of SD, they had a range of feelings including embarrassment, shame, fear, and self consciousness. This chapter identifies and discusses the strategies CLDNSs put in place to help them get in the right track and move them through the periods when they were experiencing episodes of SD. Contrary to the researcher's previously held beliefs that the students would put in place many processes and subprocesses to get through their undergraduate nursing degrees, CLDNSs enacted few strategies and behavioural changes to reduce or minimise the length of time and intensity of their SD.

In addition to the basic social process, those conditions that assisted the CLDNS's journey in SC have been addressed in this following chapter. Some were useful in facilitating the students' movement along the figurative track towards reducing SD and becoming an RN; others were less helpful and acted to prolong the students' experiences and/or intensity of SD.

Basic Social Process

The basic social process is that which is conceptualised by the researcher through the process of constant comparison, coding, and analysing of data pertaining to processes used by the participants to deal with the various components of the identified core problem. By sifting through and comparing strategy to strategy the researcher was able to see patterns of related behaviours implemented by the participants to affect their shared, social psychological problem. Many grounded theory studies identify processes with sequential steps, or stages, to affect problem resolution or at least assist the participants to deal with identified social psychological problems; however, this research has identified a series of actional/interactional behaviours that did not occur in any particular sequence.

When CLDNSs encountered a discordant situation, those who were able to implemented strategies to minimise SD. Others were more proactive and had implemented strategies in an effort to prevent recurrences of SD. The students engaged in a process of SC. This meant that students sought to reduce or minimise discord. CLDNSs, either directly or indirectly, referred to changes in their behaviour enacted to align themselves more closely with members of the dominant group. By using strategies to change or alter their own behaviours CLDNSs became more like members of the dominant group and they felt as if they were "getting in the right track" (S32, S34 & S28). The parochial phrase that Australians actually use is "to get or getting on the right track" rather than "to get or getting in the right track". In itself this may seem irrelevant, but it is important because this error, or misapproximation, is typical of errors made in use of Australian English which made CLDNSs different.

As CLDNSs changed their behaviours, differences between themselves and members of the dominant group diminished. As differences diminished CLDNSs' feelings of not fitting in and episodes of SD also decreased. CLDNSs also felt they were journeying along a figurative track towards their ultimate goal of becoming an RN. Unfortunately, student participants in this research never completely overcame their basic social psychological problem. Their experiences of SD were ongoing as were their attempts to implement strategies or processes to manage the amount or intensity of their discord. Some students were able to stay "in the right track" for longer periods than others. Students came off the track repetitively; they experienced SD episodically and changed their behaviours in an effort to get back "in the right track".

From an outsider's perspective, the researcher found it easy to understand why CLDNSs had ongoing experiences of SD. These students looked different, spoke differently, acted differently, or just simply did not fit in with the dominant group. CLDNSs, however, did not see their experiences of not fitting in as being constant. Instead, they had described the episodic nature of their encounters with SD. As students encountered SD sporadically their behaviours changed in line with their encounters. Those who did implement strategies to alter their experiences of discord did not always do so on their first encounter of difficulty. Sometimes it took many exposures to the same problem before CLDNSs began the process of SC by changing their behaviour to affect their situation.

Students who did implement strategies with the aim of reducing their feelings of SD, to get in the right track were not always successful. Some implemented strategies many times before they felt any reduction of discord in terms of either intensity or duration. Additionally, there were numerous occasions when the students' enacted strategies had no impact on reducing SD. Indeed, there were times when CLDNSs had implemented strategies to reduce their experiences of SD, but had actually increased the amount of discomfort they experienced.

From an anthropological perspective to get in the right track reflected a process of acculturation, a mixing, or blending of cultures. This mixing or blending of cultures was seen repeatedly throughout students' and teachers' interview

transcripts as well as in documented clinical observations. When faced with episodic SD, most CLDNSs adapted their usual ways of being to become more like members of the dominant group. Some of these methods, or strategies, were successful whilst others were not.

<u>Subprocesses of Seeking Concord to Get in the Right Track (SC)</u>

The processes CLDNSs used to get in the right track in an effort to seek concord are described as being actional and interactional. In other words students adopted behaviours and actions to reduce the intensity, or shorten the length, of periods of SD when interacting with others. The strategies used by the participants formed the subprocesses of saving face, clustering, being quiet, adjusting communication strategies, and blocking off the cultural self.

Saving Face

Many of the strategies enacted by CLDNSs were used in an effort to save face. Saving face referred to any actions which prevented feelings of shame or embarrassment. Students were able to save face by covertly deceiving those with whom they worked and by using the "yes syndrome". Essentially students were trying to find a place of comfort or concord. They appeared to be trying to fit in and function in a way expected of them and to stay in the right track.

Covert deception

It was apparent in data from observation field notes and interviews that there were times in clinical practice settings when students acted to save face by delaying seeking understanding, meaning, or clarification of spoken or written words until after an interaction. When they did not understand they would often indicate that they had. Then as soon as possible, the CLDNS sought meaning from another source. They would find another person with whom they felt comfortable and ask for help. It was considered beneficial to CLDNSs to seek clarification or meaning from a different person so they could save face with their preceptor or mentor. Students did not want their preceptor or mentor to know they had not understood what had been said to them because they wanted to make a good impression; they

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felt they had to avoid shame. This was demonstrated in the following student comment: "If you didn't understand them, what they saying, then I just goes and asks another one" (S29). When asked why would you go and ask someone different the student commented "I feel stupid if she thinks I don't know what it is she asks me to do" (S29).

This pretending to understand prevented the student from being embarrassed in front of their preceptor. Approaching others to seek understanding was often more acceptable for CLDNSs. They did not want the RN with whom they were working to think poorly of them. It mattered less if they asked another health care worker, not involved with their assessment, for clarification, word meaning, or other assistance. By asking other people they were able to hide their lack of knowledge and prevent themselves being compromised in front of the RN with whom they worked more closely. By not asking their preceptor there was less risk of receiving a poor assessment which equated to less risk of failure. Nevertheless, it created further discomfort when subsequently they could not follow instructions due to a lack of understanding.

When CLDNSs heard words or phrases that they did not understand some wrote these words into note-books or onto pieces of paper. In clinical practice settings, students did this so they could ask their clinical teachers, colleagues or other health care workers to explain the meaning of words at a later point in time. Others wrote words down so they could access dictionaries seeking word meaning. Difficulty existed with these strategies because CLDNSs could only guess how to spell these new words. When they sought clarification from others there were occasions when those who had been approached for assistance had to make educated guesses at what students had written. Sometimes the students wrote down unknown words and phrases as best they could and when they felt comfortable they would ask an RN the meaning of specific words or terms. Alternatively, CLDNSs would ask other CLDNSs for word meaning. Under these circumstances students experienced increased SD. They were confronted with words they did not understand causing initial discord. Then students guessed how to write down these new words. This guessing caused more discord. Those who had worked up the courage to ask others

for specific word meaning had to approximate pronunciation because they did not know how to say these new words. Students in this situation knew they were likely to make speech errors. If they did ask others they would often make errors, causing discord; if they did not ask they may never have learnt. Whilst some students had no problems asking for help, others were self-conscious and embarrassed, causing even more SD. Still, there were others who could not make themselves understood and had shown teachers and RNs what they had written. This situation added to the existing discord because these students could not get themselves understood and they were embarrassed at having to show how they had written the words they did not understand. The students who had deceived their RN preceptors covertly had done so because they were trying to fit in, they were seeking concord. Most had also made use of the "yes syndrome" but essentially the strategies used to resolve initial discord had created more discord.

Yes syndrome

In an effort to avoid SD, to appear as if one understood, and thus feel concordant, CLDNSs often made use of the yes syndrome. People from all cultures have made use of the yes syndrome. This syndrome is used when people say "yes" to others in conversation when they meant something else, for example, when they had not understood, when they disagreed with what was said and/or when they did not want to engage in conversation. Members of the dominant group used the yes syndrome more so when they had not understood concepts rather than the words used to put forward the concept. Sometimes, CLDNSs admitted freely to giving up trying to understand spoken English and instead pretended to have understood. For example, "I pretend that I understand, I say 'alright, yeah, yeah'" (S32).

When students used the yes syndrome they were able to say "yes" to patients questions, or say "yes" during conversations with patients without really knowing or understanding what had been said to them. By saying "yes" students gave an impression of comprehension when one did not exist.   This saved them the embarrassment of having to ask the speaker to repeat themselves indicating that they had not understood. CLDNSs used the yes syndrome to save face or to decrease their embarrassment or discordant feelings of not understanding what had been said,

or meant, during interactions with others. Although this may have impacted on the quality of care given it was easier and quicker for students to finish their allocated tasks without having to stop and work towards understanding.

Students had also reported other examples of using the yes syndrome whilst interacting with patients. On these occasions patients tried to engage CLDNSs in conversations on topics about which the students knew nothing. One student commented that when this happened she just allowed the patients to continue talking. She had expressed concern about not understanding what the patients had discussed but she had never asked patients to explain the conversation content. Another student commented that she had used this tactic because "Sometimes it gets you out of some very sticky situations, unpleasant spaces" (S31). As already noted, these students carried on working without seeking clarification or without really knowing what had been said to them. Essentially students had used the yes syndrome to avoid embarrassment or to save face. In doing so they avoided SD, but also failed to engage in effective communication with patients and staff.

Those students interviewed gave a variety of reasons as to why they had acted in this way. Many referred to lacking confidence or the courage to ask a person what they had meant; others stated that they would be too embarrassed to ask questions. One student believed she had responded in the affirmative when she had not understood because of pressure placed upon her by an RN. In this incident the RN, although smiling, spoke loudly to the student in front of other people. This created a feeling of pressure for the student who felt she had to go along with the RN even though she had not understood. She wanted the others present to think she had understood what the RN had said. She had acted to save face and she was seeking concord.

Another student who had used the yes syndrome reported seeking clarification and understanding from other sources, namely fellow students. This resource, however, was not always available and the student often gave up the pursuit of understanding and carried on without seeking clarification. In other words, she continued working without understanding what had been said to her. Whilst immediate SD had been decreased for some students it was more likely that

saying yes, or agreeing to everything a patient or other health care worker said, had the potential to create SD later, when subsequent interactions were based on the initial misunderstood interaction.

Clustering

Rather than being on one's own, CLDNSs grouped together or "gathered in clusters" (A13). Clustering behaviours were evident throughout the data, and of interest was the prominence of belief by teachers that CLDNSs were responsible for what in essence was a form of segregation.

> Non-English speaking background students tend to congregate together, so whether that's through choice or whether that's because … they're alienated from the … other students, I don't know. It could be a cultural thing where they prefer to be with people where they can speak … their home language or [be] with people who are from similar cultural backgrounds. Or … it could be the fact that they don't integrate well. If you go down to the lunchroom … the non-English speaking students tend to be sitting apart from the English speaking students. (A11)

Student data similarly revealed clustering behaviours, for example "At uni. [university] we tend to work together and we tend to stay in the same tute [tutorial] group. Like we tend to kind of request if we can be in the same tute [tutorial] group" (S34). But it could be perceived quite differently; perhaps members of the dominant group could be seen as sitting apart from the CLDNSs. Whilst teachers reported that CLDNSs seemed to cluster together CLDNSs gave their version as members of the dominant group congregating together leaving them no option but to form groups of their own. Further, these clustering behaviours were quite obvious during classroom field observations and the following memos from classroom field notes provided additional evidence of CLDNSs' clustering behaviours.

> The participant is sitting next to another cosmetically different student. Noted at least seven other cosmetically different students in a class of 17. One cannot assume, however, that these other seven are really students from different cultural backgrounds; after all they could be second generation Australians. But still they too would have some other cultural influences. (FN121)

And

> She is sitting by herself but has arranged another chair close to her side as if she is expecting someone. Class commences. Another student arrives about 5 minutes later. She enters the room quietly and sits next to the participant. This student is also cosmetically different, Asian. The students are told to do some exercises from the book and to work in pairs. This seems to be an expectation, working in pairs, and the participant and the student sitting next to her become a pair. (FN111)

And

> Interestingly enough there are two other CLDNSs sitting on the same row as the participant. Whilst the students are getting themselves into the tutorial room and organised the tutor is writing onto the board. Eventually the class commences. The participant works in a pair with another student who looks as if she comes from a non-Australian background. (FN122)

It appeared that CLDNSs used clustering techniques to make themselves less conspicuous, to avoid rejection, and to support one another. The cultural mix of clusters was irrelevant provided all students were non-Anglo-Saxon or Australian. Sometimes, CLDNSs preferred to cluster with students from similar cultural backgrounds but others did not express or demonstrate this preference. For students from the latter group country specificity was not important. All that mattered was the people they mixed with were not Australian or Anglo-Saxon. Students from the former group, however, had made comments similar to "you know for sure [if you mix with] … Asian they won't reject you … why should they when it's your own … similar culture" (S31). This student believed that other Asian students would welcome her into their group because she was Asian; country specificity was not a factor contributing to acceptance of group membership.

By grouping together, or clustering, CLDNSs also seemed to camouflage themselves for protection. Camouflage means to render oneself "indistinguishable from [the] background …" (Delbridge & Bernard, 1998, p. 157). By forming groups of non-Australian or non-Anglo-Saxon students, individual CLDNSs were able to make themselves relatively indistinguishable from the background. Students appeared to cluster in camouflage for protection whenever the opportunity arose. They clustered in tutorials, lectures, laboratories, on clinical practice at meal times, and off campus. By being in a group with other CLDNSs, CLDNSs were not alone. Whilst they remained distinguishable in the larger group they were still afforded a

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degree of protection and support by being in a group within a group. They no longer stood out from the crowd. They had become part of a smallish group within the larger group. They felt more comfortable and at ease when they mixed together. Mixing with other CLDNSs may have caused problems or episodes of SD for CLDNSs. However, the benefits of clustering outweighed a solo existence or having to merge with members of the dominant group. Students believed that by being in a group with other CLDNS they were less likely to be singled out by teachers in an academic setting. When they used clustering, even when teachers did approach them, they felt protected or supported by the surrounding CLDNSs. If they could not answer questions, or make comments, another CLDNS would often try to answer or speak on their behalf.

CLDNSs offered reasons why they preferred to cluster with other CLDNSs. The following student quote revealed some of these reasons:

> Because the people there that I met, I haven't really … we haven't became, you know we just met. We're not that good friends and stuff but that's why I tend to … stay with Asian people. I think … Asian people … know that if you're Asian as well the chances of being accepted with that person is higher than if you talk to a Western. You have to take a risk because some Western might not want to interact with you …. we [CLDNSs] all have the same problem, we all wanted help and we could give, help each other. Like … not problems … but we all seem to have the same sort, like … you know, … I don't know, we just seem to have something in common. (S31)

Other students' quotes reiterated the above comments and added that clustering lent support in learning and facilitated friendships. Student comments also indicated that clustering made them feel less isolated and they found they could share their concerns in a group that not only had similar experiences but who were more likely to understand cultural nuances. Others had made more specific claims of benefits like the Asian students who had commented that it was unusual for them to be on their own in their home countries. When they went outside of the family home they were usually chaperoned. This chaperoning was evident in the following student's statement: "I think I [I'm] just used to being with someone else all the time because like in Hong Kong we always … had someone like accompany [us]" (S11). The clustering behaviours of Asian students had provided a comfortable situation with

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which the students were familiar. For this student, and many like her, clustering behaviours reduced SD.

As previously stated, students gained much support with various issues by mixing with other CLDNSs. Support occurred in areas related to using and understanding English. For example, students preferred to ask other CLDNSs to explain things because they spoke more slowly and clearly. Many had to do this because English was not their first language. This kind of interaction enabled CLDNSs to clarify points they had missed in lectures.

Most of the students interviewed were aware that they needed help with their written assignments. Although academics suggested that CLDNSs arrange to have a person who spoke English as their first language read their written assignments before submission very few CLDNSs actually did so. Some had claimed they were too embarrassed by their written work and others felt that native English speakers would be wasting their time trying to read their assignments. These students did not have the courage to approach English speakers to ask if they would read through assignments to correct grammatical errors.

Often, however, CLDNSs did approach student colleagues who also came from different cultural backgrounds to read and check all aspects of their written work prior to submission. The bulk of support that had occurred between CLDNSs that was related to written communication in the form of assignments was reported to have taken place away from clinical and classroom settings. Where possible students sought others who were further advanced in the course so as to be able to make use of their experiential knowledge. The benefits of this type of support were identified as, for example, assistance with problem solving in relationship to assignment writing. This was evidenced in the following student's dialogue:

> Another person that tell you "Oh, it's all right, that's happened to me as well" and … What I did, like, how they solved the problem, what they did. They did such and such and then they solved the problem or sometimes they can show you examples of … their assignment and show you how they did it and then I can integrate that to find my own solution to, to problem that I have. (S32)

Under these circumstances students were able to help each other because inexperienced students approached more experienced students. Those from the latter group were able to assist because they had completed similar assignments. As mentioned with clustering, cultural identity was unimportant, for example, students from Italian backgrounds helped students from Asian backgrounds and Spanish students helped Fijian students. Those who were less articulate mentioned the support they had received from students who they perceived as more articulate. Students helped each other to improve their use and understanding of English. In the following example the more articulate student identified ways she believed she had supported less articulate students:

> I speak very fast normally but other than that I can speak slowly and break down the word pattern into a way that they can understand and I leave out words they don't need to know to make it easier for them to understand. (S17)

Students had also gained support from each other with regard to note taking from lectures. When students were unable to understand the lecturer or their own written lecture notes or they were unable to keep pace with the lecturer in class, or not able to understand specific words or spell them, they would ask other CLDNSs for help. Help was gained from other CLDNSs by discussing lecture content or borrowing and photocopying lecture notes. These kinds of strategies helped to fill in the missing gaps.

Those teachers who had discussed CLDNSs' clustering behaviours put forward their perceptions of why students behaved in this way. Suggestions offered were, for example, "It allows them to feel safe … less threatened" (A11) and "they're more comfortable because they are with another person from a similar background" (A12). Another academic believed that CLDNSs clustered because it gave them "emotional benefit" and "some support" (A13). Asian students were thought to have liked to "stick together" (A21) because they shared similar, if not identical, beliefs and behaviours. Other teachers also believed clustering behaviours to have benefited CLDNSs because they could help each other with language difficulties. For example:

> It's very rare that you will get … a group of them [CLDNSs] that none of them have good English skills. So it's usually you might have one or two or even just one [who is more competent with English] and the others … will help them speak. (A14)

Other distinct advantages occurred with clustering in clinical practice. Teachers believed:

> It's good to have someone of the same cultural background … because it's good for them, it's good for the students because they go to all these different hospitals and they have all these different facilitators. It's hard enough to adapt, it's hard for them to come out on their own. (A21)

CLDNSs played a vital role in supporting each other particularly in areas related to communication. This support occurred in two ways. The first encompassed students supporting each other irrespective of individual country of origin, for example, Vietnamese supporting Lebanese, Chinese supporting Philippines, or Italians supporting Chileans.

The second type of support that took place between CLDNSs occurred in a more exclusive fashion wherein CLDNSs provided support for other students who were from the same country of origin and who shared the same cultural background. In this study there were occasions where CLDNSs talked about their preference to work with other students from the same cultural background. The primary reason given for this specific preference was that identically cultured students would be able to help them with communication problems. CLDNSs felt more comfortable asking people from the same background to explain anything they had not understood. As one student had commented, "If I work with other then I ask her and she probably tell me … so I get the knowledge from them" (S12). Sometimes, CLDNSs reported having asked their CLDNS colleagues for help with issues they were unable to comprehend. Although at first these acts were viewed as one of the many strategies used by CLDNSs in an effort to facilitate their comprehension, further data collection and analysis led to the discovery that this strategy was not always successful. Success did not always occur because on a number of occasions their colleagues were experiencing their own comprehension difficulties. As one student commented "If … she doesn't know or thing like that I say '… just forget it'

…if I can't get it maybe I get it [a] disadvantage in my test, thing [or something] like that" (S21). Asking like-cultured colleagues for help was a successful strategy used by many CLDNSs; however, for some it was unsuccessful.

The following extract was taken from a memo that was written immediately following an interview with a CLDNSs. This memo demonstrates a negative case in relation to this form of clustering, and identifies influencing conditions:

> The student said to me that he had been worrying about working in this particular group of students because there was another male student from an Asian background and that the patients had trouble understanding this other male student. His clinical teacher would come up to him and tell him that patients were having problems communicating with him but in fact it was the other male Asian student. So he explained this to the teacher and he was able to, if you like, prove his case because the patients who had told the clinical teacher they could not understand the student were not patients that he'd been allocated to care for. He then realised that he would have to be in a different group and perhaps not be in the same groups as this and other Asian male students because people would confuse them. He had told me that this other Asian male student had had problems with English and with the work and that he would be told to get a bed pan and he didn't know what it was and he, the other Asian male student, would actually come and ask him what a pan was. (F.N.)

Other negative cases existed and were uncovered where some CLDNSs, when faced with unusual situations, made their own decisions to move away from like-cultured students. On these occasions the participants' colleagues were seen as having behaved poorly and individual CLDNS, believed they could be cast in the same manner if they continued to be associated with poor performers. Simply, they did not want to be associated with their identically, or similarly, cultured colleagues. The negative behaviours that motivated individual students to remove themselves from like-cultured groups included reckless driving in a hospital car park, not knowing how to give a patient a bed pan when asked, and not participating actively in assignment work. Under these circumstances CLDNSs had withdrawn from "clustering" as a form of self-protection. Those who had chosen to move away from their CLDNS colleagues, for the above reasons, had done so to decrease their SD.

On the surface the act of clustering did not seem to cause SD for CLDNSs. However, it had been reported as leading to discomfort for, or disapproval from, others

around them. Teachers, and to a lesser extent members of the dominant group, disapproved of CLDNSs' clustering behaviours and the corollary was that CLDNSs bore the brunt of other people's disapproval. In this way CLDNSs had often experienced SD even though their clustering behaviour was a strategy they had used in SC.

When teachers disapproved of CLDNS group formation, and most of them did disapprove, they acted to split such group formation, leading to further SD for CLDNSs. An example of this disapproval from a teacher's perspective follows: "This Asian … group they were all women and I remember they always gathered together in the class and never allowed anyone to fit in their group, they just communicated between themselves" (A15). Other teachers had said that they had noticed CLDNSs clustering in all of their teaching sessions and some had referred to "rows and rows of them [CLDNSs] sitting in lectures" (A11; A21). Isolation caused by clustering behaviours had also been discussed by teachers, for example:

> If their English isn't particularly good … they sit … impassively, in a group and don't tend to … participate. And … in tutorials they just, they tend to sort of sit away and cluster and isolate themselves … from the rest of the group. (A13)

And:

> They [members of the dominant group], they just got fed up, they really, it really became like two camps. Them and us! And it was them and us and it was awful, and they'd even sit on different sides of the room. It was awful and the whole thing was dreadful. (A15)

Similar comments were made by those teachers who worked with CLDNSs in clinical practice settings, for example, one clinical teacher had said "They [CLDNSs] tended to stick together and not kind of spread into the ward and do things independently, they tended to hang [around] together" (A16).

Occasionally teachers offered specific reasons as to why they, and their colleagues, disapproved of CLDNSs' clustering behaviours, for example:

> I think, I think sometimes people feel that if you allow them to continue working together a couple of things happen. Firstly they don't improve their English language skills which is often a problem. And secondly, it's sort of seeing that maybe there is, (pause) not discrimination but maybe a reverse kind of discrimination, in terms of they're always together and maybe there is a possibility here that they will be excluded. (A17)

Teachers were in a position in which they could change membership of class groups and when they felt they should break up cultural clusters they had the power to do so. In classes where teachers reported asking students to get into mixed groups, and no one moved to change group mix, the teachers had directed the CLDNSs to change groups. These direct instructions and the subsequent actions led to CLDNSs experiencing SD. Additionally, they felt as if teachers inferred they were solely to blame for the lack of cultural mixing.

Overall teachers' reasons for wanting to disperse CLDNSs' groups were analysed and labelled as idealistic and altruistic. Most teachers believed that everyone would benefit by making CLDNSs mix with members of the dominant group. For example, some teachers believed cluster dispersal would facilitate interaction between CLDNSs and members of the dominant group; others felt cultural sharing would occur and mixing of students would allow representation of different cultural perspectives of nursing. Teachers' idealistic rationales for breaking up clusters of CLDNSs often did not come to fruition. Once split from like-cultured colleagues, CLDNSs reported many feelings of SD. For example:

> I (pause) when the first clinical I go out because you know how in you put the name in the clinical but sometime it's just, sometimes they split your group up … and then you to be with someone else not your own friends and then you with someone you not familiar with. You don't know them at all and they talk to each other and they talk about what they learn today in the clinical hospital and they talk about their patients, how they deal with it and that and so they can learn from friends as well but by myself, I'm there, I'm just by myself and also have my trouble with understanding English. And see, see no friend to talk about the learning thing. So even though just one or two talking is still help a lot. You not learn from your teacher only, you learn from patient as, as well as friends you know… all people around you. (S12)

Occasionally academics' comments reflected this sense of failure in achieving the desired effects of splitting clusters. Failure was seen in the following quote: "Asian people … they've felt very uncomfortable about having to join a group of non-Asian people … the groups may be mixed but there still is a cultural gap" (A19). Some teachers believed splitting of clusters caused CLDNSs to lose the security of being in a like-cultured-group. Because they had lost this sense of security many became reluctant to mix and simply did not interact. Other teachers, having instigated cluster dispersal,

reported that once split "They [CLDNSs] sit back and say nothing" (A22); "It didn't work" (A15) and "I tried to do that, breaking them up in the classroom into different groups, they were very resistant …" (A19). CLDNSs seemed to suffer when their groups were dispersed and much of this suffering was done in silence. Clearly, from the CLDNSs' perspective, cluster dispersal could only have been described as having backfired and as having increased SD for many.

Forming friendships

Many friendships were developed between CLDNSs. These friendships provided students with much needed support. As stated before students of non-Australian or non-Anglo-Saxon backgrounds were seen to be able to connect with each other. This connection or rapport was not unlike that seen between patients and students of non-Australian or non-Anglo-Saxon backgrounds. CLDNSs reported feeling as if an already established, effortless rapport existed between themselves and other students from non-Australian and non-Anglo-Saxon backgrounds. The very differences of being non-Australian or non-Anglo-Saxon amounted to a sameness, a sameness of being different. The most poignant example of this connectedness gleaned from student interviews follows:

> You feel, like if it's morning, I mean, coffee break or lunch time you feel more comfortable to go and sit with them even though I can't speak their language or they can't speak my language some of them, not often it's from my country, my language, but still, I feel like, although we speak different language but we can understand each other's problem better. (S32)

When students had friendships they felt connected. Friendships were established for many reasons. CLDNSs commented upon feeling better about themselves when they knew other students in their classes. These comments reflected feelings of positive self-esteem, for example: "I like that class because I can feel comfortable because I know some of the other student and then we do work together on assignment or homework or something" (S22) and "when you have friends at uni. you go there to see them too … I mean you go to classes but you just feel better knowing the others are there" (S33).

During conversations with CLDNSs there were many occasions when they indicated relief to know that they were not the only one in their situation. This hint

of empathy and an appreciation and understanding of not being the only one with problems was demonstrated in the following student data extract:

> Sometimes, like, people in, if I talk to other students in lower semester they tell. I sometimes will ask, ask them, ask people, how they're doing in their things and if they have problems and somehow try to help them because, you know, like, I was been there before and I know how it feels. I feel they, they sort of in a similar situation as me and then maybe they would be able to understand me better and I can understand them better as well and so when they tell me things you know what happened, I think, I can tell them "it's alright, this, this happened like that, it's quite usual", you know so they feel comfortable. (S32)

This same student also commented:

> Like it sometime make you realize you're not the only person in a difficult situation because they maybe have also have the same problem and then when you talk with them, together, sometimes you might find … with this unit there is this problem existing in the unit outline or things like that. And then … you could have the courage to go out and talk to the lecturer or whoever is responsible for the unit and tell them about the problem. (S32)

In smaller groups CLDNSs were able to develop friendships. They were also able to discuss their problems and concerns and find out that other students shared their concerns and problems. Smaller groups also gave them the opportunity to share solutions to problems. Such sharing instilled positive feelings related to being able to help others, thus reducing SD.

Numerous Asian students had also sought support from other Asian students because they shared a level of cultural understanding. Preference was given to working with other Asian students because as one student stated "They'll [Asians will] do things, they'll [Asians will] work hard and get … the best marks possible … and because of that … we all have the same goal" (S34).

Other Asian students spoke of shared problems and understanding as the basis for friendships. This shared cultural understanding was also seen when Asian students expressed their preference to work with other Asians because they lacked familiarity with nursing students from other cultural backgrounds. This preference was demonstrated by the following student comment:

I ask my friends and because the people there that I met, I haven't really, you know we haven't became, you know we just met, we're not that good friends and stuff but that's why I tend to um stay with Asian people. (S32)

This student had in fact known the Asian people referred to in this quote for the same length of time as she had known the non-Asian people.

Most of the issues dealt with in Asian support groups were common to those addressed by the more multicultural groups. However, there were specific issues, such as parental restrictions or family responsibilities, which Asian students felt more comfortable discussing with other Asian students. Asian students did not express comfort when discussing family issues with any other group of students because as one student had said "Asian people [are] different to Australians and the others, we completely different to your culture" (S21).

CLDNSs had articulated their difficulties understanding native English speakers partly because of the rapid pace of speech delivery. Students from different cultural backgrounds expressed their preference of clarifying misunderstanding with other CLDNSs because they believed members of the non-dominant group would assist them from an experiential base. This meant that others would know the precise assistance needed because it was quite likely they too had been through the same experiences. The corollary was that if a CLDNS approached another CLDNS it was more likely they would take more time in conversation than members of the dominant group because they were thought to have a greater understanding and appreciation of difficulties from an experiential perspective. As one student commented:

[We may have] different language but we can understand each other's problem better, if for I [she] can explain this for me, she explain it very slowly so that I can understand but if I go to Australian student they, they just speak very fast, and you don't even, you know understand what they told you. (S32)

Another CLDNS had commented similarly about members of the dominant group not taking time to explain answers. Whilst she acknowledged she had asked members of the dominant group for help she was more comfortable in asking other

Asians because she believed "… Australians, they don't understand … us and don't have much time to do that" (S21).

One of the unexpected by-products of CLDNSs mixing with each other was that they usually had to speak English to be able to communicate with each other. As far as language was concerned this meant students were more or less on an equal footing because English was not anyone's first language. In such groups students were able to help each other with communication using English and students commented that they had an expressed preference in receiving this type of support from other CLDNSs rather than native English speakers.

Occasionally difficulties related to communication under these circumstances arose. Students described the difficulties they sometimes experienced when trying to communicate with another student whose first language also was not English. These difficulties were aptly described by the following student's quote: "It's frustrating and you can't help it, I try to be nice and good and if I can help, then help them but it's really hard when he or she can't even speak to you …" (S32). Seen from a different perspective one student had commented "we do eventually get to understand each other …" (S23), suggesting a willingness to spend more time trying than members of the dominant group.

CLDNSs reported having an understanding of each other's predicaments on occasions when one or other were observed to be in difficult situations. One student had recollected her understanding on such an occasion and had said:

> I suppose if I notice that someone is having a problem and it's not hard, I don't find it hard to see where people look distressed and confused and something is obviously bothering them and I … feel quite comfortable afterwards going up to say "Did you have a problem with that? Is that causing you a problem? Why don't you speak to the facilitator about it?" Especially someone with another ethnic background, if I observed that they were having difficulty with, with the situation, they weren't feeling comfortable and especially if they had a task within a group or had a certain task to do, that didn't go down very well with them, either because they didn't understand or because it's just so foreign to them. (S13)

In clinical settings CLDNSs reported receiving support from other CLDNSs when performing skills for the first time. Students who were not feeling confident approached others and asked them to "stay with me to do the skill" (S14). On one

occasion where this had occurred the student receiving support initially said, "He was just [there] to give me confidence" (S14). However, with further probing she had also said "He was telling me … the right way to do it [the patient's dressing]" (S14). Those CLDNSs who had previous exposures to nursing, often as carers employed part time in nursing homes, had also found they acted as resources for others. The former group of students had helped the others in nursing skills laboratories demonstrating how skills were to be performed and in explaining teacher instructions. Whilst this situation was likely to have also occurred within the dominant group, and between the dominant group and CLDNSs, it was more likely that when it did occur between CLDNSs greater explanations and a degree of translation were more likely to have taken place.

Students from the same country of origin and identical cultural backgrounds frequently experienced a unique level of rapport or a special type of bonding. This uniqueness existed between these students because, not only could they provide support for each other in all areas discussed so far, they could also depend upon each other when other forms of support were not available. Additionally, whenever these students held culturally specific or religious beliefs that were thought of negatively by the dominant group of Westerners these students had a like-minded group of fellow colleagues with whom they could discuss concerns. The core of uniqueness of such a group enabled the students to discuss issues without having to explain details; students implicitly understood each other and understanding and acceptance appeared unconditional.

Interacting with members of the dominant group

From data analysis it became evident that most CLDNSs preferred to work together but there were some students who wanted to work with members of the dominant group. This latter preference existed for two reasons. The first was to avoid confusion in clinical practice settings where patients and staff seemed to have difficulty identifying one Asian student from another. If one Asian student had made an error or omitted some component of nursing care all other Asian students were cast in the same way. By working with members of the dominant group this type of mistaken identity could be avoided thus reducing or preventing subsequent

SD. Other CLDNSs wanted to work with members of the dominant group only because they were able to leave cultural traditions at home. For example, Asians students did not have to demonstrate parental-type respect to little known mature aged Asian students; they could interact with members of the dominant group as peers.

CLDNSs had received occasional offers of support from members of the dominant group. Analysis of student interview data showed that much of the peer support that did take place between CLDNSs and members of the dominant group did so at the initiation of the latter group. Many CLDNSs, when discussing this type of peer support, talked of members of the dominant group approaching them, for example:

> Like I think I was quite fortunate … I met Australian students in my tutorial in the first semester and they were very helpful and some of them would come up to me and say "Are you alright? Do you need a hand with something?" (S32)

At other times when CLDNSs talked of peer support they had received from members of the dominant group, they had indicated support occurring in a two-way or reciprocal fashion. This type of reciprocal support was evidenced in the following quote:

> And we have a study group before this Health Science exam and cause [because] I'm good in Chemistry and one of them says "XXX can you come [to the] library and help me?" And I said to myself "Look even though my English", I mean (pause) she could (pause) could go and ask another Australian, but she come to me, maybe because I, I don't know, I've got that personality she's happy, for, you know, feel good, you know, something, comfortable … and I went there and a she helped me a little bit with English and I help her and that make me feel good. (S32)

Initiation of support between CLDNSs and members of the dominant group was shown at other times to have been made by CLDNSs. During several student interviews they had covertly indicated that they had initiated support from members of the dominant group by asking them to explain what the teacher was talking about. On these occasions CLDNSs were not selective as to which members of the dominant group they approached for support; they just asked the Australian nursing student sitting closest to them. For example, one scenario that took place in class

happened when the presenting lecturer spoke of "bongs". As the student said "We had no idea what these things are … so I just ask the next person to me and she said this is … what they use to sniff marijuana …" (S24).

CLDNSs used a couple of different strategies to befriend members of the dominant group. During one interview the student described the process she had used to befriend members of the dominant group in an effort not only to become their friend but also to gain their help with English thus reducing SD. As this student stated:

> You know, this is funny but sometime I had to, I had to take more lunch, not more lunch, you know, that made them, you know like the kids they wanna make friend or something. Sometime I pack few lunch, I said, "Oh, I got extra sandwich" or "Don't go and buy it" or sometime I take my flask [thermos]. I know maybe it's funny, but I did a few times. That made, made, make it for me easier, in the first [beginning]. I'm not doing it anymore but I did it like first or second week. I thought "Oh, I'm gonna get (pause) friend". You know, you know sometime, I felt like I was a sneaky or something. I'm just telling you, I put, I took my flask and I said "Do you want to go and have coffee or something?" She said "Oh yeah". I said "Come on, have coffee with me". I have coffee I even put, I take a spare, you know, cup with me, that you know, because I thought this part I can do it, you know. Then, if I sort of, I don't know how, what I say it, in the relationship I can give something and then get something, you know what I mean? If they, if they felt for me I didn't have to do this, but I thought this way I can get close to them a little bit you know. I could even buy their lunch if they help me with some of English sometime. I didn't do it but I was, it was in my mind. (S32)

From this data extract it was evident that although the strategy to bring in extra food supplies helped this student access English language support it was not sustained. Over time she did develop friendships, mostly with other students from different cultural backgrounds.

There were other reports of CLDNSs receiving support from members of the dominant group for a variety of other reasons, many of which related in some way or another to communication. The bulk of this kind of support in fact specifically related to assignments. For example, CLDNSs may not have understood assignment requirements; they may have needed help with grammar or word pronunciation and meaning for verbal presentations. CLDNSs often reported a preference for asking

any other students for help with assignment queries prior to asking academics. One student even commented that she would ask CLDNSs first; when they did not know the answers to her questions she would then ask a member of the dominant group. She would only approach academics when other students could not help her with her queries.

CLDNSs had discovered a few pitfalls along the way in regards to asking members of the dominant group for assistance. Members of the dominant group often failed to appreciate the depth and degree of assistance some CLDNSs required. This was demonstrated in the following quote:

> Like I go and ask "Do you know what assignment mean?" What that mean, summary after I know, from A to Z it was all right because, but the summary, summary … it was the simple question, the simple thing but the thing … when I said "How do you have to sort of gather information?" or something. "How you make summary from the book?" They just [said] summary, summarize it, summarize it, but they didn't even realize I don't even know what summary is. (S25)

Other pitfalls related to CLDNSs getting support from members of the dominant group were also identified. A typical example had occurred when CLDNSs put off asking academics for help believing they could ask members of the dominant group. Unfortunately, CLDNSs having made this decision, all too often found they never had the time to get the needed help from members of the dominant group. Sadly, they had then missed two opportunities of obtaining support.

Analysis of CLDNSs' interview data demonstrated that some CLDNSs experienced the benefits of support received from members of the dominant group. One of these benefits was the development of close friendships between students in which many cultural exchanges took place. Other students spoke of feeling as if their self-confidence had improved because they felt good about having asked a member of the dominant group for help and finding out that they didn't have all the answers. This made students realise that their situation was not as unique or as negative as they had thought. Another benefit of this joining of students in friendship was exposure to English language and Australian culture. CLDNSs learnt a great deal about Australian culture and Australian nursing by mixing with members of the dominant group. Many expressed their desires to befriend

Australians or Anglo-Saxons hoping to meet people who they believed would help them throughout their undergraduate degree programs.

Academics were not only aware of support offered to CLDNSs by members of the dominant group but they were also cognisant of the possibility of the burden this could place upon those in the supporting role. Some academics, aware of the voluntary nature of Australian students supporting CLDNSs had also commented on the provision of such support being unfair to members of the dominant group and believed they should be awarded credit points towards their degrees for provision of support of this nature.

Clearly, there was a need for CLDNSs to feel support and encouragement and to know they had friends in their undergraduate nursing degree. The importance of having friends was demonstrated in the following quote:

> You need friends especially when you at uni. [you are at university] and you need the friends to overcome pressures and stress. And in the group you need the help … so you do need to have friends … and help each other to pass exams and … helping each other … studying. (S26)

Making friends was important to these students because it allowed them to experience feelings of belonging and being wanted and needed. They also experienced feelings of being able to contribute in a worthwhile manner. They had something to look forward to in going to university every day. Once they had friends the students' level of self-confidence seemed to heighten and they liked to be with their friends in classes whenever possible. Students who claimed to have friends were happier people, they smiled more and laughed at interview and overall seemed more self-confident than those students who had not made friends.

Suppressing Discord: Being Quiet

There seemed to be an overwhelming number of CLDNSs who reported doing nothing and saying nothing at times when they experienced SD. By constantly comparing data the researcher eventually discovered that by doing and saying nothing the students were suppressing their feelings, their comments, and their responses. In effect they were SC by being quiet. Students sought concord by being quiet about most of the issues that caused them to experience SD. They rarely

spoke to their teachers, members of the dominant group, or RNs about their concerns. They did not speak up in class to ask questions when they did not understand. They rarely vocalized their experiences of differential treatment. Students were quiet in class and generally remained silent. They seldom complained and preferred to give reasons or excuses as to why they had been treated negatively.

Ignoring differential treatment

Many non-Anglo-Saxon CLDNSs who had opportunities and objective grounds upon which to claim differential treatment, in the forms of racism, prejudice, inequitable treatment or discrimination, declined to do so. Instead, this group of students made comments which made light of, excused, or justified the various forms of negative treatment they had encountered. For example:

> For me discrimination is like, I don't know, that topic, for me, I don't take any notice of discrimination or racism … it's life, you just, you are, everybody is like (pause) you either discriminate against one or another so … [it] doesn't affect me. (S15)

One student had thought that at times Australians were unaware of their own racist behaviours and had justified racist treatment by the following comment:

> Depending on where you're from, like your family and stuff, sometimes the, the children you know, they're influenced by the parents, because the parents may be racist and they, you know they can't think that they might be racist too. (S35)

CLDNSs were hesitant to report incidents of differential treatment for fear of "rebound effects" (S27). These rebound effects acted to gag CLDNSs. They were too afraid to formalize their concerns especially as these related to teachers. Instead CLDNSs were prepared to put up with most forms of differential treatment from teachers because the same teachers were the very people conducting their assessments. To speak out about these concerns may have jeopardized their progress in the course; they believed they would fail assessments if they discussed their experiences of differential treatment.

Furthermore, when CLDNSs encountered differential treatment during clinical practice they were unlikely to report it to clinical teachers. Clinical teachers were most likely to have found out about differential treatment experienced by

CLDNSs via the RNs with whom the students worked. In other words CLDNSs had remained silent. Very few ever reported these incidents and it became obvious at interview via body language that students disliked discussing these issues. Some had discussed specific incidents but others only made vague comments such as "I'm not really comfortable in this place … I have never said anything [to the clinical teacher], I mean about discrimination, anything like that" (S16). Comments of this type allowed students to discuss their general feelings without specificity.

When teachers heard that students had encountered racially based problems with patients they felt compelled to act and where possible they worked to effect change of patient allocation. Consequently students were given different patients to care for. This often resulted in the student working not only with different patients but also with a different RN. On these occasions students experienced SD, in the first instance when they encountered patients who treated them with disdain. When actions were employed in an effort to reduce problems associated with the care of specific patients CLDNSs experienced further SD, because they had to be shifted around. By being shifted around students had to become familiar with a new set of patients as well as another RN. These changes also alerted staff and other students that something was wrong and many approached the CLDNSs to investigate why the changes had been made, drawing unwanted attention to them.

Regardless of the form of discrimination students created the impression that differential treatment had affected them in some way. For example, one student, having discussed her belief that she had experienced differential treatment from members of the dominant group, had in fact detailed strategies these students used to avoid working with her. She spoke of being in tears because she was upset by how she had been treated and she felt others did not like her because of her accent. Still this student did not mention differential treatment from her peers; instead she had concluded the basis of this negative treatment by members of the dominant group was related to differences other than racially-based attitudes.

Even those CLDNSs who declined to discuss their experiences of differential treatment seemed marred by their experiences. Their efforts to ignore differential treatment were largely unsuccessful. In other words, these students had been able to

ignore specific incidents of differential treatment at the time of its occurrence, suppressing their responses, but transcript analysis clearly showed that many were still coming to terms with discriminatory encounters well after individual incidents.

Those who tried to ignore specific incidents of differential treatment had given insight as to how they did so, for example, by remaining quiet when such issues arose and by not discussing these incidents with anyone. Lack of discussion and being quiet was seen in the following students' quotes: "I just shut up because if I talk I think I [will] say other bad things so I think it's the best way for me, to shut up" (S16). Another student commented "I try to not think about it because [the] more I think about it [the] more like it's gonna be hard for me" (S21). And another had commented, "I try [to] never think about it" (S26).

It was clear that students often dealt with their encounters of differential treatment by being quiet and suppressing their responses; by remaining silent they were SC. It appeared that some felt if they did not discuss differential treatment it would go away, which was not usually the case. Hence, the strategy of suppressing responses and being quiet was unsuccessful in seeking concord.

Avoiding interaction

Another form of being quiet and suppressing responses related to students sitting silently in classes. They rarely contributed to classroom interactions, much to the frustration of a number of academics. By being quiet CLDNSs were able to avoid making communication errors. By avoiding communication errors they avoided SD. When they were sitting quietly in class they perceived they were behaving properly; they thought they were doing the right thing. In essence they had created an appearance of existing in a concordant environment.

In addition, those students who lived in strict family households had also learnt to be quiet about their nursing education experiences when at home. The less they said about their clinical experiences the better. If they did not inform their parents, particularly fathers, of details of what they had learnt which may not have been culturally appropriate they were more likely to be able to keep the peace at home. In this respect, keeping the peace by being quiet equated to SC.

Adjusting Communication Strategies

In order to reduce SD, participants made various adjustments to their means of communication, for example, they used body language and much repetition. It was imperative that CLDNSs were understood, not only in classroom situations but also in clinical practice settings. Students had worked hard at getting themselves understood and they worked hard at understanding others. Because these strategies aimed to improve students' communication they were seen as facilitating students' movement, not only towards the right track, but also along the right track. In respect to communication, to get in the right track meant two things. Firstly, CLDNSs had to become more readily understood in all aspects of communication and secondly, CLDNSs had to improve their comprehension of the English language and Australian ways of communicating.

Augmenting verbal communication

Augmenting verbal communication meant that CLDNSs tried to get their verbal messages more readily understood. A number of CLDNSs made use of body language or gesturing when they spoke with the aim of sending physical cues to accompany spoken words. For example, one student commented "I use my body … like my hands or my looks to say things they don't understand … I use body language" (S22) and another student commented "I'm Italian and people know we use our hands and our arms when we speak" (S17). Students were aware that it took them many words to impart simple instructions. They also understood that their gesturing facilitated comprehension of their spoken words that were at times difficult for the receiver to understand because of strong accents affecting pronunciation. Whilst for some students this combination of signing with explanations may have been successful, others found such strategies time consuming and frustrating, especially when they were not able to get themselves understood. Whilst these strategies were successful for some CLDNSs the same strategies only acted to highlight the difficulties others had in respect to communication thus emphasizing or increasing their feelings of SD. As one student said, whilst gesturing, "Sometimes it's like make it big, like I can't say one word so I just go on and on … talking such a lot of words for only one thing" (S36).

Examples of this gesturing occurred in clinical practice when students acted out their instructions to their patients. Students had talked about using sign language and teachers spoke about "charade-type actions" (A10) to assist self-expression. Students who used charade-type actions seemed more successful in their interactions with patients. Interestingly, those CLDNSs who used these strategies did not appear self-conscious when using their own bodies to augment communication with their patients, even when these messages were of an intimate nature. During clinical field observations CLDNSs were seen acting out, in charade-type fashion, their sometimes incomprehensible verbal messages. For example, students were seen to hold a wash-cloth close to their own genitals and briefly go through the motions of washing themselves. This was done purposefully and in full view of the patient in an effort to get the patient to understand that the student wanted them to wash their own genitals. This behaviour had also been described by students at interview, for example, one student said "I ask her once again and she didn't understand so I have to use it on myself. Like with the soap and that [wash cloth] … [she] took the soap and she started to wash herself" (S15).

Other students had also been observed in clinical practice settings using simple hand signals or signing to send messages successfully. These hand signals appeared to have the desired effect demonstrated by patients' reactions, as seen in the following memo from clinical field observations:

> The student and myself had been introduced to the patient by the RN. The RN and myself greeted the patient whilst the student remained silent. The RN went on and talked with the patient about nursing care planned for that shift, care the student would be performing, yet the student remained silent. At the completion of the interaction the RN had said to the patient "OK, I'll see you later then" and began leaving the patient's bedside. I bid my own farewell but the student said nothing. Instead, as she walked out of the doorway she turned and waved to the patient. The patient responded by waving and smiling. On this occasion the student did not indicate she would be returning nor did she demonstrate an understanding of the planned nursing care. (FN)

On another occasion, a different student had communicated successfully using hand signals. The student measured the patient's temperature, pulse, respirations, oxygen saturation, blood pressure, and observed the patient's groin for

blood loss. He then moved to the foot of the bed and recorded his observations, returned the file, looked at the patient, made eye contact and gave the thumbs up signal. The patient received the intended message, smiled and returned the signal. On this occasion perhaps there was no need for talk. The student left the patient's bedside without uttering a word.

Another example, seen in clinical practice, occurred when a student showed the patient the sphygmomanometer cuff [blood pressure cuff] intimating she wanted to measure the patient's blood pressure. There were many of these gesturing movements demonstrated in clinical field observations and on the whole they seemed to work effectively to assist delivery of the CLDNSs verbal messages. Furthermore, these signing gestures had at time been used successfully without dialogue.

Still other students talked about using patients' facial expressions and other forms of nonverbal communication to help them judge whether or not patients were accepting of them as a nurse or satisfied with their nursing care. Another commented that she was "always … looking for patients' facial expressions" (S18) during nurse to patient introductions and another had discussed the importance of head nodding and head shaking during his nonverbal interactions with non-English speaking patients. In these latter situations, nonverbal communication strategies were perhaps more important because neither the students nor the patients used English as their first language.

Many students were acutely conscious of their accents and during interview demonstrated a sustained effort to speak clearly with attention given to enunciation, facilitating communication with the researcher. Because students were paying particular attention to their speech, communication necessarily took more time than usual. Effectively, students spoke clearly and slowly. Students were also conscious of making speech errors and discussed their actions to correct mispronunciation. By taking the time to slow down and become conscious of speech, of every word uttered, CLDNSs seemed to make less speech errors and as a strategy augmenting verbal communication it had been largely successful. The reality of slowing and scrutinising one's speech over a sustained period of time, however, was

questionable; it caused a degree of discomfort. In some respects this strategy was successful because students became readily understood but in reality CLDNSs experienced SD due to the effort this required to sustain this strategy.

Clinical teachers had suggested that CLDNSs use simple drawings to facilitate their communication with patients. Students were encouraged to use picture cards available in most health care agencies. When these cards were not available teachers suggested students draw simple pictorial representation of messages. For example, when students wanted their patient to have a drink they were encouraged to draw a glass of water. Whilst teachers had located these picture cards and demonstrated possible use of such cards, CLDNSs did not mention, nor were they observed, using them to facilitate communication between themselves and their patients.

Another approach used by CLDNSs was word approximation. Word approximation meant that students pronounced words as close as possible to the correct pronunciation. Essentially, they pronounced words approximately. There were times when spoken words were incomprehensible and not understood but the students were trying to communicate in English. Most occasions when words were incomprehensible related to medical terms. Many people, nurse teachers, patients, and members of the dominant student group appeared willing and able to guess the words the students were trying to say. When matching occurred, that is, the receiver guessed the correct word, communication was successful. The CLDNSs acknowledged correctness and continued communication. Difficulty existed when the receiver was unable to guess the correct word or was not willing to engage in this type of communication transaction, for example, when patients were demented or critically ill. Improving communication by approximation was considered a strategy in this study because it did augment verbal communication. Additionally, CLDNSs had received some encouragement when they had been successful in communication.

Mimicking behaviours

When a person mimics another's behaviour they essentially copy the observed behaviour. Academics had characterised CLDNSs as having a "stillness about them" (A17). According to academics, by having this stillness, CLDNSs were

able to sit in class, to avoid interaction and therefore distraction, and to observe the behaviours and body language or nonverbal communication, as well as the interactions of other students around them. By sitting and watching, CLDNSs were learning how to fit in and how to reduce their experiences of SD. In many respects CLDNSs were preparing to behave similarly to members of the dominant group. Some were more confident and had more success than others when emulating Australian behaviours for the first time. Irrespective of the outcome CLDNSs tried repeatedly to mimic members of the dominant group.

There were occasions in which CLDNSs had discussed behaving like members of the dominant group at home when interacting with their parents. Those who had talked about this usually talked about their parents' inability to accept their new ways of behaving. Whilst acknowledging their parents' discomfort it appeared that home was a safe place for CLDNSs to practice "answering back" and "being cheeky". When they were unsuccessful, or aware of making errors, the students experienced SD. However, when they were successful, they moved towards concord. The whole process of sitting and observing, perhaps practising and judging, or waiting for the right time to try out a new behaviour was evidence of the students SC.

Rephrasing and repeating

Students discussed their awareness of cultural differences between themselves and those with whom they interacted and the impact these differences could have upon communication. Those who were more cognisant of these differences spoke about checking receipt and correct interpretation of messages they had sent, judging this by the recipients' responses. They watched actions and listened to responses checking to see if the recipient acted appropriately. If the recipient did not respond appropriately they believed their message had been misunderstood. They would repeat themselves, rephrase what they had said, or tried additional input such as physical gestures, all in an effort to get their message through to the recipient.

Students had used repetition or rephrasing when they were unsuccessful in their first attempts at communication. Repetition meant students repeated the same

message exactly. Sometimes students added volume, hoping loudness would clarify misunderstanding. Almost all CLDNSs interviewed had acknowledged in some way that they had to repeat themselves on more than one occasion. Repetition had been requested of CLDNSs when the recipient of communication could not understand the sent message. CLDNSs were often not understood because of, for example, their accents, misapproximation of pronunciation, rapid pace of speech delivery, or because they spoke softly. From clinical field observations it became obvious that students were asked to repeat themselves for a combination of reasons, rather than one specific entity.

There were many occasions in clinical practice settings when miscommunication had occurred when students were talking to patients. Students' initial reactions were to repeat themselves with increased volume. On these occasions, however, the recipient of speech was not deaf but had simply not understood the student. Repetition, with or without added volume, was often the only strategy used by CLDNSs and on many occasions it had been used without the desired effect. When used as a single strategy, communication was not usually successful.

Having been unsuccessful in their initial attempt at communicating, others used rephrasing to resend their message. Rephrasing meant that students changed speech content and those who did so had more successful patient interactions. They realized they had not been understood in the first instant and tried resending their message differently. Those who engaged either strategy, that is repeating or rephrasing, were effectively trying to get themselves understood and thus were SC.

Preparing and studying

Most prereading assignments are set by academics to facilitate student comprehension of lecture content. Academics also set prereading assignments in an effort to enable students to contribute in classes. In this study very few students had completed the recommended prereading prior to attending lectures. When available, for example, from closed reserve sections in libraries, a small number of participants claimed they had photocopied the lecturers' notes and read these prior to attending lectures. A couple reported that they had completed recommended prereading of

journal articles and textbooks. These students commented favourably about greater ease of keeping up with the lecturer and being able to follow the lecture content. Whilst those who completed prereading found they were able to follow lectures, one or two had reported they had tried to complete prereading related to clinical practice areas but found the reading assignments of little use because they did not understand what they were reading about. Those students who had attempted prereading assignments were considered to have been seeking concord. Unfortunately, too few students employed this strategy and those who did the prereading related to clinical did not find the strategy useful.

Even though CLDNSs often reported to have put in a great deal of preparation time for giving tutorial presentations for assessment purposes many struggled. Some had used a small number of different strategies with the aim of being understood and receiving, if not a good mark, at least a pass grade. For example, students had prepared their audience by giving them fair warning of their imprecise English language skills prior to their presentations. An example of this preparation and instruction follows:

> Like the time we were asked to present and I had, present, because of my pronunciation of words and probably, I don't know, maybe sometimes not the correct form of grammar, so I do acknowledge that and tell them in the beginning that if they hear anything or that they don't understand what I say please let me know so I can repeat myself or put in different way so they have understanding and it seems to be working well. (S26)

Others made use of their own cultural experiences in an effort to make their tutorial presentations a little different. As a strategy this personal perspective was well received and successful when used appropriately.

Practising speech

Speech practice occurred when students felt a need to practice, or 'go over' what they had planned to say. Students usually engaged in speech practice prior to presentations they were to give in front of their colleagues or prior to speaking to teachers. In respect to oral presentations, such as those given by students in tutorials, some CLDNSs reported having spent more time practising than actually giving the presentation. Practice took place in all sorts of places and in front of a

variety of willing audiences. Students practiced presentations at home in front of mirrors or relatives. Some of the students' only relatives were primary-school-aged children. These children attended Australian schools and were often able to correct their mother's errors in pronunciation. Under these circumstances mothers felt embarrassed that their children had helped them with English and as such they experienced SD. But at the same time these women beamed with pride in their children. They were pleased they were eventually able to pronounce English words correctly and they were proud that their children were capable of helping them. The following data extract demonstrated this type of support:

> I think poorly of myself but I aska why do that? Doesn't matter she is young. She is going to school and she speaka English good … so she is able to help her mother. There is nothing wrong with that ... it make me very proud of her and me. Doesn't matter who teach me English …. (S32)

Under these conditions the same processes used in SC had acted sometimes to cause more SD. This was the case because the students' practice caused embarrassment in front of their young children but that same practice allowed them to pronounce words or phrases correctly which ultimately got them on the right track. By making fewer errors when speaking CLDNSs seemed to fit in with the dominant group.

Other CLDNSs had made use of people outside of universities and families who attended the same English language courses, with whom to practice their presentations. One of the many problems associated with practicing under these conditions was that these other people also used languages other then English as their first language and most were unfamiliar with nursing vernacular. As a corollary, they were often unable to identify speech errors and few could help students when errors occurred. Students who used this form of speech practice as a strategy in SC often experienced an increase in SD. This strategy was not always successful because they had followed suggestions made to them by academics, that is, to practice giving their presentation in front of others but they still faltered during formal classroom presentations due to mispronunciation.

Students had also practiced conversations silently whilst standing amongst others, waiting their turn to talk to an academic. As a strategy, this was sometimes

successful and sometimes not successful. On occasion, speech practice made students more self-conscious and increased their awareness of speech deficits. Many changed their mind about approaching academics because speech practice had confirmed their fears of making errors. As a strategy to help them get in the right track, speech practice worked for some on some occasions but not for all students on all occasions. In many respects, this strategy only confirmed some students' fear and increased SD.

Using tape recorders

Due to difficulties students had in relation to keeping up in class, taking notes, listening to lectures, understanding concepts, copying from overheads or PowerPoint presentations, and translating back and forth from one language to another, it was not surprising to learn that some students used tape recorders to capture lessons. What was surprising, however, was the small number of students who used this strategy. Once captured on tape CLDNSs copied lectures verbatim. Students did this so they would have a complete set of lecture notes from which to study. Students felt a degree of comfort in knowing they had not missed anything the lecturer said. Only a few students had discussed the use of tape recorders in lectures; however, from data analysis it became apparent that whilst tape recording of lectures enabled these students to write lecture content verbatim it usually failed to improve their notetaking skills. These students continued to sit in a degree of discomfort because as they had said "I never know which part is important to study for exams" (S21) and "to me it is all important, so I have to know all of it" (S32).

In general the study habits of CLDNSs were time consuming and not particularly helpful. Whilst most students passed their formal assessments, some on their second attempt, many only received low pass grades. There was minimal evidence of CLDNSs achieving a majority of high distinctions, distinctions or credit grades. Students' fear of failure and the resultant loss of face were the driving forces behind the hours spent studying. Nonetheless, CLDNSs put in the time and the effort and the majority of those interviewed had passed their assessments. These students had successfully reduced their experiences of SD by dedicating much time to studying, and using strategies to increase their comprehension, to pass exams.

Nevertheless, some increase in SD also resulted from using these strategies because students spent seemingly endless hours writing out complete sets of lecture notes and studying the complete set. Instead of studying the important concepts they tried to learn everything they had written. They did this in the belief that they were working towards passing their assessments, seeking concord to get in the right track (SC).

Using dictionaries

About one third of all students interviewed had mentioned using first language dictionaries to help them understand English words. Students used dictionaries in combination with Microsoft Word spell and grammar check when they were writing essays. Many students who spoke of using first language dictionaries did so to seek word meaning in their first language so they could use their prior knowledge to make sense of new information. Still others had used nursing or medical dictionaries in English and in their first language. One student even carried an electronic dictionary. This piece of equipment not only spelt words correctly, it also gave a basic definition. Once words were located and understood from first language dictionaries, students practiced the English pronunciation.

In clinical practice settings other students would ask those around them what certain terms meant. This asking, however, was never simple or straightforward. CLDNSs often spoke of having to write down meaningless words during handover and then having to wait until an appropriate time, after handover, to ask a colleague the meaning of specific words. Because students had to wait until handover had finished they had not understood what had been said about many patients. By accessing dictionaries in clinical practice settings and finding out word meaning students were able to reduce SD. They found out what words meant and they could act or respond accordingly. Some students, however, did not have immediate access to dictionaries. This allowed their feelings of SD to continue because of the necessary time delay between hearing a word and accessing a dictionary.

Furthermore, intensity of SD increased for those students who were keen to use dictionaries in examinations but were prohibited from doing so because the university had banned dictionaries in examination rooms. The intensity of SD

increased under these conditions because students had attended classes and clinical practice settings where they had been allowed, and encouraged, to make use of dictionaries whenever they needed. Some universities had implemented policies that prevented students from using first language dictionaries in examinations whilst other universities were reported to have encouraged dictionary use even in examinations.

Blocking Off Cultural-Self

In order to find a place of concord CLDNSs engaged in behaviours that acted to temporarily cut or block themselves off from their cultural selves. These types of behaviours were discussed on a number of occasions at interview with students. When faced with situations that they found threatening, that questioned or challenged their traditional cultural belief systems, they tried to protect themselves by blocking off that part of themselves. Instead of thinking about what they should, or more likely, should not have been doing, they focused on the job at hand. In other words, they focused on being a nurse. Essentially they changed cultures to allow themselves to be able to perform in the challenging clinical scenarios in which they found themselves. The classic example uncovered at interview took place when a young Fijian nurse was allocated to care for a young man who had attempted to commit suicide. Her culture dictated that she should have nothing to do with this man, not because he was male and she female but because he had attempted to end his own life. As she commented "Like, if I saw him on the street, I should have nothing to do with him. It's like a taboo in our culture" (S18).

This strategy was only partially successful because, whilst effective during the provision of direct patient care, this particular student could not keep her thoughts from returning to what she ought to have done according to her culture. She spent time thinking about this patient well after the event and it was relevant for her to bring up and discuss at interview. Clearly, this incident had impacted upon her. The student, whilst implementing a strategy in an effort to seek concord, had experienced SD. During morning tea and lunch breaks her cultural beliefs returned quite strongly and she spent time thinking about these. Students had offered reasons as to why they

practiced cutting off, ignoring, blocking out or switching off their cultural background and adopted the persona of a nurse. As the following quote showed some did so to avoid confusion of their beliefs with those held by members of the dominant group.

> I think, because I have so many morals, that are totally different to other cultures and if I see myself as a Fijian, my morals will keep coming back to me, so if I cut that out I'll be, that moral won't interfere with what I am doing, how I am treating the patient, kind of thing. Whenever I come into a hospital I just forget about everything, I just go in and I focus on all the um [pause] on the things I have to do, you know, all the things nurses have to do …. when I'm doing, I've learnt, I switch off. (S18)

Because this student knew she had to care for her patient, irrespective of the fact he had tried to take his own life, and irrespective that if she was in her country she should not care for this same person, she did so in order to fit in and perform to role expectations.

There were other students too who spoke of similar blocking off behaviours employed when they felt challenged in clinical practice settings. This included the Black South African student who was allocated to provide nursing care for the White South African patient and the Jewish student who did not dare to identify as being Jewish for fear of being treated in the same negative way as Jewish patients. Blocking the self off from cultural identity was seen in the following data extract:

> I'm not gonna stick up for the patients even if they are Jewish … then they'll know I am too and they will treat me the same. Instead I just do lots of little extra things for the patients … it doesn't take much. (S27)

In summary, there were a range of subprocesses of seeking concord to get in the right track (SC). These included saving face by using covert deception and the "yes syndrome"; clustering (forming friendships, interacting with members of the dominant group); suppressing discord: being quiet by ignoring differential treatment and avoiding interaction; adjusting and augmenting communication (e.g., mimicking behaviours, rephrasing and repeating, preparing and studying, practising speech, using tape recorders, using dictionaries; and blocking off the cultural self). As such these subprocesses constituted the basic social process and were implemented by CLDNSs in an episodic fashion and in no particular order.

The remainder of this chapter considers the influencing conditions that impacted upon CLDNSs as they attempted to change their behaviours to seek concord to get in the right track (SC). Different aspects of the environment affected students' ability to implement strategies they felt would help them in SC. CLDNSs spoke of the support they had received from nurse teachers, different classroom set ups, student support services, their interactions with members of the dominant group, and the support from their families or lack there of.

Influencing Conditions

Thus far a number of different influencing conditions have been addressed in context, for example, the conditions or circumstances that led CLDNSs to use the yes syndrome or the conditions or circumstances that permitted CLDNSs to befriend members of the dominant group. Influencing conditions are those sets of surrounding circumstances that can be linked to events that participants report, in this case their involvement in the process of SC. Participants are not necessarily aware of the influencing conditions; however, in grounded theory research it is important to identify and discuss these sets of conditions and how they influence either the experience of the basic social process or the problem. In this study there were several influencing conditions affecting the students' journeys of SC, either by facilitating or inhibiting this process. For example, when students received support from their teachers they were more likely to try out teacher recommendations and when students were in smaller classes they felt less threatened if they were required to speak. Other influencing conditions were evident in the data. These were: access to student support services, whether these are nursing student specific or not; counselling support; regular interaction with English speakers; unsolicited support; and support from family members. All of these factors influenced CLDNSs behaviours.

Academic Support

Data analysis revealed a myriad of support measures offered to CLDNSs by some of their teachers. Of interest, however, was the fact that most of these support strategies were implemented by individual academics in an ad hoc fashion. In other

words, there was a noticeable lack of coordination of support services offered by academics and provided to CLDNSs. Essentially, when problems occurred support was offered in an as-needed manner by only a few academics. Although support given to CLDNSs had been discussed by teachers very few students spoke of the same support. Also, students had the propensity to talk about support they had received from specific teachers and the same teachers were mentioned repeatedly.

Examples of support given to CLDNSs were gleaned from teachers' transcripts and included, but not restricted to, showing CLDNSs how to use overhead projectors and helping students with pronunciation of words during classroom interactions. This latter assistance negated the embarrassment students experienced when they had problems pronouncing words and also reduced the basis for ridicule by members of the dominant group.

In addition, students felt supported by academics when they took the time to stop and talk to CLDNSs on campus, either individually or in small groups, about their lives outside of university. Academics had inquired, for example, about students' families, part time employment, and places of residence. Students felt that such inquiries demonstrated that their teachers were interested in them as people and not just as students. CLDNSs also enjoyed having their cultural differences recognised and acknowledged by others in a positive way. For example one student had said:

> The teachers have been fantastic …and she goes to us, oh well like there is another girl, she is from another country, and there is another girl who is from another country, and she goes "I love working with different nationality because it makes your job more interesting". (S29)

And another:

> It's good when you can tell the class about how you lived before you came here. Some teachers they ask our opinion on something to do with our culture. You feel as if you can make a contribution but I always wait until one of them will ask me. (S28)

Academic support had also been demonstrated to CLDNSs when a teacher regularly finished classes early and used the extra time to stay behind with CLDNSs to clarify concepts or issues they had not understood. This form of support only occurred

because these tutorials usually finished before the two-hour time period and members of the dominant group left the room leaving the CLDNSs and the academic to discuss and clarify nebulous issues.

Other forms of support initiated by academics were available to CLDNSs; however, these were discussed by academics – not the CLDNSs. For example, one academic had talked about her efforts to provide CLDNSs weekly tutorials to improve their comprehension of materials she covered in formal classes. A specialist English as a Second Language (ESL) teacher who had no nursing experience conducted these tutorials. This situation necessitated that the academic who initiated these tutorials have weekly sessions with the specialist ESL teacher so as to prepare her for the extra tutorial. According to the academic the down-side of such huge amounts of regular effort was that only a few CLDNSs ever attended these sessions. However, the academic reported that attending students performed better in exams than those CLDNSs who did not attend.

One-on-one, weekly meetings between individual CLDNSs and academics were also discussed but again only at interviews with academics. These meetings were established to address any areas of concern held by the CLDNSs. Academics were also able to use these sessions to teach CLDNSs how to study, how to make notes, and some had even developed a series of student quizzes.

CLDNSs described academics as being supportive when they took the time and listened to students. This supportive trait was seen in the following student's quote:

> Usually I ask them, I says … "If I'm having problems it's OK if I come and ask you or talk to you?" And usually they'll go "Yeah … do that". And you can tell whether they're friendly you know, … because when they talk they don't sound like if they rushing or that, that they … got other things in their mind or whatever, they're really talking to you. (S32)

From a different perspective there were occasions in which academics had facilitated CLDNSs' integration into the wider group of nursing students. This occurred, for example, when academics had asked CLDNSs to share their lived experiences of being a refugee. Thus, CLDNSs, instead of always learning about cultural issues from members of the dominant group focused on their cultures; the roles had been

reversed. Not only had such cultural exchanges been valued by academics and members of the dominant group alike, the CLDNSs seemed to experience a degree of admiration and acceptance from their colleagues. In this way academics had provided support for CLDNSs.

Some students found it difficult to take up the offers of support and assistance whilst others did so readily. Others agreed to implement recommendations; however, it was doubtful many actually did so. The reasons given often related to a lack of spare time. Mature aged CLDNSs had identified their family as coming first. But those who made use of recommendations, usually found teacher suggestions advantageous. For example, CLDNSs reported they had used spelling to get themselves understood in clinical practice settings. CLDNSs were encouraged to be more active in classes. Many used teacher recommendations on how to become more active. Teachers had encouraged students outside of formal class times to make verbal contributions in classes. They spoke to CLDNSs and talked them through how to answer questions in classes, they discussed the worse case scenarios of what may happen if they answered incorrectly. Academics followed through with encouragement and where possible they made opportunities for CLDNSs to contribute in classes. In the end, however, it was up to individual students to decide if they wished to take up the recommendations of their teachers and much depended upon their personal circumstances, for example, families and the set up of the physical locations in which learning took place.

Learning Environments

CLDNS participants had an expressed preference to work in small groups whenever possible. Smaller groups, such as tutorials, decreased SD. The rationale offered by the students was the smaller the group the fewer people to be embarrassed in front of when they made speech errors or content mistakes. In essence, students felt more comfortable in smaller classes. This preference was also evident when CLDNSs discussed asking questions or having to give presentations in class. All CLDNSs talked about fear associated with speaking in front of an audience and although the reasons for this fear remained, the fact that the tutorial group setting

afforded a smaller audience was of significance to CLDNSs. Students had stated

they remained self-conscious and still feared making speech or content errors when

speaking in tutorials but to do so did not seem as threatening in front of fewer

people. This was demonstrated in the following quotes:

> Tutorial, I think tutorial is helpful because there are like few people [and] I can ask [them things]…. I feel OK, bit friendly …. probably because I think that I'm too shy to ask, to ask people in front of many people. But not in smaller [group], you can ask all you want. (S21)

And:

> Is much easier in smaller classes. I prefer the smaller classes because sometime you with your friend and they will give you help. You all have to work together and they are more welcoming especially if you get it wrong. The friend will help me. Is hard for me when I am in group that I don't know even though I been here for nearly three years now. I do know them but not really. (S37)

Furthermore, when small groups had to be formed, for example, in class for

group work, CLDNSs who knew they were weak in areas of communication often

joined with CLDNSs who they perceived had good command of English. Similarly,

this latter group often joined forces with the former group. When such groups were

formed those with better command of English acted as communication resources for

those who were less experienced and less confident with English. These groups not

only operated in classes on campus but also existed in clinical practice settings and

outside of university. Students acted in pairs or in small groups to give each other

support with aspects of communication. Such support had been observed by

academics reporting examples such as:

> [CLDNSs] sit together, a group of them will sit together, they will be silent throughout the class, if they don't understand they are more likely to ask each other, so these sort of whispering and giggling going on, rather than ask the lecturer. (A23)

Another teacher had described an occasion in class when she had used the word

implications and CLDNSs had not understood. One student had said "'Implications?

I've never heard that word in my life' and then a couple of the others … said 'I've

never heard that word either'. Then I had to explain what the word meant" (A15).

In contrast to favouring tutorials, some had expressed a preference to learning in lectures because they felt they did not have to speak in lectures. This rationale was seen in the following comment:

> I don't have to do it [speak] otherwise you know, I mean I won't be here (laughs) or something, so yeah … otherwise, like in the classroom situation [lectures], I don't really have to [speak] if I don't want to. You know, because, that's why, you know, I just sit there … quietly. (S36)

Overall, however, students felt less intimidated when fewer people were present, they were more able to participate or ask questions because they believed they would be less embarrassed when they made speech errors.

Student Support Services

Whilst all students interviewed were aware of the existence of departments within their university that offered student support services, very few accessed such resources. The term 'student support services' (SSS) has been used in this study to refer to those departments within universities, but separate to nursing, that provided, as their name suggested, student support. All of the universities represented by student participants had similar centres. Academics put forward their beliefs that these centres had developed because of a demand created by increasing numbers of international students enrolling at universities.

The type and level of student support services offered depended upon which university students attended. Teaching staff reported that these centres provided some form of English language support for CLDNSs, along with general forms of support for the remainder of the student body. In fact, many of these departments offered educational sessions dealing with issues such as essay writing, study skills, or preparation for examinations. Some of these departments were used for other purposes ranging from access to computers and family counselling. English language support classes, however, did not exist at the time of data collection for this study.

Of those CLDNSs who attended SSS some had found their own way there, whereas teaching staff had referred others. Most of the CLDNSs who did attend these services did so because teachers had made strong recommendations that

specific individuals attend. Irrespective of the number of times teachers spoke of referring CLDNSs to support services many did not attend.

A number of academics had made reference to, and actually used the term, "sending" CLDNSs to student support services. Teachers felt they had little choice but to send students because they could not give students the support they needed as they were pressed for time. On other occasions academics had told students who had either failed, or just passed, assignments that they needed to go to support services. Many of these students were informed of their need to attend support services by way of written comments on marked assignments. In comparison, only two teachers spoke of having made suggestions, or recommendations, to the students that they visit support services. Irrespective of mode of referral many students did not attend SSS because, for example, they did not have the time or felt the pressure to be at home with family. However, some did attend and a couple of students acknowledged their voluntary use of SSS.

Outcomes of attending SSS were mixed. Students viewed their experiences positively and some teachers viewed the outcomes of student's attendance negatively. The former outcomes were reported by students as having helped them with "academic English" (S11), "presentations" (S15), "how to write assignments" (S36) and aspects of "Australian culture" (S21). The latter outcomes were viewed negatively because teachers thought attendance had made no difference to student performance. Following attendance at SSS, one student had managed to convince lecturers that she would have greater success in examinations if more culturally sensitive formats were used. Alternative forms of assessment were sought because the student:

> Knew that she was going to be unsuccessful in science subjects because she explained her English as being her third language so she would have to use her dictionary to translate … she was managing all right but she knew she could not do multiple choice questions in exams because it took her too long. (A23)

Because this student approached academics and discussed her situation she was able to work with academics and negotiated to resolve her problems. The student had not only been granted extensions of time to complete exams but had also been given

exam papers without multiple-choice questions. The corollary of these interactions was that those academics involved extended offers of alternative forms of assessment to other CLDNSs who experienced similar problems. Offers had been made because these academics had been alerted to the existence of such problems. This particular student, however, may never have approached academics in the first place had she not learnt from staff at SSS that consultation and negotiation were appropriate.

The negative comments related to student attendance at SSS were not made by CLDNSs but rather by their teachers. Summary type comments had been expressed such as "It didn't help them at all" (A13) and:

> Those courses are always in the intersemester breaks and so those students are disadvantaged in lots of ways in that they never get a break so they are working all the time because if they are not working on their academic requirements for the course they are working on their English requirements to assist them in their learning. (A111)

Nursing Specific Support Courses

CLDNS specific support courses had only been offered in two out of nine university campuses accessed in this research. Such courses had been implemented purposefully in an attempt to meet the demonstrated needs of CLDNSs that had not been met by mainstream nursing curricula or university based support services. Courses were conducted during semester, were non-credit bearing, extracurricular, and offered a series of classes designed to increase students' confidence cumulatively in many areas related to communication.

Whenever CLDNSs attended such courses and comments had been made at interview, they were positive. Students believed such courses made them feel good about themselves and encouraged them to help other CLDNSs in similar, if not identical, situations to their own. This aspect of feeling good was demonstrated, for example, in the following student's comment:

> Enjoy [I enjoyed] able [being able] to give feedback to people [CLDNSs] in lower semesters ... tell them what it's going to be like … what they will be expecting … what to look out for … helping them (S32).

In support of these claims CLDNSs had also commented that they felt that all class members from such courses were in the same situation. In other words, they understood issues from an experiential viewpoint. Students had also talked about having increased confidence to make verbal contributions in other classes. For example, one student believed that "It doesn't matter if anyone make mistake, she [the teacher] will understand me, like she has feeling for me … my situation" (S32). She also believed that course attendance made her realize that it was acceptable to say, "I don't understand [and] that's all right [to say you don't understand]" (S32).

By attendance at such courses, CLDNSs had the opportunity to learn that some academics were empathic to their situation but also to experience this empathy in an active way. The most poignant example of this type of realisation was clearly stated by one student when she said teachers in these types of courses are "really understanding and … pay … passion … for us and you realize how it's hard … when I feel like someone else realizes, I don't know, somehow it takes my pain away, a little bit of my pain" (S32).

Overall few academics were aware that such courses indeed existed. However, there were a couple of occasions in which academics referred to either similar courses being developed in their own universities or the existence of such courses but only being offered to International students rather than students from different cultural backgrounds living in Australia. Whether CLDNSs attended these so-called nursing specific support courses or the more generic international student support classes there was no doubt that they had to invest additional time and extra effort. From the student's perspective the overall aim of attendance was to reduce SD and to get in the right track. Having to attend additional classes created more SD for many students for a number of different reasons; however, attendance was concurrently seen as a way of helping them get in the right track. SD increased because additional class attendance detracted from their ability to meet other commitments, for example, being with family members at home or studying to pass exams. As one student had commented "Last year I didn't go and even this year, it's just too much time I haven't got". (S24). In other words, in seeking concord, further

SD had occurred. Occasionally CLDNSs were referred to university based counsellors.

Counselling Services

In addition to support services, nursing specific support courses, extra classes or tutorials for CLDNSs, on campus counselling services were also mentioned as a form of support during student and academic interviews. Whilst CLDNSs' transcripts showed an awareness of the existence of oncampus counselling services few students readily accessed available services. This occurred because, for many, seeking counselling was not an acceptable practice according to their culture. Essentially counselling services were considered "off limits" by these students and this belief was evidenced when students made comments such as "We, as the Vietnamese, we are, we just don't really take this come, come things, things not come is not come … like just let it be the way it is … you can't really do anything about it …" (S12). Rather than seek formal counselling students were more likely to live with SD and to discuss their personal issues with other CLDNSs. From this perspective it was important that CLDNSs forged friendships.

From a different perspective altogether there were two occasions when academics had reported CLDNSs accessing on campus counselling services. Those students who had experienced episodes of discord from well-meaning parental restrictions imposed upon their social activities related to university life had benefited when their parents had attended university based counselling. Parents accompanied students to counselling sessions aimed to educate the parents, who not only came from different cultural backgrounds but were also from different generations, about the university environment and modern students' lifestyles. Academics had acknowledged that both students benefited from the joint counselling sessions; and were seen to have "improved" (A112) or "blossomed" (A113) in due course.

Regular Interaction with English Speakers

Living with people whose first language was English had been reported as being of benefit in English language acquisition by some CLDNSs; however, not all CLDNSs had this opportunity. Those who did not have this opportunity were aware of the benefits such living arrangements could offer. This was evident in the following quote: "I always speak Cantonese … at home … everywhere, so [I] couldn't like practice English like others, so I can not like have any improve" (S11). Academics had also expressed their belief that those CLDNSs who lived in English speaking households had opportunities to improve their English language skills compared to those who did not. For many CLDNSs the only time they could speak English was at university or when they were out in clinical practice settings mixing with health care workers and patients. However, there were times when communication support was offered quite unexpectedly.

Unsolicited Communication Support

CLDNS efforts to get in the right track and seek concord did not always go unnoticed by others around them. There were occasions when people, for example, family members and teachers, including RNs, acted to lend support to students without solicitation. In other words students had received support from others without asking. During everyday interactions some members of the dominant group also helped CLDNSs with aspects of communication. When CLDNSs mispronounced words or phrases some of the students from the dominant group often corrected them. An example of this correction follows:

> I said "vagineye" [vagina]. And they say "vagineye?" And they say, "What's that?" And I say, "What you call this?" "Oh". They say "vagina". I say, "It's the same isn't it?" [And they say] "No, we call it vagina". (S32)

However, for this type of interaction to occur members of the dominant group and CLDNSs had to interact in the first place. Unfortunately, as discussed previously, there were many occasions when interaction did not occur. Without interaction there was little likelihood CLDNSs would be assisted by members of the dominant group.

CLDNSs also reported similar learning opportunities having occurred in clinical practice settings where they would use specific medical or nursing terms when conversing with RNs with whom they were working. When students had mispronounced words the RNs picked up the mispronunciation and said the word correctly to the student. At the time this type of interaction, although for some embarrassing, seemed helpful; however, those CLDNSs involved often reported continuing to have problems saying the corrected words. There was no instant or long-term fix for words that had been mispronounced. As one student commented:

> I try to remember the ways, um, they say it but sometime is not possible, yeah, like, you know, you still get, like it's in your head anyway, the way you … the way you used to pronounce it so it's always there. (S15)

Clinical teachers also spoke of this "on-the-spot correction technique" (A112) or "correct their English as you go" (A10) acknowledging that those students whose first language was tonal would have more difficulties with English language than those students whose first language was syntactical. Those who had a tonal language background were reported to place tonal inflection incorrectly when speaking English but were assisted by immediate correction. These on-the-spot interactions seemed to benefit students by using contextual situations in which to learn and practice pronunciation. By correcting students' mispronunciation efforts in this way there was an immediate, although short-lived, stop to verbal difference. Once corrected some students repeated words or phrases and actually used these given learning opportunities. As a strategy this was not always successful and there were times when incorrect practice necessitated reinstruction and encouragement from others.

Familial Support

A number of CLDNSs lived at home with extended families. Amongst parents, siblings, and other relatives students found a range of support which at times was quite unexpected. Support ranged from the simple to the more complex. Simple familial support existed when there was family present in the home especially after university classes. More complex support came from parents who

were RNs or worked in either the health care or tertiary education systems. Although few in number these mothers supported their child's comments related to nursing in front of more traditional fathers who demonstrated their dislike of their daughters' studying to become RNs. Under these circumstances mothers dealt with the fathers' disapproval.

When CLDNSs became frustrated with aspects of their nursing studies some acknowledged that they had spent time talking about their concerns and the possibilities of dropping out of, or taking a break from, university with close family members. These discussions proved supportive because students had maintained enrolment, that is, they had not dropped out and they had an opportunity to discuss their discordant feelings. An example outcome of this level of supportive discussion follows.

> My family I think is what keep me going it's my … family I think, yeah. I like, in this semester I got really stressed out and then I told my mum that maybe, I, I like to have a break, for maybe one semester or something like that and work. And after that … kind of get back to study and she said "Oh, no, just go, don't worry", you know, she said, "Oh … you'll be stressed out from last year as well, and then she said, "You'll be just fine". You know, "Just go, even if you pass it or not, doesn't matter". (S36)

Other students had come from families where there was little understanding of anything to do with nursing, let alone nursing in Australia. In such situations CLDNSs, whilst showing an appreciation of family members' interest in their work, felt family members were largely ignorant of their actual situation. An example of appreciation of family interest was discussed at interview when a student was talking about her family's daily ritual of getting together over the evening meal. Every day her parents would ask her what she had been doing. On the occasion she had told her family that she had been showering patients on the men's ward her father had asked if the men were naked. Clearly, the men had to be naked to be showered and the student had to defend her choice of studying nursing, which was something she often found herself doing. Irrespective of regular, defensive, mealtime discussions with some related feelings of SD this student remained appreciative of the fact that her parents demonstrated an interest in her nursing studies.

Some of the students from households in which English language use was not encouraged before the students attended university reported their parents as having changed allowing and encouraging English language use in the family home. As one student had commented "and then my Dad told me if you want to improve your English you've got to start talking in English at home and at school [university] so ever since then everything I been talking in English" (S19). CLDNSs were usually keen to improve their English language skills. Most used given opportunities whether these occurred at home or away from home. Those students who lived in households where English was the primary language spoken, reported their belief that this factor was of the most importance in helping improve their English language skills.

Students had also come from family homes in which English language use had been banned by parents. Students had taken a bold stand and spoke of using English at home intentionally, irrespective of their parental wishes, because they believed this to be the only way they could improve their English language skills. These types of situations caused a great deal of intense discord for those students because their parents had difficulties understanding their conversations. Students reported feeling sad for themselves as well as their parents because there was a concurrent and mutual sense of loss or a moving away from tradition and culture. This sense of sadness was exemplified by the following student's comment:

> Sometime I just feel very sad to my Mum because sometimes I just speak it out in English. But I wasn't like, I did and wasn't mean it. And she is very sad about it because my Mum, she can't speak English … so you [I] feel sad about speaking English to Mum, to my Mum … but with my Mum it's different and she also get, she also feel, [it's] tough for her too because her own daughter's speaking English to her and she don't know what it talking about … so you start to get further, even more further away from your parents. (S12)

Another student hinted at receiving family support when she commented that her parents knew she had to study a lot and they actually allowed her to do so. This student was no longer expected to take on a full-load of housework. Instead, her younger sisters were expected to take over her household chores whilst she studied.

Unexpected maternal support had been received by a male CLDNSs in countenance to his father's disapproval of his son studying nursing. This student

received unconditional support from his mother in the absence of paternal support. The student's father had ex-communicated his son because he was studying nursing which was perceived to be a job for women. Other male students had talked to academic confidantes about the unexpected supportive roles their mothers had adopted amidst their own feelings of guilt and shame related to disappointing their fathers.

Students were also known to come from families where cultural traditions dominated everyday family life and they were not given as much freedom or independence as members of the dominant group. At times when parents had questioned their child's cultural integrity and when the student's self-esteem was low they looked towards particular academics seeking support they were unable to obtain at home. At times like these students were fairly open with their academic mentors; nevertheless, their mentors had described these situations as hopeless.

Summary

The process of seeking concord to get in the right track (SC), used by participants in an effort to reduce their experiences of SD, although partially successful, in the main seemed quite limited within the context of this study. There was no instant, easy, or long lasting way to overcome the problems that caused discomfort. Students knew of very few single, successful strategies to help them avoid episodes of SD. The fact remained that these students were different, they had difficulty fitting in and so experienced episodic SD. When they were confronted with episodes of SD they dealt with it as best they could, responding to individual situations. Students were in a constant state of trying to get in the right track to effect concord. In essence, they were always seeking concord. They were haphazardly successful in achieving episodic concord by enacting a series of subprocesses. These included saving face, clustering, suppressing discord, being quiet, ignoring differential treatment, avoiding interaction, adjusting communication strategies, and blocking off the cultural self. CLDNSs would do just about anything to avoid being compromised publicly. Students would give the impression they had understood conversations to avoid discord in the form of public shame or

humiliation and in this way they had covertly deceived those with whom they had worked. Many had also suffered the yes syndrome of replying in the affirmative when they simply had no understanding.

Clustering behaviours were a different aspect of SC and one that worked well for CLDNSs but only up to a point. By clustering CLDNSs were protected in a sense and this protection offered them the opportunity to befriend other students. By making friends and feeling wanted, students seemed a lot happier and were more able to implement other strategies aimed at SC. By sitting quietly and using their powers of observation many were able watch, listen, and learn how to act like members of the dominant group. Indeed, after much watching some CLDNSs put in place what they had learnt. This learning from observing was also seen as students interacted by using nonverbal forms of communication to augment their spoken messages. Many spent a great deal of time on strategies aimed to reduce their experiences of SD. For example, copying out pages and pages of recorded lecture notes, only to find these strategies caused more discord of another nature. There were also some fragile attempts in SC by blocking oneself off from their ingrained culture which really only acted to cause SD of a delayed nature.

The conditions that influenced CLDNSs attempts at SC and the experience of SD were relevant in as much as some were more conducive to steering the students into the right track whilst others kept them off track. In other words, some conditions were more likely to be supportive of the students, facilitating the process, whilst others were not and inhibited the process or increased SD. Those students who found themselves in, or who sought, situations that offered support were more likely able to get in the right track and reduce their experiences of SD. These situations were often made available to CLDNSs by those teachers and members of the dominant group who could only be described as having cultural intelligence and who took the time to do so. Finally, some students were fortunate and lived with families which were able to give much needed support to keep the student on the right track.

CHAPTER 6
Overview of Findings and Relevant Literature

Much of the literature on related aspects of this study has lent support for these findings, although no one study has presented a substantive theory explaining the experiences of CLDNSs as was the case in this study. The following sections present an overview of the developed theory and identify literature related to various aspects of these findings and components of the theory, as presented in the previous chapters.

Overview of the Substantive Theory: Seeking Concord to Get in the Right Track (SC) – Overcoming Sociocultural Discord: Being Different and Not Fitting In (SD).

The substantive theory of SC – SD that was conceptualised from this study explained the processes CLDNSs enacted in an effort to overcome their experiences of SD. The basic social psychological problem identified in this study was SD. Students lived through these experiences of discord because they were in some way different to the groups of people with whom they interacted. This core problem was experienced by members of this student group in an episodic manner. Because CLDNSs experienced SD in an episodic manner the strategies or processes they used to deal with the discord also occurred in an episodic fashion. These strategies were devoid of any sequential implementation. When a student found themselves in a place of discord they implemented one or other strategy in an effort to reduce their discomfort. These strategies were implemented amongst an array of influencing conditions. The following schema is representative of the substantive theory SD - SC.

Seeking Concord to Get in the Right Track (SC) – Overcoming Sociocultural Discord: Being Different and Not Fitting In (SD) and Related Literature

The bulk of the literature reviewed related to student nurses and cultural diversity focused upon English-speaking student nurses becoming culturally competent, culturally aware, and/or cultural advocates for their non-English speaking patients. Much of this literature identified the patients as having a culturally diverse background and the nurses, as caregivers, were predominantly English speakers. The thrust of this literature

CONTEXT OF DISHARMONY

Sociopolitical Climate
- The media and political influences
- The Hanson factor

Cultural Diversity

Stereotyping
- Australians and stereotyping
- Level I stereotyping
    - Reflective practice
    - Teachers and Level I stereotyping
- Level II stereotyping
    - Racial, religion, gender-based
    - Stereotyping in the classroom
    - Stereotyping in the work environment

Nurse Education in Australia
- Clinical practice assessments
- Assignments
- Clinical assessment and assessor availability
- Clinical assignments
- Interactions with RNs
    - Together work
    - Lost opportunities and taking over
    - Too busy
    - Personalities
    - Behaviour misinterpretation
    - Effects of feedback
- Working with other students

Other Ways of Difference
- Multiplicity of learning
- Methodological speed
- Taboos
- Families

Roles
- Student roles
- Teachers as role models
- Cultural role models
- Interacting with teachers

CONTEXT DISHARMONY CONTEXT

THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM

Sociocultural Discord: Being Different and Not Fitting In

e.g., constancy of scrutiny, communication differences, impact of communication differences, cultural and racial differences, consequences of being different, cultural clashes, failure, clothing differences, patient conversations, facial expressions

THE BASIC SOCIAL PROCESS

Seeking Concord to Get in the Right Track

e.g., saving face, clustering, yes syndrome, forming friendships, interacting with Australians, suppressing discord, being quiet, ignoring differential treatment, avoiding interaction

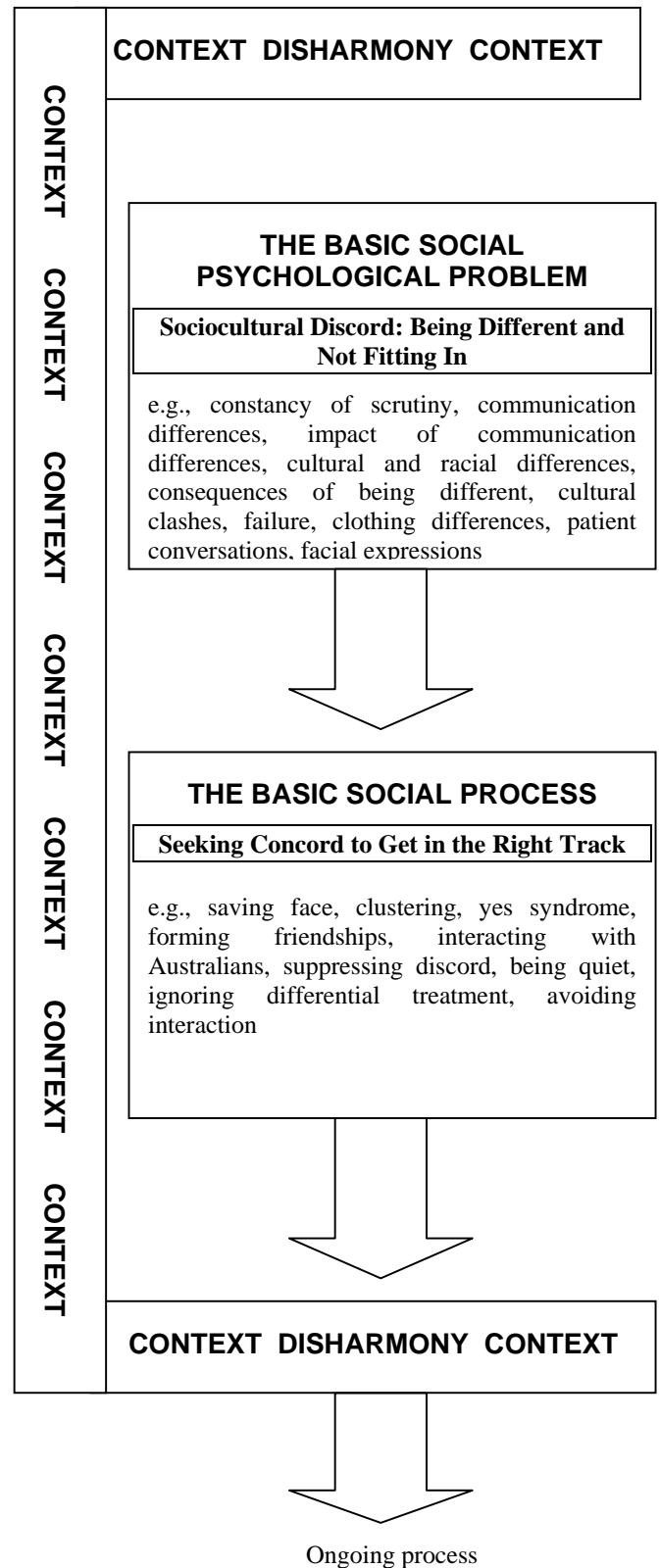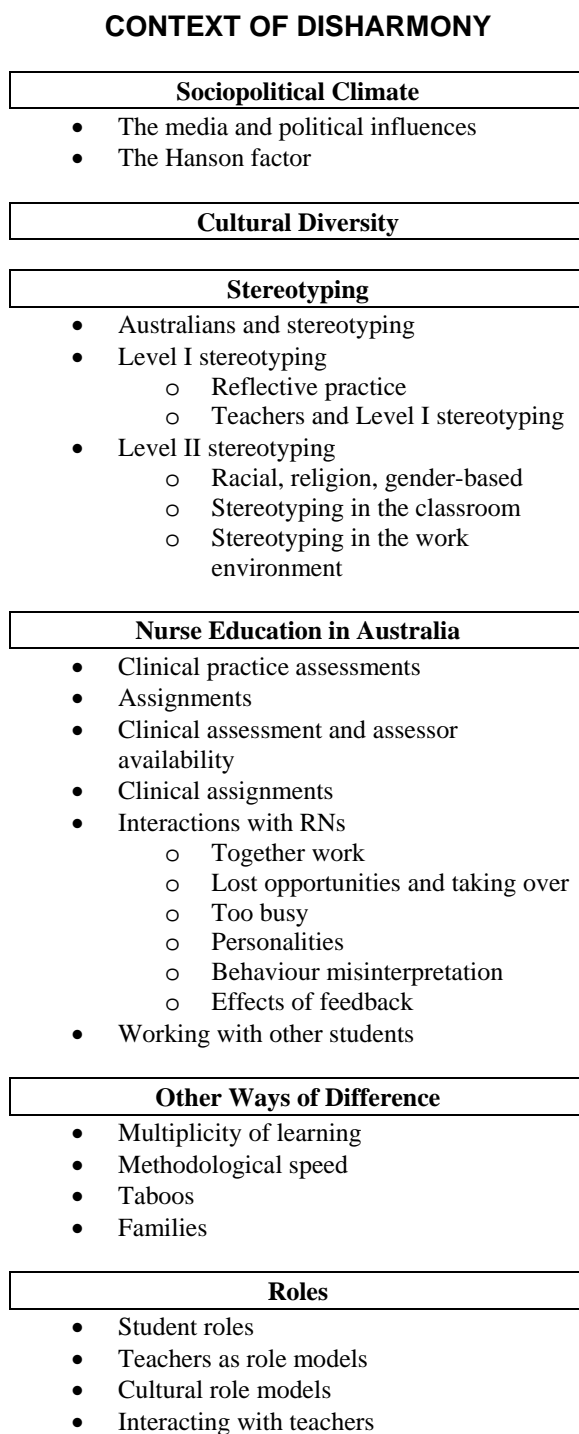### CONTEXT DISHARMONY CONTEXT

Ongoing process

Figure 2: Schema of Seeking Concord to Get in the Right Track (SC) – Overcoming Sociocultural Discord: Being Different and Not Fitting In (SD).

was teaching English-speaking nursing students how to provide culturally appropriate care for non-English speaking patients. In addition, this body of knowledge puts forward recommendations that nurses examine and become aware of their own cultural ways of being. The literature often delineated one cultural group from another, identified stereotyping, questioned attitudes towards minority groups, encouraged use of interpreter services, examined intercultural communication, discussed differences in health care preferences, and recommended approaches for teaching students to care for people of minority cultures (Eliason, 1998; Germain, 1992; Lea, 1994; Mendyka & Bloom, 1997; Sommer, 2001).

Much of the remaining literature, from American sources, looked at NESB students studying in English speaking universities. Very few articles were found that addressed education of student nurses from different cultural backgrounds and again most of these were from American academics. Thus, support exists for Villarrel, Canales and Torres's (2001) claim that "despite the lack of diversity within nursing, there have been few studies in this area" (p. 2). Even in the Australian literature very few have studied and investigated problems or difficulties of culturally and linguistically diverse students studying the health related disciplines (Brown, 1996a; Brown, 1996b; Ladyshewsky, 1996; Sandelowski, 1986).

Another pool of literature that was examined investigated the experiences of people who were overseas qualified and were transitioning in English speaking countries (Pittman & Rogers, 1990; Sappinen, 1993; Singh, 1994; Teschendorff, 1993). Literature was found that focused upon the Australian Aboriginal student in tertiary education systems; however, this literature was outside the realm of the current work. Other publications of interest were found in business scholarly journals in which academics looked at the experiences of expatriates in overseas business ventures, for example, Black and Mendenhall, (1991).

White Western Nursing

According to Ryan (1992) nursing education contributes to the loss of indigenous cultures by imposing professional norms based on the dominant society. Students have to accept and practise as the dominant culture dictates. Essentially, students must

conform to Western standards or fail in nursing school. Campinha-Bacote (1998) claimed that whilst the Western society becomes increasingly multicultural, enrolments at university Schools of Nursing continue to be nonreflective of this same diversity. She elaborates by saying that the numbers of student nurses from cultural minorities are insufficient to meet the health care needs of an ever diversifying population. Furthermore, Campinha-Bacote (1998) said that there is a shortage of academics and clinical nurse leaders from diverse cultural backgrounds to act as role models for student nurses from ethnic minority groups. This situation is also reflected in Australia where ethnic minority groups as well as Indigenous Australians are under represented in Schools of Nursing across the continent (Goold, 2003).

The dominant group of student nurses in any Australian School of Nursing are in fact Anglo-Saxon. Eliason and Raheim (2000) pointed out that American "undergraduate students enter the helping professions without significant exposure to, or education about, people from other cultures" (p. 161). They go on to say that "many students still grow up in segregated, monocultural neighbourhoods, towns, or rural areas, and enter college having given little thought to diversity" (p. 161). The situation is no different in Australia and it is likely that many members of the dominant group, whilst attending high school with students from diverse cultural backgrounds, still lack meaningful exposure to people from minority cultural groups before they embark upon their nursing education. Once they commence their nursing education they will come across other nursing students from different cultural backgrounds and will be expected to work cooperatively with these people. In addition, when they commence clinical practice they will definitely encounter people from different cultural backgrounds and be expected to provide quality nursing care for these people. These same students make up the dominant culture in university Schools of Nursing across Australia.

According to Spence (2003), "nursing people from another culture invariably means encountering behaviours and expectations that differ significantly from one's own" (p. 225). Spence also stated that those who provided nursing care for patients from different cultures are "less able to accurately interpret verbal and nonverbal messages when communicating with a person with whom they are not familiar" (p. 225).

What we often fail to consider is that CLDNSs are in this situation with the majority of people for whom they care.

Barbee and Gibson (2001) stated that as nursing moves forward it can no longer continue to ignore its many problems. They identified that "One of the most pressing problems is the lack of racial diversity in nursing" (p. 243). This claim is not new and others, well before, had identified the same issue. In 1990, Pittman and Rogers reported that the nursing profession had done little to increase recruitment of nurses from ethnic minority groups. Time has passed and in spite of the fact that more efforts have been made to increase recruitment of ethnic minorities into nursing this group of students continues to be underrepresented. Hill (1998) comments:

> In order to meet the health needs of a population with a changing demographic profile, it is vital that nursing, as a health care discipline, effects strategies to recruit individuals into the profession who reflect the diversity of the population served, and assure that the curriculum and clinical learning experiences are culturally relevant. (p 32)

This sentiment was echoed by Brathwaite (1999) who stated "the nursing profession needs to respond positively to the call for greater numbers of ethnically diverse professionals within its ranks" (p. 57).

"The recruitment of minorities … into nursing is important because the population growth being experienced by most ethnic minority groups provides a relatively untapped source of future registered nurses" (Hill, 1998). Barbee and Gibson (2001) made several recommendations to increase recruitment of nursing students from diverse backgrounds. Most of these recommendations are relevant in Australia and the first is that nursing must "acknowledge that, with few exceptions, racism is endemic in our programs …" (2001, p. 243). Secondly, they recommended that nurse teachers should treat all students, regardless of cultural background, equally. This need for treating all nurses equally is echoed by Chandra and Willis (2005) and also suggests that this is not the current state of affairs. Also, stereotyping of student nurses from different cultural backgrounds must be eliminated and ongoing institutional support that is known to be successful should be made available for students who struggle with nursing studies. Recruitment strategies should actively target prospective nursing students from

diverse cultural backgrounds by using culturally relevant materials and nursing curricula must demonstrate more aspects of other people's cultures.

Mangan (2004) referred to a report from the American National Academies' Institute of Medicine when she quoted "institutions that are training the nation's next generation of … nurses … should take immediate steps to make their programs more welcoming and affordable in order to deal with a severe shortage of minority practitioners in those fields" (p. A11). Making the profession more representative of the communities it serves requires increasing the diversity of nursing students (Rew, Becker, Cookston, Khosropour, & Martinez, 2003). Recruiting and educating students of different backgrounds will improve the ability of the profession to relate to the various populations nursing serves and in so doing better meet their need (Newman & Williams, 2003). Gorman (1999) claimed:

> If the nursing profession is to meet the needs of non-English speaking background clients, there would be benefits in providing a workforce that more closely approximates the ethnic profile of the client population and includes nurses who have knowledge, skills and attitudes that enable them to work effectively with clients from different cultural backgrounds. (p. 2)

Because of the global shortage of nurses and a similar shortage of people enrolling at universities to study nursing the more affluent countries are recruiting from other countries to fill vacancies (Bola et al., 2003; Chandra & Willis, 2005; Murphy & McGuire, 2005). Whilst there are positive and negative impacts upon both source and destination countries the current research focused upon the difficulties of CLDNSs. Difficulties occur because imported nurses and students need support to assimilate into their new organisations and countries and many organisations do not use the funding to provide adequate support. Moreover, organisations do not believe it their role to do so. In 1999, Gorman made the claim that Australian university schools of nursing were accepting student nurses from diverse cultural backgrounds without the "necessary support structure to succeed in what is essentially an Anglo-Celtic education system" (p. 2). However, "these students reflect the changing demographics of the state and their education contributes to providing a racially, ethnically, and culturally diverse nursing workforce" (Newman & Williams, 2003, p.91). In America, as numbers of foreign nursing students being accepted into nursing degree programs increases there is a

concomitant need for nurse teachers to "understand what motivates foreign nurses and to have an awareness of their educational and cultural backgrounds" Dijkhuizen (1995, p. 15). This is so that nurse teachers can relate to members of minority groups of students, so they can support the students and promote integration within the nursing course.

According to Newman and Williams (2003) English as a second language students have a higher than average chance of exam failure. "The reality of attrition must be confronted and reversed. Attrition is certainly wasteful of the University's resources and the student's time and energy. Students must enter programs with curriculum and resources designed for success" (Brathwaite, 1999, p. 59). Early intervention strategies are recommended to help those students identified as being at risk. However, to provide early intervention strategies increased staffing levels are required (Brathwaite, 1999). Clearly, recruitment, retention, and graduation of nurses from minority cultural backgrounds remains a global issue of importance.

Although the literature suggests retention strategies, to date, there appears to have been limited success in this area. Campinha-Bacote (1998) claimed traditional ways of teaching that focus upon the multicultural student's problems, or shortfalls, have failed and recommended different strategies that focus upon the positive aspects of multicultural students. She went on to say that "total acculturation of a culturally diverse student should not be the primary goal in retaining the student" (1998, p. 2). This would suggest that the focus of previous retention efforts may have been acculturation.

While nursing is still a predominantly White profession (Eliason, 1998) it can no longer ignore the student nurse who comes from a different cultural background. As, Spicer, Ripple, Louie, Baj and Keating (1994) claimed "there is a growing need to match the ethnic and cultural profiles of nurses and patients" (p. 38). Without students from a variety of different cultural backgrounds this would not be at all possible. According to Gorman (1999) the predominance of Anglo-Celtic nurses in the Australian workforce impacts upon the standard of care provided to non-English speaking patients. However, this author did not discuss the impact this predominance has upon those student nurses who are culturally and linguistically diverse. Weaver (2001) reported that nursing culture is strongly grounded in European American traditions and one of the many goals

of nursing education is socialising its students into this professional culture. Whilst it is important to socialise student nurses into the professional culture of nursing Weaver (2001) suggested it is also important to ensure that this is done in a culturally appropriate manner that does not focus on complete acculturation. This would suggest that CLDNSs should be encouraged to maintain their cultural links and differences and be supported in doing so.

As Australia's population continues to age there will be a concomitant increase in the number of people admitted to hospital and community care whose first language is not English. This is mainly because previous and present governments have increased migrants quotas and increased refugee capping numbers. As people reach the senescent years of their lives there is an increased chance that they will suffer from aged-related illnesses such as Dementia, Parkinson's, and Alzheimer's diseases. When people suffer these diseases they experience dyscopia and confusion and those from different countries will often revert to their first language (Pittman and Rogers, 1990). Greater numbers of bilingual nurses will be needed to provide adequate nursing care for this group of patients. Work towards improving interpreter services could be achieved with the necessary injection of funding but as Pittman and Rogers (1990) infer only as "a momentary intermediary" (p. 4).

"Whilst the importance of cultural issues in nursing practice has been recognised, little attention has been directed to evaluating to what extent nursing education respects the cultural norms and values of students from diverse populations" (Weaver, 2001, p. 252). As reflected in the findings of this current study, Williams and Calvillo (2003) claimed that methods to maximise learning in culturally diverse classrooms are essential. They recommended teachers use a variety of delivery methods and commented that if the teacher uses one method for information delivery some students learn less effectively. By using a variety of teaching strategies teachers maximise student learning.

Culture in the Curriculum

As previously stated, nursing curricula usually includes teaching students how to care for people from different cultural backgrounds. According to Grant and Letzring

(2003), university Schools of Nursing attend to this aspect of the nursing curricula in three ways. They may choose to send students to overseas countries where they are immersed in a different culture for varying lengths of time. Alternatively, or in addition, they may have a specific unit or course of study designated to transcultural nursing or they may purport to offer a curriculum that has aspects of transcultural nursing threaded throughout. As Eliason (1998) pointed out "Students entering the nursing profession are often not prepared for the multicultural world of the university or health care systems" (p. 27). But "Cultural competency is essential for providing individualised client care and in meeting the changing health care needs of a growing pluralistic society (Leininger, 1994; Leininger, 1997). Whilst "Schools of nursing recognise the need to incorporate content about culture and culturally appropriate care" (Grant & Letzring, 2003) very few acknowledge the same need to incorporate the teaching and learning needs of CLDNSs. "The nursing profession is committed to promoting the health of all people" Newman and Williams (2003, p. 91) yet it is well recognised that all aspects of health care for minority populations could be improved.

Communication Difficulties for Nurses from Culturally Diverse Backgrounds

Findings from studies of foreign-educated nurses working in English-speaking health care environments as RNs mirrored those reported by CLDNS studying for their nursing degrees in Australian universities. It was generally accepted that foreign-educated nurses have many difficulties assimilating into their new place of work. Issues faced were said to relate to all aspects of patient care, for example, communication with patients and other staff members, pronunciation of medical terms, medication names, medication dosages, … medical abbreviations, documentation, and measurements (Bola et al., 2003; Chandra & Willis, 2005; Davis & Nichols, 2002).

Although different studies have identified a range of problems or difficult issues, collectively referred to in this study as SD, the problems encountered by CLDNSs seem to be universal. Abu-Saad, Kayser-Jones and Gitierrez (1982) reported loneliness as the major problem of student nurses adjusting from their home culture to American culture. Differences in values and customs along with financial problems were also strongly represented as difficulties of adjusting. Latin American students in that study also

identified language problems as causing them the most difficulties in their nursing program, along with the rapid pace of material delivery, too much content to be absorbed, too much reading, not enough time to grasp subject matter, difficulties in writing assignments, taking tests and learning new terminology. Pardue and Haas (2003) made claims similar to other authors who wrote about their experiences of teaching student nurses from diverse cultural backgrounds. They commented on the problems or difficulties students have in the academic setting, for example, language and oral communication, translation, note taking, speaking in front of an audience, fear of missing key points, fear of failure, use of native tongue, scholarly writing, and cultural adjustment. Still there are other researchers who have identified the problems of people from culturally and linguistically diverse backgrounds who choose to study nursing, or who are RNs educated in non-English speaking countries and who are working in English speaking countries. Guttman (2004) has written about complaints of non-English speaking nurses speaking in their native tongue in health care settings. She continues on to identify other issues of concern, for example, ability to understand instructions and listening skills.

CLDNSs in the current study also made these claims. They too had language and communication problems, translation and note taking difficulties, issues related to speaking in front of an audience, fear of missing key points, fear of failure, inappropriate use of native tongue, difficulties in scholarly writing, and major problems associated with cultural adjustment. These differences created barriers between foreign educated nurses and all others with whom they came in contact. Further, Bola et al. (2003) highlighted communication differences as being the seat of much frustration for foreign-educated nurses leading to "significant limitations" (p. 40). Ladyshewsky's (1996) work with physiotherapy students from different cultural backgrounds found that clinical practice outcomes were affected by the students' ability to use English. The clinical practice outcomes of nursing students in the current study were also significantly impacted when the students were hesitant to engage in conversation or become involved in patient care. Gorman (1999) also reported that students from different cultural backgrounds had "missed out on opportunities to observe or participate in particular procedures, or worse, failed to carry out instructions correctly" (p. 11). CLDNSs in the

current study had identified occasions when they had identical experiences. Interestingly, Armitage (1996) reported that it took non-English speakers five to ten years to acquire English skills which would place them on academic parity with English speaking students. However, there is an expectation that "Nurses graduating with a bachelor's degree from Australian tertiary institutions are expected to have high-order communication skills, competent technical skills, and the ability to make decisions in the demanding and complex context of practical situations" (Grealish, 2000, p. 231). Bola et al. (2003) also claimed that foreign nurses must be able to communicate effectively. They stated that "whether verbal, written, or nonverbal, foreign nurses must be able to offer and receive communication in a manner that leaves no room for misinterpretation." (p. 41). This situation is no different for CLDNSs. It appears that minority students on any university campus experience episodes of SD for a variety of reasons. Dijkhuizen (1995) stated that:

> The foreign nurse is highly motivated and anxious to learn and be accepted. It takes a great deal of courage to travel to a strange land, live among foreigners, and practice one's chosen profession. However, this enthusiasm may be seriously undermined before the educational process is begun if the basic needs and problems of the foreign nurse are overlooked. (p.15)

Gunn-Lewis (2002) claimed that students whose first language was different to the majority of students and teaching staff and who did not have English proficiency "will fail or … will need a lot of extra learning support" (p. 9).

There were numerous issues that created barriers, difficulties, or SD for CLDNSs in the present study. These ranged from the Muslim student waking up in the morning and getting dressed in a student nurse's uniform and incorporating their hijab to the Chinese born student nurses interacting with Australian Aboriginal patients in a community health care setting. In respect to these difficulties the literature was found to be scant from an Australian perspective; however, the Americans have done much more work over a number of years. A lot of the American literature, however, addressed problems of Latino, Hispanic, American Indian and African American nursing students. At first, their problems appeared different to those of the CLDNS studying nursing in Australian universities; however, on closer examination similarities were identified. The problems or difficulties experienced by CLDNSs in the current study do not appear to

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occur in any particular order. Some students experienced more of one problem than another. Problems for one student were different to those of another and some students were impacted upon more significantly than others, depending on a variety of influencing conditions. To represent the pattern-less presentation of episodic SD, issues discussed in the proceeding literature review are in no particular order.

In 1990, Pittman and Rogers reported their research findings of NESB RNs in the Australian state of Victoria. Participants reported a number of real and perceived barriers to successful socialisation into the nursing profession. Content analysis determined six main barriers or difficulties to successful socialisation of the NESB RNs. Aspects of all six were identified in the current study of CLDNSs. These were as follows: "lack of acceptance by colleagues and superiors and discrimination in the workplace because of cultural background" … "institutional barriers" … "various language difficulties" and "the multicultural society in Australia …" (p. 56).

Gorman's (1999) Australian study looking at the difficulties experienced by student nurses and patients from different cultural backgrounds can perhaps be considered as one of the most comprehensive and important papers published in this area to date. Gorman's work reported similar difficulties as those experienced by the student participants from the current study and essentially encapsulates many students' problems. From her vast experience in education of student nurses the researcher has developed her awareness that nurses are expected to communicate using an increasing multiplicity of strategies. According to Pittman and Rogers (1990) "Adequate language skills are of even greater importance for nurses from non-English speaking backgrounds. Without such language skills, building relationships with colleagues and patients is extremely difficult" (p. 70). When relationships are not developed learning by modelling other peoples' behaviours is less likely to occur.

Urgency in understanding

In this study clinical teachers had expressed their concern about the possibility of CLDNSs not being able to function adequately in emergency resuscitation situations because of communication difficulties. This issue was also expressed by Baj (1997) and Bola et al. (2003) who identified the lack of translation time being available in emergent

situations. Nurses as well as student nurses did not always have the luxury of translation time and subsequently performed to a lesser standard than their colleagues who had English as their first language.

Mixing genders

In regards to communication, those from different cultural backgrounds were reported in the literature to have mixed patients' genders (Bola et al., 2003). CLDNSs in the current study also mixed patients' genders. When students did this they had referred to male patients as females and female patients as males, sometimes in the same sentence. This mixing of people's genders created problems because such errors had the potential to lead to incorrect patient care and litigation. Written errors in documentation also led to reduced credibility in the eyes of the students' co-workers creating an even greater cultural divide between locals and CLDNSs.

Cultural Disconnection

In this study the process of cultural disconnection was evident on a number of occasions. When students disconnected from their cultural identity they actively chose to behave differently to their cultural norm to reduce SD. For some, this meant speaking English at home whilst for others it meant blocking off their connection to their cultural beliefs for a certain period of time. However, when the latter occurred CLDNSs were unable to sustain the block for long periods of time. CLDNSs practiced cultural disconnection in an effort to move to a place of concord. For most, their cultural beliefs and connections returned when they let down their guard. There were times, however, when disconnecting from one's culture caused CLDNSs problems, as discussed previously.

Being Invisible

Whilst Villarrel et al. (2001) reported faculty and peer discrimination as barriers to success in nursing other students in a study by Bowen and Bok (1998) claimed they felt invisible except when they were called upon to contribute to discussions related to cultural differences. During these times students felt they were expected to act as the experts and representatives of their culture. Students in the current study had also identified times when teachers had called upon them in class to discuss specific issues

from their own cultural perspective. Some felt uncomfortable by this request but others were pleased to be able to make a contribution. None had referred with any specificity of feeling invisible; however, they did not discuss many other times they had contributed actively to classroom discussions.

Racism

There is little doubt that CLDNSs encounter episodes of racism and discrimination throughout their undergraduate years and there is ample evidence in the literature that suggests graduation and registration do not mark the end of these types of episodes (Branch, 2001; Chandra & Willis, 2005;). Barbee and Gibson (2001) found that institutional racism exists in nursing education because of the beliefs, attitudes, values and symbols about non-Whites that are embedded in nursing curricula and taught to nursing students. Because these beliefs, attitudes, values, and symbols are being taught to nursing students they are also passed from one generation of nurses to the next. Campinha-Bacote (2004) stated "we can no longer avoid the reality of racism in health care" (p. 239). She went on to quote from the Summary Section of the American Nurses Association Position Statement on Discrimination and Racism in Health Care (American Nurses Association, 1998) stating that "Discrimination and racism continue to be part of the fabric and tradition of American society and have adversely affected minority populations, the health care system in general, and the profession of nursing". Abrums and Leppa (2001) stated that "instances of oppression towards clients and health care workers because of race …are not isolated incidents and continue to create multiple problems in the health care arena" (p. 270).

According to Barbee and Gibson (2001) the majority of White nursing students and teaching staff are likely to deny this claim and fail to realise that racism is a deeply ingrained attitude that exists in nursing. These authors believe that the nursing profession "pays lip service to diversity by highlighting such concepts as 'cultural diversity' and 'culturally competent care'" (p. 243). They also claimed that instead of confronting the real issue of a lack of cultural diversity in the nursing profession, nurses quickly divert discussions to gender issues and the need to increase numbers of male nurses. Alternatively, they will discuss previous efforts to increase numbers of students

from culturally diverse backgrounds. The reality, however, is that most efforts to increase cultural diversity of the nursing workforce in America could be improved (Barbee & Gibson, 2001).

Gorman's (1999) study puts forward the notion of people from different cultural backgrounds feeling a sense of separateness, aloneness, and experiencing a feeling of 'them and us'. Those who have these feelings often adopt a subordinate role, feel alienated and marginalised and can not relate to members of the dominant group. These feelings were expressed repeatedly by CLDNSs in the current study.

Pittman and Rogers (1990) reported that RNs from Asian backgrounds experienced the greatest amount of discrimination; however it was not the role, or intent, of this research to determine which group of CLDNSs experienced the greatest amount of discrimination. Rather it is important to acknowledge that CLDNSs did experience racism, discrimination, and inequity during their undergraduate nursing education. This was the case in a study conducted by Villarrel et al. (2001) in which they found that perceived discrimination has been widely cited as an issue affecting African American and other minority students in higher education in America. Bowen and Bok (1998) also believed that minority students experienced discrimination when they were isolated on campus and taught by teachers who lacked cultural sensitivity or cultural competence.

American Indian nursing students in Weaver's (2001) study reported that they had felt out of place and inferior to the dominant group. They felt their lifestyles were too dissimilar to those of the dominant groups and they also believed they had to study harder to understand foreign or alien concepts. In addition, they had experienced stereotyping and racism from patients, teachers, and preceptors and had grown tired of having to explain who they were and why they were studying nursing. As was the case in this study, other authors found that students were hesitant to report incidents of bias because they feared such reporting would have a negative impact upon their grades (Smith, Colling, Elander & Latham, 1993). Instead, these authors found that reports of bias were only ever received after a student had completed all of their course requirements. Students in the current study were clearly hesitant to formalise their concerns related to inequitable treatment. They too were concerned about the repercussions on their grades should they make their concerns formal. In addition, they

were also wary of reporting individual academics for discriminatory treatment because they were never sure when, or if, they would come across that same academic later on in their studies.

Sommer (2001) acknowledged cultural diversity was found within classrooms and recommended that teachers assess the cultural makeup of their class groups before teaching commences. She also suggested teachers should complete a self-assessment of their beliefs and values prior to teaching racially mixed classes. These recommendations were put forward in an effort to encourage nurse teachers to become aware of how their values and beliefs may impact upon learning in their classes.

As the nursing profession continues to recruit students from minority cultural backgrounds and it is known that these students may experience one form or another of discrimination, racism, or inequitable treatment it is important to provide on campus support services that are preferably course specific and culturally relevant. Reinforced by the findings of this study, the researcher also believes that it is relevant for universities to encourage and reward those nurse teachers who can demonstrate their efforts of becoming culturally aware and competent teachers.

The Student Role

It is little wonder that CLDNSs experienced confusion moving from classroom situations to clinical practice settings. Essentially students were expected to adopt inquiring lines of questioning in classroom settings but in clinical practice settings they were meant to do as they are instructed without question. As Gorman (1999) put forward, the undergraduate nursing student is expected to challenge university faculty members at a theoretical level but the situation changes in clinical practice settings. As Gorman (1999) wrote "best practice involves compliance to professional norms" (p. 11). The existence of opposing philosophies, whilst obvious to an educated person, poses confusion to CLDNSs.

Furthermore, Gorman (1999) noted that overseas students were often hesitant to speak in class because they believed their student role was one of passivity. Overseas students came from a background where they are not allowed to speak in class unless called upon to answer a question. In their home countries students would not be

expected to verbalise an opinion much less present a tutorial to the entire class. Instead, teachers were considered the authority figure, were never questioned, and given a great deal of respect. In an Australian study of non-English speaking physiotherapy students Ladyshewsky (1996) noted that teachers were also treated as the authority figure and given due respect. Students from different cultural backgrounds had difficulty in asking teachers questions because to seek clarification inferred a failure on the part of the teacher. This equated to a criticism of the teacher and students considered these behaviours as improper. In Gorman's (1999) study nursing staff and university teachers saw students from different cultural backgrounds as being "non-assertive, retiring, overly respectful of authority figures and reluctant to engage with others by disclosing personal information and sharing experiences" (p. 7). It is not difficult to appreciate the development of a 'them and us' culture.

Them and Us

Gorman (1999) had described CLDNSs as not mixing with other students; however, Australian students were identified as perpetuating the status quo of 'them and us'. Both groups reported difficulties working with each other because of communication barriers but Australian students acknowledged that they preferred to work with other Australians because they were wary of CLDNSs having difficulties meeting assignment requirements. CLDNSs in the current study had verbalised their apprehension of working with Australian students because they did not want to be thought of as being less capable. CLDNSs were also known to lack the tacit knowledge of the Australian culture rendering them in a disadvantaged position and unable to participate in classroom and clinical interactions that required parochial knowledge. Furthermore, Gorman (1999) identified CLDNSs as having "difficulty socialising because they have different cultural beliefs, values and rules" (p. 9). These same sentiments were borne out repeatedly in the current study and there were many occasions where socialisation could have occurred but CLDNSs and members of the dominant group refrained from doing so.

Lewis (2005) had also found instances of 'them and us' in her study looking at the experiences of foreign women immigrating to New Zealand. Foreigners found

themselves left out of committees and in a position in which they were unable to have influence.

Asian Students

Some of the literature identified specific groups of students as having greater difficulties than others. According to Abu-Saad, Kayser-Jones and Tien (1982) Asian students grow up in traditional families that value obedience, conformity, and subordination. When these children grow up and travel abroad to study they experience varying degrees of culture shock because the countries that they travel to value self-expression, assertiveness, individual success, independence, creativity, and autonomy over their being quiet, shy, gentle, good mannered, and having a willingness to 'go with the flow'. Many Asian students travel to America but more and more Asian students are travelling to Australia. In addition, there are many Asian students in Australian universities who are second or third generation Asians. Regardless, many Asian-Australian students experience a range of the same difficulties experienced by their counterparts studying in American Universities because of the differences in culture. Teachers often interpret this kind of behaviour as "overdependence, acquiescence … incompetence … and … non-assertiveness" (Abu-Saad, Kayser-Jones & Tien, 1982).

Families

Villarrel et al. (2001) identified those family members who were RNs or who worked in the health care system as positive role models and mentors for students. Whilst the literature reports that some students received a great deal of support from their often extended families there is evidence from the current study that suggests otherwise. There were some students who reported that family members acted as barriers to their progress, for example, parents who asked too many questions about nursing care of patients of the opposite gender. Others felt demoralised by comments made by members of their extended families about their nursing studies. Academics had also reported situations in which comments from family members had impacted negatively upon individual students. Congruent with the literature, however, CLDNSs whose mothers were RNs reported having received a great deal of support. These mothers had debated issues in support of their child studying nursing with other family

members who offered no support at all. In this study, as in the literature, there were no fathers reported as working in the nursing profession. In fact, fathers were not identified as a support for students in this study at all.

Gorman (1999) also acknowledged the differing family values of foreign students compared to Australian students. Foreign students, or those from different cultural backgrounds, were not only expected to pass but were often expected to get good grades. When they did not get good grades they disappointed their whole family. Additionally, Gorman (1999) found that those students from different cultural backgrounds had other roles related to family commitments which at times conflicted with study requirements. CLDNSs had similar experiences. Many were expected to participate in family rituals including outings and caring for family elders. In addition, when a student's family owned a business, the students were often expected to contribute in some way. These contributions usually interfered with the CLDNSs ability to study.

Nursing –Not A Good Job

It was evident that nursing is not considered a worthy occupation in all cultures. This was said to be related to the intimate nature of nursing care and dealing with bodily fluids and functions. In many cultures nursing is thought of as a lowly occupation and members of those cultures who are RNs or nursing students can struggle to gain support from family members (Gorman, 1999). In this study some parents held nursing in a poor light and would have preferred their child study a better paid profession, one with a better standing particularly in their own community. Williams and Calvillo (2003) also found similar evidence that parents often wished their child would study another profession aside from nursing; however, they commented that parents, and the community in general, lacked an understanding and appreciation of modern day nursing. The profession of nursing has moved far beyond the images portrayed in the popular press and members of the profession who are in positions to influence the greater public could contribute as change agents to imbue a more modern, dynamic, and almost futuristic image of the profession. This may impact upon those families and communities who hold nursing in a somewhat outdated perspective.

Student Support Services

During the last decade the overall number of minority students studying on university campuses around the globe has increased. Along with these increases the numbers of students needing counselling services has also risen (Lucas & Berkel, 2005). These authors also claimed that of these increased numbers of students seeking counselling support, too few are from culturally and linguistically diverse backgrounds. Unfortunately, many CLDNSs did not attend counselling services either on or off campus. CLDNSs, nurse teachers, and the literature all suggested that this was the case because it was culturally inappropriate for them to do so.

According to Burns (1991) students from different cultural backgrounds are better equipped than English speaking counsellors to help each other with personal, social, and cultural adjustment issues. This is primarily because students from the same or similar cultural backgrounds are better able to understand problem situations from a cultural perspective. Burns (1991) put forward the idea that students from culturally diverse backgrounds are more likely to be able to offer culturally appropriate support and make recommendations with a genuine, empathic understanding. Kosowski, Grams, Taylor and Wilson (2001) also suggested that CLDNSs turn to each other for support because they lack culturally appropriate role models. Essentially, they claimed there are too few counsellors representative of all the different cultures of nursing students. This claim was evident on Australian campuses too. Many nurse academics invited the researcher to look around campus to see the lack of academic role models employed in teaching roles on university campuses.

Students attend university counselling services for a variety of reasons. As previously stated, those who come from minority backgrounds, by and large, do not attend for personal or family reasons. Attendance is for other, broader reasons, for example, assistance with study skills, essay writing, and examination preparation. These are similar to the reasons Australian students' attended counselling or support services (Lucas & Berkel, 2005).

Lucas and Berkel (2005) reported that issues of concern for Black students in America focused on perceived barriers to career progression because of skin colour. In

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the current study, CLDNSs were worried about their career progression because they spoke accented English. Lucas and Berkel (2005) also identified that Asian students' experienced anxiety and stress associated with pleasing parents with academic success. Asian students have also been identified in the literature as experiencing cultural confusion and mental strain; however, these students are also known to underutilise student support services (Abu-Saad, Kayser-Jones & Tien, 1982).

Problems that CLDNSs encountered in classroom settings extended into clinical practice areas too. Hussin (1999) identified that first year nursing students needed access to specific support services to help them in areas of communication in clinical practice. Areas identified as problematic were as follows:

> Students were not spending enough time communicating with patients eg. explaining procedures and offering reassurance to patients while performing a nursing task; it was not clear if students were understanding instructions, eg. they tended to 'nod and smile' when asked to perform a task rather than respond verbally; the students' productive communication was often unclear, eg. pronunciation of medical terminology during a 'handover' … was often difficult to understand; students were not taking enough verbal initiative with team members, eg. not taking an active role in team meetings or engaging in 'clinical reasoning'. (p.2)

Whilst Hussin's (1999) claim that first year nursing students needed access to support services goes unquestioned, the current research demonstrated that CLDNSs need similar access to support services all year round irrespective of year of study. CLDNSs demonstrated a need for ongoing support to meet their needs both on university campuses as well as in clinical practice settings.

Wang (1998) found that Asian students often looked for support for academic writing. Problems they experienced usually stemmed from broader cultural differences including education. When support staff was able to be accessed they worked with Asian students to identify specific problems. Once identified the students were advised accordingly. In the current study, CLDNSs from Asian backgrounds preferred not to attend student support services even though they had identified problems related to academic writing. There were occasions when they had tried to approach academics but most times the academics were too busy to be able to offer the students the amount of time they felt necessary to assist with academic writing. Wang (1998) also

acknowledged that Asian students had problems getting themselves understood when speaking in English. This was no different in the current study. According to Wang this was because students had learnt English as an academic objective rather than learning or acquiring English in natural setting. The latter allows for practising English in a relaxed, natural environment with English speakers. The former does not allow practice and adheres strictly to grammar and use rules. Wang put forward the notion that learning English in natural settings facilitated a "more natural sense of the language" (p. 117) than learning English for academic purposes. Moreover, she warned that "… international students run the risk of altering, or even losing, their own cultural values and identities in order to ease cultural conflicts and to receive positive comments on their writing" (p. 114). CLDNSs in this study reported these exact feelings not only related to academic writing but also related to the use of English instead of their native language. Finally, Wang (1998) concluded that teachers should keep an open mind and listen to the students and work with them to help them understand what is required from university assignments. In doing so she purports we can "enrich ourselves and develop a higher level of international communication skills" (p. 120).

In an effort to provide support for CLDNSs some academics (Brown, Thomson, Kulski et al. 1997; Hussin, 1999) developed specialised workshops which were implemented by nurse teachers in collaboration with specialist staff. These workshops addressed issues specific to nursing and associated aspects of communication with, for example, patients, other students, clinical teachers, nursing staff, and academics. Other areas in which students required coaching included how to interrupt assertively and politely, pronunciation of medical terms, interacting with superiors, making immediate responses, nursing handover, and social conversations (Hussin, 1999). Hussin went on to identify that some students whose first language was not English required individual consultations with specialised help to correct mispronunciation.

Participants from Villarrel's et al. (2001) study of Hispanic nurses identified useful resources and support services that were available to them because of their student status. Although the participants claimed that barriers to their success existed they were able to work through such barriers because they made use of the support services that existed both formally and informally. In Villarrel's et al. study Hispanic

nurses mentioned financial, familial, and institutional support as well as forming informal groups of culturally different nurses. All participants had talked about the importance of having encouraging mentors and they went on to describe the characteristics of academics they thought were supportive. These characteristics included academics having an 'open-door' policy, being able to communicate in a supportive manner, and valuing the expertise of Hispanic students. CLDNSs in the current study reported difficulties accessing nurse academics because they appeared too busy. Very few had identified nurse academics with open-door policies and as previously stated a number of nurse academics had commented that they did not have the time to help CLDNSs with their problems especially those related to academic writing.

CLDNSs in the current study had made use of informal support networks made up of other culturally diverse nursing students. Many found a degree of comfort from belonging to a group irrespective that group members were a minority. CLDNSs felt they were able to survive a variety of conflicts because of the support they gained from informal group membership. Abu-Saad, Kayser-Jones and Gitierrez (1982) indicated that minority students had a tendency to congregate in groups of like-cultured people and further, that these same people helped them to adjust to their new surroundings. Nevertheless, Abu-Saad, Kayser-Jones and Tien (1982) found that Asian students would have adjusted better to American nursing culture if they had made American friends, attended support groups in the community, found and made use of supportive faculty and engaged more with American classmates and foreign student support groups. They also reported that Latino nursing students believed that having American friends would have assisted their cultural adjustment process by facilitating their integration into the American mainstream culture. A number of CLDNSs studying nursing in Australian universities held similar beliefs but struggled to make friendships with members of the dominant group.

Because of the increasing awareness of racial and religious differences culminating from repeated terrorist attacks in the Western world those students who look foreign are likely targets for local discrimination and racism. Student nurses who encounter discriminatory interactions with academics, other students, heath care workers

and/or patients need an empathic, nonjudgmental and supportive outlet. Winston (as cited in Mangan, 2004) stated that "Medical schools should set up an informal and confidential mediation process that students and faculty members could report to when they feel that they have been harassed or discriminated against" (p. A 11). Those academics who acted as secondary participants to the current study and who were also from culturally and linguistically diverse backgrounds had mentioned the need for a similar mediation processes to be established on Australian university campuses. They believed this would allow CLDNSs to have their concerns regarded confidentially and provide them with the support necessary to succeed in their chosen professions. Whilst most Australian universities have multicultural or equity policies and counselling or student support services the bulk of services offered sit in the big picture of academic support. Too few schools, departments or colleges have taken up the challenge of offering contextually based support programs (Brown, 1996a).

Support at Home

Previous studies have also found that foreign students who share houses or live together are more inclined to use their first language at home and are less likely to make satisfactory social connection with English speakers (Upvall, 1990). The end result of these living circumstances was thought to have major impact upon the foreign students' ability to communicate verbally and nonverbally. Whilst the literature suggested CLDNSs would benefit, in more ways then one, from living in shared accommodation with native English speakers, CLDNSs found it difficult to make friends with these students. Further, CLDNSs who found it difficult to make friends with members of the dominant group were more likely to live at home with their parents or in shared accommodation with other students from the same, or similar cultural backgrounds.

Ongoing Nature of Sociocultural Discord: Being Different and Not Fitting In (SD)

The literature reviewed indicated that problems associated with communication do not disappear once a student nurse graduates and becomes an RN. Pittman and Rogers (1990) reported RN problems in the area of communication. These were identical to those communication problems faced by CLDNSs, that is, speaking with an

accent, expression, being understood, slang words, language customs, parochial speech, swear words, and understanding others from other NESBs. Dijkhuizen's (1995) findings supported those of Pittman and Rogers (1990) of the difficulties related to the use of English language for overseas RNs entering America with the aim of working. Dijkhuizen (1995) went a step further and identified problems associated with cultural adjustments.

Whilst advances in communications technologies continue to facilitate immediate and easier global interaction, real time, face-to-face interactions between different peoples of the world continue to be punctuated by errors and misunderstandings. Previous studies have demonstrated that accents or English as a second language act as barriers to communication and mobility of the nursing workforce (Villarrel et al., 2001). The importance of being accepted by superiors as well as by colleagues can not be overlooked, nor can the difficulties associated with communication and the shock associated with coming to terms with a new culture (Dawes, 1986; Meleis, 1979).

In a recent study of student nurses from different cultural backgrounds enrolled in a New Zealand university Gunn-Lewis (2002) reported that the majority of participants found their first year of study the most stressful. Students reported problems adapting to a new culture and to the university environment as well as experiencing stress because of a lack of English language proficiency.

Cultural Adjustment

When people decide to move to another country they embark upon a process referred to by Oberg (1986) as "uprooting". In a way, uprooting is the preparatory phase of cultural adjustment. Upvall (1990) discussed the uprooting process of international students when they leave their home country to study nursing in another country. This author described the three different phases as preseparational, separational, and postseparational and looked at gratification achieved or not achieved in each phase. The author then identified the difficulties students encountered along the way, such as, "disruption to cultural, cognitive, linguistic, and other habitual contacts" (p. 96). Upvall

(1990) also identified an upward and a downward rhythm of adaptation when saying that the process of adapting "may become less painful at certain periods of time … and the students' problems may vary" (p. 98).

Much of the literature reviewed that was related to cultural adjustment focused upon either international students, who usually travelled on their own, or company employees moving to a different country. The latter group usually moved to the new country with their immediate family (Sappinen, 1993). Irrespective of the differences between these two groups, problems associated with cultural adjustment were often similar. Business men were quite adept in their business dealings in their home countries but when located in a different country many were far less successful. This lack of continuing or ongoing success was directly related to differences in culture and the business man's inability to adapt or adjust to the way of doing business in the new culture (Sappinen, 1993). Similarly, the success of the international student depended much upon their ability to adapt to their new culture and to being a student in their new host country. It is now timely to discuss cultural adjustment or cultural adaptation.

Cultural adjustment curves

Cultural adjustment has been described in the literature as a "U-shaped curve" or the "J-shaped curve". The U-shaped curve was first identified in 1955 by Lysgaard. Both Oberg (1986) and Black and Mendenhall (1991) described the U-shaped curve as having four stages. Whilst labels of stages differ the concepts are the same. The researcher had decided to use the labels put forward by Black and Mendenhall.

Black and Mendenhall (1991) referred to the initial phase as the 'honeymoon stage'. Essentially they claimed the honeymoon stage existed because the newcomer had entered a new environment and he/she was excited by new prospects. The second stage was given as the "Disillusionment" stage and involves disappointment and frustration. Oberg (1986) reported that the individual in this stage becomes disappointed with their new country and highly critical of the host culture. Black and Mendenhall referred to the third stage as the "Adjustment Stage" in which the individual adjusts to the new culture slowly and learns how to behave and interact appropriately. This coincides with Oberg's (1986) 'Improved Adjustment' stage as the individual gains a better understanding of their new culture, including the language. The fourth and final

stage of the Black and Mendenhall model is called the "Mastery Stage" and is characterised by the individual's ability to function meaningfully in the new culture. Oberg (1986) called this the 'Bi-culturalism stage' and suggested this reflects the individual's acceptance of their new culture and marks the completion of the uprooting process.

When applied to CLDNSs in the current study, the reader has to be reminded that not all CLDNSs are international students. Nonetheless, the researcher believed they still went through a stage of uprooting. Uprooting involved the period of transition from high school to university studies. When CLDNSs went through this stage they uprooted from all things comfortable and familiar. When CLDNSs began their nursing studies at university they went through a honeymoon period. They had begun a new adventure and were excited by future prospects. Further down the track many experienced disillusionment and culture shock. These CLDNSs were disappointed and at times clearly frustrated. Some became angry with nurse teachers and RNs with whom they worked. Others were disappointed with certain aspects of their education.

Those CLDNSs who were in their final years of study had spoken of many changes they had made throughout their undergraduate nursing education. Essentially they had worked towards adjusting to their new culture which happened to be the culture of nursing. This coincided with their improved understanding of their new culture, including the language.

The next stage for CLDNSs was the mastery stage. However, not all students reached the mastery stage, and of those who did, many rebounded back out when encountering episodes of SD. In other words the individual's ability to function meaningfully in the new culture depended upon challenges they had to face on a daily basis.

Black and Mendenhall (1991) had criticised previous studies using the U-shaped curve because previous researchers did not use statistical analysis in their work. Criticism was also levelled at the same studies because some researchers depended upon the participants' abilities to recall their experiences of cultural adjustment from eighteen months beforehand.

According to Black and Mendenhall (1991) the J-shaped curve is similar to the U-shaped curve except that the honeymoon period is less pronounced and the decline into culture shock is less dramatic. Of more interest are the adjustment and mastery stages of the J-shaped curve. Individuals exhibiting a J-shaped curve of cultural adjustment are better able to function meaningfully in their new culture.

In contrast to the U-shaped curve, Klineberg and Hull's (1979) study of sixty-eight foreign students' (as cited in Black & Mendenhall, 1991) experiences in America found that most of the students exhibited a linear, upward-sloping pattern of adjustment. Similarly, in the current study, CLDNSs did not fit Lysgaard's recognised U-shaped curve theory. From an overarching perspective both curves seemed to have merit; however, neither adequately described or allowed conceptualisation of the processes CLDNSs used to reduce their levels of SD.

Foreign medical students were found to have similar experiences when studying medicine in other countries too. Singh (1994) described the ongoing nature of his own cultural adjustment made working as a medical student with an Indian background in England. He described his preparation for the move as inadequate and ill informed. He wrote about his "impossible, engulfing feelings of being the other" (1994, p. 1169). Whilst Singh (1994) acknowledged that his feelings of being the other reduced over time, these same feelings returned whenever he came face to face with racism or discrimination. Furthermore, he questioned his sense of personal and professional worth during such times and questioned his long held beliefs about Western culture being the "pinnacle of liberal, secular, and tolerant attitudes to differing social and religious lifestyles" (p. 1170). CLDNSs in this study had similar feelings of being the other. They also shared Singh's feelings of self-doubt especially when confronted with episodes of perceived racism or discrimination.

Khan's (1994) book 'Seasonal Adjustment' reflected the stages of cultural adjustment as proposed by Oberg (1986) and Black and Mendenhall (1991). When describing his own feelings about being a foreign person in Australia Khan stated "there is a lingering foreignness about Australia that I find disturbing. I don't have anything to hang on to with conviction, nothing I can really call my own. I don't feel passionately for anything that happens here." (1994, p. 117). In respect to his thoughts about social

occasions he wrote "I have discovered the powers of invisibility" (p. 150). CLDNSs shared Khan's feelings of being invisible. However, their experiences were in professional rather than social situations. Both of these quotes refer to the deflection of the U-shape curve as does the following quote:

> I am weary of exploring the barren coldness of rejection. It is the helpless despair of being stranded on an iceberg, talking to a world empty of understanding. I have learned that pariahs are unsettling for any community. They bring with them too many strange ideas. They upset the communal rhythm of ignorance. They need to be kept out. (Khan, 1994, p. 144)

Khan also identified his movement into the Adjustment Stage of the U-shape curve when he stated "I am a free floater. I take and adapt what suits me. I have been indelibly tainted with a diversity of experiences embracing a cross-current of customs and behaviour. I am a composite of lifestyles and rituals" (p. 249). Further evidence of this shift exists when he wrote:

> I was no longer being apart from the disordered pattern of living. This unpredictable rhythm, with its wildly irregular beats, was also my pulse of life. It had taken time to find it, but it was there beating feebly. I was no longer imprisoned within my own resentments. There was an acceptance of irreconcilable facets of my polarised self. Perhaps I was meant to live as a fragmented being. The idea did not disturb me any more". (p. 217)

He went on to say:

> I even felt a tinge of remorse for those I knew. It could not be easy to accommodate people like me – bumbling agents of change who spread themselves across the globe and unwittingly seek to impose their hybrid perceptions on closed cultures. (p. 217)

In contrast to the U-shaped and J-shaped curves or the linear model of cultural adjustment the students in this study process of cultural adjustment is better described or conceptualised as a never-ending wave pattern. Periods of relative adjustment, or calm, were punctuated by episodic waves. The waves ranged in size. Some were merely a ripple but others were as big and as devastating as a tsunami. Students experienced this wave form of cultural adjustment just as RNs from different cultural backgrounds surely must when they commence working in the Australian health care system. Students' experiences of SD have been described in this study as never-ending because CLDNSs experienced episodes of SD in an ongoing fashion. Whilst there may have been periods

of apparent concord, given time and the episodic nature of SD, any steady wave form was usually disrupted. These wave forms are depicted in Figure 3.

Based on experience and data analysis in this study, the researcher also believes CLDNSs, once graduated and qualified, will continue to experience episodic SD. During the interview process, CLDNSs had asked the researcher if there was evidence that qualified RNs from different cultural backgrounds were discriminated against when applying for promotion. From her own experiences, of higher education in nursing and clinical nursing, the researcher has witnessed multiple apparent discriminatory events against RNs as well as nursing students from different cultural backgrounds. The researcher has also worked alongside many Australian and Anglo-Saxon RNs who have verbalised their racist or discriminatory feelings and beliefs about people from other cultures.

Upvall (1990) found that those international students who adjusted better to the uprooting process had a better understanding and command of English and were able to have social contact with American students. He went on to say that:

> Realising that social contact with Americans is an integral part of adjusting to uprooting contributes to a holistic view of the students. International students are not only students, but rather individuals with unique past experiences which, when integrated with current experience, enable the students to transcend cultural boundaries. (p. 106)

"Psychological adaptation or adjustment implies a harmonious relationship between the individual and society" (Upvall, 1990, p. 95). CLDNSs must make efforts to adjust to their new environments and the people within these new environments. These adjustments can lead to successful cultural adaptation which according to the literature occurs over varying lengths of time.

Black and Mendenhall (1991) put forward a social learning theory of cross-cultural adjustment using the ideas from the U-shaped curve. The elements of the social learning theory (SLT) as described by Bandura (1977) were: attention, retention, reproduction, incentives and motivation. Black and Mendenhall (1991) placed importance on the attention element of the social learning theory. They believed that before behaviour could be modelled it had to be noticed by the learner. In other words,

the behaviour had to gain the attention of the learner. According to these authors there are five factors that influence the attention process. These are firstly, the status of the model; secondly, the attractiveness of the model; third, the similarity of the model to the observer; fourth; the repeated availability of the model; and fifth, past reinforcement for paying attention to the model, either actual or vicarious (p. 233).

Black and Mendenhall (1991) described retention as the process by which the behaviour becomes encoded as memory by the observer. In other words the behaviour is remembered. They go on to explain that there are two systems involved in the retention process and these are known as are imaginable and verbal. The imaginable system comes into play whilst the learner is observing. During this time sensory images corresponding with physical contiguity are acquired. Images are stored in the brain as cognitive maps which get used when the observer engages imitation of the behaviour. The verbal system refers to coded information and groups constituent patterns of behaviour into larger integrated units.

Bandura (1977) believed that repeated modelling and cognitive rehearsal, or thinking the process through, both served to solidify retention. As the third element, he stated that reproduction meant reproducing the desired behaviour. Individuals check their behaviour against their memory of the model's behaviour. The fourth element consists of the incentives that will motivate the individual to model the observed behaviours. Incentives act as important influences on the learning process. They affect which model is chosen, the amount of attention paid to models, the degree of retention and rehearsal. When behaviours are learnt but not rewarded it is likely that they will not be replicated. However, rewarded behaviour will often be repeated and retained. In this study there was evidence of students repeating behaviours that had been rewarded by positive feedback from their teachers.
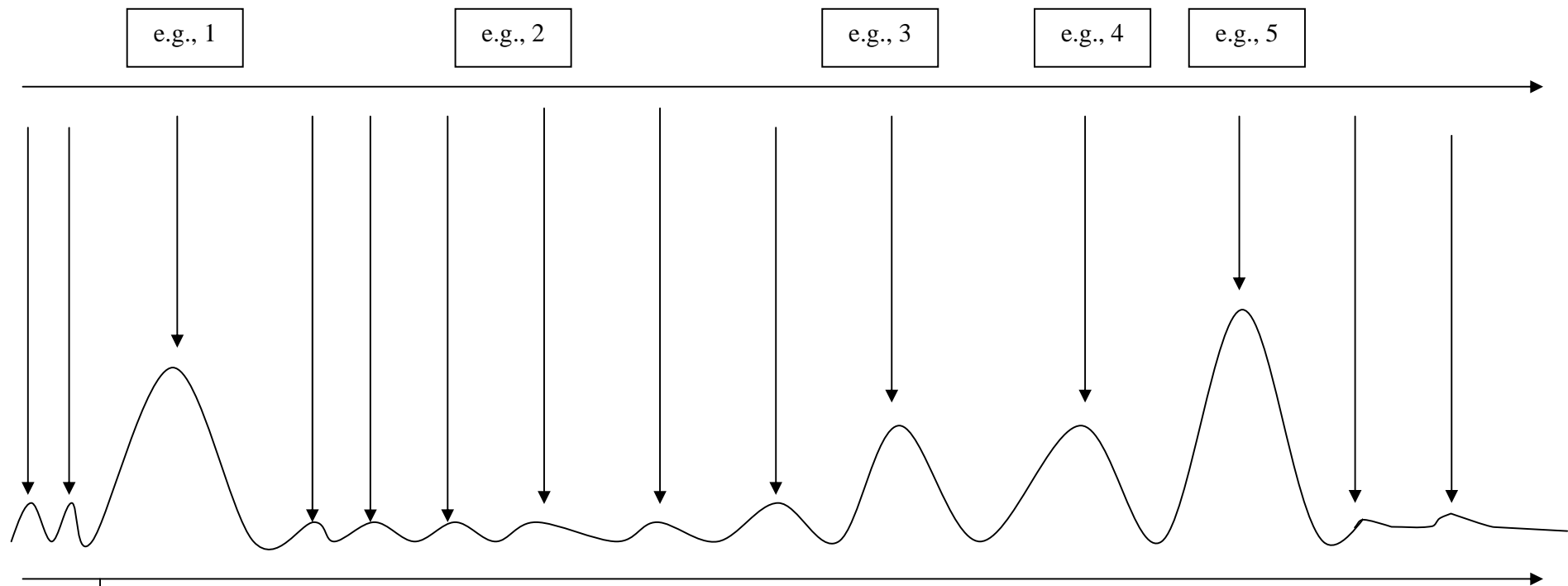
e.g., 1: Catching public transport to university and has to deal with the stares encountered because she wears a head scarf.

e.g., 2: Goes to the bathroom before classes commence and reads racist graffiti on the walls in the bathroom.

e.g., 3: Lunch time, wants to try to make friends with Australian colleagues. SD discord increases as she prepares to introduce herself to members of the dominant group.

e.g., 4: Attends tutorial after lunch. Teacher asks her to share her thoughts related to the tutorial discussion.

e.g., 5: Attends a nursing practice laboratory. The class is instructed to get into groups. She is the only student in the class wearing a head scarf. She's left out. All students have dispersed into small groups of six. She feels pressured, self-conscious, embarrassed, unwanted, different and left out. She experiences SD discord.

Figure 3: Sociocultural Discord: Being Different and Not Fitting In (SD) caused by psychological, sociological, cultural and contextual factors.

Essentially Bandura (1977) believed the greater an individual's level of self-efficacy the more likely he or she would be to rehearse and model the observed behaviours. This also applied to new or novel behaviours. Outcome expectations were also important. If an individual believed a particular behaviour would lead to a desired outcome, it was more likely they would perform the behaviour. Gradual modelling of behaviour involves successful approximations of the desired behaviour and according to Bandura (1977) is more effective than modelling the final behaviour. There are many reasons for this but of particular interest in this study is that observers pay more attention to models and modelled behaviours that are familiar.

Black and Mendenhall (1991) put forward the notion that, because foreigners find themselves in a place where their learned behaviours and consequences are no longer acceptable and that they have to learn new behaviours, and that new sources of learning are different from the past, the SLT can inform the teacher whether or not to expect to see a U-shaped curve of cultural adjustment. Bandura (1977) asserted that, in addition to learning on the basis of the consequences of one's actions, individuals could learn and behave from their observations of other people's behaviours and associated consequences, as well as imitating the observed behaviours. He also identified, or acknowledged, that people learn vicariously. Black and Mendenhall (1991) claimed that during the honeymoon period foreigners pay attention to, or notice, features of the new environment that are similar to their home environment. Foreigners search for anything familiar. During this time period, foreigners are only likely to notice those features that are strikingly different or outstanding. As far as behaviour is concerned, the foreigners are likely to execute those behaviours which are familiar to them and have been successful in their previous culture. In essence, foreigners engage in behaviours that are usually inappropriate in their new culture, resulting in negative consequences. These kinds of interactions should lead to culture shock, not a honeymoon period.

Black and Mendenhall (1991) also assert that several factors work towards the existence of the honeymoon period and these are time, lack of knowledge, ignorance, and maintenance of a self-concept. A honeymoon period can be expected when foreigners first move to a new country because they simply have not had enough time immersed in their new culture to have experienced culture shock or negative interaction

with others. When foreigners begin to interact with members of their new culture they are least likely to recognise their culturally inappropriate actions. Foreigners can also be in the honeymoon phase when they choose to stay with their own self-concept as it was in their own culture.

Culture shock is experienced because the newcomer begins to identify or recognise their own inappropriate ways of being on an increasingly regular basis. They are in the midst of learning new ways of being but they are not always equipped to implement these newer ways. Oberg (1986) listed frustration, anxiety, and anger as symptoms of culture shock. CLDNSs in the current study had identified these same symptoms and many others. Black and Mendenhall (1991) believed that this was primarily because the newcomer pays little attention to the behaviours of members of the host culture and thus thwarts their learning process via observation. Effectively, the newcomer continues to exhibit inappropriate behaviours and receives negative feedback for doing so. Culture shock is experienced to a greater degree by people whose own culture differs greatly to their new host culture. Hofstede (1980) referred to the disparity, or the degree of difference, between two cultures as the "cultural distance". The greater the distance the more likely group members were to experience culture shock. When host culture behaviour is far removed from home culture behaviour it is least likely that host culture will be easily adopted. R. Walsh (personal communication, July 12, 2003) and Gorman (1999) put forward the notion that the more different the student's culture from the host culture the more problems the student will encounter. In addition, Black and Mendenhall (1991) claimed that culture shock for these individuals was likely to be severe and protracted. Black and Mendenhall (1991) endorsed the idea that modelling of new behaviours needs to occur in context and be available for the newcomer to observe over a period of time. Because modelling of new, culturally-specific behaviours takes time the newcomer can not avoid a period of culture shock. Whilst the availability of the model is important the amount of time the newcomer spends observing behaviours in context must occur over an extended period to be retained. If this time is not factored into to the process of cultural adjustment then disappointment will follow because the newcomer will be modelling behaviours that

have not been learnt properly. It is inevitable that poorly learnt behaviours will be modelled which could lead to episodes of SD, which was the case in this study.

Black and Mendenhall (1991) also claimed that whilst in the adjustment phase the newcomer begins to model learned behaviours correctly. As a consequence the foreigner senses a reduction in negative feedback, frustration, anger, and anxiety. Positive reinforcement is found in place of these negative consequences and it is more likely the newcomer will continue to exhibit appropriate behaviours. As appropriate interactions occur the newcomer is likely to experience feelings of increased self-confidence, self-worth, and a degree of acceptance not previously experienced. According to Brislin (1981) these are the affective components of cross-cultural adjustment or the hall markers of successful cross-cultural adjustment.

All of these stages of cultural adjustment occur over time which allows the newcomer to become increasingly familiar to, and comfortable with members of the new culture (Black & Mendenhall, 1991). As the newcomer gains confidence their ability to learn more by observation increases. Furthermore, their increased comfort levels facilitate retention of new ways of being. During this time period the distance between the newcomer and members of the host culture diminish as the newcomer behaves more appropriately.

Anticipatory adjustments are thought to have impact upon cultural adjustment especially in the honeymoon period (Black & Mendenhall, 1991). Anticipatory adjustments are those changes conceived vicariously as necessary before immersion in the new culture. If one is aware of the need to make these changes and then does so when immersed in the new culture they are more likely to experience a J-shaped curve of cultural adjustment. Effectively their honeymoon period is averted and their decline into culture shock is shortened. It is important, however, that information given to people about their new culture and new country before they leave their home culture is accurate.

It is difficult to impose the U-shaped curve, the J-shaped curve or even the linear model upon CLDNSs in the current study. Nursing curricula across Australia purports to teach respect for individuality therefore each student participant in this study was thought of as an individual. Effectively, they all experienced episodes of SD and

patterning of resultant behaviours were identified. Some students were far more articulate than others, some had greater fluency using English, some appeared more relaxed than others, some even appeared to enjoy the process of interview. Yet at the same time some expressed their frustration, anxiety, fear, and dealings with discrimination. Individual experiences along with individual characteristics clearly impacted upon the student's processes of cultural adjustment. Those who had negative experiences would have spent more time in deflected parts of waves than those who had positive experiences.

Black and Mendenhall (1991) believed that those newcomers who were more willing to form relationships with members of the host culture faired better than those who were not able to form relationships. This was because the former newcomers had more exposure to hosts upon which they were able to model behaviours. Repeated exposure to models over a period of time in relevant contexts had favourable impact upon the newcomer's attention process. Attention was said to have a positive impact on retention and reproduction. Those willing and able to form friendships spent less time in the process of cultural adjustment. Effectively, SLT provided a theoretical explanation of why being able to form relationships with host members affected cultural adjustment favourably.

The belief that one's own culture is superior to all others is known as ethnocentricity. As such, ethnocentricity is known to consistently inhibit cross-cultural adjustment. People with ethnocentric beliefs fail to believe that members of their host have any similarities and they fail to pay any significant amount of attention to these people. As a consequence, the newcomer has little or no meaningful exposure to host members or their culture and they fail to learn from observation and modelling. Ethnocentric individuals are most likely to experience greater amounts of culture shock and take extended periods of time to adapt to their new culture because they are not motivated to learn and therefore often fail to do so (Black & Mendenhall, 1991). Nurse teachers, however, are reminded that interaction between CLDNSs and members of the dominant population on a university campus is not always as easy as it seems. Those who come from different cultures may have cultural edicts that prohibit them from initiating and maintaining contact with members of the dominant group (Upvall, 1990).

Self-efficacy is also important in the process of cultural adjustment. Those individuals who are more willing to try out new behaviours are more likely to succeed than those who have low self-efficacy levels. It is equally important that people who work with newcomers recognise the potential effects of self-efficacy and provide the necessary environments and positive feedback for those CLDNSs, who at the very least, attempt new skills and ways of interacting. Black and Mendenhall (1991) proposed that provision of positive feedback would lead to the newcomer trying again.

Summary

This chapter has provided an overview of the substantive theory of Seeking Concord to get in the Right Track (SC) – Overcoming Sociocultural Discord: Being Different and not Fitting In (SD). Essentially CLDNSs perceived themselves, or were perceived by others, as being different and not fitting in. This resulted in students experiencing episodic sociocultural discord. To counter this situation, students attempted to change their behaviours. More often than not these attempts were unsuccessful.

In an education system that is largely Anglo-Celtic and ethnocentric, it is difficult to meet the needs of individuals from cultural minority groups. Within nursing education this has been highlighted by Pittman and Rogers (1990), as well as Barbee and Gibson (2001), who report a lack of racial diversity in nursing students. Whilst cultural issues are addressed in nursing curricula within Australia, few university Schools of Nursing address the needs of CLDNSs, with respect to learning about Australian culture. Instead, nursing students studying in Australia are taught about caring for patients from NESBs.

As previously discussed in chapters 4 and 5, CLDNSs demonstrated a broad and diverse range of communication differences that led to episodes of SD. Whilst students were aware of the 'student role', many were unable to meet expectations because of cultural differences. Students also found themselves in "them and us" situations in which they felt isolated and were unable to interact with members of the dominant group. Asian students, in particular, had difficulties related to all aspects of communication. Some students' families were supportive, whereas other families were

unsupportive. While SSS were available to all participants in this study, very few accessed these services. CLDNSs encountered episodic SD throughout their undergraduate nursing degree studies on university campuses, in clinical practice settings, and in most other areas of their daily lives.

Previous researchers have identified and discussed models of cultural adjustment that have a clear start and end point (e.g., the U shaped or J shaped curve) (Black & Mendenhall, 1991; Oberg, 1986). These models indicate cultural adaptation from culture shock through adjustment eventually to a levelling point. However, the findings from this research are dissimilar to both curves. Instead, the pattern for CLDNSs in this research was a wave-shape indicative of episodic SD. There was no end point; effectively students experienced episodic SD throughout their undergraduate nursing degree. The next chapter concludes this research and makes recommendations from the findings for further research.

CHAPTER 7
Conclusions and Recommendations

Conclusion

There is no doubt that Australia is a multicultural country and that people in need of health care are representative of this diversity. It is also acknowledged that the nursing profession does not reflect this same diversity. In this study the researcher interviewed student nurses from culturally and linguistically diverse backgrounds. In addition nurse teachers were also interviewed. Other data were obtained from field observations in clinical practice settings and on university campuses, in classrooms, and nursing skills laboratories. The researcher chose to use a qualitative research methodology known as grounded theory. Data were analysed using constant comparison, synonymous with this methodology. The core problem, shared by every student was sociocultural discord: being different and not fitting in (SD).

CLDNSs were different to members of the dominant group and these differences, whether they occurred in clinical practice settings or on university campuses, created episodes of discomfort for the students. This discomfort was experienced in an episodic fashion meaning some students experienced SD on some occasions whilst similar experiences would not have caused others to have the same feelings. These experiences varied in the presence or absence of identified influencing conditions. Nevertheless, episodes of SD dominated data analysis and conceptualisation.

When CLDNSs experienced SD some attempted to counter or reduce the discomfort by initiating specific behaviours. The behaviours were labelled collectively as seeking concord to get in the right track (SC), and were identified as forming the basic social psychological process. In a broad context of disharmony, CLDNSs experienced episodic SD, and enacted behaviours in an effort to get in the right track in a sometimes hostile and sometimes welcoming environment. Those background issues identified by the CLDNSs were allowed to emerge from the data. Collectively there was evidence that these students lived, studied, and worked in what could indeed be conceptualised as a journey along a bush track with few markers along the way to the completion of their degree studies.

Recommendations

　　　　Having completed this study the researcher has identified a number of relevant implications and recommendations. Most of these are based on these research findings or relevant literature and have been presented as part of this final chapter.

　　　　Whilst university Schools of Nursing around Australia work hard to increase enrolment numbers and governments of the day continue to increase government funded places in nursing programs very few, if any, nursing programs have successfully targeted specific cultural minority groups for recruitment purposes. Because Australia is a multicultural country it seems logical that people from a wide variety of cultural backgrounds be encouraged to take up nursing as a career. To be more successful in recruiting student nurses from different cultural backgrounds university and government advertising needs to include people representative of cultural minority groups in the recruitment process. Advertising should be contextually based and presented in languages other than English. Recruitment should occur in metropolitan high schools known to have large numbers of students from minority groups.

　　　　It is recommended that contextually based support groups and programs should exist in all Schools of Nursing and their existence should be widely advertised. These groups and programs should have a designated nurse academic leader who would be responsible for assisting the nursing students to meet their needs. This academic leader should be an RN to ensure that support offered is contextually orientated.
Lepp and Zorn (2002) recommended that:

> The learning environment must be a safe space for expressing personal experience, developing a feeling of trust, and accepting each others differences, such as gender and cultural backgrounds. Only when learning space is perceived as safe are vulnerabilities exposed and masks removed. In this way, a willingness for sharing will be established. (p. 383).

In line with the findings of this study, university Schools of Nursing could incorporate aspects of Lepp and Zorn's recommendations of safe places into their mission, vision, and values statements. And to make these recommendations real, or tangible, they could be printed onto unit outlines that are handed out to all students in the first week of each semester.

Lepp and Zorn (2002) went further and suggested that safe spaces for learning also require that students have a choice of assessments and have input into learning activities. These aspects of safe space should act to demonstrate to the students that "flexibility, openness, and respect exist" (p. 385). Flexibility in assessments would go a long way to assist CLDNSs' grades. Students in this study had commented that they disliked multiple choice questions. They claimed this type of assessment confused them and they often felt the teacher was out to trick them. The fact was it took CLDNSs a lot longer to read multiple choice questions and therefore they believed they were being disadvantaged when this type of assessment was used. The researcher is not advocating that CLDNSs receive different forms of assessment to local students. However, it is suggested that all students have a choice in assessment format.

CLDNSs have been found to experience episodes of discrimination, inequitable treatment, and racism both on university campuses and in clinical practice environments. Where these behaviours are identified universities should deal with them appropriately and do all they can to prevent recurrence.

Based on the findings of the current study, CLDNSs who are likely to struggle with course content should be identified at the beginning of their nursing education. Those students who struggle with their nursing studies could be encouraged to study part-time and if problems related to English language exist students should be advised on how to improve their English language skills. These students should be directed to contextually-based support programs and at least offered appropriate counselling. Contextually-based support could be offered by the School of Nursing and, where possible, counselling should begin with counsellors of the same cultural background as the student requiring counselling services.

Jefferys and O'Donnell (1997) stated that those academics, and/or nurse teachers who work with student nurses from different cultural backgrounds "must not only recognise but also appreciate the diversity in students and develop interventions targeted at enhancing transcultural nursing skills" (p. 18). These authors' comments, along with findings of this study, would indicate that teaching CLDNSs is indeed a sophisticated and complex branch of nursing education and one that to date has not received a great deal of attention by researchers.

There is ample evidence suggesting that the majority of student nurses who have different cultural and linguistic backgrounds struggle throughout their undergraduate nursing degree programs. Perhaps there is a need to investigate the possibility of conducting separate classes for those CLDNSs who experience SD. There is also the need for further investigative work to be conducted on the success, or otherwise, of specialised programs developed specifically for students from minority cultures. Perhaps it is time for Australian Schools of Nursing to work collaboratively to establish one, or more, campuses that specifically cater for the needs of CLDNSs. These nursing programs may even include some classes being conducted in first languages and some assignments being submitted in first languages. Clearly these recommendations or suggestions require funding and staffing and would not work without commitment from those in key positions.

From a more balanced perspective the establishment of such programs may be seen to hinder the development of students' abilities to interact with members of the dominant group, hospital staff, community care workers, and patients. Obviously, such programs would need to be researched further and curricula would have to focus upon Australian culture and the Australian nursing profession.

The organisations that are responsible for accrediting Australian university Schools of Nursing could assist in the development of inclusive curricula if they mandated the demonstration of cultural sensitivity in undergraduate nursing programs. university Schools of Nursing would then have to reassess curricula and make the necessary changes to become wholly inclusive.

Malu, Figlear and Figlear (1994) put forward their recommendations as "tentative first steps" (p. 18) to increase retention of multicultural ESL nursing students in American university Schools of Nursing. Firstly, they recommended that an ongoing and conscious commitment be made by universities and staff to make relevant resources available. Specifically they noted that staff should act as student advocates, counsellors, and advisors. They went further and stated that "if schools choose to admit multicultural ESL students, they have a moral and an ethical responsibility to do all they can to ensure the students' success" (p. 18). They also discussed a two phase admission process. In the first stage all prospective nursing students are interviewed and made aware of the life

of a nursing student. Faculty members give an honest appraisal of what it takes to be successful at nursing school. This first phase also gives the faculty member an opportunity to assess the applicant's ability to use English and to become informed of their individual career goals and aspirations.

Malu et al. (1994) developed the second phase of the application process to assess the multicultural prospective nursing student holistically. In this phase of application the student engaged in further interviews as well as reading and writing assessments. During this time the faculty member evaluated command of English by the answers the prospective student formulated. Faculty were geared towards sensitivity and skilled in counselling those applicants who struggled with entry requirements. In Australian university Schools of Nursing prospective international nursing students are required to complete an English language proficiency assessment prior to enrolling in nursing studies. When students apply to enrol in nursing studies provided they have attained a predetermined score of English language proficiency they are admitted to nursing studies. Very few universities have the staff to take the time to interview prospective students to determine English language proficiency for themselves and many are reluctant to do so as the prospective student has already passed the necessary admission requirements. This study, however, not only recruited international participants but also students who were classified by university definitions as locals. English language proficiency skill assessments were not a requirement of those students considered as locals (residents of Australia) entering nursing studies.

Student nurses from different cultural backgrounds are, as Murphy and McGuire (2005) noted, "embarking upon a huge and courageous transition in their lives" (p. 26). If the nursing profession truly aspires to the provision of holistic nursing care then these students need extra assistance and support to graduate from their undergraduate degree programs and embark upon their careers as RNs.

Congruent with the findings of this study Ekstrom and Sigurdsson (2002) suggested there are benefits associated with having international students in clinical practice settings. Those mentioned were improved global relations, increased sensitivity of staff towards cultural differences, demonstration of leadership skills as RNs look out for international students, improved profile of the clinical agency, and stimulation of

alternative ideas for recruitment. However, unless there are relevant support services and understanding of experiences of CLDNSs, these students themselves appear to have limited benefits.

The researcher also commends and encourages those universities that offer what are essentially immersion programs. Understanding of being 'the other' can be facilitated as Grant and Letzring (2003) suggested by participating in immersion programs. Immersion experiences enable the participants to gain first hand feelings of "being the outsider" (p. 9). Students who have immersion experiences develop rather expediently a higher level of cultural sensitivity.

A number of CLDNSs in this study had difficulties gaining and retaining support from their family members or members of their cultural community. Part of the reason for this lack of familial support was thought to be related family members' misunderstandings related to the nursing profession. Many parents held outdated, culturally monocular thoughts of the nurse. For CLDNSs these beliefs and thoughts acted as barriers in gaining family support. Further, the profession of nursing has moved far beyond the images portrayed in the popular press and members of the profession who are in positions to influence the greater public could contribute as change agents to imbue a more modern, dynamic, and futuristic image of the profession. This may impact upon those families and communities who hold nursing in a somewhat outdated perspective.

Quality teachers are always prepared for their classes. Nursing is no different, so nurse teachers should be prepared for their classes including teaching students from diverse cultural backgrounds. Sommer (2001) acknowledged cultural diversity found within classrooms and recommended that teachers assess the cultural makeup of their class groups before teaching commences. She also suggested teachers should complete a self-assessment of their beliefs and values prior to teaching racially mixed classes. These recommendations were put forward in an effort to encourage nurse teachers to become aware of how their values and beliefs may impact upon learning in their classes.

As the nursing profession continues to recruit students from minority cultural backgrounds, and it is known that these students may experience one form or another of discrimination, racism, or inequitable treatment, it is important to provide on campus

support services that are preferably course specific and culturally relevant. Based on the findings of this study the researcher also believes that it is relevant that universities encourage and reward those nurse teachers who can demonstrate their efforts of becoming culturally aware and competent teachers.

As shown in this thesis, the findings have implications for those involved, at all levels, in nursing education in Australia. Recommendations from this research are summarised in the following list:

- Targeting specific cultural groups for recruitment of prospective nursing students
- Use of culturally relevant role models in recruitment strategies
- Use of advertising materials in other languages
- Provision of contextually based support groups and programs for CLDNSs
- Employment of nurse academics as designated support people for CLDNSs
- Commitment to a philosophy of cultural diversity printed on all unit outlines
- Taking steps to eradicate racism, discrimination, and inequitable treatment on university campuses
- Creation of culturally safe environments in which to study
- Provision of flexibility in student assessment methods/approaches for all students
- Increasing or allowing opportunities to study nursing part-time
- Provision or facilitation of access to culturally specific, contextually orientated counsellors
- Offering realistic and relevant support to nurse teachers to update skills in areas related to teaching CLDNSs
- Further research into separate classes for CLDNSs
- Further research into the development of specialist programs for CLDNSs
- Accreditation of Nursing programs dependent upon demonstration of inclusivity of CLDNSs
- Increasing the English language assessments scores necessary to enter nursing studies

- Provision of compulsory immersion programs for student nurses who are members of the dominant group
- Campaigning in the popular press to update the public image of nursing

Further Research

This study has investigated and documented the experiences of CLDNSs in their undergraduate nursing degree programs in Australian universities. The researcher found that, in a context of disharmony, CLDNSs experienced unpredictable episodes of sociocultural discord: being different and not fitting in (SD) during the course of their nursing studies. These unpredictable episodes of SD were caused by sociological, psychological, cultural, and or contextual differences. In an effort to reduce the degree of SD, CLDNSs changed many of their usual behaviours and ways of being. Students were seeking concord to get in the right track (SC).

It is recommended that further research be conducted that investigates the experiences of those who work alongside CLDNSs. This includes RNs, nurse teachers, and English-speaking student nurses. Research from the patient's perspective of being looked after by a nurse from a culturally and linguistically diverse background is also needed. Findings from such studies would act to inform academic decision makers of the future. Academics would have the information they need for improving the experiences of CLDNSs, to decide whether CLDNSs should be educated alongside the dominant group, or to consider whether alternative curricula need to be developed. Heads of Schools need research evidence to support their fiscal requests to enable nurse teachers to more fully support and educate student nurses from culturally and linguistically diverse backgrounds. In addition, further research evidence about the experiences of CLDNSs could be used to assist nurse academics when planning curricula.

Further study needs to occur in respect to the assessment of prospective student nurses to ascertain if they possess the necessary level of communication skills to graduate from their undergraduate nursing degree programs. According to Chandra and Willis (2005) some American states have introduced programs in which RNs who gained their initial nursing qualification overseas are tested and routed through specific

programs that support the development of individual communication skills in context. These authors put forward the notion that there were greater chances of individuals achieving licensure in America having completed such programs. These programs could be adapted for CLDNSs studying nursing in Australian Universities.

Academics from Western countries are also involved in setting up Schools of Nursing offshore. Whilst curricula are modified to meet the local needs, Chandra and Willis (2005) reported that many of these programs are taught in English. Education, in English, of nurses from non-English speaking countries stands to decrease the amount of SD experienced when individuals move to an English speaking country to work..

In an effort to support CLDNSs throughout their undergraduate student years perhaps Australian university Schools of Nursing could investigate and possibly adopt strategies already in place in some American institutions. Guttman (2004) described a technique referred to as 'integrated skills reinforcement' that aims to improve culturally diverse students' reading, writing, listening, and speaking skills. This program works in such a way as to integrate the essential skills of communicating in English whilst the student gains content and context. Effectively, the students learn American-English and ways of culture along with nursing content. Similarly, learning Australian-English may be facilitated.

Final Comment

This study was aimed at exploring the experiences of CLDNSs studying for their undergraduate nursing degrees in Australia. The grounded theory method was used enabling the researcher to identify a basic social psychological problem and a basic social process. A substantive theory has been developed referred to as: seeking concord to get in the right track (SC) – overcoming sociocultural discord: being different and not fitting in (SD). This substantive theory encapsulates the experiences of being different and not fitting in. It also documented the processes used in attempts to "get in the right track". The experience of being different and not fitting in is perhaps at the core of the human experience and is a phenomenon that drills down past what Morse (2001) referred to as "the veneer of culture" (p. 721).

As an Australian RN, a clinical nurse manager, and nurse educator the researcher believes that all nurses working with student nurses from different cultural backgrounds, whether they work in the tertiary or clinical sector, should develop a deeper, clearer understanding of what it means to be Australian. By discovering and developing a deeper, or more thorough, understanding of what it means to be an Australian, then Australian nurses will be more likely to develop a greater degree of cultural sensitivity. Increasing one's cultural sensitivity can only make us more aware of the differences between our own culture and the culture of other peoples whether these other peoples be our students, colleagues, or patients.

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APPENDIX A

Example of journal notes of preconceived ideas

Take extra time

NESBs take so much more time to teach. Many of my colleagues come down and ask me to help them. They should be putting in the time themselves. None of us really have the skills to teach the NESBs English. Why were they accepted in the first place? I wonder how many hours we put in to help these students. I find my self teaching things the local students already know. Something should be done to help them. Perhaps someone should look at the curriculum. A lot of people believe that the curriculum is over stuffed but what about the lectures. They are over stuffed too. I know I teach with the NESB students in mind but it's not easy. It's really hard to meet their needs and everyone else's needs. They take extra time because firstly, you never know whether they've understood you or not. So you have to keep going over things all the time. Then, even though you think you've taught them they go out into prac and do other things. Sometimes you need to work with these students one on one. I've even found there are times when they have no idea of what I am discussing with them. That's OK in a way though but you have to teach them step-by-step. You need to start at the beginning and teach them the words and phrases. You've got to pronounce the words for them and with them. You've got to practice saying the words with them over and over. You can write the words down on paper for them. That way they've got something to take away. They've got the job of learning and remembering the words, how to say them and spell them. They also have to remember the meanings. This is part of the reason they take so much time to teach. You shouldn't assume they have the same knowledge base as the local students. Not when they don't even know the words and can't pronounce them.

Even in clinical you have to take more time with these students. You have to explain all the time you are with them. You've got to help them with most things, more than you do with the local students. You've got to start by checking out the others can understand them and if they can't you've got real problems in prac. When you do tasks with them you often find you use more physical cues with them than you do with the local students. They just don't understand what you're saying to them so you do it for them.
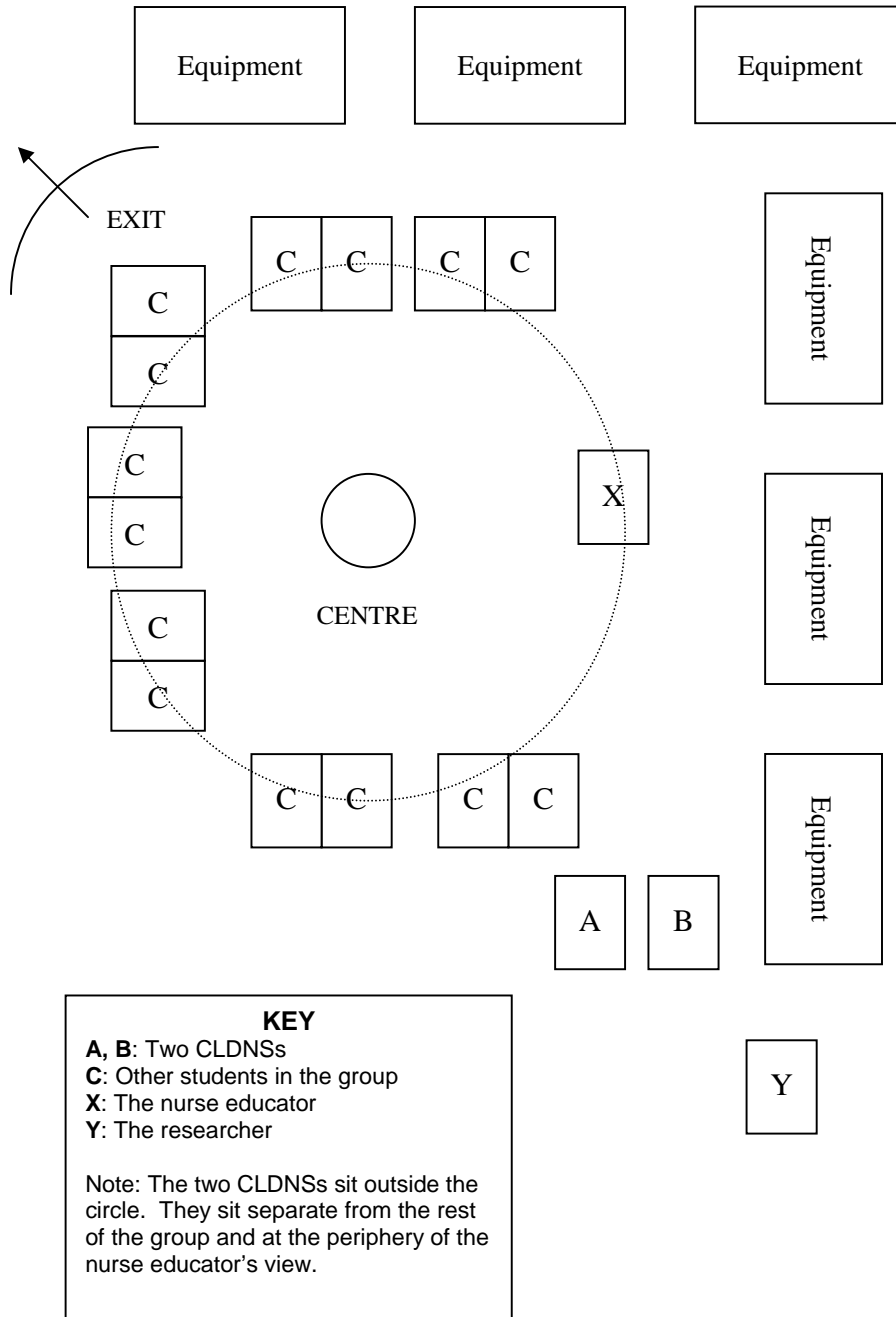
Often fail

They fail so often. There are so many reasons why they fail. They misunderstand exam questions and answer the whole question incorrectly. They spend so much time reading to understand, I feel sorry for them. You just have to watch them to see how long they spend on one multiple choice question compared to the other students. Sometimes, well often really, they don't even finish the paper. They're always the last ones in the room, usually still going even after "pens down". We make it harder for them and then we make some policy that they can't bring in their first language dictionaries. I find it hard when they fail and they come and see you and they want to go through their paper. Even then you wonder if they have understood. It's often because they don't understand what the question was actually asking.

They're usually given supplementary exams and often fail that too. In some ways I think I expect them, well some of them to fail. When I ask myself why I know it's just from my own experiences. They hate it though. And I don't get why they think they've been discriminated against when they fail. Everyone attends the same lectures, the same tutorials, they all do the same assignments and the same exams and tests. They all get the same registration at the end of their degree programs.

APPENDIX B

Example of seating arrangement sketches made during classroom field observations

KEY
A, B: Two CLDNSs
C: Other students in the group
X: The nurse educator
Y: The researcher

Note: The two CLDNSs sit outside the circle. They sit separate from the rest of the group and at the periphery of the nurse educator's view.

Consent Form (Students)

(agreement to participate in the following research study)

My name is Vickey Brown and I am currently enrolled in a postgraduate (Ph.D.) program in the School of Nursing at Curtin University of Technology, Perth, Western Australia. The study I am conducting aims to develop a theory explaining, and thereby increasing the understanding of, the process of undergraduate non-English speaking background (NESB) students' educational experiences. The knowledge gained from this study will be of significance to education from both the students and academics perspectives. The study primarily involves NESB undergraduate students. Information for the study will be collected via:

a.   audio-recorded interviews
b.   field work – observation – clinical setting
c.   field work – observation – academic setting

You are asked to participate in _____

A. Audio recorded interviews will last approximately 60 minutes. They will be conducted at a time, and in a place that suits you and me. Follow-up interviews (or a second or third interview) may be required at another time to expand or clarify details given in the first interview. It is hoped that you will also be able to take part in these interviews should the need arise. During the interviews you can decide whether or not you want to answer questions I ask you. You may also volunteer information not directly asked. You may ask me to turn the tape recorder off. Your interview will be typed out onto paper (word for word) but your name will not appear on the paper. Parts of the interview may be used in the research report but you will not be identified. All tapes will be erased following study completion. All copies of interview transcripts will be securely stored for 5 years (in line with University policies) and then shredded. Your participation is voluntary and you may withdraw at any time without any penalty. Likewise, there is no risk related to your participation; you will not be disadvantaged by declining to participate nor disadvantaged should you decide to withdraw from the study.

B. Field Work - Clinical Setting. Field Work involves a period of time, whilst you are on clinical practice, when you will be followed around by the researcher. During this time the researcher will, as unobtrusively as possible, make observations of your clinical experiences. The researcher can not grade you or help you in any way with your work.

C. Field Work - Academic Setting. Field Work involves the researcher sitting in on a minimum of two classes that you 'normally' attend. The researcher will make observations of your classroom experiences. These observations are to be made as unobtrusively as possible.

Please contact me on **9409 2015** should you have any concerns or questions regarding this study. My supervisors can also be contacted should you feel the need:

Dr. Vera Irurita 9266 2191 or 9457 2587
Dr. Angelica Orb 9266 2051

Participants statement

I, _____ (print your full name)

have read the above information related to the study of NESB undergraduate education.

I am aware of and understand the nature and intent of the study;

I know I can ask questions and I know where to direct these questions should I wish to;

I have received a copy of the consent form;

I understand that my participation is voluntary and that I may withdraw at any time without penalty.

Signed:_____ (participant)

Signed:_____ (researcher)

Date:_____