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Voices of Perseverance: A Phenomenological Exploration of the Life Histories of Female African-American Registered Nurses

by

Marva E. Brooks

Dissertation

Submitted to the College of Education

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In partial fulfillment of the requirements for the degree of

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April 28, 2016
Ypsilanti, Michigan
Dedication

To my loving and understanding husband, Robert Cornelius Brooks, III

and

My patient and understanding daughters, Sydney and Kelley Brooks

and

My supportive family and friends
Acknowledgments

First of all, I give honor, glory, and thanks to God for providing me with the wisdom, strength, and grit to undertake and complete this dissertation. It is my special, personal relationship with Him that guided me through this labor of love. My earthly thanks begin with my husband, Robert Cornelius Brooks, III, whose patience, unwavering support, technological skills, and push for my personal tenacity still resonates in my spirit; and my daughters, Sydney and Kelley Brooks, who displayed amazing grace and patience while “Mommy” was trying to accomplish this goal. I appreciate your making the ultimate sacrifice by sharing my time and attention over the past five years. I am thankful for my mother, Geneva Tanner, for interceding on my behalf with her unceasing prayers. I love you and want you to know you epitomize a praying mother, and I appreciate every prayer sent forth on my behalf. I also am thankful for my brother, Craig Spottsville, who encouraged me to stay the course on a daily basis. I love you and look forward to your daily phone calls and hope they will continue. My aunt, Annette, I thank you for the phone calls, inspirational songs, and your witty sense of humor that helped me endure those rough spots.

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appreciated. Continue to “pay it forward!”

But as you, be strong and do not give up, for your work will be rewarded.

2 Chronicles 15: 7 (NIV)
Abstract

There is a demand in the United States for a representative body of registered nurses to meet the needs of an ever-growing, aging, and increasingly diverse population. The implementation of the Affordable Care Act and the aging and retirement of the majority White nursing workforce created a need for a diverse body of competent and culturally-sensitive nurses to care for the aging baby boomers, an increasingly diverse population, and to counter healthcare disparities. Lack of diversity in nursing has been compounded by the high attrition rate of minorities in nursing education programs, particularly African Americans, the largest minority group in nursing. This qualitative study explored the lived experiences of African-American women who have become registered nurses.

Phenomenology was the primary qualitative research method used, with a focus on life histories. A purposive sample of 14 registered nurses participated in this study. The purpose of this study was to gather understanding of the participants’ lived worlds and experiences before, during, and after becoming registered nurses by examining how their childhood, K-12 education, nursing education program, and life and professional experiences influenced their journeys to become registered nurses. Participants were interviewed using open-ended, semi-structured interview methods.

Critical race theory and Black feminist thought were the conceptual frameworks used to guide this study. Analysis was grounded in the impacts of the intersection of race, class, and gender and contextualized historically by the decade participants attended nursing school. Significant themes that emerged from the participants’ narratives were violence, living in poverty, overcoming educational obstacles, paying for nursing school, grit and tenacity, lack of diversity, and support/lack of support. Findings from this study provide...
insight into the effects of educational inequity, socioeconomic status, role responsibilities, and marginalization each woman encountered on her journey to become a registered nurse. Additionally, participant grit and tenacity were highlighted as each persevered to become a registered nurse while overcoming personal, social, and structural barriers. This study aimed to illuminate the oft-absent voice of African-American women in nursing and to contribute to the discussion of strategies, policies, and practices to increase the number of African-American registered nurses.

Keywords: African American; barriers; diversity; grit; life history; nursing education; phenomenology; qualitative; registered nurses; resilience; success; support; tenacity; women
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Chapter 1: Introduction

Background and Significance

The United States (US) is facing a shortage of registered nurses (RN). The growth and aging of the US population is creating a great demand for nurses. Future employment projections show a need for more than one million new registered nurses by the year 2022 (US Department of Labor—Bureau of Labor Statistics, 2013). Recent years have revealed a growth spike in the number of RNs; however, the current upward trend in the number of persons entering the profession is not keeping pace with the demand. Although there are many factors contributing to the nursing shortage, it remains a simple case of supply and demand. This trend is being outpaced by the confluence of the aging population, retiring nursing workforce, and the number of baby boomers needing healthcare, resulting in nursing education programs (NEP) not graduating enough new nurses to keep pace with the population growth. In addition to the consistent population growth and the accompanying nursing shortage, the US is experiencing a steady growth in the minority population. With the implementation of the Affordable Care Act, the aging of the US Population, and the retirement and aging of the nursing workforce, there is a need to grow a diverse population of replacement nurses. According to the US Census Bureau (2012), minorities currently comprise 37% of the US population, with projections for future population growth showing that minorities will become the new majority by 2043. Interestingly, in the current state of NEPs, admission officials are often faced with more applicants than their programs are able to accommodate and are forced to cap enrollment due to a shortage of qualified nursing faculty to allow growth in the NEP (American Association of Colleges of Nursing [AACN], 2014; Joynt & Kimball, 2008; Klestzick, 2005; Michigan Center for Nursing, 2014). Hence, the continued shortage of nurses is expected to exist well into the 21st century.
Implicit in the need for nurses and the growth of the minority population is a demand for minority nurses to create a nursing profession more reflective of the ever-changing racial and ethnic composition of the end-users of healthcare. There is a need to recruit, retain, and graduate minorities in nursing to mitigate the nursing shortage and create a nursing profession more closely reflecting the US population. Lack of minority representation in nursing has been an ongoing historical trend. According to the AACN, “Nursing leaders recognize a strong connection between a culturally diverse nursing workforce and the ability to provide quality, culturally competent patient care” (2015a, p. 1). NEPs in the US are challenged with recruitment, retention, and graduation of minority students. The disproportionate representation of minority students in NEPs continues to contribute to a lack of diversity in the nursing profession today. This is supported by the findings of a survey conducted by the National Council of State Boards of Nursing (NCSBN) and the Forum of State Nursing Workforce Centers indicating that Caucasian nurses make up 83% of the RN workforce, while minority representation includes 6% African American, 6% Asian, and 3% Hispanic (Budden, Zhong, Moulton, & Cimiotti, 2013). Comparatively, the US census population in 2010 was composed of 72.4% Caucasian (White alone), 12.6% African American, 4.8% Asian, and 16.3% Hispanic or Latino origin or race (US Census Bureau, 2012).

As the racial makeup and expansion of the aging population in the US continues to evolve and swell, respectively, there is an increasingly proportionate need for a diverse nursing workforce (AACN, 2014; Phillips & Malone, 2014). The lack of diversity in nursing is not lost on the policymakers and governing bodies for the nursing profession. AACN (2015a) reported, “All national nursing organizations, the federal Division of Nursing,
hospital associations, nursing philanthropies, and other stakeholders within the healthcare community agree that recruitment of underrepresented groups into nursing is a priority for the nursing profession in the US” (p. 2).

Lack of diversity among healthcare providers has been shown to be a factor in the reluctance of some minorities to use the healthcare system and, subsequently, a contributing factor to ongoing healthcare disparities (Harris, 2010; Phillips & Malone, 2014). Healthcare disparities are an ongoing public health issue in the US (AACN, 2014; Institute of Medicine (IOM), 2010). There is a disproportionate incidence of disease, disability, and death among minorities, as well as an inequity in access and delivery of healthcare (Ayotte & Kressin, 2010; Bull & Miller, 2008; Einbinder & Schulman, 2000). In 2003, the groundbreaking IOM report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, revealed three main causes of healthcare disparities: lack of trust in the healthcare system, the government, and healthcare professionals. Boulware, Cooper, Ratner, LaVeist, and Powe (2003) found that African-American patients were less likely than White patients to trust a hospital. Thus, African Americans were less likely to seek healthcare or follow up with a healthcare plan. Leading healthcare organizations propose increasing the diversity of the nursing workforce as an important part of the campaign to reduce the healthcare disparity (AACN, 2014; IOM, 2010; Sullivan Commission Report, 2004). Nurses as the frontline healthcare providers are the key to combating the ongoing healthcare disparity, particularly for African-American patients. African-American patients generally hold registered nurses in high regard. According to Hine (1989),

The majority of black people perceive nurses to be the one group of health-care professionals most responsive and sympathetic to their needs. This is especially the
case among those blacks who, for reasons of racism, poverty, and powerlessness, continue to experience limited access to quality health care, and who register a higher incidence of morbidity and mortality than any other segment of the population. (p. xv)

Given the rapidly changing U.S. demography, it is “axiomatic that the majority of future health care professionals will be called upon to care for many patients with backgrounds far different from their own” (Cohen, Gabriel, & Terrell, 2002, p. 92). The ethnic and racial homogeneity of nursing remains an unspoken phenomenon that exists in silent dominance (Ackerman-Barger, 2010; Allen, 2006; Childs, Jones, Nugent, & Cook, 2004; Schroeder & DiAngelo, 2010; Wilby, 2009). Unfortunately, many nurses do not possess the cultural competence to care for an ever-growing diverse population. Cohen, Gabriel, and Terrell (2002) found that nurses are lacking “the knowledge, skills, attitudes, and behavior required of a practitioner to provide optimal health care services to persons from a wide range of cultural and ethnic backgrounds” (p. 92). Healthcare based on knowledge and sensitivity to minority cultures will contribute to a reduction in healthcare disparities (Sullivan Commission Report, 2004). With a reduction in healthcare disparities, positive collateral effects can result in a decrease in healthcare costs, increased longevity, and improvement in the general wellbeing of minorities.

The quest to improve diversity of nursing and meet the need for competent, culturally sensitive, diverse nurses is a current focus throughout the nursing profession. It is not a complicated formula; a diverse nursing workforce will be better suited to serve a diverse population. Yet there remains a scarcity of minority nursing graduates to meet the needs of an increasingly diverse population. This has been evident for quite some time. In 2001, the
National Advisory Council on Nurse Education and Practice (NACNEP) report recommended a diverse nursing workforce as an essential component to meeting the healthcare needs in the US and reducing the persistent healthcare disparities among minorities. Furthermore, “strategies directed toward attracting and retaining increasing numbers of racial/ethnic minorities into nursing are a prime consideration in the reduction of health care disparities” (NACNEP, 2001, p. 21). Yet nursing in the US remains a primarily White profession.

Underrepresentation of minority students continues to be a characteristic of NEPs today. The Annual Survey of Schools of Nursing conducted in 2012 indicated that 27% of students enrolled in basic nursing education programs identified as minority. Of this, 13% were Black (National League for Nursing, 2013). NEPs continue to face challenges in recruiting, retaining, and graduating minority students, resulting in the graduation rate of minorities from nursing programs lagging behind the demand for a diverse nursing population (National League for Nursing, 2010). Additionally, the need to attract, recruit, and retain diverse nursing students is paralleled by the need for more minority nursing faculty. The AACN survey of its member schools revealed that minorities represented 12.3% of full-time nursing school faculty (2014). NEPs are challenged to produce enough new registered nurses to meet the needs to serve the increasing growth in population, keep pace with the changing demographic, and employ strategies to promote retention and graduation of a diverse nursing workforce and faculty. A diverse nursing population and nursing faculty has been shown to have many benefits to the community, such as African-American having a willingness to serve in communities traditionally underserved and to generally be more inclusive in one’s thinking (Collins, Hughes, Doty, Ives, Edwards, & Tenney, 2002; Lillie-

These patterns continue today. AACN (2011) reported that minority students make up 26% of students in baccalaureate nursing education programs and 13% of nursing faculty. The nursing profession does not approach being reflective of the general US population, either. Minorities represent 17% of the nursing profession, with African Americans constituting 5% of the minority group (AACN, 2011). This paltry representation of minorities in nursing is a mismatch for the rapid growth of the US minority population and has significant implications for ongoing healthcare disparity. The demand for minority nurses remains a hurdle for the nursing profession and the Whiteness of nursing serves as a deterrent to many minorities seeking healthcare. The Institute of Medicine (IOM, 2010) and AACN (2011) acknowledge healthcare disparity as a public health issue in the US. The emergence of the new majority perpetuates a need for diversity among nurses to provide quality healthcare services in traditionally underserved areas of the increasingly diverse population. Disparities in healthcare exist, and diversification of healthcare providers is vital to improving the overall health and quality of services for racial and ethnic minorities (Agency for Healthcare Research and Quality, 2013).

The purpose of this dissertation is to examine the lived experiences of individual African-American RNs before, during, and after becoming RNs. This research will be contextualized in the reality of the projected need for nurses and the lack of diversity in nursing. Although the US is rapidly changing into a country with a minority majority, nursing continues to be cloaked in Whiteness. Since the 19th century, the White female nurse as the care provider has been the societal norm. African Americans have had a long struggle
to integrate nursing and gain acceptance in the profession. Until the mid-20th century, admission to most nurses’ training schools was restricted to White females. There were only a few schools of nursing in the US that would admit African-American students, and these schools were primarily located in the South. The US did not have its first official Black professional nurse until 1879, when Mary Mahoney received her nursing diploma from the New England Hospital for Women and Children Training School for Nurses. Mahoney became an exemplary professional nurse and an early advocate for equality in nursing education (Public Broadcasting Service, African American Medical Pioneers, n.d.). Although exclusionary admission practices are not officially sanctioned and practiced today, the struggle for inclusion of African Americans in nursing has continued over the years. The barriers African Americans face today are invisible and are not solely based on human capital but also on skin color. However, some African-American women have been able to overcome the associated oppressions of race, gender, and living on the margins to become RNs.

Growing the number of African-American nurses is key to increasing the diversity of the nursing workforce. First-level providers who are able to speak the language and have an awareness of religious or cultural practices and societal norms of ethnic groups can improve trust, build rapport, and expedite quality care. Exploring the personal experiences of African-American nurses can offer insight into strategies effective for successful completion and graduation from nursing education programs. Life histories are used to provide an overall picture of each participant’s lived experience. Using life histories creates a living picture of an invisible person and places the person at the heart of the story, essentially offering the participant the opportunity to describe what it is like to be “me” (Berteaux, 1981).
The African-American woman has a unique history of experiences related to the ongoing effects of social injustice, exclusion, and marginalization (Hine, 1989; 1994). The nursing education experience and the nursing profession is a smaller scale representation of American society. The African-American RN is the focus of this study because this population can offer a glimpse into the wealth of rich data pertaining to this population and the effects of the aforementioned phenomena on the opportunities afforded to these women. This study focuses on each nurse’s experience and perceptions of her early childhood and her education during her NEP and nursing career. It includes people and circumstances that have contributed to shaping her life and career. All participants matriculated through a predominantly White NEP. This study is situated in the reality of the minority nursing shortage with an emphasis on the African-American RN experience and perceptions. Ultimately, it is anticipated that this study will provide insights into long-term change in nursing education and the profession and will contribute to the development of more efficient educational processes to create a continuous stream of diverse and well-educated nurse to enhance the health of the increasingly diverse US population.

**Problem Statement**

The challenges and barriers associated with pursuing nursing education can be insurmountable for some minority nursing students, while others find a way to successfully navigate the nursing education program. Many of these minority nursing students, who are often female and low-income, can also be categorized as disadvantaged. These students could benefit from higher education to improve their life station. In the US, higher education serves as the road to a promising economic and social future. Jones-DeWeever and Gault (2006) refer to higher education “as a gateway to middle-class” for minorities and women (p. v). However, many students from disadvantaged backgrounds have restricted access and limited
success in higher education, particularly minority students living in urban areas. The US education system perpetuates forms of social domination that create oppressive conditions and social circumstances that fortify barriers to life opportunities. Students in schools are oppressed because of race, gender, class, and culture (De Lissovoy, 2008). Students from urban schools in poorer neighborhoods are often subject to inexperienced teachers, higher teacher attrition, and subpar and outdated materials and books (Barnes, Crowe, & Schaefer, 2007; Borman & Maritza Dowling, 2008). Freire’s (1970) work in Latin America is particularly relevant in the US, where class stratification has created a permanent underclass. Freire’s *Pedagogy of the Oppressed* argued against a pedagogy of exclusion and marginalization in Latin America and against conditions where the poor and disenfranchised were made invisible through lack of access to education. Freire was critical of what he described as the *banking model* of education. This model supported the teacher as the dominant figure and the students as the *bank* into which knowledge was deposited. Freire believed in situating education in the lived experiences of participants and giving voice to those who had been made voiceless by the oppressive conditions created by society. His educational model emphasized dialogue, helped students challenge domination, and encouraged people to see themselves as change agents.

Hochschild (2003) posited that students in the “worst-off” schools have a different experience than students in the “best-off” schools, with a completely different educational outcome. Low income and minority students are traditionally underprepared for college and even less prepared for the rigor of a nursing education program. These students are often faced with balancing the barriers associated with lack of finances, inadequate academic preparation, institutional and social integration, and family responsibilities. This is
particularly evident in nursing, where there is a shortage of qualified nurses and a profound lack of diversity, ultimately reflected in the disproportionate representation of African-American students in nursing education programs today. Furthermore, Hunn (2014) suggested that retention of African-American students in predominantly White nursing education programs can be adversely affected by a pedagogy lacking cultural sensitivity.

Nursing is also characterized by the dearth of minority representation among nursing faculty and administrators (AACN, 2014). The National Sample Survey of Registered Nurses (2008) indicated that a higher percentage of Blacks are more likely than Whites to pursue bachelor’s and graduate degrees. Unfortunately, this has little impact on the overall diversity of the nursing profession due to the comparatively small number of Blacks in nursing.

Significant attention has been devoted to ascertaining the barriers affecting African-American nursing student success. Yet limited attention has been given to identification of strategies employed by African-American students who complete nursing education programs and become nursing professionals.

**Purpose of the Study**

The purpose of this dissertation research study is to explore the lived experiences of African-American women who are now professional RNs. This study seeks to examine the impact of the intersection of race, gender, and class as perceived by the women before, during, and after nursing school. African-American students may hail from unique backgrounds that may restrict access and limit success in higher education. As nursing students, African-American women have faced challenges of negative stereotypes and inequitable treatment woven throughout the US educational school system (Allen, 2006; Childs et al., 2004). Evidence indicates that one of the primary factors accounting for underrepresentation of Blacks in nursing is lower overall educational attainment and lower
entry to, and successful completion of, nursing programs (Coffman, Rosenoff, & Grumbach, 2001; Grumbach & Mendoza, 2008; Xue & Brewer, 2014).

This study is significant because it features the voice of the African-American woman who is an RN. Many studies have been conducted on the underrepresentation of minority nurses or racism and discrimination in the healthcare workplace, but limited studies specifically identified the perceptions of African-American RNs’ lived experiences in their pursuit of the profession. Taylor (1998) argued that critical analysis of African-American women’s experiences should occur from the perspective of African-American women. The path of African-American nursing students is often marked with balancing the barriers associated with lack of finances, inadequate academic preparation, institutional and social integration, and family responsibilities. This research study seeks to gain a meaningful understanding of the perspective of each participant from her viewpoint as an African-American girl, nursing student, and professional RN, as she moved through the educational system and joined the professional nursing world. Additionally, this study examines retention and success strategies for African-American RNs before, during, and after nursing school by exploring each RN’s life and educational experiences across the lifespan. In this study, the life histories of African-American RNs who attended nursing school in the 70s, 80s, 90s, and 2000s are portrayed. The sharing of lived experiences through the compilation of life histories can offer other African-American girls, stakeholders, and policy- and decision-makers insights into pathways for educational achievement and professional success of future generations. Strategies employed for success can be highlighted and disseminated to nursing education programs to implement with the goal of improving access and supporting success of future female African-American nursing students.
Theoretical Frameworks

Sociological theorists have long studied factors that affect educational achievement, social status, and career choice. The educational system is credited with perpetuating the effects of oppression by the majority class. Minority students are often subjected to inadequate K-12 academic preparation due to inequity among US education systems and the commensurate opportunities, opportunities that are circumvented by some guidance counselors steering students to vocational as opposed to professional programs. Lipman (1998) further contends that schools fail to develop the potential of students of color. Subpar education predisposes minority students to being less academically prepared for post-secondary education than their majority counterparts—especially rigorous programs such as nursing education, which are grounded in math and science. The hegemonic nature of the public education system and its associated practices of bias, preconceived notions, stereotypes, racism, sexism, and classism are embedded in primary and secondary education and have also permeated post-secondary education. The critical theorist Gramsci (1971) coined the term cultural hegemony to describe how the ideas of the dominant class are wielded in such a way that they are viewed and accepted as the only logical and sensible way to see the world. Gramsci argued that the dominant class was fluid and shifted to form different alliances. Groups who try to counter the thinking of the dominant class with a different view are marginalized. Gramsci further explained that the power of cultural hegemony is its invisibility. It is not a concrete and tangible weapon like a gun or a sword, but it lies within people’s beliefs.

Bourdieu (1996) is a pioneer thinker of cultural reproduction theory. His primary assumption is that society is divided into classes, and reproduction occurs by way of symbolic violence (Bourdieu & Passeron, 1990). Symbolic violence is a term that describes
the use of power by the dominant social class. Bourdieu argued that the educational system allows the dominant social class to remain invisible in the educational system to better serve their interests. As a critical theorist, Bourdieu focused on domination through academic proficiency as the method for the dominant class to transmit its domination from one generation to the next. Students who are labeled *smart* will be funneled one direction—to become professionals and leaders—and the others will be directed toward the working class, such as vocational training or laborers.

Paulo Freire adds to the discourse on marginalization. In *Pedagogy of the Oppressed* (1970), Freire argued that dominant elites in society practice exclusion and marginalization that cause the dominated to internalize their oppression. Freire posited that society is intentional in creating conditions of oppression for some groups. Education is used as a tool of domination where teachers deposit into students what they want the students to know, in what Freire called *banking education*. However, in addition to criticism of the conventional pedagogical approaches, Freire expressed optimism about individual ability to contribute to social change and challenge the oppressive dominant pedagogy.

Nursing as a predominantly White profession with a pipeline of predominantly White nursing education programs as feeders is a reflection of hegemony. Students from diverse backgrounds are subjected to the influences of the dominant group, which creates an atmosphere of exclusion and social isolation for African-American students and registered nurses. Zou and Trueba (2002) described this as how the broad system of educational inequality uncovers the power structures and how students experience education. Negative ideas about students become naturalized, and “hegemony works both through silence and repetition” to reinforce the view of the dominant group (p. 124). They argued that students of
color are treated differently from the moment they enter the schooling system, and that is considered the norm. Scheurich (2002) added that the “dominant social construction in our society is a white racist one” that destroys the self-esteem of children of color early, dismantling any belief that they can be smart and successful (p. 51). According to Scheurich, the educational system exposes children of color to increased discipline, more special education, fewer opportunities for gifted programs, more frequent episodes of negative attention, and, conversely, less positive attention from teachers. This view of the educational system was used to frame the lived experience of schooling for the women in this study.

In this study, critical race theory (CRT) and Black feminist thought (BFT) were used as the analytical framework to examine the experiences of racism, oppression, marginalization, and the struggles of African-American females to integrate nursing and gain acceptance into the profession. The primary tenet of CRT is that racism and race are embedded in US society (Bell, 1992; Delgado & Stefancic, 2001). Inequity in education has been demonstrated by the disenfranchisement of people of color, by structures such as tracking, standardized testing, and admission requirements (Ladson-Billings & Tate, 1995). CRT explores how laws, policies, and practices perpetuate inequality among African Americans. CRT addresses the assumptions of racism as a normal part of US history and society and as inherent in a capitalistic society with a dominant group of people. It can be used as “a new analytic rubric for considering difference and inequity” and as a means to scrutinize societal structures that fortify social, political, educational, and economic inequality (Ladson-Billings & Donnor, 2005, p. 291). CRT uses counter-storytelling to give voice to the contemporary version of the sustained civil rights struggle (Jones, 2002). Bell (1992) argued that members of marginalized groups tell stories differently, and those stories
need to and deserve to be heard. However, there are many voices that go unheard because the focus is on the dominant discourse. Critical race theorists believe that societal oppression is reproduced through discrimination by the dominant culture, power, and inequity; change occurs only when there is a perceived positive outcome to the majority; any benefit to the oppressed is just coincidental (Bell, 1987; Crenshaw, 1995; Delgado, 1995; Guinier, 2004). Bell (1980) originally labeled this the “interest convergence” theory (p. 1). He explicated the legal system’s use of *Brown v. Board of Education* as a symbolic pacifier of the inequality in the education system. Although this case is paraded as a victory for the educationally oppressed, inequity has persisted in our society. Bell argued that the *Brown* case was a way for the majority to create a sympathetic image of the US during the Cold War and to maintain political capital and gain the loyalties of the Third World (Black, Brown, and Asian) people. It was in the *interest* of the majority to do something to appear to help the less fortunate.

The voices of the oppressed provide a counter-narrative to the dominant discourse. Delgado (2000) emphasized the need for such counter-narratives to provide a source for those who are marginalized and oppressed to share their stories and lived experiences and have their voices heard to challenge the majority way of thinking. The use of counter-storytelling is a method to challenge the dominant discourse and to provide a different point of view than those promoted by the majority. Counter-storytelling is a way to hear a counter-narrative in the voice of those affected and to dispel some of the preconceived notions and stereotypes cast upon those who are usually rendered voiceless (Delgado & Stefancic, 2001).

CRT in concert with Black feminist thought (BFT) was used as a contextual framework to examine oppression and marginalization of female African-American nurses. Collins’ (1990) BFT is used to clarify the viewpoints and perspectives of Black women
characterized as other in a society that assumes the White male is the norm, and anyone else is other or less than. BFT was developed by Black women for use with Black women. It has a basic assumption that Black women will share some commonalities of perceptions but also have uniqueness to their perspectives. The goal of BFT is to clarify a Black woman’s viewpoint for Black women. Black women’s experiences have been excluded or ignored, and this disregard masks the insights of Black women in contemporary society (Barbee, 1994). Additionally, BFT accounts for the way Black women resist being the other and being marginalized in a society wrought with political, social, economic, and educational systems of dominance. Collins (1990) argued that BFT is a way to explore how:

Being Black and female in the United States continues to expose African-American women to certain common experiences…similar work and family experiences…

[and] diverse expressions of African-American culture…overall, U.S. Black women as a group live in a different world from that of people who are not Black and female… [and how] for individual women, the particular experiences that accrue…can stimulate a distinctive consciousness concerning our own experiences and society overall. (pp. 23-24)

BFT can be a critical social theory for change in the societal structures of power for African-American women. It exposes the way that domination is organized and offers an interpretive framework for analyzing the lived experiences of African-American women. Alinia (2015) supported this argument as she describes BFT as “not only concerned with oppression, but equally concerned with resistance, activism and politics of empowerment” (p. 2334).
CRT and BFT provide a theoretical framework to analyze the experiences of the African-American RN population, a traditionally voiceless and oppressed population. Because of their historical position, this group of nurses can be classified as a vulnerable population. Wilson (2003) found that vulnerable populations are groups that experienced “compromised autonomy…and marginalization” (p. 61). Populations living in poverty and people of color are included in many definitions of vulnerable populations (Bailey, 2010).

The nursing literature typically defines vulnerable populations to include women, children, homeless, elderly, poor, victims of abuse, mentally ill, disabled, ethnic and racial minorities, and those marginalized because of race, gender, class, or sexual orientation (de Chesnay & Anderson, 2008; Douglas, Pierce, Rosenkoetter, Pacquiao, Callister, Hattar-Pollara, et al., 2011; Flaskerud & Winslow, 1998; Meleis & Im, 1999; Phillips, 1992; Stanhope & Lancaster, 2012; Wilson, 2003). Vulnerability lends itself to marginalization where individuals feel they must live on the edge. There is a triangulated relationship among the concepts of vulnerability, marginalization, and oppression; one is hardly present without the other. In Vulnerable Populations in the United States, Shi and Stevens (2010) offered a framework to study vulnerable populations that encapsulates the “convergence of vulnerable characteristics” (p. 3). In addition, Roberts (1983) and Wilson (2003, 2007) contended that African-American female nurses are subject to the oppression imposed by the dominant medical model in healthcare and the oppression of being a Black woman. As African-American women and RNs, these study participants can be categorized as experiencing double oppression, linked to both gender and race.

For this study, counter-storytelling methods of CRT and tenets of BFT were used to capture the lived experiences of the participants to give voice to the counter-narratives of the
dominant discourse. Using counter-storytelling refutes the racist characterizations of societal life and contests the dominant discourse (Bell, 1992; Delgado & Stefancic, 2001; Hughes-Hassell, 2013; Jones, 2002). The self-reflective life history of African-American RNs brings forth a distinct perspective to understanding the African-American RN experience through each participant’s lens. This study gives voice to this vulnerable population, those that are traditionally oppressed, voiceless, marginalized, and invisible.

**Research Questions**

This dissertation research study explores the life experiences of African-American females who have become registered nurses. This study examines their lifespans with focus on their childhood and education, nursing education program, life, and professional experience of each participant. This research is grounded in a basic understanding that nursing as a primarily White profession creates an inimitable lived experience for female African-American RNs. The primary questions guiding this study are *How do African-American girls become RNs? Why do African-American women choose nursing? How do life histories contribute to an understanding of the lived experiences of African-American female registered nurses? What is the impact of schooling on the African-American female registered nurse? What are the effects of gender, race, and poverty on the African-American RN?* These research questions embrace an explication of the lived experiences of African-American women related to educational inequity, role stratification, and marginalization as they pursue becoming registered nurses.

**Chapter Organization**

This dissertation is organized into eight chapters. Chapter 1 provides an overview of nursing and introduction to the research literature. Chapter 2 includes the literature review of relevant published research to further contextualize this dissertation research. Chapter 3
discusses the methodology used for this study. Chapters 4 and 5 include an overview of the life histories of seven RN participants, with an emphasis on themes emerging before, during, and after their nursing education program. These two chapters highlight the themes of violence, living in poverty, and overcoming educational obstacles. Analyses of themes emerging from the life history narratives of the featured study participants are included in Chapter 6. Chapter 7 features the thematic analysis of the themes: paying for nursing school; lack of diversity, with the subthemes of social isolation and perceived discrimination; support/lack of support, with the subtheme of paying it forward; and grit and tenacity. Each theme is highlighted with additional participant narrative. This dissertation concludes with Chapter 8 and the discussion of the implications of this research and recommendations for future study.
Chapter 2: Literature Review

What is a nurse? According to Merriam-Webster (n.d.), a nurse is “a person who cares for the sick or infirm; specifically: a licensed healthcare professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health.” This definition focuses on the caring aspect of being a nurse. It also refers to the requirement that a modern-day nurse must be licensed as a healthcare professional. However, nurse did not always refer to a person trained, educated, and licensed to provide care. In the US, nursing is one of the oldest known professions. Nursing came naturally to women as care providers for children, family, and the community. Early nursing included enslaved Africans who were used as nurses, root healers, and midwives. As nursing evolved, the first professional nurses were usually middle-class White women appointed within the community to provide care for the sick in the home. Women were viewed as natural caregivers based on their experience with caring for their own infants, and the common belief was that these nurturing and caring skills were easily transferrable to providing care of the sick or injured. Before the 1800s, there was little formal education or training for nurses. Early nurses acquired their skills through oral tradition, intergenerational transfer of knowledge, apprenticeship with a senior nurse, and trial and error (Egenes, 2009).

Historical Perspective

In the late 1700s, women and men served as nurses during the Revolutionary War. It was difficult to retain nurses during this time because of the low wages. Nurses were compensated poorly at a rate much less than physicians and apothecaries. A well-trained private duty nurse would be pressed to gross $600 per year (Kalisch & Kalisch, 2004). Perhaps this is due to the overwhelmingly female representation in the profession and the tendency to place less value or importance on the skilled care that was primarily provided by
women. There has been an ongoing lack of appreciation for what nurses bring to the table. Nonetheless, the nursing workforce continued to grow. The Civil War created a great need for nurses to care for the sick and wounded. In 1861, more than 20,000 nurses served to provide relief work and nursing care to the troops, including some of the African-American pioneers in nursing: Sojourner Truth, Harriett Tubman, and Susie Taylor (Davis, 2009; Joel & Kelly, 2002; University of Pennsylvania School of Nursing, n.d.). Few of these nurses had any formal education or training in nursing. There was no governing body to determine the scope of care or practice, and nurses performed a variety of tasks including wound care, cleaning, reading to patients, and preparing food. Nursing remained unregulated with no formal education programs, and quality of care delivery varied greatly. The Civil War was the impetus for large military hospitals being built, opening up opportunities for more women to serve as nurses, but nursing duties still varied greatly. New hospitals were being built in densely populated cities. These hospitals were also unregulated. Some provided high quality care, while others were mediocre at best. This awakened the need to establish training schools for nurses (Joel & Kelly, 2002; Whelan, n.d.).

There was a need for standardization and a quality-controlled approach to nursing. Driven by both the large number of people requiring nursing care and recognition of the importance of quality nursing care, nursing care moved from home-based nursing to hospitals. This was the beginning of formalized nursing education in the US. These first hospital-based nursing training programs served to meet a major demand for nurses to provide care for the many sick and wounded from the Civil War. By 1872, the first state chartered school of nursing, Women’s Hospital of Philadelphia, offered a 12-month course in nursing. Although the need for nurses was still great, not everyone interested in nursing was
allowed to pursue training in all hospitals. Admission policies to nurse training programs remained restricted by race and class. Access to these nursing training programs was not a problem if one met the criteria. However, during this time the primary criteria to enter nurse’s training included being a single, White, female, and middle-class (Gilchrist & Rector, 2007). Entrenched racism served to continue to deny Blacks access to the new schools and hospital training programs (Hine, 1989). The New England Hospital for Women and Children exemplified these exclusionary admission practices. This school’s charter, in 1872, stated it would admit only one Black and one Jew per year. Since the inception of professional nursing, the White Anglo-Saxon Protestant female has been the symbol of the professional nurse. During the days of Florence Nightingale, the prototype of a nursing student was a middle-class, single, White female. These qualifications limited the number of candidates considered for nursing education programs. Nursing did not have its first Black professional nurse until 1879, when Mary Eliza Mahoney received her nursing diploma from the New England Hospital for Women and Children (Hine, 1989; Public Broadcasting Service, n.d.). In the early 1900s, there were still very few schools of nursing that admitted Black students. Exclusionary admission to nursing education programs remained in place through the mid-20th century. Black students were relegated primarily to nursing programs located in the South. In 1925, of the 1,696 schools of nursing accredited by American Nurses’ Association (ANA) in the US, only 6% (102) schools admitted Blacks (Burnette, 2004).

Much of the literature depicting the history of nursing conveniently omits the restricted admission practices to nursing training programs, and the struggle among Black women to be included in nursing training. Blacks have had a long-term struggle to integrate
nursing and to gain acceptance into the profession and its organizations. A growing nexus of Black hospitals and nursing schools were established with the help of leaders in the Black community and private White philanthropists. These training grounds were neither regulated nor equal to those of their White counterparts. In 1886, Spelman Seminary (Spelman College) became the first two-year program for Black women, culminating in a diploma in nursing within an academic institution (Hine, 1989). Nursing education continued to evolve as training programs became education programs and were moved to institutions of higher education. However, there remained separate nursing education programs for Blacks and Whites. Separate but equal education was bolstered by the US Supreme Court decisions in *Plessy v. Ferguson* (1896) and *Cumming v. Richmond County Board of Education* (1899). These two court decisions laid the foundation for segregation of education, housing, and health care (Kouser, 1980). The segregated nursing education system remained in place until the mid-20th century.

This struggle was a reflection of a greater social issue for Blacks: exclusion. The struggle to be included in the nursing profession parallels the struggles of Blacks in American society. “The entrenched racism of late-19th century America operated to deny to the vast majority of Black women access to the new schools and hospitals responsible for training nurses” (Hine, 1989, p. xvi). Being Black, lower-income, and female created invisible barriers for many women seeking nursing training along race, class, and gender lines. The solution to the severe discrimination experienced by Black women in the North and South was for the Black community to form nursing schools in the Black hospitals and educational institutions within the community. This had been the practice for many years. Hine (1982) conducted the first historical analysis of African Americans in nursing. She
unearthed the undisclosed findings of the Rockefeller Foundation funded *Johns Report*, 1925. The purpose of this report was to survey conditions of training and employment for African-American nurses in the US. The findings of this report remained unpublished for 50 years because it “provided stark evidence of the plight of African American nurses” (p. 77). This report provided insight into the complex US racial situation and the prevailing attitude of the White nursing establishment toward Black nurses. It revealed the view of the White majority in nursing towards Black nurses as a lesser class, the White racist views of Black nurses being of lesser intelligence and moral fiber, and the limited opportunities for Blacks in nursing.

The turn of the 20th century brought more of the same for nursing. Nursing education programs, professional organizations, and military remained segregated. Although Black soldiers were fighting in the war, the Army Nurse Corps established by Congress in 1901 accepted only White nurses. The endemic racism of American society was again reflected in the nursing profession. White nursing leaders wanted nursing to remain White and lobbied for licensure of all registered nurses, veiling their desire for segregation under the guise of licensure being critical to the protection of the public. There was some truth in this argument, as very few practicing nurses had graduated from hospital nurse training schools, and there was no distinction between educated and uneducated nurses. The Nurses’ Associated Alumnae of the United States and Canada, the precursor to the American Nurses’ Association (ANA), was established in 1896 to lobby for licensure of “registered nurses” and continued to support the segregated conditions of the nursing profession and organizations by excluding Blacks from membership into the ANA. In 1903, North Carolina passed the first licensure act in the US. This was a permissive nursing licensure act, allowing nurses to use
the title “registered nurse” if one had graduated from a nursing school that met certain standards and had also passed an exam. Prior to this act, anyone could call herself a nurse. Nursing became regulated at the state level, and licensing exams were required for nurses to become registered (Joel & Kelly, 2002; Mason, Leavitt, & Chaffee, 2007). Black nursing leaders believed that these laws were being passed to continue to restrict the movement of Blacks in the nursing profession. The conditions became so intolerable for Blacks that some leaders in the Black nursing community established the National Association of Colored Graduate Nurses (NACGN) in 1908 to combat the continued racism of American society and White nurses. This organization was focused on desegregating nursing schools and organizations as well as creating access to job opportunities for Blacks (Lomax, 2012). Yet the White majority in the nursing profession continued to construct barriers for exclusion of Black nurses. Exclusionary practices based in segregation and discrimination throughout the US banned Black nurses from attending segregated schools, accessing preferred job opportunities, taking state nurse registration examinations, and holding membership in professional organizations at the state and national levels (Mason, Leavitt, & Chaffee, 2007). This hegemonic practice allowed the White majority in nursing to leverage regulations to continue to exclude Black nurses. The allegiances formed by the White majority exerted the invisible power of the dominant class to the detriment of the marginalized Black nurses (Gramsci, 1971).

Regulatory agencies did not allow Blacks to take state licensing exams after graduation, so Blacks were unable to get licensed and unable to secure the best employment. Blacks could call themselves nurses, but not “registered nurse.” However, the NACGN continued to secure small victories. In 1920, Ludie Andrews won a ten-year battle with the
Georgia State Board of Nurse Examiners so Blacks could take the state board exams, and the NACGN was eventually able to desegregate the US military nursing corps and the ANA. In 1951, the NACGN was dissolved and joined with the ANA. The ANA had agreed to allow direct membership of Blacks who had been barred from their state nurses association (University of Pennsylvania School of Nursing, n.d.). Even with the progress made during the Civil Rights Movement and court decisions such as *Brown v. Board of Education* (1954) outlawing racial segregation of public schools, the ongoing racial barriers constructed by White nurses were still evident to Black nursing leaders. Integration of the ANA had yielded mere “imperceptible improvements” for the status of Black women in the nursing profession (Hine, 1989, p. 192), so much so that the National Black Nurses’ Association (NBNA) was formed in 1971 to promote equality, representation, and professional development for Blacks in nursing and to improve the healthcare of Black people. The NBNA remains active today.

Consistent with the historical patterns of exclusion of others by the White majority, African Americans have struggled with inclusion within nursing and remain significantly underrepresented there. The history of African-American women in nursing brings forth questions related to race, class, gender, and the restrictions placed on Black women seeking upward mobility in society, in concert with acceptance into the nursing profession. Blacks in nursing faced internal and external barriers to full professional inclusion. In addition to the battle for inclusion in nursing, multiple levels of entry into nursing and the social stratification incurred by being Black and female in America; Blacks faced the foundational problem of discrimination by Whites and by middle-class Blacks in the US (Hine, 1994).

The diversification of the nursing workforce has been primarily examined in history from a White and Black perspective. However, other minority groups experienced
discrimination and exclusionary practices as well. The history of minorities in nursing in America is somewhat myopic when examining the impacts on all minority groups. The primary foci of nursing history literature are the causes of Black and White nurses. Nurses of minority groups other than Black or White are not mentioned in historical accounts until 1975, when the Hispanic Nurses Association was founded to address the needs of Hispanic nurses (National Association of Hispanic Nurses, n.d.). Hispanics are the largest and fastest growing ethnic group in the US (US Census Bureau, 2008). *Hispanic* is a label often misused to represent a race of people as well as an ethnic group. Hispanic nurses, like African Americans, are disproportionately underrepresented in healthcare. In a study of self-identified Hispanic nurses, Moceri (2014) documented that they often faced bias, felt a sense of “only-ness” and felt overlooked and undervalued (p. 19). However, all minorities have struggled for inclusion within nursing, and a lack of diversity remains an impediment to providing culturally competent care today (Smedley, Stith, & Nelson, 2003). Research primarily aggregates all minorities into one category. However, African Americans are consistently underrepresented in nursing and their obstacles and challenges are understudied and often misunderstood.

**Nursing: Whiteness and Feminization of Poverty**

Nursing today continues to exist in a state of Whiteness, and minority students continue to struggle for inclusion in nursing. Minority nursing students face barriers to higher education associated with nursing as a female profession, the effects of poverty, and the state of urban public education. Nursing has seen an increase in the number of men entering the profession, and these men are often included in the minority group numbers. Including males as minorities does not diversify the nursing profession, and the word *nurse* still conjures up an image of a White, female professional (Gilchrist & Rector, 2007). The recent influx of
men into nursing has not affected the traditional ethnic and racial diversity categorizations of nursing, nor has it had a significant impact on the heavily female presence in the profession. The Whiteness and feminization of nursing continues to exist in unspoken dominance in nursing practice and in nursing education (Allen, 2006; Childs et al., 2004; Schroeder & DiAngelo, 2010; Wilby, 2009).

The nursing profession has a paradoxical quality. Nurses are placed in high regard and even revered in some communities, yet they remain undervalued. As nursing evolved from a primarily male profession during the Revolutionary War to a primarily female profession, the power and hierarchal relationships in society between men and women, doctors and nurses, and the majority and the other continued to add to the complex gender and race relationships in nursing. The overwhelmingly female representation in the profession, the tendency to place little value on the skilled care primarily provided by women, and the lack of diversity within the profession factor into the paradox. In the mid-19th century, nursing and the nurse’s role reflected the majority family institutional model where the physician is the father (head of household), the nurse is the mother (caregiver and nurturer), and the patients are the children. Nursing care was viewed as an extension of domestic roles held by women and the associated beliefs of the nurse’s role as unskilled and of little value (Palmer, 1983; Porter, 1992).

Consistent with the historical patterns of exclusion of others by the White majority, the history of African-American women in nursing brings forth questions related to race, gender, and class. African Americans have faced a multitude of barriers to full inclusion in nursing. In addition to nursing having multiple entry points into practice, restricted admission practices to nursing education programs, and classism, Blacks also faced exclusion by Whites
because of race and middle-class Blacks because of class lines (Hine, 1994). These exclusionary practices are indicative of the oppressive relationships among Blacks and Whites, men and women, and middle-class and poverty, and they result in multifaceted oppression and marginalization (Carmichael & Hamilton, 1967; Miller, 1986).

The Whiteness and feminization of nursing existing in concert contributes to creating an exclusionary community for some students. The US Department of Health and Human Services (DHHS) (n.d.) defines a student with a disadvantaged background as a student hailing from an environment that prevents the student from “obtaining the knowledge, skill and abilities required to enroll in and graduate from nursing school” or one who “comes from a low-income family” (Paragraph 3). These are often students from urban settings and from minority backgrounds, such as the African-American female nursing student. Additionally, living in poverty predisposes women to inequality, a lack of access to education, discrimination, and barriers that prevent achievement of educational goals (Hess et al., 2015).

As a primarily female profession, a career in nursing could serve to remedy some of the impacts of the feminization of poverty for the disadvantaged African-American nursing student. Although women and children are overrepresented among the poor—particularly households headed by single mothers (Goldberg & Kremen, 1990)—higher education through a nursing degree could be a route out of poverty for some disadvantaged nursing students. A college education, such as a degree in nursing, has the potential to lessen the impacts of poverty among African-American female nursing students and break the cycle of intergenerational poverty for these women and their families (Jones-DeWeever & Gault, 2006).
The nursing profession is still not reflective of the general population today. Minorities constitute 37% of the general US population (US Census Bureau, 2012), yet the nursing workforce and faculty remains primarily White (83%; Budden et al., 2013). A substantial gap exists between the minority representation in the general public and that in nursing. According to a 2013 survey conducted by the National Council of State Boards of Nursing (NCSBN) and the Forum of State Nursing Workforce Centers, African Americans constitute only 6% of nurses. Nursing essentially remains an “ethnically homogenous” profession (Ackerman-Barger, 2010, p. 678). The homogeneity of nursing is an unspoken phenomenon that exists in silent dominance (Allen, 2006; Childs et al., 2004; Puzan, 2003; Schroeder & DiAngelo, 2010; Wilby, 2009).

Healthcare Disparity

The Whiteness of nursing is considered a factor in the reluctance of some minorities to use the healthcare system and is viewed as a contributing factor to the ongoing healthcare disparity (Boulware et al., 2003; Smedley, Stith, & Nelson, 2003). The Institute of Medicine (IOM) affirms that a healthcare workforce with the character of cultural similarity not only strengthens the patient-provider relationship for those with similar backgrounds but also better meets the healthcare needs of an increasingly diverse society (Smedley et al., 2003). Healthcare disparity is recognized as a major public health issue in the US (IOM, 2010; AACN, 2011). There is a disproportionate incidence of disease, disability, and death among minorities, as well as inequity in healthcare access and delivery. Minorities experience increased ongoing chronic and medical conditions such as diabetes, cancer, cardiovascular disease, obesity, and asthma related to this disparity (Bull & Miller, 2008). Leading healthcare organizations propose increasing the diversity of the nursing workforce as an
important part of the campaign to reduce the healthcare disparity (Sullivan Commission Report, 2004; IOM, 2010; AACN 2013). Hine (1989) proposed the following:

The majority of black people perceive nurses to be the one group of health-care professionals most responsive and sympathetic to their needs. This is especially the case among those blacks who, for reasons of racism, poverty, and powerlessness, continue to experience limited access to quality health care, and who register a higher incidence of morbidity and mortality than any other segment of the population. (p. xv)

Healthcare disparity is particularly evident in impoverished areas. Persons living in poor, urban communities are often minorities predisposed to chronic diseases and acute illnesses and are in need of quality healthcare. Yet impoverished citizens are least likely to use the healthcare system. This can be partially attributed to extreme inequality. Epstein (2003) posits that the separation of the poor and the affluent “predispose the poor to a number of social ills” (p. 1). This separation is revealing, as a solution to the healthcare disparity crisis remains at large.

**The African-American Woman and Nursing**

There is limited research focusing strictly on the African-American female nursing student or the African-American registered nurse. This group is usually presented as an aggregate with women or all minorities. African Americans are also underrepresented in the nursing workforce, composing 6% of the total nursing population (AACN, 2013). The academic success of African-American students has collateral effects on the diversity of the nursing workforce. It has impacts on admission, recruitment, and retention of African-American women in nursing. African-American nursing student retention is not a new problem. Nursing education programs (NEP) continue to face challenges in recruiting,
retaining, and graduating African-American nursing students. The national dropout rate for all nursing students in all pre-licensure programs was approximately 20% (National League for Nursing, 2010). It is difficult to pinpoint the attrition rates specific to African-American students. NEP attrition/retention data are usually reported with minorities as an aggregate, including African American, Latino, Asian, international, and male students. Existing literature suggests that minority attrition outpaced White students in NEP. Although evidence of a consistent process for calculating attrition rates specific to African-American nursing students is non-existent in the literature, previously conducted studies show an estimated overall minority attrition ranging from 15–85% (Coleman, 2008; Gardner, 2005a; Giddens, 2008; Taxis, 2006).

The challenges of African-American female nursing students can be multifold. Being African American and female presupposes this group to many life obstacles. First, women are more likely to live in poverty than men, with nearly 56 percent of people living in poverty in the US being women and girls (Hess et al., 2015). Additionally, Blacks (27%) are more than twice as likely to live in poverty as Whites (13%; Hokayem & Heggeness, 2014). Poverty rates for unmarried mothers are the highest among all women, at 46.8% (Gault, 2012). Being African American, female, lone mothers and living in poverty predisposes these students to life hardships and failure in higher education. In her landmark article on the feminization of poverty, Pearce (1978) posited that the disadvantages incurred by poor women are “exacerbated by racism and prejudice…[and] reinforced or increased by the indirect effect of being female and/or a single mother” (p. 34). Nussbaum (2000) explained this as part of her human capabilities approach to women’s rights. The human capabilities approach examines what each person is actually able to do and become, and it positions that
against opportunities afforded each person. Nussbaum argued that public policies should not disregard the gendered consequences for women who are poor and who experience both work and family discrimination within patriarchal systems, as they strip women of their human capabilities and fail to affirm the basic human needs for dignity and self-respect. Nussbaum posited that poverty and gender inequality create barriers for a woman to attain her full human capabilities. Women who have to deal with the competing demands of parenting—particularly lone parenting, low-wage jobs, and intense demands on their time with little choice and flexibility—have difficulty achieving their full human capabilities.

Higher levels of education can remedy some of these ills by positioning women to increase their earning potential and likelihood of employability (Lyter, 2002). According to an Institute of Women and Poverty Research (IWPR) wage analysis, from 1979–2008, women with education beyond high school have consistently had more earning power than women with only a high school diploma (Gault, 2012). The US Department of Labor—Bureau of Labor Statistics (2014a) data reveal that for adults over age 25, the median weekly earnings for someone with a high school diploma is $651. The median weekly earnings increase with the attainment of an associate’s degree and bachelor’s degree, to $777 and $1,108, respectively. This amounts to a work-life earning power of $1.2 million more for a person with a bachelor’s degree and $325,000 for someone with an associate’s degree. Women without some education beyond high school are predestined to be a member of the “working poor” and become a permanent member of the “Other America,” where they earn too much to be classified as poor but not enough to live a comfortable and productive life (Polakow, 2007, p. 71). A college education and a nursing degree can serve a two-fold purpose: reducing the health care disparity by diversifying the nursing workforce and
improving the life station for a historically oppressed group. Yet institutionalized barriers
disguised as policy continue to exclude some groups from successfully completing a nursing
degree.

Jeffreys’ (2012) *Nursing Undergraduate Retention and Success* (NURS) model offers
a framework for examining factors that affect undergraduate nursing student retention and
success. In this model, retention decisions are based on interaction of student characteristics:
affective, academic, environmental, integration with professionals, academic outcomes, and
external factors. Jeffreys posited that undergraduate nursing students engage in a decision-
making process with each class on whether to continue or drop out. NURS is applicable to all
nursing undergraduates; however, some factors will be more heavily weighted based on
student characteristics. Students coming into NEP with more external factors affecting their
decision-making process may find certain barriers overwhelming and be quicker to
disengage, while others may be more resilient and likely to persist.

The barriers and challenges to African-American nursing student success are well
researched. Barriers to nursing student retention and success can be divided into three
categories: institutional, academic, and social. Challenges reported by African-American
nursing students include discrimination, isolation and social adjustment, financial and
academic adjustment, and lack of academic preparation (Bellefleur, Bennett-Murray, Gulino,
Liebert, & Mirabito, 2009; Childs et al., 2004; Igbo et al., 2011). Financial problems were
identified related to the cost of nursing school and having to work while going to school
(Goff, 2011; Loftus & Duty, 2010). Nursing degrees can be cost-prohibitive for some
students. In 2010–2011, a student pursuing a four-year degree could expect to pay, on
average, $18,456, and the cost for a two-year degree was $8,909 (National Center for
Education Statistics, 2012). Although federal financial aid can be a major assistance to relieving some of the financial burden, many African-American students reported finances and the related family responsibility as an additional limiting factor (Amaro, Abriam-Yago, & Yoder, 2006; Goff, 2011; Loftus & Duty, 2010; Seago & Spetz, 2005).

Students reported feeling unprepared academically, and the strict requirements for nursing school admission were perceived as impediments. With the ACT being the institutional indicator of college readiness, the results shared in the *ACT Condition of College and Career Readiness* (2012) indicated the severe racial disparity in preparation of high school students for college, with 50% of Asian and White students meeting benchmarks in three out of four subject areas. In contrast, *none* of the benchmarks were met by at least 50% of African-American, American Indian, or Hispanic students. Nursing curriculum is laden with science, math, and technology but is typically categorized as a health science. This can be misleading to some students who may be expecting something different in their NEP. It is also a misnomer for secondary educators and counselors who generally steer students expressing interest or aptitude in science and math into a career traditionally associated with Science, Technology, Engineering, and Math (STEM). Lack of adequate preparation has been linked to student access and success in NEP. Standardized test scores, grade point average, prerequisite nursing course achievement, essays, healthcare experience, recommendations, and interviews are among the criteria commonly used to determine admission, creating a competitive admission process for the coveted nursing student slots (Bolan & Grainger, 2005; DeLima, London & Manieri, 2011; Gardner, 2005a; Murray, Merriman & Adamson, 2008; Schmidt & MacWilliams, 2011; Seago & Spetz, 2005).
Marginalization and Microaggressions

Nursing researchers have found that not all reported barriers are tangible or measurable. Several studies provided details regarding students’ feelings of social isolation, perceived discrimination, and lack of support. Unless located at a historically Black college or university (HBCU), NEPs are primarily filled with White, female students, and faculty. Generally, Black students at primarily White institutions were less successful than Black students at HBCUs. This was attributed to microaggressions experienced by Black students on White campuses as opposed to the nurturing and cultivating settings found at HBCUs (Allen, 1992; Allen, Epps, & Haniff, 1991; Fleming, 1984; Nettles, 1990). In 1969, Pierce used the term offensive mechanisms to explain subtle forms of racism experienced by people of color. Pierce (1970) revisited this concept and coined the term microaggression. Pierce, Carew, Pierce-Gonzalez, and Willis (1978) further described microaggressions as the “subtle, stunning, often automatic, and non-verbal exchanges” experienced by people of color from the dominant group that can be labeled as “put downs” (p. 66). Microaggressions occur in three forms: microassaults—explicit racial derogation; microinsult—communication that conveys rudeness and insensitivity; and microinvalidation—exclusion, negating or nullifying the thoughts, feelings, or reality of a person of color (Sue et al., 2007). Microaggressions can be conscious or unconscious and are part of the subtle everyday racism embedded in society. They are the subtle nuances that occur in the course of everyday life, such as the woman who clutches her purse as the young Black man walks by; the boss who expects the Latino employee to be a hardworking laborer; the teacher who gives the Asian student the “hard” problem to work out on the board; the admission requirements based solely on standardized test scores and GPA; the group leaders who pick the athletes of color last to be members of their workgroups but first to be members of their pickup games; or even the person who
proudly states, “I work with a lot of Black people.” Microaggressions are everywhere. Incidences of microaggression occur in everyday life and are brief, common, verbal, behavioral, or environmental. Pierce (1988) posited, whether intentional or unintentional, that microaggression “controls space, time, energy, and mobility…while producing feelings of degradation, and erosion of self-confidence and self-image” (p. 31).

Nursing is merely a small subculture of American society. Where there is hegemony in society, the same hegemony exists in nursing. Where there are microaggressions and marginalization in society, so be it in nursing. Microaggression and marginalization play out in nursing and can shape a negative campus racial climate or professional workspace. Allen and Solórzano (2001) identified various microaggressions that Black students encounter on predominantly White campuses in social and academic spaces. The message sent from microaggressions can be damaging. These messages sent by the White majority imply that students of color are unintelligent and create an atmosphere of social marginalization (Yasso, Smith, Ceja, & Solórzano, 2009). The White majority holds the leadership and dominance in nursing education programs and in the nursing profession. African-American nurses express feeling like outsiders in the workplace and nursing organizations (Hassouneh, 2008). They shared experiences of social isolation, perceived discrimination, racism, microaggressions from faculty, peers, patients, and hospital staff, and described the general environment as nonsupportive. Faculty responses to students or disregard to students were also shared. The overall perception of minority students (which included African Americans) included feelings of exclusion, bias from faculty, social isolation, and disconnectedness (Amaro et al., 2006; Coleman, 2008; Frances, Fields, & Garth, 2004; Gardner, 2005a; Mills-Wisneski, 2005; Wong, Seago, Keane & Grumbach, 2008). This is consistent with the informal theme
in nursing education and practice of nursing as an “elite sorority” where nurses are “eating their young.” The prominence of such incidents border on “bullying” and still occurs as a “common experience” in nursing education, perpetrated by Whites toward nurses of color in overt and “aversive racism” (Hall & Fields, 2012, p. 34). These reported social environment factors are counter-productive to the movement to remedy the lack of diversity in the nursing profession. Hall and Fields posited (2102) that the effects of such microaggressions are actually cumulative for the targeted person. In higher education, the impact of peers and faculty on college student success cannot be ignored (Pascarella & Terenzini, 2005).

As stated before, copious amounts of literature exist regarding barriers and challenges facing minority nursing students. However, current literature specific to African Americans in nursing is comparatively limited. In the literature available specific to African-American nursing students and nurses, there are four consistent themes that emerged. In summary, the literature consistently revealed financial problems, lack of diversity/wanting to belong, impact of faculty on student success, and the importance of support. Gaps in the literature exist regarding successful African-American female nursing students and nurses and specific strategies these women applied to become registered nurses. A recent dissertation study by Stokes (2013) added to this discussion. Stokes explored the lived experiences of 11 African-American registered nurses who attended predominantly White universities for their baccalaureate degree. Stokes’ participants revealed a variety of strengths and attributes that contributed to their success; among them were resilience, approach-and-avoidant style coping, key support people, and code-switching. An additional gap exists in the literature regarding the African-American nursing students who are not successful, what they felt prevented them from completing the NEP, and what could have been more helpful to their
success. Research in these areas can assist in determining what NEP should do and what needs to be eliminated to promote recruitment, retention, and success of African-American nursing students and nurses.
Chapter 3: Methodology

A qualitative research approach was used to explore the life experiences of African-American females who have become registered nurses. The primary qualitative research method was phenomenology, with a focus on life histories. The purpose of this study was to gather an understanding of the participants’ lives before, during, and after nursing school, by examining how their childhood and education, nursing education program, and professional experiences influenced their journeys to become registered nurses. This research is grounded in a basic understanding that nursing as a primarily White female profession creates a unique lived experience for African-American female RNs (RNs). The primary question that guided this study is How do African-American girls become RNs? This is explored by probing the following questions: Why do African-American women choose nursing? How do life histories contribute to an understanding of the lived experiences of African-American female RNs? What is the impact of schooling on the African-American female RN? What are the effects of gender, race, and poverty on the African-American female RN? These questions explicated the life experiences of African-American girls related to educational inequity, role stratification, and marginalization as they journey to become RNs.

Phenomenology

Phenomenology is the study of phenomena, perceptions, and experiences, and their meanings in a person’s lived world. Phenomenology seeks to determine how an individual experiences her life-world and tries to understand how a person forms meanings from individual experiences. Phenomenology is drawn from a first-person perspective and allowed me to describe experiences of participants in their lived worlds. Moreover, phenomenology allows the voice of the participant to be heard. It is a method to gain understanding of the human experience in their lived world from the perspective of the participant (Benner, 1994;
Husserl, 1970; Roche, 1973). Phenomenology builds a partnership between the researcher and the participant to gain in-depth understanding of individual phenomena based on rich data from the primary source: the participant. It is not simply the words a participant shares, but also “the symbols and signs in our environment that ‘speak’ to us and tell what is going on in the environment” (Munhall, 2007, p. 186). This is most often done via an in-depth interview, which is the method I used with the participants for this study.

**Existential phenomenology.** This study was grounded in existential phenomenology. Existential phenomenology focuses on concrete human existence, including individual experience of free choice or action in certain situations (Smith, 2013). It is a study of the existential world as it is lived and experienced and is sometimes referred to as ontological phenomenology or simply ontology. Ontology is the study of being or what is. Merleau-Ponty (1962), one of the classical existential phenomenologists, explained this as “the world is not what I think, but what I live through” (p. xvi-xvii). An existential approach facilitated analysis of participant experiences and gained a meaningful understanding of each participant’s world as she lived it. Existential phenomenology allowed me to unpack meaning of phenomena with each participant and to allow individual voices to be heard through the stories shared, based on how the participant experienced it.

Qualitative research is concerned with social structures, individual experiences, and the relationships existing among them, and it is augmented by immersion of the researcher. There is not a specific amount of time identified. Glesne (2011) advised that qualitative researchers should engage with participants long enough to achieve a “full description and a deep understanding” (p. 66). A phenomenological approach allowed me to explore the meanings the participants had regarding their experiences before, during, and after becoming
an RN. Consistent with existential phenomenology, this permitted me to develop a deep understanding of the participant’s context. Without contextualizing, an experience may have very little or often misinterpreted meaning. A person’s behavior has meaning when it is contextualized in their lives and includes the what, who, why, where, when, and how of the experience (Seidman, 2006). In his seminal work, Geertz (1973) argued for the use of “thick description” to determine the context of interpreted data, both verbal and non-verbal. For example, the closing and opening of an eye can be interpreted as a wink or a blink depending on context and perspective. Employing a phenomenological approach allowed me to conduct an inquiry into the personal experiences and gain understanding of the life-world of each RN and the meanings she has assigned to her experiences. Using phenomenology also created an opportunity for me to analyze the participants’ experiences in a variety of contexts from their perspectives. It allowed me to apply an interpretive approach to this study of the human condition (Schram, 2006). For this study I was able to engage with the participants and ask probing questions to facilitate responses that would provide context to their life-world.

**Embodiment.** Merleau-Ponty (1962) summarized the lived experience of individuals as how “[her] body is the vehicle of being in the world… [she is] conscious of the world through the medium of [her] body” (p. 82). This is referred to as embodiment. Embodiment is not simply a physical happening. It means that the story is rooted in everyday lived experiences and is an interactive relationship between the person and her environment (Merleau-Ponty, 1962). In existential phenomenology, embodiment is a condition where the body is the subjective source of data, but the study is about the culture and environment surrounding the experience. It is experiencing the phenomenon as lived through your own body. Embodiment allows for understanding of human behavior in the context in which it
happens. It is more than just the actions of the behavior; it also encapsulates the things, people, events, and situations that make up the environment surrounding the event. Munhall (2007) described this as finding meaning in the situated context. Phenomenology is a good fit for nursing qualitative research because it “resists homogenizing responses to experiences, categorizing individuals, and placing them in stages” (Munhall, 2007, p. 206). This approach considers the whole person, values their experiences, and holds caring as a key component in the research process (Priest, 2002). Like nursing, phenomenology is about being perceptive and understanding people by validating individual experiences. Nurses are taught to be good listeners, to establish rapport in a short period of time, and to believe what people tell them. Applying qualitative inquiry for this study allowed me to simultaneously answer questions while seeking meaning and understanding from the participants’ perspective (Geertz, 1973; Munhall, 2012).

**Epoché and intentionality of consciousness.** Husserl (1859–1938) is considered the founder of classical phenomenology. Roche (1973) described Husserl’s pure phenomenology as a method to determine “how all meanings are constituted by consciousness” (p. 16). The concept of epoché evolved from Husserl’s work. Epoché is a process of suspending judgment and deliberately setting aside preconceived ideas about participants. It involves critically reflecting on and suspending one’s own biases and assumptions to explain how a phenomenon is presented in the participant’s world (Husserl, 1970; Roche, 1973). This concept is sometimes referred to as bracketing. Context is centrally important when studying people and the meanings in their lives. Phenomenologists further explain this as the *intentionality of consciousness*, meaning researchers must have an understanding of the person’s experience related to a given phenomenon, and the ability of the mind to form
representations. Roche (1973) discussed how the researcher should seek understanding of a person’s lived experience as it happens in her natural setting and warned how when using this approach it is important to know oneself and not allow one’s own lived experiences to affect one’s approach. Efforts should be made to identify how culture, social context, and time frame in the history in which they lived play a part in their story (Campbell, 2001; Draucker, 1999).

Phenomenology is suitable for this study because it allowed me to explore the lives from the perspective of those considered disadvantaged and living on the margins in American society: African-American female nurses. The primary supposition was that these women would actually have something to say. I had to tame my subjectivity and be conscious of who I am as an African-American female RN. Shelving my own biases was central in allowing the participants’ stories to come to the forefront. Using a phenomenological approach in this study allowed me to construct each individual participant’s story about becoming an RN and what experiences along the way meant to her. I used exploration and inductive analysis to find the meaning in each woman’s story. I began with the narrative data collected in the interviews, monitored for patterns, and then progressed to forming themes. To help me organize the narratives, I created a wall-sized grid with participants along one axis and themes along the other. As I read and re-read the transcripts and wrote the life histories, I used this grid as a reference to identify patterns and page numbers of the transcript where each participant shared information on each emerging theme.

**Life History**

Life history is a qualitative method that allows exploration of the intersection of personal experiences within a societal context. Life history is derived from anthropology and
psychoanalytic case studies with the purpose of telling the story of an individual situated in her family, social, and cultural worlds: “A good life history illustrates the uniqueness, dilemmas, and complexities of a person in such a way that it causes readers to reflect upon themselves and to bring their own situations and questions to the story” (Glesne, 2011, p. 20). It is both interpretive and biographical, encapsulating experiences from birth to present with the assumptions that everyone has a starting point and family beginnings.

I used life history to chronologically tell the story of each participant’s life, to provide a sense of order. A life history approach is formulated around the idea that participants can recall their life stories and make sense of their past (Berteaux, 1981). This is accomplished primarily through interviews conducted to allow the participant to share by telling stories. In *Oral Literature in Africa*, Ruth Finnegan’s (1970a) classic study traced the history of storytelling and its value as a compelling way to understand the human condition. Life history allows for examination and exploration of actions and to gain insight and evaluate experiences and what they mean to the individual (Cole & Knowles, 2001; Locke & Lloyd-Sherlock, 2011). Using a life history approach positioned me to learn about events or experiences that one cannot see or no longer see by conducting interviews to create a life narrative from the perspective of the participant. Lewis (2008) posited that life history can assist in providing historical depth, humanize the research process, and challenge the dominant discourse by using personal narratives to counter established knowledge. However, when conducting life history research, the interviewer has to “listen carefully between the lines of what is being said” as he or she reconstructs someone’s story (Denzin & Lincoln, 2011, p. 452). Life history inquiry facilitated my ability to understand the relationship between time, place, and context of experiences in each RN’s life while gaining insight into
the complicated relationship of decisions, consequences, and rewards across her lifespan.

Josselson and Leiblich (1993) described how people are the best sources to capture their past experiences, actions, decisions, and reactions. Using life history as a method of individual life exploration also enabled me to gain understanding of an individual life in cultural, social, emotional, and intellectual contexts and how clusters of individual lives make communities (Cole & Knowles, 2001).

The strengths of life history are (a) level of depth, (b) detail and context into personal history, (c) the opportunity to challenge existing structures and agency, (d) humanization of the research process, and (e) the possibility of contradicting established knowledge and wisdoms. Finnegan (1998) described how using storytelling is a way to present events or experiences in a sequential order, featuring a life plot and moral overtones that are integral in providing a framework in life history. Olmedo (1997) found similar benefits in using oral history for research with minority women. Olmedo posited that oral history allows for exploration of the reality of minority women and the intersectionality of race, gender, and poverty and can offer insight and provide hope to others who are trying to overcome similar barriers. De Chesnay (2015) further explained that “life histories are collected to round out the perspective of culture from the point of view of members or to focus attention on aspects of living common to a group of people who share cultural experiences” (p. 1). These tenets are beneficial in telling the life stories of African-American female nurses. Finnegan (1970b) argued that shared personal recollections are the best sources in formulating a life history. A focused life history refers to the process of attentively contextualizing a participant’s experience in the multiple worlds she inhabits (Seidman, 2006).
Hagemaster (1992) was one of the first nurses to suggest using life history in nursing research because it could provide insight into health and healthcare to guide developments in future care and treatment. Life history was meaningful in this study because it allowed for an approach that is individually descriptive and personal (Benham, 1997). However, life history research is not without its limitations. It is easily influenced by the researcher’s being too close or not taming subjectivity. Life history interviewing can be further complicated by participants not telling their story chronologically and by human elements such as personal prejudice, special interests, and exaggeration. Finally, the life history method involves a large amount of work for both the researcher and the participant. Interview transcription and data analysis require a tremendous amount of time. Furthermore, the participant may not have the capacity or recall ability to share her life history (Lewis, 2008).

In this study, life history was applied to tell the story of those who have been historically oppressed or marginalized. Each participant’s story will be offered to bring attention to those not represented in the dominant majority-based society and the associated “power relations and competing truths within the wider society” (Bron & West, 2000, p. 159). I asked participants to simply tell me about themselves, including their early childhood and family, schooling, education, and experiences becoming and being a registered nurse. I used probing, open-ended questions to facilitate the participant’s telling of her story.

Pairing phenomenology and life history in tandem allowed me to explore the life-world of each participant within the paradigm of being an African-American female in a historically White female profession. For this study, I used what Seidman (2006) described as in-depth phenomenological interviewing. This interviewing approach combines components of life history interviewing and assumptions based in the focused interviewing
generally associated with phenomenology. Seidman suggested that this interviewing approach can be applied to almost any issue involving the experience of people. These two research modes assisted me in gaining understanding of how each participant came to be an RN and what inspired, facilitated, or interfered at different times in her life juxtaposed on the intersection of race, gender, and class as she became an RN. In this study of African-American female RNs, a qualitative research approach was useful in determining meaning and amplifying the voices of a traditionally marginalized and oppressed population (Glesne, 2011).

**Subjectivity and Positionality**

It is critical in qualitative research for the researcher to convey the participant’s story as clearly as possible. Qualitative methods work through the researcher and require active self-discipline on his or her behalf. As the researcher, I must become the teller of someone else’s story. This was a very challenging part of the investigative process, as I was the instrument for this study, and the human element of being the instrument is not without its complexities. As humans we come with certain experiences, values, and beliefs that shape our subjectivity. Peshkin (1988) described our subjectivity as “a garment that cannot be removed” (p. 17). Hence, our subjectivity is always with us. As the researcher/instrument, it is imperative to employ a disciplined subjectivity in qualitative research and to remain critically reflexive of the roles one has and the recognition of self in a particular situation. Glesne (2011) explained this as “how researcher, research participants, setting, [and] research procedures interact and influence each other” (p. 151).

I am keenly aware of my positionality regarding the shortage of African-American female nurses in the profession. I have witnessed firsthand the role of African-American RNs from the perspective of a student, staff nurse, manager, and educator. It was critical that I
maintain my level of interest and fervor for this research but not allow that to jade my ability to suspend or tame my subjectivity to conduct research. I am committed to bringing the voice of the African-American female registered nurse to the forefront. I am equally committed to seeking remedies to the shortage of African-American female RNs by sharing stories and strategies that have helped and hindered current African-American female RNs with future RNs and decision-makers in professional nursing. I have experienced and witnessed how African-American female RNs, as members of a traditionally oppressed and underserved population, are subjected to stereotypes, preconceived notions, judgments, and perceptions based simply on the color of their skin. I have been that student who is surprisingly “articulate.” I have been that RN whose opinion was dismissed. Knowing this, I had to employ disciplined subjectivity to suspend my judgment and allow the data to speak to me and not be influenced by my own viewpoint. As the researcher, it was my role to gather and analyze data and construct meanings of the participants’ experiences with care not to insert myself into their stories. I had to employ self-reflection to maintain awareness of my positionality and discipline to keep my subjectivity tamed, in order to allow the participant’s viewpoint to be illuminated (Peshkin, 1988). Reflecting on my positionality allowed me to approach the data collection process “with the mind as a ‘clean slate’ and not convey [my] own perspectives on the issues into which [I] inquire” (Glesne, 2006, p. 140). More importantly, I had to shelve my opinions, perceptions, and personal bias.

Disciplined subjectivity is critical to qualitative research, as untamed subjectivity mutes the emic voice, understanding the meaning for the participant. By suspending my knowledge and values and listening to each participant tell her story, I was able to avoid becoming the mute button and silencing the participant’s voice. I found this to be the most
challenging part of this phenomenological research study. I had to use a strong reflexive approach to suspend my preconceptions and distance myself from the experiences. I had to acknowledge and understand my personal experiences to gain a deeper understanding of my own assumptions, preconceptions, and presuppositions so that I could tell someone else’s story; it was important that I remain in the background. As the researcher, I strove to reveal the emic meaning for each participant while disciplining my own subjectivity. The tricky part of bracketing is controlling my positionality to prevent interference with the participant’s story coming to light. This was an ongoing process requiring attention before, during, and after data collection, and as I was analyzing and interpreting data (Peshkin, 2000). During the interview processes, there were times when some participants unwittingly tried to draw me into their stories. I had to make a conscious effort to redirect her comments and refocus the story back to the participant. To accomplish this, I would rephrase the initial probing question, strategically restate her statement to her, or simply remain silent to allow her to continue. Finally, with some of the sensitive, alarming, and emotional nature of the lived experiences of the participants, there were times I needed a place to personally debrief. The colleagues on my dissertation committee were valuable assets in helping me to manage my subjectivity and positionality. I used them as an additional source of support and sounding board during the research process. In addition to my research diary, I was able to share with committee members my feelings and reactions to the unexpected findings of the participants’ stories. This allowed me to have an additional repository for my feelings, reactions, and assumptions and to continue to approach the study participants and their stories with my mind clear and ready to receive their perspective.
Clearly, I would not conduct a research study on a topic that is not of interest to me. I concur with Henry (1995) as she argued, “I am concerned about the ways in which educational research excludes and [misinterprets] the subjectivities of black women and girls” (p. 280). That same level of concern and interest can also be a catalyst for blurring the lines of my story and each participant’s story. As an African-American female registered nurse who attended a primarily White nursing education program, I surely have my own meanings constructed from my experiences. I also brought the varied experiences of many roles to the table when conducting this research. Professionally, I have practiced in both hospital and academic settings. I have had my own network of experiences and have witnessed firsthand the disparity and inequality offered to African-American women in nursing. Additionally, during my own nursing school experience, I had to face challenges that my non-minority counterparts did not. I have felt the prejudgment and need to prove myself worthy of being in a nursing education program. My research was also influenced by my childhood as an underserved youth subject to subpar public education, forced integration, and being raised in a low-income, single-parent household. Although she was not a college graduate, my mother instilled in me the value of education and the doors that can be opened with education. Not going to college was never an option for my brother and me. Finally, on a personal level, as a mother of two African-American girls, I have seen the effects that teachers can have on the educational development of this population. I have watched as my daughters and other children of color are often assumed to be less capable than their White counterparts and are unfairly cast with labels that follow them through the educational process before they have an opportunity to perform. These personal experiences and
observations sparked my interest in this topic but also have the potential to affect my ability to feature the participants’ story and need to be constrained as I proceeded with this study.

**Field Notes and Research Diary**

The amount of data in qualitative research can be overwhelming. Tracking multiple interviews with participants, phone calls, and general logistics surrounding participant interactions can produce large volumes of information and should not be left to memory. I kept a field notes journal to track and document details of interaction with participants. The journal provided a place to keep a record of my work in the field and created a historical timeline for this research (Munhall, 2012). Hence, I recognized the critical value of keeping comprehensive field notes and used them to capture components and compared what was being said with what I saw.

I also kept a separate research diary. Implementing a research diary is a recommended methodological qualitative approach to assist the researcher in critically reflecting on one’s assumptions (Behar, 1996). The research diary can assist with bracketing by creating a space for the researcher to write down assumptions, feelings, and other reactions (Wojnar & Swanson, 2007). To assist me in remaining critically reflexive, I implemented use of my personal research diary to provide me with a method to share and document my feelings and thoughts. I also used this diary to document questions to ask myself, as well as meetings and phone calls with my dissertation committee as I progressed through the study. I found that this approach helped me to remain conscious of my own subjectivity. Taming my subjectivity allowed me to preserve the essence of the meaning through the participants’ data throughout the research process. This allows for the participant experiences to remain their experiences and the researcher to elicit the meaning she attached to it. Holloway (2009) referred to this as “experience-near.” Behar (1996) suggested that keeping a research diary
serves this very purpose: to help the researcher document her thoughts, feelings, and assumptions that may correspond to her own personal experiences so the participants’ voice can be illuminated. My research diary provided me a place to process through my own stuff and allowed me to be truthful with myself about what I was thinking and feeling and how it may relate to the research study. As I was conducting this research, I had to pay special attention to my personal feelings and emotions. Kleinman and Copp (1993) explained that “ignoring or suppressing feelings are emotion work strategies that divert our attention from the cues that ultimately help us understand those we study” (p. 33). I had to create a balance between inquiry and personal curiosity to some of the participants’ life experiences, particularly when I wondered what I would have done in a situation. Documenting in my research diary helped me to tame my subjectivity. A research diary is recognized as an essential component of a qualitative research process and is imperative in trying to maintain disciplined subjectivity. The research diary is a place for notes that are autobiographical in nature. It serves as a repository for by behaviors, reactions, and emotions experienced throughout the research process (Glesne, 2011). This was particularly helpful when I felt close to a subject being discussed; regardless of the feelings the subject evoked in me, I was able to use the research diary to work through it, remain in the background, and allow the participant’s story to come forth (Behar 1996; Glesne, 2011).

**Trustworthiness and Authenticity**

The premise of qualitative research is the idea that there are multiple truths. Within the qualitative paradigm, the researcher concentrates on interpreting the data presented, as opposed to the quantitative method of establishing validity and reliability. I used several procedures to solidify the value of phenomenology and life stories and applied these procedures to contribute to the trustworthiness and authenticity of this study. These strategies
served to make sense of personal stories and the ways in which they intersect and are woven throughout the research process (Glesne & Peshkin, 1992). For this study I aligned my processes with some of the strategies outlined by Creswell and Miller (2000) for substantiating trustworthiness and authenticity: prolonged engagement, triangulation, peer review or debriefing, negative case analysis, clarifying research bias, member checking, and use of thick descriptions.

**Establishing rapport.** First, prolonged engagement provided me and the participant with the opportunity to establish rapport and gain the best understanding of the participant’s context. Rapport development with study participants is critical in qualitative research; it is the foundation of building a relationship (Glesne, 2006). I found establishing rapport was done with relative ease. This can probably be credited to the fact that I knew some of the participants prior to the study, and that we shared similar qualities of race and gender. Cole (1986) asserted that similar characteristics bind women together, thus forming an allegiance and a willingness to participate freely. Shared characteristics gave me what is often referred to as an insider perspective (Gibson & Abrams, 2003). An insider may be more easily welcomed into a homogeneous participant group. Porter and Villarruel (1993) argued that “shared group membership of research team members and subjects has been described as facilitating disclosure of sensitive topics” while also minimizing the problems associated with race and language (p. 64). Thus, my being female and African American could be considered a contributing factor to the ease in establishing rapport.

Establishing rapport was not a simple process, as the participants had varying levels of familiarity with me. Some participants were unknown to me, while others were distant colleagues or had been a part of my pilot study, *Lived Experiences of African American RNs*
(Brooks, 2012). Although there were some I had never met before, all participants were ready to share their stories with me. I had to strike a delicate balance with the participants who were familiar to me. In some instances, familiarity breeds ease of rapport, and in other circumstances it can complicate matters. I was attentive to quickly decreasing the relational space and moving into what Buber (1970) coined an “I-Thou” relationship with each participant. An “I-Thou” relationship acknowledges a living relationship where the human relationship is foremost (Buber, 1970). Seidman (2006) described interviewing as a type of “I-Thou” relationship. I was particularly attentive to perpetuating “I-Thou” orientation for the interviews. It took care not to allow that orientation slip into a “We” relationship, where the “interviewer would become an equal participant, and the resulting discourse would be a conversation, not an interview” (p. 96). I worked diligently to keep enough distance and to assure each participant that every story was an important contribution to her life story and to the overall quality of the research study. I encouraged and allowed her to tell the story and perhaps even retell a story she thought I might already know.

**Triangulation, member checking, and peer debriefing.** Prolonged engagement allowed me to build trust and offered me the opportunity to clarify and avoid misinformation. Member checking was applied to confirm the authenticity of my findings and for clarifications to be made. I would follow up with individual participants to ensure the meaning I found was as she had intended, to expand on details of her story, or to seek clarification of certain narrative. Peer debriefing was used to enhance credibility and validity of findings. I worked together with committee members in groups and individual sessions to examine transcripts. Transcripts were reviewed with dissertation committee members for clarification and confirmation of thematic coding as part of the data analysis process.
Triangulation was used as additional confirmation in seeking to understand and support my findings. I gathered data via multiple methods and sources to substantiate my arguments. According to Glesne (2011), effective triangulation requires the researcher to use multiple sources, such as interviews, documentation, and artifacts to better understand the perspective of the participant. I also used my dissertation committee members to provide a check of the research process and examine my methods, meanings, and interpretations throughout the process. These strategies were implemented to enhance the credibility and trustworthiness of this dissertation research study.

**Consensual Validation, Structural Corroboration, and Referential Adequacy**

Each of the triangulation strategies contributed to establishing consensual validation, structural corroboration, and referential adequacy. Eisner (1991) identified three vital components of qualitative research essential to establishing trustworthiness and authenticity. These practices make up the summative backbone of qualitative research. Applying these components helped me to achieve my ultimate goal as a qualitative researcher to “seek a confluence of evidence that breeds credibility, that allows [me] to feel confident about [my] observations, interpretations, and conclusions” (p. 110).

**Consensual validation and thick descriptions.** Thick descriptions and narratives were added to establish consensual validation. Rich, thick descriptions provide full descriptive details of the participant and the setting so as to paint a picture for the reader. Qualitative research seeks to explain how a simple nonverbal gesture like winking, pointing a finger, or raising a hand can mean many different things depending on context. In qualitative research, actions cannot be described in purely physical terms. Geertz (1973) used the term *thick descriptions* to describe how providing rich details of observations can provide contextual details. I used rich, thick descriptions as an important part of establishing
authenticity of my qualitative research findings. Thick descriptions include the narrative from the participant and a full description of the environment, setting, and nonverbal cues offered by the participant. Thick description is rich in describing what is seen, what is heard, and context by using words and pictures. Geertz further explained this as how “small facts speak to large issues” (p. 23). Field notes helped me to coordinate what I heard the participant say with her nonverbal behavior and surroundings. Using thick descriptions helped to solidify consensual validation and promote intersubjectivity, the moment the reader can relate to the participant’s perspective and see oneself in the story and find agreement with the themes through the carefully selected narrative.

**Structural corroboration and referential adequacy.** Structural corroboration is heavily dependent on triangulation, the use of multiple methods to authenticate and elucidate the participant’s perspective—in other words, how I put together the overall product so the reader can understand the participant’s story. I used various data sources to establish structural corroboration. Artifacts such as transcripts, diplomas, photos, and online licensing databases were used to substantiate facts and build the stories. Last, I established referential adequacy by using multiple outside references and literature to support or corroborate findings. The references are used to answer the question “What do others say about what I am saying?”

**Study Population, Sample, and Sampling Techniques**

I collected data via initial interviews from 18 African-American female RNs; of those, 14 were included in this study. All interviews were conducted in Michigan. Each participant met the following inclusion criteria:

- African American
- Female
Current licensed to practice as an RN or retired from nursing
Attended a primarily White nursing education program
Living in the US

While the participants in this study were all African-American females, during the course of interviewing I discovered that the participants used a variety of terms to describe their race/ethnicity. Participants alternated between using terms such as Black, Afro-American, and African American as race/ethnic descriptors. In this study, African American and Black will be used interchangeably to refer to race/ethnicity.

**Study participants.** The 14 participants included in this study ranged in age from 29–67. Of the 14 participants, two had a nursing diploma, six had an associate’s degree, and six had a bachelor’s degree for their first nursing degree. Today, five have a master’s degree, one participant has two master’s degrees, three are currently working on a master’s degree, one has a PhD, and one is working toward her PhD. There was a wide variance in experience of the participants, ranging from a new graduate with no experience to a retiree from a long nursing career. Participants’ RN license status was confirmed via the online license look-up process for the State of Michigan. All actively practicing RN licenses were current, and none of the participants had any citations on their RN license listed; one of the participants included in this study was retired. This sample was collected via purposive sampling. A recruitment flyer (Appendix A) was distributed to the Chi Eta Phi Sorority, Inc. Midwestern Region members via its database. Participants were also sought using informal networking, personal contact, word of mouth, and snowball sampling. The characteristics of the study participants are presented in aggregate form in Table 1.
Table 1

*Participant Characteristics (N = 14)*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [Mean yrs (SD)]</td>
<td>43.1 (11.07)</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>21.4</td>
<td>3</td>
</tr>
<tr>
<td>In a relationship</td>
<td>21.4</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>42.8</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Socioeconomic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public assistance in family of origin</td>
<td>64</td>
<td>9</td>
</tr>
<tr>
<td>Employed during nursing school</td>
<td>86</td>
<td>12</td>
</tr>
<tr>
<td>Current income level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $25K</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td>$50K–$100K</td>
<td>42.8</td>
<td>6</td>
</tr>
<tr>
<td>More than $100K</td>
<td>42.8</td>
<td>6</td>
</tr>
<tr>
<td><strong>Educational obstacles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed Nurse Entrance Test</td>
<td>7.1</td>
<td>1</td>
</tr>
<tr>
<td>Failed nursing course</td>
<td>35.7</td>
<td>5</td>
</tr>
<tr>
<td>Failed NCLEX-RN</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td><strong>First nursing degree / Highest nursing degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>14.3/7.1</td>
<td>2/1</td>
</tr>
<tr>
<td>Associate’s</td>
<td>42.8/7.1</td>
<td>6/1</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>42.8/35.7</td>
<td>6/5</td>
</tr>
<tr>
<td>Master’s</td>
<td>NA/42.8</td>
<td>NA/6</td>
</tr>
<tr>
<td>PhD</td>
<td>NA/7.1</td>
<td>NA/1</td>
</tr>
<tr>
<td>First nursing degree grade point average &lt; 3.0</td>
<td>28.6</td>
<td>4</td>
</tr>
<tr>
<td><strong>Father’s education level (n = 13)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>7.1</td>
<td>1</td>
</tr>
<tr>
<td>High school graduate</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td>Some college</td>
<td>28.6</td>
<td>4</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>21.4</td>
<td>3</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>7.1</td>
<td>1</td>
</tr>
<tr>
<td>Master’s degree or higher</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Mother’s education level (n = 14)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High school graduate</td>
<td>35</td>
<td>5</td>
</tr>
<tr>
<td>Some college</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>7.1</td>
<td>1</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Master’s degree or higher</td>
<td>21</td>
<td>3</td>
</tr>
</tbody>
</table>
Sample size and saturation. The final sample size was driven by sample saturation. Munhall (2012) has supported this approach, stating, “Data saturation determines sample size” (p. 544). The application of the concept of saturation is debatable when used in life history and phenomenology research, as these methods center on the uniqueness of each individual’s lived experience intermingled with emerging patterns and themes and not on saturation. Munhall (2007) posited that two types of saturation exist: saturation based on sampling until no new information is revealed and saturation where the investigator is examining specific incidents related to a phenomenon of analysis. In the second type of saturation, sampling could go on infinitely. Munhall emphasized that data analysis is ongoing and researchers should note where “thin” data exists and continue “sampling for saturation” (p. 536). Saturation remains an ongoing discourse in qualitative methodologies. I approached this study aware of the concept of saturation, yet recognizing the value and uniqueness of each individual’s life history. I actually interviewed 18 participants but found, after collecting data from 18 cases, that there was no additional data revealed in the four cases excluded from this study. I was deliberate in sampling to ensure that the experience groups I am interested in (i.e., graduates from 60s–70s, 80s–90s, and those graduating since 2000) are represented by more than just one participant. For this study, two graduates from 60s–70s, five from 80s–90s, and seven from 2000 onward are included.

Measures to Ensure Safety, Confidentiality, and Anonymity for Human Subjects

Informed consent. Each participant in this research study completed the process of informed consent. The informed consent (Appendix B) for this study was submitted and granted approval from the Eastern Michigan University Human Subjects Review Committee (UHSRC) as part of the complete research application. The informed consent included a scripted explanation of the purpose of this research study in clear terms, which I read to each
participant. Participants were then given the opportunity to read the procedure for the study on the informed consent, and I reiterated the instructions orally. Inclusion criteria for the study were clearly identified on the consent form, as well as the requirements for each participant, the process for the study, and the duration of her involvement in the study. A copy of the informed consent was given to each participant. The supporting documents are included in the appendices. The UHSRC Approval Letter with a date stamp is included in Appendix C.

**Confidentiality.** Participant confidentiality is integral to research with human subjects. Confidentiality of data and protection of the identity of the participants were maintained by use of a mutually agreed-upon pseudonym for each participant. The participants were shown a list of names of former and current First Ladies of the United States and were allowed to select the name that she wanted to use. This was easier for some than others. Several participants wanted to make sure they chose a name that represented who they were without giving hint to her identity. Additionally, each participant was assigned a participant number to be used with the demographic data information sheet. The results of the interviews were stored separately from the informed consents and the code key linking the participants to their participant numbers. The participant’s given name and the interview data were never associated. The chosen pseudonym was used for all study materials. Informed consents were kept in a locked file cabinet; all electronic data were stored on a password-protected laptop, and study results were presented without individual identifying information. During the process of completing this dissertation, components were disseminated to committee members for the purposes of fulfilling the doctoral degree
requirements. Participants were also informed that anonymous results of this study may, in the future, be shared at conferences or published in journals.

**Safety, risks, and benefits.** This research study had no foreseeable associated risks. No harm came to the participants as a result of this study. However, some of the participants did experience personal distress when drawing on personal lived experiences that evoked an emotional response. I worked to remain sensitive to their feelings and allow time for processing of emotions throughout the research process. I was cognizant of the fact that my research outcomes were a subplot to their wellbeing. There was no direct benefit for participating in this research study. Participants were not compensated, but study participation will contribute to the body of knowledge regarding African-American women in nursing. Participation in this study was strictly voluntary. Several of the participants expressed how they were glad to share their story, as it may inspire someone else. Participants were aware they could withdraw from this study at any time without explanation or any negative consequences. I had no one express desire to withdraw from participating in this study. As a matter of fact, most were eager to participate in hopes of contributing to the greater body of research regarding African-American RNs. This fit well with my goal of generating emic knowledge about African-American RNs while developing theories and practices that directly address the gaps in the nursing research specific to African-American RNs.

**Data Gathering**

**Interviewing for data collection.** One-on-one interviews were the primary method of data collection I used for this study. I conducted in-depth interviews with 18 African-American female RN participants in southeast Michigan. Most interviews were face-to-face; three follow-up interviews were conducted by phone: one with Thelma and two with Julia.
Open-ended and semi-structured interviews were employed to collect narrative data. My approach to interviewing the participants was framed by Seidman’s (2006) three-step interview process, which includes a step-wise process of first obtaining a life history, followed by an investigation of each participant’s experiences, and then allowing the participant to reflect upon meaning. For most of the participants, I was able to encapsulate this process within two interviews, with the first being a longer, open-ended interview focused on gathering the details of her life history and experiences, and subsequent interviews being semi-structured to allow the participant to reflect on how she understands her own experiences and the meaning she placed on them. The goal was to capture lived experiences during three distinct time frames in the participant’s life: childhood education and experiences, nursing education program, and nursing professional career. According to Seidman, this approach to interviewing facilitates exploration of the participants’ life experiences and personal perceptions, and, more importantly, the “meaning they make from that experience” (p. 9).

The interviews were conducted in a variety of locations convenient to the participant. Some participants were interviewed in their homes, others at the library, coffee shops, at their workplace, or in my office. Interviewing took place between October and November 2012 and from November 2014 to February 2015. For this study, a total of 37 interviews were conducted. Eighteen were initial, open-ended interviews that were at least one hour in length. The follow-up semi-structured interviews ranged from 30–90 minutes. With the advent of technology and smartphones, participants also offered supplemental narrative to the interviews via voicemail or text message. Texting in particular proved an effective method
for some participants to share stories and to add details or clarification of interview concepts at their convenience.

Interview questions were linked to the exploration of distinctive time periods of childhood, nursing education, and professional career for each participant. A sample of interview questions reflecting on a participant’s childhood included “What was your childhood schooling like?” and “Tell me about your background.” As I delved into each participant’s nursing education experience, sample questions stemmed from questions such as “Why did you decide to become a registered nurse?” and “Share with me your experience during nursing school.” Finally, for gathering insight into each participant’s professional experiences I used questions like “What type of work experience(s) have you had?” and “How do you define success?” These are sample questions reflective of the initial open-ended interviews conducted. Appendix D highlights the general narrative script that I used to engage the interview process.

**Researcher as the instrument.** I served as the primary instrument in this study. In-depth interviewing allowed me to explore and elicit stories as opposed to simply having participants answer questions. I found that the three-interview format of Seidman (2006) was rather prescriptive and not always practical or necessary to capture the participant’s story. I also discovered that clear demarcation of topics during each interview was not always appropriate. I had to allow the participant to tell her story when the story came to her and not during a scheduled interview topic time. There was some natural overlap in each interview based on the flow of the conversation; thus interviews were not mutually exclusive. Overlapping of life time frames occurred naturally and could not be strictly serialized as in Seidman’s three-interview approach. My role as the instrument was to be aware of some of
these constraints and be adaptable and flexible during interviewing and respond to these situations with skill, tact, and understanding (Munhall, 2012). Interviews were used to identify and analyze nodal moments across the lifespan to gather understanding of life decisions, influences, and choices made and the impacts on her life. This approach permitted me to “explore a person’s microhistorical (individual) experiences within a macrohistorical (history of time) framework” (Hagemaster, 1992, p. 1122). Additional data were gathered via a standard demographic data form (Appendix E). Each participant completed a demographic data form with basic demographic information before the start of the initial interview.

All scheduled interviews were audiotaped and transcribed verbatim. A backup recording device was maintained to address unexpected failure of audio-recording equipment. There were a few instances where participants reached out to me via unsolicited phone calls to add to their stories as they remembered them. Interviews conducted via impromptu phone calls from the participants were not recorded. I welcomed these phone calls and took copious notes to assure authenticity and accuracy of what the participant was trying to relay. Additionally, audio-recording of the scheduled interviews was augmented with note-taking via interview notes and compilation of a research diary. My research diary and notes were kept as separate documents because I wanted to be intentional in differentiation of descriptions associated with notes and the personal entries regarding my responses and thoughts that arose throughout the research process. It provided me a place for my personal impressions, thoughts, insights, and potential theme development. The research diary served as a place for me to write my own feelings and self-monitor regarding this topic, which I am so passionate about, and helped me to tame my subjectivity. It was different from
my interview notes because the research diary is about me, and interview notes are about the participants.

**Transcribing and coding.** Interviews were transcribed verbatim by me and another trusted transcriptionist. I read and reread transcribed interviews and compared the transcripts to the audiotape for accuracy with the intent of identifying significant statements and phrases. I then converted transcribed interviews into interpretive summaries and analyzed them using the process of thematic coding to organize data according to the emerging patterns. I sought confirmation and clarification as needed, either by returning to the original audio-recording transcript or directly to the participant as necessary. Thematic coding of emerging patterns was augmented by a color-coding process. This allowed me to compare and contrast narratives and develop clusters of formulated meanings, categories, patterns, and themes. According to Glesne (2006), coding is an effective way to organize data and formulate emerging patterns into themes. I conducted the primary coding of data and it was corroborated by dissertation committee members. Participants were clustered in several different manners before settling on the presentation in this dissertation.

**Data Analysis**

Colaizzi’s (1978) method of rigorous analysis was used as a general guide to the analysis of data. This method is suited for phenomenology. Developed by Colaizzi and later by Diekelmann, Allen, and Tanner (1989), this analysis involves a step-by-step process of analyzing narrative text in phenomenology. This process involves seven steps and can be summarized as 1) reading the interviews, 2) writing interpretive summaries and coding for emerging themes, 3) identifying themes, 4) clarifying interpretation by returning to the text or participant, 5) comparing and contrasting narratives to identify shared practices and commonality among meanings, 6) identifying patterns, and 7) eliciting responses and
feedback from the interpretive team (dissertation committee). Benner (1994) further collapsed these steps for analysis into three basic steps: 1) isolating paradigm cases, 2) identifying repetitious themes for within and between cases, and 3) selecting exemplary quotes to illustrate themes. I employed a combination of these two processes to identify the participants’ meaning by combining narrative and other participant-generated data, data from other relevant sources, and my understanding of the phenomena.

**Limitations/delimitations of the study.** One limitation of this study was the participant’s ability to recall historical events. Varying amounts of time had elapsed since participants had completed nursing school, and the time lapse and memory decay affected the ability of individual recollections. Unexpectedly, the variance of time since program completion also added value to the study as personal experiences were aligned with specific time frames in society and history, and themes were revealed to persist across generations of RNs. However, those raised during the Jim Crow era seemed to have more tolerance for marginalization than those raised in more recent years. Hence, there was a different interpretation of microaggressions among these age groups. I was also concerned that participants might exclude stories or events they deemed were not *important* enough to be told. I had to reassure some that every story was *important* and to share even those they felt were not valuable.

**Conclusion**

This chapter described the process of the qualitative research methods of life history and phenomenology used in this study to explore the lived experiences of African-American women who are registered nurses. Qualitative research allows the investigator to see the world through the participant’s eyes and to gain understanding of the person or group being studied. Performing the role of both the researcher *and* the instrument is complicated. Using
a research diary gave me a repository for my thoughts, feelings, and notions. It allowed me to self-monitor and suspend judgment to allow the participant’s viewpoint to come through. Interviewing as the primary data collection method provided me with a rich data set. Colaizzi’s (1978) process for analysis served as a framework to extract, organize, and analyze the narrative data. Combining life history and phenomenology afforded me a methodological approach that was applicable to understanding the stories of African-American RNs. Life history was an appropriate research approach for this study because it “generates rich data that tell the story of individuals who might be ordinary in their lives but extraordinary in what they have to teach us about the culture in which they live” (de Chesnay, 2015, p. 5). Coupling the two qualitative research approaches offers nurse scholars an approach to inquiry that is an appropriate fit with nursing philosophy and nursing art: following guidelines to relay stories accurately and interpreting stories within their context to explore meanings and interactions with others and the environment (Atkinson, 1998; Lopez & Willis, 2004). Life history and phenomenology are an excellent way to give voice to African-American registered nurses.
Chapter 4: Life History Profiles, Part I: Violence, Living in Poverty, and Overcoming Educational Obstacles

This chapter features the narratives of four African-American registered nurses (RNs) and their lived experiences before, during, and after nursing school. Violence was an overwhelming theme among the participants in this study, with eight of the 14 study participants sharing lived experiences intertwined with some type of violence. The life histories of Eleanor, Rose, Jackie, and Hannah are the primary cases shared in this chapter to exemplify the combined underlying themes of violence, living in poverty, and overcoming educational obstacles. These cases illuminate the themes emerging from the lived experiences of these RNs and include their family background, childhood, and early adult life, with supporting narrative to illuminate each individual experience with violence and living in poverty. The uniqueness of their individual stories is a backdrop for the commonality of experiences with violence, academic challenges, overcoming educational obstacles, and living on the edge. The life histories of the RNs featured in this chapter expose the similar challenges in the background of these African-American women and the atrocious nature of violence experienced as they were trying to become RNs. Participants candidly offered details of their family of origin and nodal moments in their life experiences as they navigated through their lives managing poverty, academic problems, and surviving different forms of family and community violence. The additional themes of paying for nursing school, lack of diversity, support/lack of support, and grit and tenacity are also revealed in the profiles of these participants.

Eleanor

Eleanor is 44 years old and juggles many roles: mother, wife, student, part-time nurse practitioner (NP), and full-time faculty member in nursing education. She lives a
comfortable, middle-class existence with her husband, who works for an automotive company. We met at Eleanor’s home for both interviews. Eleanor resides in a single family home in a newer suburban development in southeast Michigan of ranch-style homes with manicured lawns, high-vaulted ceilings, and newer model vehicles. Her home was decorated in a comfortable contemporary style with a few toddler toys strewn about as evidence of her grandson’s visits. It was early evening, and Eleanor was still wearing her work scrubs. The interviews were conducted at her dining room table, which also served as a makeshift desk for her work on her graduate degree. As we settled in after her long day at work, she poured herself a glass of red wine to “wind down” while we talked. Eleanor has been married since 1998. She and her husband each brought a young daughter to the marriage and have raised their girls together through adulthood. However, the circumstances of her life have not always been so comfortable.

Eleanor was born and raised in Detroit. The youngest of four children, two boys and two girls, she was raised by both her parents in a traditional nuclear family. The family lived in a middle-class area of the city among many other middle-class African-American families. She expressed how her early family life mirrored that of The Brady Bunch, which included family trips, ballet classes, music lessons, and a standing six o’clock dinner hour. Eleanor’s father went directly to work after high school as an electrician, and her mother stayed home, managed the household, and took care of the children. When Eleanor started kindergarten, her mother began attending night school to complete her GED, associate’s degree, bachelor’s, master’s, and her PhD in social work over a 25-year period.

As Eleanor got older, she recognized the emotionally abusive behavior her father expressed toward her mother. Her dad took pride in providing for his family. She
characterized her dad as “…the breadwinner…He brought home the money. The bills were paid.” Yet he was not very pleased with her mother trying to educate herself. She reflected:

My mom, in the beginning, she did not work. My mom had all of four of us by the time she was 24. She didn’t have her high school diploma. And my dad—they went through some things…I do remember one instance I was sitting in her lap and she was reading a…I remember him walking past and snatching it out of her hand, and I remember her crying.

Eleanor was educated in the public school system. She described herself as a good student who was well behaved throughout elementary and middle school. That changed as she was preparing to enter high school and her parents announced they were divorcing after 23 years of marriage. Eleanor rebelled and started to skip school, fight, and run with the wrong crowd. She shared her high school transcript and described what she was going through: “[I had] 80 absences, one semester I had all Fs…and then in the last semester of my 12th grade year I got pregnant, dropped out of high school, and went on welfare. [I] was with my daughter’s father, he was a drug dealer.” Her parents were very upset about her pregnancy. Her mother became emotionally abusive. Eleanor recalled, “Actually she was really mean to me. She used to wake me up in the middle of the night for me to clean the bathroom with a toothbrush.” Eleanor tired of the emotional abuse and bizarre corporal punishments handed out by her mother and moved out of her childhood home. At age 17, with the help of public assistance, Eleanor got a place of her own. This began a period of personal struggle and poverty for Eleanor. She faced her new reality of being a high school dropout, having a broken relationship with her parents, living on public assistance, and being the pregnant teenage girlfriend of an emotionally and verbally abusive drug dealer.
Domestic violence and poverty: Generational intimate partner violence. She lived with her daughter’s father, who was “verbally abusive,” in an apartment that was “full of roaches…It was so many roaches that you turn on the light they would just stay there.” Her drug dealer boyfriend was of little assistance financially or emotionally. She recalled:

After they [public assistance] paid all of the rent, I only had five dollars left to try and buy diapers and formula. I had to ask him for everything and if I didn’t do something that he wanted me to do he would tell me no. When we broke up one time, he had taken one shoe from each pair, took the TV, took toothpaste, took my toothbrush…knowing that I couldn’t afford to go buy any shoes. But, used it as a—actually like a weapon like of control.

Eleanor’s relationship with her daughter’s father mirrored that of her parents. Her life was perpetuating the generational cycle of family violence. She explained the nature of her parents’ marital relationship, saying, “She depended on my father…he possessed everything…and she had to ask for it…If he didn’t want to give it to her, he didn’t have to give it to her. Then I found myself following in those footsteps.”

Determined to make a better life for herself and her daughter, Eleanor went back to high school. Having been expelled from her neighborhood high school for fighting, she had to return to a new school as a senior to complete the classes she needed to graduate, with students who were chronologically a year behind her. It took her an entire school year plus summer school to complete her high school diploma. She was determined to finish because she…“didn’t want to be a statistic.” While trying to complete her high school diploma, Eleanor was dealing with the abusive relationship with her boyfriend and struggling with poverty while raising her newborn daughter alone. In the second semester of her new senior
year, one of her teachers noticed her “despair” exhibited in a paper she had written. This teacher wrote her a note from which she still receives inspiration. She carries this note with her, and she carefully removed it from her workbag. It is written on a tattered piece of notebook paper; the note is dated 2-17-88. Her eyes brimmed with tears as she read it to me, “Dear [Eleanor], Thank you for the paper about yourself. You are a winner! DO NOT quit school or on life. I know you can and will do well.” She remembered how this teacher’s note made her feel and uplifted her to continue to do well. This note reminded her that it takes only one person to care to make a difference in someone’s life. She beamed, “He wrote this in February of ‘88 and [on] my report card for June of 88 I had three A’s and two B’s, with no absences. And then my last semester I had two A’s and one B, with no absences. So this right here...” (She points to the note as her voice trails off and she gathers herself). A few kind words from a teacher helped her at a most difficult time. She knew that the way to a brighter future was paved through education.

“I was going to leave him.” Eleanor did not receive any help with her daughter from her boyfriend. Her older sister and friends helped her with her daughter while she went to night school. Her relationship with her boyfriend worsened and she attempted to break up with him. The verbal and emotional abuse escalated into more threats and acts of violence. She wanted out of the relationship, but could not figure out how to leave. Eleanor explained:

I broke up with him. When I broke up with him he went into the bedroom and got a rifle, went into the bathroom…and shot hisself in the mouth…while my daughter was there. He went into the hospital, he survived, and I remember we had gotten back together. The only reason I got back with him because he told me that if I didn’t that
he would kill me and next time it would be—he would kill my daughter, he would kill me, and then he would kill hisself.

She knew her current living situation was not a healthy long-term solution, but she did not have a clear exit strategy. She stayed for almost three years, until her boyfriend ended up going to prison for life without the possibility of parole for a drug-related murder. Eleanor admitted this provided her with a feeling of “relief” as he was “out of my life permanently.”

“My daughter saved my life.” Eleanor finished high school and completed a program to become a medical assistant. She began working as a medical assistant, but still needed welfare to make ends meet. Her young daughter became her inspiration for pursuing a higher standard of living for the two of them. It became clear to her that she did not want to live a life of being poor and that the way out of poverty was through higher education. She emphatically shared, “My daughter saved my life…I always promised myself that before my daughter could talk that I would be off of welfare…I wanted us to have money to go grocery shopping.” Her daughter provided the motivation she needed to continue her education.

Things began to fall into place. She reconciled with her mother and was doing fairly well on her own. Unfortunately, one winter day, she and her five-year-old daughter were in a terrible car accident. Her car “did a 360 and then flipped over in the ditch,” but she and her daughter sustained only minor cuts and scrapes. After the accident she developed a new drive and focus. Proud of Eleanor’s efforts, her mother gifted her the family house. She proudly recalled, “I had two years to pay it off at $290 a month, and when it was paid off, she actually gave it to me. She said that was something for me since I was actually doing something with my life.” Tired of living payday to payday, Eleanor set out to improve her quality of life and become an RN. This was the beginning of Eleanor’s life turnaround.
**Overcoming educational obstacles.** Ten years after graduating from high school and constantly struggling to make ends meet, Eleanor decided to pursue an Associate’s Degree of Nursing (ADN). This was not the first time she had to make a tough career choice. As a teenager, Eleanor was a very talented dancer and passed on a chance to tour with a national rap artist. Eleanor chose family over fame. She shared, “I chose school because I had a daughter and I wanted to make sure she had a stable life.” Eleanor had a clear understanding of the earning power of a post-secondary degree. Even as a teenager, she knew that as her education level increased, her earning power increased. She selected nursing because it would allow her to continue to help people and “to have more income.” What she did not anticipate was the challenge she would have getting admitted to the nursing education program (NEP).

Although Eleanor’s college GPA was very good, her score on the Nurse Entrance Test (NET)—an unsubstantiated predictor of nursing school success—did not meet the requirements for admission the first time she took it, nor the second time. She passed it on the third try and began her journey toward becoming an RN and escaping the life of financial struggle. Her life was changing for the better educationally, professionally and personally. Her acceptance into nursing school coincided with being introduced to her future husband. His support for her pursuit of an ADN was unwavering. He provided childcare, encouragement, and financial support. She described his role, saying, “Actually, he came along right…when I was waiting to get accepted into the nursing program…He bought me my first book bag, nursing uniform—all the stuff that we needed, where I couldn’t afford it at the time.” Even with the added support she was unprepared for the academic rigor and struggled throughout nursing school. Eleanor described nursing school as “very difficult…it
was an abundance of reading with comprehension, and remember with my high school, I was still playing catch up.” She began to employ journaling as a strategy for detailing her vision for her future. It was a way for her to release her thoughts and set her personal goals. Eleanor had set her sights on becoming a registered nurse; she shared, “It was no way that I couldn’t be a nurse…It was no other thing that I was going to do and I was gonna make it happen.”

She elected to complete her ADN first because 1) community college tuition was far less expensive, and 2) she would be able to double her income in two years. As a young, single mother she was able to take advantage of Pell Grants to cover some of the cost of tuition, uniforms, and student nurse insurance. Although located in the heart of the city, the NEP student body and faculty were profoundly White. This was foreign to Eleanor, as she had never been to school with White people before. Eleanor had to adjust to being in a school with mostly White students. The NEP lacked diversity, and it was also academically challenging. She struggled with a voluminous amount of reading and comprehension required for nursing school. Early on, she bonded with two older African-American nursing students, and they would remain one another’s support system throughout the ADN program.

She found additional support from two nursing faculty. One introduced her to a note-taking strategy to assist her with comprehension. She explained how they contributed to her success: “My theory professor who actually told me not to write any notes down…she wanted me to tape her…just listen…then…go home and go back over and read…she gave me structure, how I should read to comprehend.” Eleanor credited the second faculty member with pressing her to excel academically: “She was really, really hard on me…she told me that she saw something in me…from that point on I was a B [student] or better.”
Eleanor has been savvy in avoiding one of the largest pitfalls of nursing school: financial burden. As a mature student she knew how challenging it would be to balance school, work, and being a single parent. In preparation for the last six months of her ADN, Eleanor saved diligently, prepaid her bills, and stockpiled the necessities for her home. Eleanor outlined her plan: “I planned not to work for six months and paid up all my bills.” She was able to complete her ADN and immediately began working as an RN and taking classes toward completing her Bachelor of Science in Nursing (BSN). She breezed through her BSN and Master of Science in Nursing (MSN) degrees, teaching certificate, and the credits for clinical nurse specialist (CNS). She started taking classes for her PhD in 2012. Ultimately, she was able to navigate through multiple degrees while securing minimal debt with careful planning and by taking advantage of grants, scholarships, graduate assistantships, employer tuition reimbursement, and loan forgiveness programs. In her professional career, Eleanor progressed from staff nurse to clinical improvement specialist to clinical nurse specialist (CNS). She remained at Memorial Hospital for 15 years, until 2012, when she began to work as contingent staff nurse and as adjunct faculty.

**Eleanor’s current reality.** Since 2014, Eleanor has been full-time faculty. She is one of two minority faculty teaching in a suburban ADN program while she is working on her PhD. Eleanor’s story is one of perseverance and determination in spite of generational domestic violence and poverty as a young single mother. Her narrative exemplifies how domestic violence and poverty are not life sentences and how the cycle can be broken with self-determination and some support from those around you. Her story illustrates how intimate partner violence can be transmitted from one generation to the next, and how that abuse can escalate over time. Her boyfriend’s violence started as emotional abuse and threats
and progressed to gun violence and a suicide attempt. Her story also highlights how women often end up living in impoverished conditions after striking out on their own as she lived on welfare after initially moving out on her own. Key to Eleanor’s successes were instances when supportive and encouraging people entered her life when she needed them most. The support of others, along with her personal tenacity, helped her to overcome the barriers in her life. Finally, Eleanor’s narrative illustrates how internal motivation can help someone to overcome barriers and how a small act by one person can provide inspiration. Despite a variety of life obstacles, she has been able to achieve her goals and exceed her own expectations. Eleanor has turned the pitfalls of life into stepping stones.

Rose

Rose is a 30-year-old married mother of two young daughters. She and her family reside in a quiet, tree-lined suburban Detroit neighborhood in a cozy, sparsely decorated home. She currently works full-time as a nurse practitioner (NP) for a major healthcare system in metro Detroit. Rose is comfortable and settled into her family life and dotes on her children. She and her husband are mutually working toward improving their lives, raising their children, and achieving their goals. Rose’s current life is in sharp contrast to the story she shared of her upbringing.

Rose was born in Detroit. She is the firstborn child of her mother and father, who were not married when Rose was born. Her parents married when Rose was about five years old, but Rose spent the first six years of her life living with her maternal grandmother, whom she described as her “best friend.” She moved in with her parents after her brother was born. Her younger sister was born 18 months later. The family lived in a working-class neighborhood in Northwest Detroit, and Rose attended a private Catholic school until third
grade. Shortly after moving with her parents, they enrolled her in the neighborhood public school. As a little girl, Rose liked school and stated, “From like first through fifth grade I did really well in school. I got mostly A’s…I think I was overall a good kid.” She has fond memories of her early family life filled with large family gatherings hosted by her parents.

Like many families seeking a better life, safer neighborhoods, better schools, and upward mobility, Rose’s parents moved the family to a nearby suburb when Rose entered middle school. Rose was enrolled in the neighborhood public school, and the influences of her peers took over. She looked away as she shamefully remembered:

Being in middle school is when I really got into trouble. I started hanging with the wrong people; I got involved with a gang. I smoked. I drank. I was young. I was in middle school, 11–12. Smoke, drank, you know boys—just the wrong people.

Her grades dropped and she was “barely passing.” It also became apparent to Rose that her family was bordering on working poor. Her mother worked as a receptionist, and her father owned a fledgling construction business. Her mother’s low-wage salary was the only steady source of household income. She expressed some discontent with how her parents tried to maintain a “façade” that their life was better financially than what it really was, but behind closed doors, it was a daily financial struggle. She recalled how her mom advised her about money management:

I remember my mom saying once, and this stuck with me, “There’s no such thing as a nest egg. There’s no such thing as not living paycheck to paycheck.” And I said it’s gotta be. I mean that was like there was no hope to like have more money than you need exactly every month.
With both parents working, it was her responsibility to care for her brother and sister after school and all day during the summer. She was their nurturer and disciplinarian. This was not always a positive experience for the three of them. She confessed:

My brother…I wasn’t that nice to him…I made fun of him a lot…we didn’t have a really close relationship…My sister…just did what I said…They looked at me like I was like the one in charge. We didn’t have like a real brother-sister relationship.

Her role with her siblings included providing discipline to them, including spanking. She would punch, slap, and spank her siblings with a belt. These were familiar forms of discipline to Rose, and she practiced on her siblings what she learned from her parents.

**Violence and poverty: Corporal punishment—spanking or abuse.** Even with the responsibilities for her younger siblings, Rose continued to hang out with the wrong crowd whenever she could. Her friends influenced her to do things she had never imagined herself doing. Her parents tried to control her by using threats, verbal assaults, and physical punishments. She stated:

I was like getting slapped or yelled at and that’s how they dealt with it. Like, I would…just get smacked in the face! You know, yelled at, cussed at. They threatened to kick me out. They said I had to move out…They were threatening to take me to like juvenile detention place…they made a lot of threats. They grounded me. I remember like Christmas I would get like nothing. That kind of stuff…punishment [was] like a reactive kind of thing versus trying to find out why are you acting like that?

When she turned 16, although she was still a poor student and getting in trouble on a regular basis, her parents gave her a car. She still does not understand why her parents “rewarded”
her with a car. Her newfound independence allowed her more freedom to hang with the wrong crowd, until one critical incident that spurred her to turn her life around. She spoke in fragments as she recalled this nodal moment:

I don’t know if I was like drinking too much or just being around the wrong people too much…I ended up at the wrong place at the wrong time with somebody—like a girl that I thought was my friend and she let—like when I was under the influence, she let some bad things happen to me. You know, I think at that point that was kind of my turning point…and I never like reported it. I should’ve.

She did not feel comfortable reliving the details of this event. When I inquired further about the “incident” she was not willing to acknowledge that it was a sexual assault, but she did not deny it either. She did identify it as a critical moment in her life, causing her to take a real hard look at the choices she was making and the people she associated with. She identified this event as seminal in her getting more serious about school and changing her friends. Rose proclaimed, “I started hanging with people who had like similar interests, but they weren’t bad influences like I used to have.”

Rose stopped drinking and smoking. She changed her friends, and her grades improved. Born with club feet, she renewed her interest in becoming a podiatrist. However, harsh reality set in for Rose when she took the ACT and scored 14, limiting her choices for post-secondary education. With only one college acceptance letter in hand, Rose set out for Kentucky State University (KSU), a historically Black college and university (HBCU).

Rose was a different person in college. As she neared graduation from high school, she had begun to live her life as a Christian. She became a straight-A student in college. Rose was still enamored with the idea of becoming a physician and stayed on the premed track her
entire first year. When she realized the number of years it would take to become a doctor, Rose explored nursing at KSU. Unfortunately, one of the admission criteria for the nursing program was an ACT score of 21. She took the ACT again and got a 20. Frustrated, Rose transferred back to a public university in Michigan about 45 minutes from her parents’ home. She got accepted directly into the nursing school. Before leaving KSU, Rose met a young marine, fell in love, and became engaged. The engagement and relationship were short-lived, and they parted ways before Rose returned to Michigan.

**Trials and tribulations of nursing.** Transferring from an HBCU to a suburban Detroit public university was a huge transition for Rose. She went from an environment that was all Black to a school with an NEP that was primarily White. Rose’s family’s financial situation had not changed. Her parents were still struggling and trying to present a “façade” of being well-off. Being closer to the family home helped remedy her homesickness, but her financial problems blossomed. As a first-generation college student, Rose had no one to help her navigate through the processes of college and how to pay for college. She shared her knowledge regarding financing a college education:

I had no idea. I thought your parents took care of that until I got there and realized that—Oh, what is this financial aid? I don’t think anybody ever really talked to me about like paying for college until I got there. I took out a huge amount of loans. That first year it was like $17,000…It was really expensive.

Nursing school also exposed Rose to the diversity she thought she desired. There were approximately 80 students in her cohort, and Rose “was one of three African Americans in my class, like my whole class.” This was dramatically different from the HBCU she had transferred from. She felt like she was on the outside looking in. She shared, “They [the
White students] didn’t really like engage or take to me much…they didn’t really pick me to like be in their groups…I didn’t really exist to them almost.” In spite of this she worked hard to keep up with her classmates. Her lack of attention to her academics in high school and the remedial classes at the HBCU had not prepared her for the academic rigor of nursing or to keep pace with her peers. She explained:

I remember like a feeling of inferiority…it seems like my all A’s at [HBCU] was [not] all A’s there. It wasn’t comparing apples to apples. It was harder…The majority of them…really had like a lot of confidence…They were smarter. They knew more…They were spitting out A’s like you wouldn’t believe and I’m like studying all night to get a B…Like they knew something I didn’t know…We all went from kindergarten to twelfth grade and they got something out of it that I didn’t…I had to work harder just to kind of stay in the bell curve.

Rose found it difficult adjusting to the new nursing school. She worked hard but never really felt connected to any of the students or faculty there. In contrast to the HBCU, where the faculty are nurturing and border on meddling to keep students on track, she felt the faculty at the BSN program “were just teaching the content.” Things changed when she crossed paths with an older nurse who was an adjunct faculty. The interest she took in Rose really helped her. She helped Rose get selected—as one of a few BSN students among graduate students—for a 10-day trip to Ireland to study dementia. She was well respected in the nursing community and would eventually write Rose a letter of recommendation to help her get into graduate school. As she reflected on this relationship, Rose seemed puzzled as to how it came about; she shrugged as she quizzically stated, “I guess she saw something in me.”
Financial struggles. After one year living on campus, Rose moved back home to live with her family to cut costs. With the ongoing financial struggles in her family, she could not expect any help from her parents. Her only choice if she wanted to become a registered nurse was to continue to use student loans to pay her tuition and living expenses. She embarrassingly shared, “Like almost every semester I remember I had a hold on my account...you can’t register if you have a hold on your account...Finances was always a problem in college.” Her student loan debt grew with the passing of each term. The work-study jobs were not enough to help Rose meet the financial demands, so she took an off-campus job as a waitress in a bar. The tips from this job helped her to pay for an entire semester of tuition and fees in the Bachelor of Science in Nursing (BSN) program. Working as a waitress in a bar just did not feel right to her. So she quit the job as a waitress and reverted to loans. She also found additional temporary relief in support from public assistance. She shared, “I got like the bridge card. That was like food assistance...I applied for it...and I got $83 a week or a month or whatever.”

Unfortunately, school expenses were not her only financial challenge during nursing school. Rose’s family of origin continued to live near the poverty line. Her parents’ financial troubles finally caught up to them, and their home was foreclosed. Her entire nuclear family was soon to be without a place to live. Rose explained the solution her parents suggested:

They...asked me to put the mortgage in my name...so I was able to get approved for a $229,000 mortgage...I had a couple thousand dollars in the bank...Of course, that money in the bank ended up going to the house, too. And when I was living there, I was working. I hadn’t graduated yet, I was still in school...I was paying like $500 a month like to help with the mortgage.
She still expressed surprised disbelief as she recalled how her parents asked her to put the family home in her name. Rose was emotionally torn. She felt as if she were obligated to help her family; she admitted that she “wanted to help” and “needed a place to stay,” and felt like she could not say no. She displayed a hint of anger as she remembered, “It was packaged like…maybe this can be your house and—or we can try to get it out of your name in a year or so. It was packaged like this was temporary.” Rose was working and trying to complete the NEP, and the new family mortgage was slowly going bad. It was a balloon mortgage, and it finally became more than the family could bear. The bank foreclosed again, ruining Rose’s credit along the way.

Although her financial life was a mess, just like Eleanor’s, Rose’s personal life was taking a positive turn while she was in nursing school. Being in the right place at the right time, she met her future husband at a coffee shop. He was studying for an accounting certification exam, and she was studying for a nursing exam. He noticed her, introduced himself, and the rest is love history. Less than a year later, she had finished nursing school and gotten married. She expressed gratitude for her husband’s ability to help her find direction: “I had a lot of baggage when we first met. Since meeting him my life has gotten better you know. Together. Stable.”

However, Rose’s financial troubles were not quite over. As newlyweds they were faced with her very poor credit score and a $229,000 foreclosed mortgage. It took seven years to correct her credit history, and they were able to purchase a house together this year. Rose remained bitter as she reflected on her financial history; she explained, “We shouldn’t have to come out like crawling up.” Her husband also agreed to take in Rose’s 17-year-old pregnant sister.
Rose quickly discovered that bedside nursing was not something she wanted to do long-term. She decided she would go straight to graduate school to become a family nurse practitioner. The graduate program cost $25,000 a year, and her total student loan amount for both degrees would exceed $90,000. The loans got so large, she “just stopped opening” the loan statements when they came in the mail. She started working as an RN and went directly to graduate school simultaneously.

Coping with microaggressions. Rose’s early professional career started as an emergency room (ER) nurse. She loved the excitement and daily adrenaline rushes, but two body fluid exposure incidents in less than a year were enough to make her transfer to Labor and Delivery. She stayed there until she graduated from the NP program and then took a job at the Veteran’s Hospital (VA). Working 60-hour weeks at the VA as a newlywed, and now a new mother, got to be more than she could bear. She transitioned to working 12-hour midnight shifts on the rapid response team at a suburban hospital. Unfortunately, it came with some things that she never expected. She loved the work and the high intensity of the care she was able to provide, but she soon tired of the work atmosphere laden with covert racism and microaggressions. She explained:

I don’t know, maybe I look young or maybe it’s the skin color I don’t know…If I’m like giving a directive to the other nurses they might stop and say like, “Who’s she?”…It only really takes a couple of encounters where you really know what you are talking about for them to respect you…You definitely had to prove it [your competence].

Rose felt there was some embedded racism and very little room for upward mobility for her as an African-American woman at the suburban hospital. She shared her frustration:
[For] a couple of the jobs I got passed up because somebody else had more experience or they were White. I mean [this hospital] can be a little bit prejudiced, a little bit. I’ve learned that, just from…being called a “nigger” by a patient. But, in that place it’s about who you know. And if you are Caucasian it can be easier sometimes. She tired of midnights and the lack of upward mobility and left to become an Employee Health nurse practitioner. The best part about the job was, “no nights, no weekends, no holidays.” She has been in this position since March of 2013.

**Rose’s current reality.** Rose and her husband are now the proud parents of two daughters: a three-year-old and a three-month-old. Her husband works from his home office and provides care for their infant daughter. Rose works full-time and carries the healthcare benefits for the family. The family is growing a nice nest egg through stock market investments to secure their financial future. They are working to liquidate their combined student loan debt and build their wealth. Rose explained, “They have me on a 30-year plan right now. Last year I paid $780 a month and this year they increased it to $1000…it’s close, you know, to my mortgage. It’s more than my daughter’s daycare.” As their loans are eliminated and their finances become increasingly stable, Rose looks forward to the day when she can be a stay-at-home mom and possibly homeschool her daughters.

The narrative of Rose highlights her experience growing up as working-class poor with parents who used corporal punishment, spanking, threats, and beatings as a method to discipline her. Her upbringing in a two-parent household with both parents working was filled with financial struggle. The family lived paycheck to paycheck on a regular basis. The financial struggle from her childhood seeped into her college and young adult life. Rose used the poverty and abuse she suffered in her family of origin as motivation for what she did not
want in her adult life or for her own family. Deciding to become an RN was life-transforming for Rose. It was her way out of poverty, but was not without its own challenges. The reality of the lack of diversity in her NEP and the profession was not something Rose had considered when she selected nursing as her career. During nursing school she faced similar barriers as other African-American nursing students: trying to pay for nursing school, social isolation, and discrimination. These barriers carried over into her professional life as well, where she felt being young and Black restricted her opportunity for advancement. In spite of these challenges, Rose enjoys nursing. It has provided her with a career with options even in the face of perceived discrimination. She has been able to find a position that meets her skill set and allows her the type of schedule conducive to her family life. Nursing also provides her with a career that will help her to achieve her long-term goal of staying home and raising her daughters in a traditional setting with loving, nurturing, and spirit-filled parents—unlike the way she was raised.

**Jackie**

Jackie is a 35-year-old married mother of three school-aged children. She is a native Detroiter. She, along with her older sister and younger brother, was raised in the projects of Detroit, primarily by their mother. She and her siblings each have a different father. She explained her birth circumstances:

I wasn’t a product of love. I was the product of a one-night stand. My dad and my mom met at [a nightclub]. My mom ended up sleeping with him. My mom got pregnant. Actually my dad wanted her to get an abortion, and my mother refused to. Her father remarried when she was five years old and moved to Florida with his new wife and their two children. Her younger brother’s father became the father figure in her life thereafter.
Jackie and her siblings were raised in poverty. She shared, “We weren’t rich. My mother was on welfare the majority of my childhood.” The neighborhoods she grew up in were not the most family-friendly. Her family lived in the projects of Detroit for most of her childhood. Jackie was exposed to many of the ills of an impoverished urban setting. She reflected, “It was rough. It was rough. I seen violence. I seen people selling drugs. I had people in my family that’s been drug addicts, alcoholics, criminals…One of my uncles is locked up for life for murder.” While the neighborhood was tough, she perceived that the early aspects of her education were positive.

Jackie attended Detroit Public Schools for her entire K-12 education. The family moved a lot, and each time the family moved she changed schools. She attended at least four schools for grades K–8. Her most positive experiences are from Stevens Elementary-Middle School. This school had an exemplary band program, and Jackie became a self-proclaimed “band kid,” as she earned the seat of first clarinet. Jackie got to travel and participate in many public events and performances as part of the band. She raved, “I was even lucky enough to go to Japan…It was so fun. That was really the best times of my life.” Being in the band allowed Jackie to suspend her reality for a while when she was with the band.

Violence and poverty: Community violence impacts. Jackie was never “a problem child,” and spent most of her time “on my porch and play[ing] my clarinet, sit on my porch and read a book.” She preferred to socialize with her band mates and “not the neighborhood kids.” She avoided the “drama” of the neighborhood and its associated violence, and she found solace in her world of music and literature. But her self-contained world could not protect her from the effects of living in an impoverished urban area. When she entered high school, her life changed for the worse. Her little brother was born and she struggled with a
number of personal losses of family and friends to death. She tried to continue to move forward in her education, but the losses consumed her. She matter-of-factly listed off the incidents of death from ’94 to ‘97:

I lost like so many people, back-to-back-to-back. I lost my brother’s father, I lost my auntie, I lost my cousin, I lost one of my really good friends…I lost my sister’s [boyfriend]…he got murdered. Then, it was an ex-boyfriend…he got murdered. Then my sister’s current boyfriend…got murdered…My sister was pregnant at that time and she lost the baby. It was like death after death after death. It was just horrible.

**Overcoming educational obstacles.** This closely sequential cluster of deaths affected Jackie in a major way. She added, “I just felt like my world was coming in on me. By the time I got to 12th grade, I decided I didn’t want to be at school anymore…I ended up giving up.” She transferred high schools, hoping a new environment would reenergize her fervor for her education. The change of venue did not help, and she ended up dropping out of high school. She moved out of her mother’s house at 18 and found an apartment of her own. She explained how she was able to qualify for public housing, saying, “At that time I was able to get my own apartment because it was a place…that had subsidized housing. Since I was 18, I was old enough to get my own apartment. My rent was probably $25 a month.” She was living on her own with very little direction. Eventually, she enrolled in a special high school for students over 18 and completed her high school diploma right before her 20th birthday.

**Community violence continues.** At 20 years old, Jackie was now living with her boyfriend and had begun training to become an emergency medical technician (EMT). However, her life continued to be infiltrated by the inner city urban ills and violence in her community. Her sister got into an altercation with another girl who had been bullying her,
and killed the girl in self-defense. This all happened on her mother’s doorstep, Jackie testified:

My sister was banging on the door...and at the same time my sister was reaching in her pocket to get her key to open the door… [my sister] had a small pocket knife connected to her keys, and when she grabbed the key she grabbed the knife and she opened it and stuck the girl…the girl actually died and it was because my sister had stuck her in her heart. That was another traumatic thing.

Jackie had witnessed a lot of violence in her life, but this incident with her sister possibly facing murder charges really upset her. She worried about her sister being prosecuted, even though she “knew she was innocent.” Her sister was defending herself against a bully who was trying to turn her on to a lesbian lifestyle. She grew nervous for her family’s safety as their neighbors begin to align themselves with the victim. Her sister was eventually released from a 72-hour hold after the county prosecutor could not find enough evidence to file charges; the case was ruled self-defense. Jackie was unemotional as she retold this story. When asked why, she replied, “I have seen a lot. I am kind of numb to it.”

Jackie was relieved by the prosecutor’s decision and was able to renew her focus on her own goals. She had always been encouraged by her mother and father to further her education. None of her maternal relatives had attended college. She would subsequently become the first and only one in her maternal family tree to complete a college degree. Both of her siblings’ fathers were drug dealers; her father had a high school diploma and grew up in poverty in Jamaica. Her mother lived in the projects all of her life. They both understood and “they knew what it was like to be poor. They just felt like in order to get a better job, or be able to take care of yourself, you had to educate yourself.”
Financial struggles: Time to make a change. By 2000, Jackie was working as an EMT and had her first son. She knew she had to provide for this new life. Her boyfriend held a series of low-paying jobs, but that was not enough. The poverty from her childhood was extending into her adult life. Their daughter was born a year later, and the young family continued to scrape to make ends meet, living paycheck to paycheck. Jackie knew she wanted more. She had always wanted to be a pediatrician but chose to become a registered nurse (RN) because she felt “my personality fit more with being a nurse than a doctor.” She completed her nursing prerequisites and was accepted to an 18-month accelerated associate’s degree nursing education program (NEP). Jackie found out she was “four months pregnant with my last child” when she started the NEP in January 2004. She already had two toddlers at home. The young family was struggling to make ends meet, and the family’s financial woes were compounded when her boyfriend lost his job. Jackie attended school full-time and worked on the weekends as an EMT to pay the family household bills. Her boyfriend, who would soon become her husband, stayed home with the children. She financed her Associate’s Degree in Nursing (ADN) using student loans. Money was very tight. She shared her difficulty in maintaining her household during that time:

It was hard, it was hard…I am pregnant. I had medical problems. I had a cerclage in my cervix. I could’ve lost my baby at any time, and my husband’s at home…He did a good job…doing things at home…but it was still like, ok, how am I gonna pay my rent this month? I only make $12 an hour, and I only work 24 hours a week…48 hours every two weeks. It was real hard!
Although she had a high-risk pregnancy, Jackie understood the financial reward a nursing degree could provide for her ever-growing family. She recalled the emphasis her mother had placed on education for inspiration. She explained what her mom told her:

‘You know you can’t go out here and have babies, you gotta educate yourself…If you have babies, you gotta take care of them. You can’t expect the system to take care of them. You gotta do what you need to do in order to survive and you have to be a good role model for your kids.’

Thus Jackie felt a sense of urgency and worked diligently to complete her nursing degree. She was walking a true tightrope of life. She acknowledged her mixed feelings of stress and determination:

Stressful, real, real, stressful…I went to school all year round for a year to get my prerequisites done…then I went into an accelerated program in my associate’s degree program. It was 18 months…within two and a half years I had my nursing degree…I was constantly in school, even in spring and summer, I was in school.

As a high-risk pregnant student, she lobbied for special permission to participate in the clinical portion of the program. Waiting until after her son was born was not an option for her. Nursing school placements were at a premium, and for Jackie, the fear of being wait-listed and having to postpone her pursuit of her nursing degree outweighed her fear of the risk to her unborn child.

Jackie delivered her healthy second son at the end of her first semester in the NEP. After three children and ten years of dating and cohabitating, she and her boyfriend were married in October 2004. With one part-time income and the expenses of nursing school, Jackie and her young family encountered obstacle after obstacle financially, but Jackie never
wavered on her goal to complete nursing school. She was attending school on a cash pay
method, and the student loans were piling up. Jackie remembered:

Thank God, my mother-in-law was real supportive, my mother was real supportive.
Between the two of them, if we fell short on anything, if they had it they were there to
supplement…(later adding) They knew that I was doing something positive…They
helped us the best they could.

Jackie put increased effort into her academic performance and professional conduct,
and attacked her nursing studies with a renewed vigor. She completed the NEP and began
working as an RN in Labor and Delivery. After a little over a year, Jackie transferred to the
Emergency Department (ED). She quickly realized she needed more than an ADN to have
any vertical mobility in her career. After working a few years, Jackie accepted an offer to
partner with her employer to finance her BSN through a tuition-reimbursement program in
exchange for three years of RN service post-degree completion.

Jackie was moving forward, but her husband was not moving in sync with her. He
had found full-time employment as an automotive supply store manager; however, his wages
were being heavily garnished for defaulted student loans. Eventually the family home was
foreclosed, and they rented a market-rate apartment paying $1,200 per month. The financial
situation of the family and lack of shared vision had a horrific effect on their marriage. Jackie
described the marriage as “really rocky,” and the couple separated. She knew her potential
for upward mobility in nursing was linked to her education level. Yet Jackie continued to
struggle financially as she tried to pay for her BSN completion. The employer-sponsored
tuition program “only [paid] for the nursing courses.” Even with her RN salary, Jackie still
had financial challenges; she added, “I [wasn’t] getting financial aid…I [was] paying for classes on my own, out of pocket.” It took her four years, but she finally completed her BSN.

**Jackie’s current reality.** While working in the ED, Jackie became certified in Advanced Cardiac and Pediatric Advanced Life Support and became one of the more valuable employees in the ED. Jackie loves the ED and has spent most of her RN career there, except for a brief spell in 2013 where she spent six months in the Interventional Radiology (IR) department. Jackie is currently in her first semester of the Midwifery program. She is enrolled part-time, and it will take her three years to complete the program and become a nurse midwife.

Jackie was raised in poverty and in an urban environment with all the accompanying societal problems. She viewed education as a way out of poverty. Her exposure to community violence and deaths of loved ones during her childhood briefly short-circuited her educational path. Interestingly, the violence also was an additional motivator for her out to get out of the environment to she grew up in, and returning to school to complete her high school diploma as a young adult. Unlike Eleanor and Rose, Jackie never used the public welfare system to support her family. She watched how her mother used welfare and public housing to support her and her siblings, but Jackie chose to struggle to balance the financial difficulties by working while going to nursing school and receiving help from her family when things got tough. She viewed a nursing education as a way to get her family out of poverty. She is raising her children in a comfortable four-bedroom home in Detroit. Finally, Jackie is a talented and “good nurse”; however, she found working as a staff nurse provided her with episodes of racial discrimination and no potential for upward mobility. After several years as an RN, she wanted to pursue an unfulfilled dream and recently enrolled in a master’s
program to become a mid-level provider as a Nurse Midwife. Meanwhile, she and her husband are fighting to maintain their marriage and keep their family together.

**Hannah**

Hannah is a 67-year-old divorcée who still speaks with the slow Southern drawl and sometimes broken language evident of her Kentucky roots. She is a well-groomed lady with a bountiful head of silver hair that rests in loose curls on her shoulders. Hannah relocated to Detroit over 40 years ago. She was married for 15 years, but she and her husband never had any biological children. Hannah did help raise her sister-in-law from the eighth grade through college, even after her divorce from her husband. She has been retired from nursing since 2011.

Hannah was born in northern Kentucky, in “a very small town of about 6,000 people” near the Ohio border. She is the oldest of four children born to her mother, and the only girl. As she tried to tell me about her family birth history, she explained, “My mother was just wild.” Her mother was not willing to raise them, and her grandmother could not afford to raise four children. So, Hannah and her brothers grew up in an unusual living situation. She clarified:

> We were raised by grandmother—two of us, me and the oldest boy…both of my [younger] brothers were given away to people in the community by mother because she said that she couldn’t raise all four of us and my grandmother refused to take all four of us, but we all kept in touch…We all went to the same school.

Later adding:

> Back in the day you could give away children. You could make sure that your children were taken care of. Now, I’ll tell you the baby boy was given to his father’s
mother. Ok, the second boy was given to one of my mother’s friends, ‘cause she was
childless.

Her grandmother was the sole provider for Hannah and her brother. Hannah matter-of-factly
stated that the family was “poor.” Her mother qualified for welfare to provide for the care of
her children, but kept the monthly assistance she received for her children for herself. Her
grandmother supported Hannah and her brother by doing “day’s work…for White people’s
homes.” With her grandmother as the primary provider, the family struggled financially. The
family did not have a television until Hannah was in the fifth grade. Although Hannah grew
up poor, she never felt as if she were less than anyone. She recalled, “We was always taught
that as long as you had clean clothes and food to eat, you was just as good as someone else.”

Hannah was raised in the segregated South; her early childhood bordered on the edge
of the Civil Rights era, and the town she grew up in “had a lot of racism and stuff.” There
was one school for Blacks and a school for Whites in her town. She recalled the obvious
difference in the external grounds of the schools. Her school “just had a playground, you
know, versus a campus” at the school for the White children. Housing, transportation, and
businesses were also segregated. The Blacks could live in only certain parts of town, and the
invisible barriers were clear to all residents. Hannah remembered, “The boundaries that we
lived in… the residents could not go beyond its perimeters…only the very light-skinned,
good-haired person family [could] live over there…Light-skinned and the status of middle-
class.” Poor Black residents like Hannah’s family were restricted in their movements by the
invisible barriers of race and class differences. The town had no Black public officials or
police officers and had only one Black doctor. Jim Crow laws were in full effect.
Hannah was in junior high when the laws changed and schools were integrated in the 1960s. Black and White students could choose what school they wanted to attend. Hannah was an excellent student and “loved to learn.” Tired of the disparity in the quality of education provided to the poor Blacks, Hannah’s mother placed her in the “White” school, so she could receive the “best education.” Her mother recognized that Hannah had the gift of intellect and frequently impressed upon her that she “had the mind to do better.”

**Sexual violence: Rape and molestation.** Poverty and racism were not the only hardships in Hannah’s childhood. She also endured the physical trauma and associated emotional anguish of being raped and molested as a young girl. She hesitated and gave thoughtful consideration before she described horrific incidents of sexual assault and child molestation that occurred when she was a school-aged child. With her eyes cast downward she spoke softly, pausing carefully to choose her words:

My childhood was ok, it was ok. But I had some very traumatic times too. I was—raped when I was in the third grade. It was two young boys that lived on our street…I had gone up to the railroad track…and wanted to go to the ice cream store…So I was coming back down that hill and these two boys jumped out and grabbed me and they raped me right there. I will never forget that…They were teenagers…And, uh, um, I was crying and I was trying to tell my grandmother. Because of the community being the way it is, what would’ve happened? You come in here and things you don’t say. So we just didn’t say…Just act like it didn’t happen. “You’ll be alright. Run the tub.”

Per the directive of her grandmother, she prepared herself a bath and never brought it up again. She simply tried to “forget” about the rape. It was never mentioned again but would affect Hannah throughout her adult life.
This was not the end of being violated for Hannah. A year later, she also experienced molestation at the hands of an uncle, an uncle she revealed was not her uncle by blood relation, but considered a close family friend that was part of her personal “village” growing up. This molestation went on for about three years, and yet again, she said nothing and just carried this with her. She explained what happened and how it affected her:

He would just show his parts and stuff…I was a young girl. I was like in the fourth grade and [through] seventh [grade]…there was always some type of remark or something like that and I used to—like I said I was quiet in the first place—but when things like that happened when I was around him I would withdraw myself.

These events impacted her emotionally for years to come, the long-term effects of which were not revealed until much later in her married life.

**Education matters.** In her eighth-grade year, Hannah had a Black female mathematics teacher who encouraged her to excel academically. She had never had a Black teacher before and had always thought that in the South, girls had very few choices after high school. This teacher made her believe in her abilities and potential. This was the beginning of a new outlook for Hannah. She recalled, “She was the one that said, ‘If you continue you could go to college and be a mathematician or whatever.’” So instead of taking the traditional home economics track earmarked for girls in high school, Hannah opted for the academic track. She laughed, “I didn’t like home ec, even in junior high…I couldn’t whip a stitch…So, I went into the academic [track]…as a means of getting away from all the trauma and I dug into the academics.”

**Financial struggles.** Hannah loved learning and knew that college would open doors for her to have a brighter future. Unfortunately, like Rose and Jackie, her family had no
money saved for college. She explained, “The Blacks in our little town was unaware of any grants or how you could further your education…people did not have that type of credit, or my family didn’t” to get loans. Her dreams of attending college were deferred. She explained her post-high school plans, saying, “Initially…I went to work ‘cause I wanted to help my grandmother…’cause my brother was right behind me…I worked in the hospital as a nurse’s aide. I really liked working in the hospital. I enjoyed the patients.” Inspired by the feelings of satisfaction of working in healthcare, Hannah began to save her money so she could go to the licensed practical nursing (LPN) program at a local hospital.

She finished the LPN program and applied to be an operating room technician. The LPN program was not academically difficult for Hannah, but she did face an invisible barrier of double-discrimination at being Black and female, which she felt when she started working. She shook her head as she recalled the LPN program and the work environment during this era:

[The nursing program was] primarily White, yes. You will find one or two Blacks like I said in a class. I was in a class of 66. I started and graduated in ‘67. The nursing experience then, even going through training, it was very different. Nurses were not empowered then…they were the slaves for the doctors no matter if you were LPN or RN…when a doctor entered…you had to stand up, you had to give them a seat…There was no empowerment because you was…a slave servant.

Hannah did not remain a floor nurse for long. She quickly transferred to the operating room to become an operating room technician. The hospital sent her to New York for training to become certified, and she would become one of two Black operating room techs in her hospital, she and a male. She felt the male was treated with a bit more kindness and
respect than she received. She was valuable to the team, and she learned a lot in her position, but the other employees in the operating room did not always see her value. She shared:

I got a lot of the work...but I put that under my belt as a means of...be[ing] able to be sustained and kept in that area...Prejudice was all over, it was always...some discriminatory actions...It was another OR Tech...she trained me...but during...if I had a craniotomy to do, well craniotomy were 8–12 hours...and you stood on your feet...they wouldn’t even relieve me for lunch or something. I had to keep requesting it and then it would be some sarcasm or some remarks made.

After working a few years as an LPN operating room technician, in 1970, Hannah moved to Detroit and started working at a downtown hospital in the emergency room. She recognized that working as an LPN limited her professional mobility and her earning power, and Hannah began to take prerequisite classes toward earning an associate’s degree as a registered nurse. She eventually enrolled in an Associate of Science in Nursing Degree (ADN) program, but she had no idea how she was going to pay for nursing school. She was working as an LPN, but she also had living expenses that were her responsibility, and her salary was not enough to cover both. Simply put, “There was no money for college.” She encountered a problem typical of the working class poor: Hannah did not qualify for federal financial aid because her income from being a full-time LPN exceeded the limits to receive federal grants. She had to figure out how to self-pay for college. Just by happenstance, she overheard some of the White students in her class talking about local grants. She strategized, “I applied for the grant because I heard them talking one day and...the White kids...were getting the grant.” Prompted with this new information from her peers, she applied and received a grant to help her with the associate’s degree program expenses. Armed with this
new information, during the second year of the program she shared, “I got a grant…the second year because I was only working part-time.” Hannah had figured out how to make the financial aid system work for her.

**Overcoming educational obstacles.** While in nursing school, Hannah was still single and nearing a critical age for a Southern girl. She shared, “Where I come from at 25 if you weren’t married they called you a[n] Old Maid.” Hannah did not want to be an old maid. So through a co-worker she met her future husband, and they were married shortly thereafter. Having a second income helped her with nursing school, but she now had to manage multiple roles of employee, student, wife, and parent. The ADN program was difficult. Hannah shared, “They were tough on us.” The students had to excel in the academic portion and the clinical portion. Hannah did well, except for the care plans. She struggled to master this and eventually ended up tutoring others in care planning. Even more frustrating for her was the incident where she was falsely accused of cheating by one of the few Black professors. She described how she felt:

> It hurt me real bad…I was…very, very bitter and upset that a Black teacher would do that to us and we already have enough problems with others…Where I come from I was so used to racism…I wouldn’t expect it from them, our own.

**Sexual violence: Impacts of violence against women.** The stressors and rigor of nursing school was complicated by the multiple life changes she incurred simultaneously, including instantly becoming a parent to her husband’s 14-year-old sister. Hannah’s marriage was rocky at best, and as she and her husband tried to build a life together, the sexual assault and molestation from her past crept into their marriage. She and her husband had different views on how to manage their finances, public versus private education for his sister, and
their level of obligation to help family. Hannah later admitted that her biggest marital problem was her unresolved issues from her childhood rape and molestation. She is still bothered by how this affected her marriage. She hesitated frequently as she confessed:

He [her husband] was very nice. I think I had a lot of issues…My issues was, you know, it still was a trust thing. I mean—men was like, I don’t know…So, we got married and without a lot of discussions about this and that. You know, you meet, you go together for so long then you get married. Then the issues start coming up and I wasn’t really open to tell him about my life; what happened, the rape, about those things…We had money, but we wasn’t seeing eye to eye. We wasn’t spending as much time together. I was in nursing school and then I was not…taking care of home, like providing a home other than for her [his sister]…I wasn’t being the wife I was supposed to be.

She later clarified further:

I believed that what you say, how you say in nursing, you suppress things and then it becomes repressed, because during that time you did not say things…Then the rape was, it would have been on you, you the nasty little girl…I’ll tell you when it really became a problem with me was when I got married…I did not tell him before…when I got married it was a difficult time for me…it was hard for me…I could not enjoy what God had brought together as supposedly pleasure among both individuals, married couple, sexual relationship. It was hard. I could go through the motions, but I could not have the feeling. It was like I was just cold to me.

She never sought help to work through the trauma of childhood rape and molestation. Her marriage suffered, but Hannah was not going to be denied her goal of becoming an RN.
She shared, “My determination as I start, once I start something I’m determined to do it.”

Hannah finished her ADN in 1978 and began working as an RN. Although she was determined to advance her career from LPN to RN, that same determination could not save her broken marriage; she and her husband eventually separated, finally divorcing in 1988.

**Hannah’s current reality.** Hannah spent her entire RN patient care career at the same hospital. She held positions in inpatient, outpatient, day shift, night shift, floor nurse, supervisor, and ten years as the clinic manager for Obstetrics and Gynecology. She also took an occasional side job for extra money for “paying off credit cards and stuff” at the “Black hospital” in Detroit. Like many nurses who are working as an RN with an associate’s degree, Hannah combined her work-life and her continuing education to complete her bachelor’s degree in nursing. Hannah spent the remainder of her career as a grant-funded research nurse at a local public university. She retired in 2011. Since retiring, Hannah has filled her days with “charity work.” She feeds the homeless on a regular basis and does a lot of work in community education, ministry work, and church activities. She is also a colon cancer survivor and shares her story with whoever would like to learn about the before, during, and after of colon cancer. Her retirement is filled with daily activities of giving to others.

Growing up in the South, Hannah was well-versed in the differences between what she was allowed to do as a little Black girl and what her White counterparts were privileged to. She was exposed to the interpretation of the law for Whites and the Jim Crow and unwritten laws for Blacks. She was able to persevere through the poverty, racism, and discrimination with sheer determination and the encouraging words of one teacher. Hannah used education to transform her life and escape the oppressions of the South. However, she
found out she could escape the poverty but discovered she could not escape the effects of the traumatic rape and sexual molestation of her childhood.

Conclusion

The narratives of the women presented in this chapter represent the emerging themes of violence (family, sexual, and community), living in poverty, and overcoming educational obstacles. African-American women are disproportionately represented among those living in poverty and among those affected by domestic violence (West, 2004); and living in poverty also predisposed them to educational challenges in urban public school systems. The RNs in this chapter are triple jeopardized as all are African Americans, experienced violence, and lived in poverty at some point in their lives. The link of poverty and violence emerged from each narrative. Violence against women comes in a variety of manners. Domestic violence against girls and women can be intimate partner violence (IPV), often referred to as domestic violence; sexual violence; threats; emotional abuse; child abuse; molestation; or community violence, such as suicide and murder. Each nurse featured in this chapter lived through different forms of violence, including IPV, child abuse, rape, child molestation, attempted suicide, and murder. Hannah was raised in a family with a lower socioeconomic status and experienced two different types of violence during her formative years. Hers was not intimate partner violence like Eleanor, nor that of a parent using physical abuse as discipline for a child such as Rose experienced, nor was she exposed to violence in her community like Jackie. Hannah was the survivor of childhood rape and child molestation. The traumatic events of childhood rape and molestation she experienced were never reported, and Hannah had to carry the emotional strain of these events with her throughout her adult life. Authorities were never notified of either assault, which is not uncommon. Hence, the prevalence of child sexual abuse is difficult to ascertain; however, experts agree that the
incidences of child sexual abuse exceed any number of incidences reported to authorities (Victims of Crime, 2015). In her case, she was taught it was considered better to not make waves and to go on with your life. She never really got the help she needed to learn to be a survivor of childhood rape and molestation, and it was manifested in her marital relationship.

Violence, living in poverty, and overcoming educational obstacles were central to the stories of the four women in this chapter. This is not an unusual finding, because according to the National Women’s Law Center (2015), “Poverty is a women’s issue” (Paragraph 1). The challenges they experienced were often disruptive to their continuance on a path of success but were not unfamiliar to them because it existed as their frame of reference from their family of origin. The multigenerational pattern of poverty and family violence were illuminated by the lived experiences of these RNs. The theory of intergenerational transmission of violence states that children who experience abuse or violence at the hands of parents or actually witness parents’ abuse or violence toward one another learn that this type of behavior is appropriate and, in their adult relationships, will imitate or tolerate these lessons learned in their own families (Egeland, 1993; Insetta et al., 2014; Smith, Ireland, Park, Elwyn, & Thornberry, 2011).

Each of these women also experienced poverty and exposure to the welfare system. Rose, Eleanor, and Jackie used welfare as it was actually initially intended, as “a temporary aid during a crisis or adjustment phase,” avoiding the pitfall of becoming a victim of “a system that is creating a permanent underclass of welfare recipient/low-wage workers” (Pearce, 1978, p. 32). Hannah’s experience with welfare was, regrettably, not as beneficial. Unfortunately, her mother abused the welfare system by collecting money for Hannah and
her siblings but kept the monthly allotments for herself, and used them to supplement her gambling and party lifestyle.

Lastly, living in poverty and violence predisposed these participants to a variety of educational obstacles. The stress of living in a community of violence or poverty affected their ability to achieve a quality education. Eleanor and Jackie dropped out of high school for a time due to their life circumstances, and Rose’s feelings of inadequacy were manifest throughout her nursing school experience, whereas Hannah was raised on the cusp of integration and faced the double bias of being a girl interested in academics instead of home economics and being the only Black at the “good school.”

The narratives of Rose, Jackie, Hannah, and Eleanor highlight examples of African-American girls who experience growing up poor, and are affected by violence, educational obstacles, and the associated struggles as they were trying to become an RN. Each had personal experiences of poverty, educational challenges, and diverse types of violence either in family of origin or in their young adult life. The life histories of these nurses were often painful and difficult. Poverty and family violence emerge as themes with overlapping boundaries, affecting their immediate educational experience and across their lifespans, causing each to overcome educational obstacles. Each understood the value of a college education as a way to remedy poverty and expressed a sense of urgency to become a registered nurse. Nursing was viewed as a respectable, steady, and stable career to help them live an independent life free of violence and to improve her and her family’s life station.
Chapter 5: Life History Profiles, Part II: Violence, Living in Poverty, Overcoming Educational Obstacles

The life histories of participants in Chapter 5 continue to illuminate the themes of violence, living in poverty, and overcoming educational obstacles, featuring the narratives of Michelle, Julia, and Thelma. The women in this chapter also share the common experience of being single mothers, raising their children alone at times while trying to become registered nurses (RN). Their life histories offer a glimpse into their lived experiences and provide supporting narrative to highlight their voices and the individual experience of violence, living in poverty, and overcoming educational obstacles of these African-American women as they worked toward their goal of becoming RNs while balancing the duties of multiple roles, as student, employee, and lone parent. As with the participants in Chapter 4, the triangulations of these three themes were at the core of their experience of becoming an RN. This chapter will give voice to their lives as they navigated through the triangulated web surrounding nursing school.

Michelle

Michelle is currently married to her second husband and is the mother of two adult daughters. She presents as a very straightforward, yet warm and engaging woman who smiles easily and laughs heartily. Michelle is 45 years old and has been an RN for 16 years. She works primarily as a contingent nurse in the emergency room at a Level One Trauma Center, while taking on seasonal assignments as a travel nurse and moonlighting in home care when she needs extra money. Michelle and I met for both interviews at her home. She lives in a quiet neighborhood in a somewhat downtrodden part of East Detroit. Her living room is immaculate, bookshelves filled with framed pictures of family members, and a variety of
family diplomas and award certificates line the walls. As we settled into each interview she emphasized how the road to get to where she is today has been pockmarked with pitfalls.

Michelle was born in Detroit and is the oldest of three children. She does not have an abundance of memory before age seven, but she does recall the family lived in an apartment building in her early years. The family first moved to a house when Michelle was around eight years old, and her parents subsequently divorced when she was nine years old. She and her siblings stayed with their mother, and she attended Detroit Public Schools (DPS) until fifth grade. After fifth grade she moved with her siblings to live with their father and his wife in Ann Arbor, and they attended school in the Ann Arbor Public School system. Over the next few years the siblings moved back and forth between the parents. With all the moves, she attended five schools from 6th–12th grades. The schools were diametrically opposed demographically. The Ann Arbor district was mostly White and middle class, and the Detroit district was almost all Black and low-income.

Michelle was a good student throughout her primary and secondary years. She was academically gifted and made good grades without much effort. With all the transitions and social adjustments, her parents did not waver on their emphasis on education. Michelle stated, “My family has always been adamant about continuing education into college…That was just a given.” Her dad holds a PhD from a prestigious Midwest research university, and her mom earned a bachelor’s degree in business management. Michelle loved the sciences and dreamed of becoming a pediatrician. Her father had “always been forthright and forthcoming with education and it being important in what it can provide a Black person…in this country in spite of the obstacles that White America puts in our path.” However, as much as her parents emphasized college, they had made no provisions to pay for it for Michelle and
her siblings. Michelle had been raised in a fairly comfortable existence as a child, but there was no extra money for college.

**Financial struggles: Young, single, and pregnant.** Michelle’s life changed the summer before her senior year. By the time she was 17, she held two part-time jobs at fast food restaurants while she was taking a summer school course she needed to graduate. It was during this summer that her personal life began to change. She explained, “I met [my oldest daughter’s] father over the summer, then I ended up getting pregnant.” She did manage to graduate on time with her class, albeit nine months pregnant as she walked across the graduation platform. But being a young, single mother brought forth a new set of problems for Michelle. She had become estranged from her mother, and her father and his new family lived too far away to help her.

She began to really face challenges financially, including being able to provide for her child. She recalled, “We started out living pretty poor.” She had serial part-time jobs and transient living conditions. She had difficulty finding a decent place to live and affordable childcare. She and her infant daughter moved in with her aunt, her aunt’s boyfriend, and their children. Her aunt and uncle were willing to help, but both were known drug abusers. Michelle was not comfortable with their drug use, but because of her financial limitations, she had to make some hard choices at times, such as allowing her aunt to serve as a babysitter. This was less than ideal, but her aunt offered her a support she could not otherwise afford: free childcare. She did not want to leave her daughter in this environment, but she felt caught between a rock and a hard place. She had to go to work and she was trying to go to school. She reflected:
I was basically dependent on her. I felt like I didn’t really have a whole lot of other choice…in the few hours that I would go to class or go to work and come back and get my child…I knew when I got there…I just knew I had to go get my kid, clean my kid up, feed my baby, but I had to get us out of there. It was some rough times there.

With her salary working two fast food jobs and welfare, Michelle was able to move out when her daughter was still an infant. She and her oldest daughter began their life on their own for the first time. She explained:

I was on aide a little bit. They knew how much money I was making, it was small, and I was still being supplemented. I just saved and back then Governor Blanchard was a lot more generous than Governor Engler was of people on aide. I used aide as a stepping stone so when I would get my money, I would save my money…Me and my daughter moved into a two-family flat. We had no lights, no nothing. No furniture…It was pitch black. But I didn’t want to stay another night at my aunt’s house.

Things were starting to look up, but Michelle still struggled. Her financial situation forced her to make many tough choices, such as feeding her daughter while she went hungry, juggling bills, and working extra shifts. She knew there had to be a better way. Eventually, things started to look up and Michelle was able to move into a house. She came to the realization that she needed a career, “something that I felt was quick but was relatively lucrative, something that would allow me to, in my heart, pay the bills and buy the shoes as opposed to paying the bills or buying the shoes.” Although she had always dreamed of becoming a pediatrician, she decided to pursue nursing, because she loved the sciences, and “two years wasn’t that bad” to complete an Associate’s Degree in Nursing (ADN) program. This was a way to help people and make a decent living. Michelle viewed nursing as a career
that would provide “for my retirement, my social security, and my children’s health…something that was more substantial and consistent.” She had her second daughter now, and to Michelle, becoming an RN would be well worth the long-term payoff of a better life for her and her daughters.

**Overcoming educational obstacles: Nursing failures.** She completed her application and enrolled in a diploma nursing program. Unfortunately, her path to her nursing degree was littered with pitfalls, barriers, and personal roadblocks. Michelle failed out of nursing school two times before she was able to successfully complete a nursing education program (NEP). The first time she failed, Michelle was devastated by her first ever academic failure. School had never been difficult for her; even as a pregnant teen, the academic workload of high school “wasn’t difficult.” She explained how she felt after failing:

> It affected me to the point I didn’t even want to go back. You know when you fail a class you can come back one more time. I didn’t even go back because beyond the fact that I had failed the class and the embarrassment of that. I was crushed.

With the failed nursing course fresh in her mind’s eye, she decided to become a nail technician. Michelle completed a three-month training program but failed the state certification exam. Her already fragile ego took another blow when she had to re-sit for that exam before she could begin working. She stayed in the nail technician business for four years. The nail tech money was “good,” and she was able to provide fairly well for herself and her daughters. Yet she remained unfulfilled. As a nail tech, she worked in an environment laden with chemicals that she knew were not healthy for her. Although the money was flowing in now, Michelle was not an efficient manager of her cash-based income. It was then she “sucked it up and went back to nursing school” for the second time.
She immediately faced her second nursing school failure in the same dreaded fluids and electrolytes course. This time, instead of retreating to the world of nail care, she immediately repeated the failed course the next term. She recalled her response to the second failure:

When I failed that time I pulled up my boot straps and was like, “grow up.” I failed it by one point. I think that I failed it because I had psyched myself out. It was the same class, fluids and electrolytes…I think because I had failed it before I kind of expected to fail it again. This time I went right back when the class came around. I went right back…entered the program and I did not fail another class.

She later added, “I was determined that I was going to get through this program and I was going to provide a better life for my children without the struggle.”

For her third attempt at nursing school, Michelle was a much more mature student. She was now the mother of two daughters, and she had gotten married to her first husband. With the addition of her husband’s income as an auto factory worker, her financial outlook had improved. Yet, as supportive as her husband was financially, it took him some time to realize the effort involved in her completing the NEP. She did not want to fail again, and he could not relate. She shared:

He…felt like I was studying too much...He…was giving me a lot of verbal bullshit!...I think that played a part when I failed the class…I told him it was his fault I failed…He was pissed off…and he never bugged me about nursing school again.

“He molested my girls.” Michelle worked hard in nursing school. Her study habits sometimes included writing out the entire chapter to improve her comprehension on certain topics. She was engrossed in her studies and focused on completing the NEP. She progressed
well, graduated, passed the nursing state board exam, had just begun her first job as an RN, and was on the verge of enjoying a life as a double-income family. Her economic future was beginning to brighten, when it abruptly came to a screeching halt. Unbeknownst to Michelle, while she was attempting to complete the NEP, her husband had been sexually molesting her daughters. Her oldest daughter was 12 years old and had gotten into trouble at school. In an effort to “get herself out of trouble,” her daughter told a teacher that she was being sexually abused by her stepfather (Michelle’s husband). Michelle rationalized, “He was sexually abused as a child and instead of getting help for it, he manifested it out in a very negative ways.” The teacher called the police and Michelle pointedly stated, “He turned himself in, admitted to what he did and went to jail.” He had molested her oldest daughter since she was nine years old and had been molesting the younger daughter for the past year. He would bribe each girl with toys, shoes, clothes, and other items in exchange for her performance of a variety of sexual acts. Michelle claimed that the girls cooperated and showed no overt signs of fear of their stepfather, so the abuse went unnoticed. According to Michelle,

He didn’t threaten them or emotionally abuse them. I guess he bribed them, like “I’ll give you this if you do this. I’ll give you that if you do that.” And he…kept his word. If they did what he told them he would get the gym shoes that he promised them or if they did what he [asked] he promised them he would get that. So there was no, “I’ll kill yo momma if you say anything.” You know, so they didn’t have that fear.

Michelle divorced her husband and started over again as a single mother. She had to realign her priorities and get counseling and therapy for herself and her daughters. They had therapy sessions with a woman who specialized in molested girls, and the therapist was pleasantly amazed at how the three of them were progressing through the emotional recovery
and psychological stress. The therapist attributed this to Michelle’s role as the “strong support system” and the fact that she “believed them from day one. They didn’t have to prove anything, and she said that made a big difference.” While her girls were adjusting through therapy and the passing of time, Michelle was facing her own personal demons. She was disheartened by what her daughters had to endure, angry with her ex-husband, and saddened by the fact that she had to start over. She angrily questioned:

Damn, why this shit have to happen to me?! Why my babies?...I had set my life up with this man and I had known him for all these years prior to setting up my life with this man. I mean, my life was getting better with him, only for it to be snatched out from underneath me…It was like it was a form of suicide. I just say that because it was his fault…He killed our life with that.

Michelle began to embark on her renewed life as a single head-of-household. She struggled with the emotional aspect and guilt of a mother not knowing. She received much needed support and respite from her stepmother. Michelle had come to the realization that “my marriage was gone and now my children are hurt and she allowed me to have some time to deal with me…[to] go home and just cry and pray and eat and sleep.” Her emotions swung from anger to sadness to fear and relief. She and her daughters adjusted to their new normal and were able to move forward. Michelle has been able to be steadfast in her efforts to move to the other side of the child molestation that had occurred in her home. Her oldest daughter is a recently divorced mother of three daughters, and her youngest is a recent college graduate.
Michelle’s current reality. Michelle had a comfortable upbringing in her family of origin. Although her family did not have a nest egg for her to go to college, she did not experience poverty until she became a single mother and became the sole provider for herself and her children. Her adult life has been riddled with poverty, academic challenges, and the molestation of her daughters, yet she has been able to achieve her goals. She readily admits that her stubborn will has a lot to do with her success in achieving her goals, and that nursing was integral in changing her life. Like Jackie (see Chapter 4), she viewed nursing education as a way to get her family out of poverty and out of the public welfare system, the time she reflected on as “the 10 years prior to me becoming a nurse.” Michelle has been an emergency department nurse for her entire career. She now supplements her income by working additional shifts as a contingent RN. Her career as a nurse has allowed her to put her youngest daughter through college without accumulating any student loans. There were times when she would “work 60 hours a week” to pay tuition and cover their expenses. She loves the flexibility nursing offers her and wants to teach nursing to others in the future. She is currently working full-time and supporting her second husband as he pursues his associate’s degree in nursing. Her future plans include enrolling in an ADN to master’s nursing program to allow her to pursue her dream to teach others and share her life experiences with future nurses.

Julia

Julia is a 48-year-old single mother of three adult children. She lives in a cozy suburb north of Detroit in a neighborhood of neatly maintained ranch-style homes. Initially, Julia was a bit hesitant to share her story in the presence of her 19-year-old daughter, so she excused us from the common family area and we met in her study. As she spoke hurriedly in a hushed tone, it was clear she did not want her daughter to hear us. I would soon understand
why she was careful about being overheard. Julia openly shares her story, which is filled with traumatic nodal moments, and she spoke freely as she started at the beginning.

**Domestic violence and poverty: Generational intimate partner violence.** Julia was born and raised in a small city near Detroit, Michigan. Her family of origin consisted of her parents, three brothers, and three sisters, with Julia holding the position of the middle child. Her mom and dad were economically challenged through her entire childhood. Their impoverished life was compounded by her dad’s drug use and the general disharmony among her parents. She rapidly explained:

> My mom and dad was struggling. In fact, my dad was on drugs so he would steal stuff out the house…We always had hand-me-downs. We always got free lunch. We was always on like a program for assistance, like Focus Hope or food stamps…We never had firsthand stuff.

Her father moved in and out of the house, and when he was in the house her parents’ marital relationship was volatile. She recalled, “My mother and father fought a lot, so my mother kicked him out every other weekend or whatever…He had a prominent job at Chrysler and he ended up losing it after I was born because of drugs.” The loss of her dad’s job put the family into a larger tailspin. Her parents continued their on-again/off-again marriage, resulting in three younger siblings for Julia. The older siblings tried to intervene in the domestic issues of their parents. Julia shared, “When my mom and dad used to fight, everyone used to run up there like we gonna break it up.” She continued on to describe her learned indifference to the domestic violence among her parents: “I just stayed in bed. I said, ‘Forget it.’ They gonna fight tomorrow, they gonna fight next week. Ain’t nothing I’m gonna say or do to change it.”
Most of Julia’s early childhood recall is centered on the violence in her family and on their impoverished living conditions. Julia attended school in the city’s public school system for her entire K-12 education. After graduation she married her high school sweetheart and joined him for his first military assignment in Germany. She explained her thinking at the time:

[I could either] marry him now and leave with him or stay home and wait on him…This was the opportunity to get out of Michigan…I didn’t see no need to stay…and get an education. I can get an education later. I can travel the world and see the world and live a little.

However, when they got to Germany, she found out what type of man she had married. Soon after arriving in Germany, Julia found that her husband “was very violent and very jealous.” Her life with her husband mirrored the marital home which she grew up in, where her parents fought constantly. She explained:

He didn’t want me to do anything. We would fight daily. He didn’t never want me to go to work, and I was like, “You don’t rule me, I’m working.” I would go to work with two black eyes. He would try to lock me in the house and everything.

The young marriage was filled with turmoil. In between her husband’s violent attacks, they had their first child, a daughter. The newlyweds completed the overseas military tour, but the relationship remained troubled. Julia had planned to leave her husband when they returned stateside, but she had a change of heart and stayed with him for his second assignment in North Carolina. Instead, Julia enrolled in a computer program course in North Carolina and took out a loan to pay for it. Unfortunately, her marriage did not change. She wanted to leave North Carolina but was informed by the school that she would owe immediate repayment of
the loan if she did not finish the program. Julia and her husband remained in an on-again/off-again relationship, just like her parents had modeled, and “in between our separation I ended up getting pregnant again with another child,” yet another reflection of what she had witnessed in her own family of origin. She shook her head in disgust as she reflected on these times.

She again planned to divorce her husband and called her sister to come and live with her in North Carolina while she finished the computer program. Having her sister present exacerbated the violence in the family. Her sister felt compelled to protect Julia, and her husband’s violence escalated and spread to include her sister, even while Julia was pregnant. She described the ongoing violence:

Me, him and my sister was fighting. I was like this big (extends her arms out wide in front of her to indicate her size)…He tried to kill me a couple of times. You know, put a gun to my head, choke me unconscious. He was always threatening he was going to kill me. If he couldn’t have me no one can.

Fueled by the desire to have her family together, Julia stayed with her husband. The intimate partner violence continued until she finally left the marriage after completing the computer program. She packed up her two young children and moved back to Detroit. When her husband finished his time in the service, he also moved back to Michigan. Her slumped shoulders and cast-down eyes suggested she is not proud of what happened next in their relationship. Julia described the nature of their relationship and what finally made her leave her husband for good:

We got back together again—had a third child. At that time he was still a jealous
person…You know, I had to make up my mind to leave him…I had enough. I got three kids. You are constantly threatening to kill me. You are constantly fighting me. I don’t want my son to grow up thinking this is normal…So I ended up leaving him.

Julia’s desire to break the cycle of domestic violence helped her muster up the courage to leave. Now, Julia was on her own, raising her three children. Even with the divorce, the violent episodes from her now ex-husband continued. Julia was living with her mother and working as a housekeeper in a suburban hospital. Her ex-husband was still threatening to kill her and even came to her mother’s house and “shot up my car.” Her concern for her safety did not subside until her former husband remarried and “kind of left me alone.” As a single mother of three with no emotional support and sporadic financial support from her ex-husband, Julia decided she needed to make a change in her life. Looking for a means to support her family, Julia decided to pursue her dream of becoming a registered nurse (RN).

**Overcoming educational obstacles: Becoming a Registered Nurse.** Julia enrolled in a local community college to start her prerequisites for nursing. Things were going smoothly; she explained, “I always liked science, I always liked math and I always did very well in those subjects.” Things did not become challenging for her until she got to the English and history courses. She struggled tremendously in those subjects. Julia blamed her academic problems with these particular subjects on the education she received in grades K-12. She succinctly described her K-12 education as “terrible!” She did not realize how academically underprepared she was until she was in college. She outlined what this discovery was like:
I didn’t know how to basically, spell, or write until I got into college…I had like a 2.7 grade point average in high school…and I applied for [University] and…when I test I score very, very low…I didn’t even know the eight parts of speech, I didn’t even know what that was. I don’t even remember ever takin’ English…After I had my kids, I went back for my nursing…I really realized I didn’t know how to write and put stuff together…so I started learning that stuff with my kids.

Julia struggled to get through the prerequisites, but she never quit. She understood the difference a nursing degree could make for her and her children. She shared her reason for her determination, stating, “All I could see was I gotta take care of my kids. I gotta take care of them now.” Unfortunately, after her first semester at the community college, the governor cut the budget and immediately shut down the registered nurse (RN) associate’s degree program she was enrolled in. Students were offered the choice to stay on and complete the program as a licensed practical nurse (LPN) or transfer to a different community college and start over. Julia still teemed with anger when she reflected on this experience, stating, “I never wanted to be an LPN…I wanted my RN…I need a degree. I was very shocked and upset when they switched our program.” Julia chose to stick it out and complete the LPN certificate program. She really wanted to stop working as a housekeeper and stop living a paycheck-to-paycheck life. She wanted an immediate career that would allow her to provide better for her children. She explained, “I wanted to get a job making some money…and live comfortable because I’m tired of being poor. I’m tired of filling out applications to dead-end jobs and they can fire you whenever they feel like it.”

The LPN program was very intense. Julia recalled not only the rigor of the curriculum but also the added academic struggle of being an African-American student:
We had to be much better than the White students...It seemed like I got questioned more and they pretty much scrutinized our papers more...It just seemed never ending...It seemed like we had more to prove...Plus some of the patients preferred the White nurses over us, because I guess they figured we didn’t know as much as them or whatever.

In spite of this, Julia never wavered from her goal. Despite her frustration with the closure of the ADN program, she knew that completion of the LPN program would be the jumpstart she needed to get her family off of public assistance. She finished the LPN program and immediately began working in a nursing home as a LPN and also took a second job as a nurse technician in a local hospital. This was only the beginning of a dynamic trip through nursing education and careers. Julia still wanted to be an RN. She knew it would offer her better long-term opportunities, and she wanted a college degree. Soon thereafter, Julia enrolled in a suburban community college’s nursing program. She finished the ADN program and for the next few years she bounced around in a variety of nursing units as an RN.

Like Rose (Chapter 4), Julia knew she did not want to be a floor nurse for her entire career. She completed her BSN and went directly into a master’s program. The master’s degree prepared Julia as a nurse practitioner (NP). Her earning power increased significantly as she began work as a mid-level practitioner. She was able to provide very well for her family. However, her family could not escape the generational nature of family violence that infiltrated her life again while she pursued her advanced degree.

**Domestic violence: The next generation.** During the course of advancing from an LPN to NP, Julia faced many obstacles. As a single mother, her obligation to her family
responsibilities often derailed her educational efforts. Her children did not get along well with one another, and she spent much of her energy mediating disputes among them. She described the nature of the relationship among her children: “My youngest daughter was so angry at my oldest daughter and my son…she said they would always throw her down the clothes chute, make her eat things she didn’t want to eat, and [were] always just picking with her.” Julia believes her children’s behavior was rooted in the abusive environment she raised them in with her ex-husband during their formative years, coupled with the trauma of the suicide of their biological father when they were all teenagers. On Super Bowl Sunday 2006, their father barricaded himself inside his home, shot their stepmother, and killed himself. He did not harm their infant daughter and left no suicide note. Julia felt a bit of guilt in the relief she felt after the suicide of her ex-husband. She was relieved that he was no longer a threat to her. Julia’s children never spoke much about their father’s suicide, and she could not convince them to go to counseling. They just continued to go about their daily lives, tolerating each other but not relating like she thought siblings should. She bluntly stated, “They never really acted like brother and sisters.”

The domestic violence that began in Julia’s family of origin and her marriage continued into its third generation and was now being manifested through her children. Her older children tormented and bullied the younger daughter, and Julia felt caught in the middle. This culminated in a violent incident between her two daughters. Julia’s younger daughter has a history of Attention Deficit Disorder (ADD), depression, and seizures. Her mental health has been a long-term management issue for Julia, and she had done fairly well until a fateful day in January 2009.
Julia had completed her associate’s degree in nursing, returned to complete her bachelor’s degree in nursing, and was working on her master’s to become a nurse practitioner. She was working full-time as an RN while going to school. She was in her last semester when the dreaded phone call came. Julia was at work and her three children were home together when her youngest daughter assaulted her older sister with a kitchen knife. She detailed what happened that day in an exasperated cadence:

I was at work and my son called me screaming, “Mom, Terri stabbed Shannon!...”
I finally told my son to call 911…I’m thinking what the hell is going on. One is on [her] way to the hospital, one is probably on her way to jail…I went to the courthouse instead of going to the hospital…The prosecutor…would not let me talk to her. He would not let me see her. He would not take her medicine. I was hysterical because she has seizures and she has to take her medicine.

Julia spent the next 24 hours going back and forth between her two daughters. She explained her situation: “I left her at the jailhouse ‘cause I couldn’t do no more there, [and] I went to the hospital…And so um, the whole time my oldest daughter was in the hospital, my youngest one was in jail.”

She was able to get Terri released with the help of a bail bondsman by paying 10% of the $100,000 bail. All the while, Shannon remained in the hospital with stab wounds to her chest and back. The division in her family made her put all of her educational and work efforts on the back burner. Shannon wrestled with the decision of whether or not to press charges against her sister. Julia was caught in the middle of this cycle of intra-family violence. She felt she had to be there for both of her children and not “take sides.” As a result of the stabbing, Terri was facing charges of aggravated assault and attempted murder;
Shannon was indicted for not showing up to court; and Julia was being accused of tampering with a witness. Her family life was going haywire. Shannon opted not to press charges against Terri, and eventually all court charges were dropped. Now, Julia was faced with trying to mend the relationships between her daughters and getting everyone’s life back on track, including her own work and school life.

In the aftermath of the stabbing, Terri’s behavior vacillated between being super-angry one minute and ultra-friendly the next. Julia returned to school and was close to finishing the NP program. Then early one April morning around 6:30 a.m., Julia was awakened by a noise in the house. Terri had attempted to commit suicide. She recapped what happened: “She was just looking at me…She said, ‘Okay ma, I took all my pills in the bathroom.’” Terri had attempted suicide by taking over-the-counter medications. After informing her mother what she had done, she ran out of the house. Julia searched the neighborhood for her daughter. She finally found her at a friend’s house, locked in the bathroom. Julia matter-of-factly recalled that morning, “She finally open the door…she’s so lethargic she…could barely stand…She’s just a crying, ‘I want to die, I hate my life, no one loves me, I don’t want to be here.’”

Terri was hospitalized on a psychiatric unit for two weeks, followed by intensive counseling for three weeks. The aftermath of the stabbing forced Julia to take a Family Medical Leave from work and school to support Terri. Julia was trying to finish her NP degree, but her family responsibilities interfered with her academic progress. She could not leave Terri to go to class or work. Terri required someone to be with her 24 hours a day. With no one else to turn to, that responsibility fell to Julia. Her savings were rapidly depleted paying for living expenses and counseling for Terri not covered by insurance. Further
complicating matters, her lack of attendance in classes and clinical threatened to derail her ability to finish her master’s degree. With the family responsibilities of the court proceedings, hospitalizations, and mental health care, Julia had not been able to attend to her coursework and clinical hours needed for degree completion. She was notified by her clinical instructor of her status in the NP program. “My teacher tells me she not going to pass me…You know, everybody else passing me, but she not. So the school…calls me in and say, ‘Well, you can’t graduate…You can’t get your degree until you finish these hours.’” Julia explained, “I got 100 hours to finish by June 6th and it is April 2nd.” Julia remained determined about finishing her master’s degree. She cast her eyes downward as she outlined how this affected her:

I’m dealing with my daughter who was trying to commit suicide and everything else. I’m like real upset and everything. I got to get through this. I didn’t get this far to fail…Shit! I called the pulmonologist who was going to hire me and told him I can’t start working for you until I finish school…I asked him is there any way I can do these hours at your clinic since I am going to be working for you? He was like, “Yes, that would be great.” So I was able to finish my hours with him without being stressed.

Overall, Julia ended up taking about seven months off from her work dealing with her family’s issues. Most of these issues were related to Terri, the stabbing, shoplifting, and the suicide attempt. Julia shook her head and stated she was “in trouble all the time. I was always in court with that child. Flicking out money like crazy to keep her out of jail…I was out of a whole lot of money.” However, being off work did permit her to complete the volunteer clinical hours needed for her NP and graduate.
**Julia’s current reality.** Since February 2015, Julia has held a position as a mid-level provider with an insurance company. Although she has faced many obstacles in life, Julia is pleased with her success in nursing. She has moved along the nursing continuum from LPN to NP and has seen her income grow correspondingly:

I mean I’ve climbed the ladder. It was hard doing, hard work. It was not easy. I went from making $16 an hour as an LPN and now I make…$101[thousand] plus a year…I have all kind of money now, and choices.

Her children are now 22, 25, and 27 years old. Although financially stable, she is still involved in caring for Terri. Shannon has a career as a behavioral medicine nurse and dreams of using her nursing experiences to pursue her true love of becoming a writer. Her son is working at an insurance agency. Terri still struggles with completing anything and still lives with Julia. Julia explained, “She’s in school off and on and she works off and on…then she quits or gets fired…Depending on where she is in her illness whether she pass or fail the class. She’s trying.”

Julia has survived through a life cycle of poverty, poor foundational education, and multi-generational family violence. She now lives a very comfortable life financially but still has to help her youngest daughter, who is an adult, as she lives with her mental health issues. However, she is clear that she would rather have taken a different route to her success. She regrets not heeding her mother’s advice. Julia shared:

She said, “You have the mind and opportunity to be whatever you want to be and it’s up to you whether you pursue it or not. You can’t blame nobody. Don’t blame the fact that you grew up poor…Just because…we are poor doesn’t mean you have to stay this way.”
Her mother instilled in Julia the belief that education will allow her to have freedom in life, freedom to do what you like and be whatever you want. Julia never budged from this belief. Julia proclaimed:

Through anybody’s life they have stories they can share that’s not pleasant—that’s life. You keep living, you’re gonna live through some stuff...What doesn’t kill you, make you stronger...My mom struggle[d] with seven kids. She always instilled in us you have to be able to stand on your own two feet and get education...Be able to take care of yourself. Don’t be with nobody because they can take care of you...because all they’re gonna do is cripple you and abuse you.

Yet like many of the women in this study, she wants her life to be an inspiration to others. Her determination, will to provide for her family and stand on her own, is what drove her. She hangs her head and shyly summarizes her life:

If I had to do it all over again I probably wouldn’t get married at such a young age. I would’ve stayed in school and got my education...before doing all the other stuff I did...it’s not easy out here but you know if you put your mind to it you can do it...If it’s something you want to do then you can do it.

In spite of her early academic struggles, Julia now has a very successful career as a NP. However, she is still dealing with the collateral effects of survivorship of intimate partner violence and family violence between her children. The physical scars have healed, but the emotional damage of being a survivor of generation after generation of family violence has been taxing for her and her children.
Thelma

Thelma is a 45-year-old divorced mother of two adult children. She is currently working full-time as a registered nurse on the electronic medical records team at an urban healthcare system. She is living with her fiancé, with no firm wedding date set. She is contemplating returning to school for her master’s degree.

Thelma is the fifth of six children born to her mother, and fifth of “seven, eight, or nine” children born to her father. Her mother was an auto factory worker, and her father owned a funeral home, sold real estate, and retired as a grocery warehouse worker. Her parents divorced shortly after she was conceived. She does not have a lot of early childhood memories, but she recalled moving frequently and crowded living conditions. She shared, “We lived in a family flat that had all of like two or three bedrooms, and you had three boys and three girls, so you know it was packed.” Her most lucid memories begin at age eight.

When Thelma was eight years old her mother remarried and moved the family to “this big, big house” in a pristine African-American, upper-middle class neighborhood in Detroit. She described her neighborhood, saying, “[The] area was very affluent. Our neighbors consisted of physicians, attorneys, police chief. I lived next door to [a musician]. I used to play with [famous children]…I grew up in a really nice neighborhood…a community, an incredible village.”

Community violence: Gangs or school? Thelma attended the neighborhood public school and described herself as “pretty good in school” during the elementary and middle school years. She was a quick learner and relished the praise from the teachers. This changed when she entered high school and became affiliated with a street gang. Thelma stopped doing schoolwork and started fighting. This behavior went on for the first two and a half years of high school. The fighting escalated to gun violence. Her friends were being shot, and she
began carrying guns to school with her for protection. When she was in the 11th grade, “they decided to expel all of the problem childs [sic]…So months before ending 11th grade I got kicked out…They actually kicked me out of the entire Detroit Public School system.”

Her mother had moved to Ohio for work, and Thelma was left under the non-legal guardianship of her maternal aunt. Her mother found out about her gang activity and moved Thelma to Ohio with her. Thelma viewed this new start in a new city as lifesaving:

There is where my life changed for me. It was like the best thing ever that could have happened to me…I never talked about college when I was in Detroit. I never even saw beyond high school. When I got there they [other students]…already knew what college they were going to. My baby sister was in middle school, [and] they were already talking about college—*in middle school!*...It was a totally different environment…That’s when I began to change the way that I thought, the way that I saw things, my perspectives on life, and I thought about college. I actually applied and I was excited.

This was a critical juncture in her life. It was her first time in an integrated school, and she began to reflect the thinking and culture of the new high school. College became a real possibility for her, something she had never considered in the past. She was amazed at how the girls in the student body carried themselves as “young ladies…I was in awe,” and how everyone was planning for their futures. Thelma was shocked; she had never thought beyond surviving the current day.

She had also never considered the importance of academics in her life. Unfortunately, changing focus during the last year of high school was not enough to undo the academic damage already done during her first three years of high school in Detroit. Even with all her
renewed academic effort, her GPA at graduation did not get up to a 2.0: “I believe the last
time I saw it [her high school GPA] it was a 1.67. I mean that’s like horrible, because I
wasn’t doing anything [in Detroit] basically.” This was disheartening as the time came to
apply to college. Her new peer group was excited about attending the popular State
University; she applied to numerous major public universities and was not accepted to any.
Her only acceptance letter was from a local historically Black university, so that is where
Thelma enrolled for her freshman year.

In college, Thelma quickly reverted to her behavior from Detroit where she was
“hanging with the wrong people and I missed class for all five weeks straight. Partying…just
wild. I had fun.” This did not rest well in her spirit and she quickly reprimanded herself and
changed her approach to college: “I didn’t want to do that anymore…I woke up…started
doing my work, talked to my professors, got caught up on my work and bust all A’s and by
the end of that semester I moved into the Honors dorm.” She was determined to earn her
college degree. Thelma was on her way to becoming an accountant, or so she thought at the
time.

Financial struggles. Unfortunately, her mother’s income as an autoworker exceeded
the federal guidelines, and Thelma did not qualify for federal financial aid grants. Her college
bills had to be paid on a cash basis or through student loans. Before she could begin her
second year, she had to pay a $3,000 balance owed. Thelma did not have the cash, and
neither did her mother. She approached her biological father for the money. Her father
consulted with his wife and elected not to provide Thelma with the money she needed to pay
off her balance and return to school. She shared her devastation: “It was like how could you
not support me? I made a significant change in my life. It was not like you didn’t have it.”
Thelma returned to Detroit, but she had lost focus and had no drive for success. She recalled, “[I was] getting up in the morning, not doing anything. Living off my mother, drinking and all that.” One day while out running an errand for her mother, she saw a portable set-up advertising training for becoming a medical assistant. This stimulated her interest and became the impetus for her career in healthcare. She enrolled into that medical assistant program and excelled. She shared, “I was doing very well. I loved it. I never knew...that I would like it [healthcare] so much.”

Thelma went from having no purpose to envisioning herself providing the public with healthcare. The program was nine months long. She was very excited, and life was looking up. Then, on the first day of the medical assistant program, she found out she was pregnant with her first child. She continued with the program and in June of 1988, she had her son “two or three days prior to graduation.” She literally gave birth to her son and figuratively birthed her life in healthcare in the same week.

Thelma moved in with her “baby daddy” and worked as a medical assistant for approximately a year. She began to desire more in her career and decided to start nursing school. Her “baby daddy” did not encourage her educational pursuits either. She started taking nursing prerequisite courses anyway but found it difficult to stay the course. Thelma reflected on the challenge of balancing her love for her son’s father and her pursuit of her nursing degree:

[I was] just in love and stupid…he was just not supportive…I think I quit after the first or second semester. I was doing good. I had straight A’s and a B when I was in there. I got...so distracted that I quit.
She spent the next few years working as a receptionist and medical assistant. She worked full-time to provide for her son and stay off public assistance. She proudly stated, “I was never without a job. I was on welfare for seven weeks. Seven weeks of my entire life.”

**Domestic violence: “We fought all the time.”** She married her son’s father in 1992 but never lost the desire of wanting more in her life. She really wanted to be a registered nurse. Her husband was working for a local bakery, but their income was not sufficient to meet all their needs. Thelma resorted to selling small quantities of marijuana to supplement the family household income. Tension soon developed between her and her husband. He was not fulfilling the role she thought he should as head of the household: “He was working…And I guess I had that drive, that thrive to want more, but he didn’t want more. And he was content, but I wasn’t content. That’s essentially how we wound up growing apart.” The marriage was in trouble. Their marital conflicts were centered on interference from his family, infidelity, her vision of his role as a husband and father, and the lack of commonality for future goals. The marriage had become physically violent as well. The couple would have fights regularly. The intimate partner violence was perpetrated by her husband and reciprocated by Thelma. She explained:

> We fought all the time…He [was] cheating on [me], and I fought the man and all that…It just wasn’t working anymore…I’m not condescending but he doesn’t have an education. I think he has like a 9th or 10th grade education…He didn’t spend time with me…You know, he wasn’t a provider also. Essentially, I was taking care of my kids and my husband…As I continued to mature, he wasn’t maturing with me. And I did everything I could to preserve it ‘cause I still loved him when I left him.
Thelma tried to hide the domestic violence from everyone, but it began to wear on her emotional wellbeing. Making the final decision to leave her husband was very stressful for her. The tipping point came when she became unable to function at work. She would go to work and sit mute, in the fetal position on an exam table for the entire eight-hour shift. She knew she needed help. She sought counseling and started on medication to help her sleep, but she was not forthright even with the behavioral health physician she consulted. Her breakthrough came when she finally confessed to the behavioral health physician about the domestic abuse and infidelity, stopped the medication, and made the decision to leave her husband. She recalled the darkness she felt surrounding the IPV and troubled marriage:

“Actually I feel I had a nervous breakdown. I swear I did…It was like there was a gray cloud over me every day when I would go to work…I was very depressed at that time. Until I left.”

Thelma divorced her husband after a little more than three years of a turbulent marriage. She was now the single parent of an eight-year-old boy and a three-year-old girl. She was working and doing her best to raise her children on her own. She found comfort in studying the Bible, going to church, praying, and hanging out with her friends. She credited her friends and her faith with helping her “get through that dark stage of my life” and reclaiming her vision for her future as an RN.

**Overcoming educational obstacles: “I wanted to be a nurse.”** Thelma enjoyed being a medical assistant, but when she turned 30, faced with providing for her children alone, she felt compelled to do more. “I looked at where I was and what I’ve done…I really had like an epiphany. I looked at where I want to be in the next 10 years…I wanted something different and better and it was go to nursing school.”
Thelma started applying to nursing education programs again, but she had an unpaid student loan from the medical assistant training 10 years earlier, which made her ineligible for any financial aid until it was repaid. Without financial aid she could not pursue her dream of going to nursing school. With one income and two children to care and provide for, she did not have any extra money for a lump sum loan repayment. One of the doctors she worked with overheard her talking about this “roadblock” and paid her $500 loan debt so she could get started in her nursing coursework. She could not go back to the NEP she started years before, as it had since closed. She completed her prerequisites at a suburban community college and then found out that the waiting list to get into the NEP was up to a yearlong. As a nontraditional student and a single mother, Thelma felt, “I don’t have a year to wait.”

She found a NEP that had immediate openings in enrollment. It was a bachelor’s degree program at the local private faith-based university. At age 32, Thelma began nursing school. The nursing program presented her with some new challenges. The course and clinical schedule was not conducive to the life of a single mother with two young children. She needed to find childcare for her children that would provide services outside of the normal business day. She was fortunate to have a neighbor she entrusted to help her. She explained her desperation:

I didn’t have a lot of familial support. I wound up befriending my neighbor across the hall and…had to give her a key to my apartment…My children could stay in the apartment when I had night classes…She would just come in and just peek on them and…make sure they were ok.

Knowing her children were “ok” allowed her to focus on her studies. But she also struggled to pay for school using loans, her medical assistant salary, and an employer-
sponsored reimbursement program, but she earnestly pursued her nursing degree. Yet she still faced challenges academically. She had personally observed many African-American students fail classes or drop out completely. She did not want to be in that category. She reminisced about her nursing class, saying, “It was about ¼ African-American and ¾ Caucasian, but when it ended it…[was] much less. Probably 10 [African Americans] out of 80. Everyone didn’t graduate.”

Thelma’s personal academic struggles were filled with bouts of test anxiety. No matter how well she had prepared, when test-taking time came along she failed miserably. She described her experience during testing, saying, “I would start questioning myself and my abilities, and it would just get me all nervous.” Thelma sought help from the university student services department. The school supported her tremendously. She was allowed to “sit out of the class, just somewhere else away from everybody else,” to take her tests. She was able to manage her test anxiety. Unfortunately, like many other students she failed a class during her NEP, but she did not let this alter her course: “I had to repeat my psych class…I had failed psych nursing by two points… So, instead of having that summer off, I wound up taking that class right away so I never fell off track.”

Thelma’s current reality. Thelma survived the triad of living in poverty, domestic and community violence, and academic struggles. As a single mother, she teetered on the edge financially, and as a married mother, she took risks to support her family and endured a volatile marital relationship. The gang violence she grew up in within her community filtered into her marriage as a method of problem-solving. Her husband assaulted her and she fought him. His infidelity and her perception of his lack of commitment and purpose fueled the abusive relationship until it finally self-destructed. As a single mother of two, she realigned
her priorities. Her goal was to become an RN, and she was not to be deterred. Thelma’s resolve was nourished by her knowledge that a career as an RN was a vehicle to a better life for her and her children. She understood the simple math; a life wage as a medical assistant did not compare to that of an RN. However, the hours and workload of a working mother/nursing student were not conducive to family life. Her young children had to become modern-day latchkey children while she was in nursing school. She also established a small support group of nursing school friends with whom she studied and commiserated. She utilized her self-made support network to propel her toward her goal.

Thelma spent many years as a staff nurse. Emergency room nursing has been the mainstay of her career. She has also spent some time as a nursing clinical instructor. For the past few years Thelma has been a part of the electronic medical record team. Thelma is currently preparing to begin pursuing her Masters of Science in Nursing degree. Her ultimate goal is to become full-time nursing faculty at the university level. She would like to be an advocate for the struggling African-American student and offer an educational experience laden with understanding.

**Conclusion**

Michelle, Julia, and Thelma faced a variety of barriers that impeded their ability to successfully complete a nursing degree. As minority students from urban areas, these participants experienced restricted access and limited success in higher education. Each of these participants had her own academic struggle that impeded her success in nursing education. Hochschild (2003) argued that socioeconomic class differences affect educational outcomes, such that children who attend schools in poorer neighborhoods do not perform as well academically as children hailing from schools in neighborhoods with higher socioeconomic status. Urban neighborhoods have been shown to have an influence on the
academic performance of African-American students of all grade levels (Francois, Overstreet, & Cunningham, 2012; Milan, Furr-Holden, & Leaf, 2010). Additionally, the impacts of family violence on academic performance cannot be ignored. These women matriculated through urban public school systems where academic preparation proved inadequate to prepare them for the competitive admission processes of nursing education programs and success once admitted. They also had an overwhelming lived experience of family violence. Further compounding their challenge to complete nursing school were the limited openings that nursing education programs routinely face. In 2011, 75,587 qualified nursing school applicants were turned away due to inadequate seats to accommodate the demand (AACN, 2012). Additionally, nursing education programs often consider grade point average, pre-admission test scores, essays, recommendations, and interviews as admission criteria, and will simply admit the best of the best each year, not taking into consideration soft character traits such as motivation and tenacity. These admission policies can create obstacles for economically disadvantaged nursing students seeking admission to nursing school.

Once admitted, they encountered the collateral effects of inadequate academic preparation during their primary and secondary education. The results of inadequate academic preparation are manifested in higher course failure and attrition rates (Robert Wood Johnson Foundation, 2012). Compounding the academic barriers to success is the sequential nature of nursing courses. Nursing courses build one upon the other, and students cannot progress until each prerequisite course is completed sequentially. Course failures derail this process, adding financial burden and immediate feelings of rejection and failure, compounded by having to wait up to a year before being able to repeat the course and
continue progression in the program. The additional time and expense can be enough to deter some from continuing.

The narratives of Michelle, Julia, and Thelma illuminate experiences of single mothers as they lived through family violence, endured family responsibilities, and navigated beyond academic struggles in their pursuit to become registered nurses. The financial challenge of poverty was a persistent factor for all of the RNs discussed in Chapters 4 and 5. However, these women remained earnest in their goals. Each of them felt driven by a responsibility to provide a better standard of living for their children and viewed education as a registered nurse as the critical element in doing so. Like the women in Chapter 4, having been raised in poverty or lived on welfare as a struggling adult, these women expressed a desire to not have government assistance be a long-term staple in their lives. Neither allowed the circumstances of her life to interfere with her goals. Actually, no matter the nature of the violence, each woman recalled the violence rather matter-of-factly and did not see it as an obstacle or barrier, just a circumstance of life. Welfare was viewed as a vehicle to assist them temporarily as they pursued what Julia’s description synopsized for all of them as “a better life.” Although each struggled academically in nursing school, each woman subsequently worked to achieve success in nursing school. The meanings attributed to these experiences were impactful and impressionable on Michelle, Thelma, and Julia and inspired them to want to help other African-American women become RNs.
Chapter 6: Violence, Living in Poverty, Overcoming Educational Obstacles—Thematic Analysis

The women in Chapters 4 and 5 all experienced some type of gender violence in their lifetimes. Each had her own experience with family or community violence, but all shared how it was a major factor in their journey to become registered nurses. These women also had a phase in their lives that was affected by the living conditions of poverty, and how they had lived on the edge was not something they wanted to continue into their adult life and, in most cases, the lives of their children. These women shared how their academic obstacles—either before or during nursing school—provided a barrier for them that at times seemed insurmountable. Finally, all expressed how their nursing education was affected by the confluence of violence, poverty, and academic challenges they endured during their lived experiences in becoming registered nurses. In this chapter the following themes will be extrapolated: violence, living in poverty, and overcoming educational obstacles. Additional narratives from other study participants—Elizabeth, Grace, Angelica, Hillary, Sarah, Eliza, and Laura—are also included in this chapter to further illuminate these themes. Although their full life history profiles are not presented in this chapter, summaries of their participant profiles are in Appendix F: Registered Nurse Participant Profiles (pp. 288–299).

Violence

The women in Chapters 4 and 5 experienced domestic violence in a variety of forms, as well as community violence. Table 2 shows the type of violence, experience with poverty, and educational obstacles experienced by the featured participants (Appendix G). The term *domestic violence* has traditionally been used to refer to physical violence of a man perpetrated against a woman. The US Department of Justice (2015) defines domestic violence as “a pattern of abusive behavior in any relationship that is used by one partner to
gain or maintain power and control over another intimate partner” (Paragraph 1). Domestic violence (in more recent years the term intimate partner violence has replaced this term) includes physical abuse, sexual abuse, psychological abuse, emotional abuse, and economic abuse. The National Child Traumatic Stress Network (n.d.) defines community violence as the exposure to intentional attempt to hurt another person committed by individuals who are not intimately related to the victim. These acts occur in a public space; exposure to these acts results in community violence.

**Generational nature of domestic violence.** Eleanor, Julia, and Elizabeth (Appendix F) grew up in homes where domestic abuse was perpetrated to their mothers by their fathers. Eleanor’s father’s behavior toward her mother was an indication of the intimate partner violence (IPV) that existed between her parents. Her father’s actions were intended to harm her mother’s sense of self-worth, which is characteristic of an emotionally abusive relationship. Her mother, in turn, projected an emotionally abusive relationship onto Eleanor. The generational nature of family violence became evident when Eleanor embarked on an emotionally and physically abusive relationship with her daughter’s father. Eleanor’s story is not unlike that of many women who experience violence in relationships. These women often have an early home life with poverty and domestic violence as their frame of reference. Elizabeth explained how this was manifested in her life: “My mom was…abusive…mentally [and] physically to me…My mom was in an abusive relationship with my younger brother’s father…That’s how I ended up in abusive relationships, because both of my children’s father[s] abused me.”

**Intimate partner violence.** Intimate partner violence (IPV) is a major problem in the US. It is estimated that three out of 10 women experience some type of IPV in their lifetime.
It is widely believed that these numbers underestimate the magnitude of the real prevalence of IPV in the US due to fear and the resulting underreporting (CDC, 2012). Reported statistics suggest that African-American women make up 8% of the US population, but compose 29% of women who report domestic violence (Institute on Domestic Violence in the African-American Community, 2015). Ultimately, this results in a woman being beaten or assaulted every nine seconds (National Coalition Against Domestic Violence, 2015). These numbers are not believed to be a true estimate of the breadth of the problem, as family violence is often underreported due to fear that no one will believe them (the victim) or that the authorities cannot help (CDC, 2012). Julia never reported the physical abuse to authorities. She explained, “I didn’t try to drag anybody into my situation.” Thelma’s life story illustrates how women live with IPV and forego truthfully reporting the violence to authorities. She sought help for her physical symptoms—including the use of prescription medications—without being completely forthright with her doctors, and she used her informal friend network as her support system. She shared how she finally confessed to her doctor about her home life: “I went in and I said ‘look I’m not taking these pills anymore…because I’m leaving him.’ She’s like ‘I knew there was something else’…It was my friends that helped me get through that dark stage of my life.”

In *Black Women’s Roundtable: Black Women in the United States*, Jones-DeWeever (2015) posited that Black women are even less likely to report IPV, stating, “Navigating a cultural context that is itself, bathed in both racism and sexism, Black women often feel the need to protect their abusers from police involvement which may escalate to the use of lethal force” (p. 13). The violence perpetuated by Black men against Black women has been connected to the historic oppression of Black men in society. It is a relationship of
victimization and the cycle of violence that is grounded in racism and fueled by the patriarchal structure of society. Thus, Black women often have an embedded sense of protectiveness of *their* Black men from the involvement of police and social services for fear of the outcome for the men (Bent-Goodley, 2013; West, 2003). Additionally, some Black women do not report domestic violence because of economic reasons. Facing life on one’s own may not seem like a reasonable solution to the horror of family violence. Black women often choose to live in a state of personal danger rather than face economic hardship alone.

**Community violence.** Community violence is a relatively new term and can encapsulate many events. According to the US Department of Veterans Affairs National Center for PTSD (2015), community violence includes many events, such as stranger threats and violence or violence among family members, close partners, or peers in their neighborhoods and schools. It is not exclusive to urban inner city areas or gangs; however, non-White children who live in poor, inner city areas—particularly those with a gang affiliation—are at the greatest risk for community violence.

Thelma and Jackie are classic examples of women who lived surrounded by community violence as children. Thelma was from an affluent neighborhood, but she chose to align herself with a gang she joined one day by happenstance while walking to school. Hence, she was surrounded by gun violence and fighting. Every day was a lesson in survival for her, particularly as she walked to and from school. She shared, “It was a lot of gang activity…One of my friends had gotten shot…A whole lot of back and forth, cussing and arguing…my friends shot up this house, these guys…pulled guns on…all three of us…but I managed through that.”
Conversely, Jackie was raised in an urban setting, in a variety of housing projects all of her developmental years. She recalled violence as part of her regular day. She expressed a decreased sensitivity to the violence surrounding her that bordered on indifference. She was exposed to violence in many different forms and witnessed things most children could not dream of. As a child, Jackie was immersed in a community that yielded the murders of her friend, her sister’s boyfriend (across the street from their home), and her brother’s father. She explained the violence surrounding her during her formative years: “I did see people get murdered in the Projects…at the recreational center… [this] guy’s brain was on the wall and he was laying on the ground…I seen people get stabbed, I seen people get murdered.” Her lived experience included so much community violence that she expressed a decreased sensitivity towards it when she recalled these violent incidents.

Children’s exposure to community violence has become a major public health issue (CDC, 2010). Merely existing in today’s society threatens the wellbeing and health of children and adolescents. Garbarino (1995) argued that children are our most vulnerable members of society and compared the social environment to the toxicity of lead in the water or air pollution. African-American youth living in urban neighborhoods are more likely than their White counterparts to be exposed to community violence (US Bureau of Justice Statistics, 2006). Exposure to community violence is a reason to be concerned for many African-American youth. It has been linked to a web of psychological, physical, and academic problems for adolescents (Busby, Lambert, & Ialongo, 2013) and elementary school-aged children (Ratner, Chiodi, Covington, Sokol, Ager, & Delaney-Black, 2006; Wilden, Williamson, & Wilson, 1991).
Violence against children. Growing up, Elizabeth’s mother routinely disciplined her by physically attacking her. Elizabeth suffered beatings with a broom and other incidences where her mother “jumped on me real bad,” leaving her with visible physical scars, such as a busted lip, scratches, and bruising. She also described how these physical onslaughts were accompanied by psychological abuse that affected her self-esteem. Elizabeth characterized the punishment received from her mother as abuse. This is supported by the findings of Durrant, Trocmé, Fallon, Milne, Black, and Knoke (2006), who documented that most cases of physical abuse begin with parents using physical measures to punish their children. Being told by her mother that she was worthless, or being called a “whore,” left a mental imprint that she believes still affects her self-esteem today. Studies have documented a broad range of negative effects of childhood abuse that can persist for many years, including anxiety and lower self-esteem, and that can affect school functioning, anxiety, and difficulty forming relationships (Fitzpatrick & Boldizar, 1993; Springer, Sheridan, Kuo, & Carnes, 2007). Rose was raised in a home where corporal punishment was the norm, and her parents used a variety of spanking methods. At that time, Rose accepted that as the way to discipline children. Like Rose’s, many parents believe spanking is an effective form of discipline—a way to elicit an expected change in behavior. Others argue that spanking is an ineffective form of discipline. Rose was the main target of her parents’ form of discipline which included hitting, slapping, and spanking with belt. Graziano and Namaste (1990) called this type of discipline as *subabusive violence*—“socially acceptable violent behavior toward children” (p. 450). Their research with first-year college students found that 93.2% reported being spanked as a child and were accepting of spanking as a form of discipline for themselves and their future children. This intimates a generational transfer of such types of
discipline. Strauss’ (1991) work with data from the National Family Violence Survey found that spanking may produce short-term immediate conformity but increases the likelihood of deviant behavior in adolescence and adulthood. Greven (1991), an anti-spanking advocate, argued that many of those who support spanking have grounded their rationale in religious doctrines supporting this type of discipline. Ossea Hawkins et al. (2010) found that ethnic/racial minority parents were more likely to use physical discipline and that said discipline over time can escalate. Spanking can also cross the line to beating and then slip into the category of physical abuse. The American Academy of Pediatrics (AAP; 1995) joined many other voices in its position against spanking, calling spanking the least effective method to discipline. The AAP position statement admonishes spanking for the physical harm produced from spanking and teaches children that violence is acceptable. Most importantly, spanking interferes with socio-emotional development of trust, security, and effective communication. Rose’s situation was similar. Her parents used corporal punishment and considered this an acceptable method of discipline, which Rose in turn employed on her younger siblings. She shamefully admitted how she used these discipline strategies, saying, “I was taking care of them… I was it. You know making sure they ate. I even spanked them. I was like expected to like [be a] grownup.”

Spanking has a long tenure in human history. It has long been used as a method for correcting children’s behavior. In America, we have tried to make spanking a socially acceptable way to describe hitting children, while postulating that hitting is not a proper means for adults to solve problems. Today, however, professionals and human rights advocates argue that spanking (corporal punishment) is ineffective and harmful and push for parents to stop spanking their children (Gershoff, 2013; Hineline & Rosales-Ruiz, 2012).
Others have taken a stronger position against spanking in labeling it as a human rights violation and an act of violence against children (Committee on the Rights of the Child, 2006; Gershoff & Bitensky, 2007).

Hannah and Michelle’s stories illuminate the sexual violence perpetrated against children. Many victims of sexual violence were first victimized at a young age. Hannah’s rape by two neighborhood boys familiar to her is not unusual. According to the CDC (2014a), 94.4% of perpetrators of sexual violence were someone familiar to their victims. Additionally, among female victims of completed rape, an estimated 40% occurred before age 18 years (Breiding, Smith, Basile, Walters, Chen, & Merrick, 2014). Child molestation and sexual abuse data are difficult to ascertain accurately. There is agreement among reporting and tracking agencies that the number of such occurrences is underreported. Data published by the CDC (2014a; 2014b) indicate that 42.2% of female rapes occur before age 18, females are more at risk than males, minorities have an increased risk, and being from a lower income family increases risk more. A more specific survey, the Developmental Victimization Survey, was conducted by Finkelhor, Ormrod, Turner, and Hamby (2005) to gather data on victimizations from birth to adulthood over one year. Findings indicated that one in 12 youth experienced sexual victimization, including attempted rape of 22 per 1000, with the highest rate of physical assault victimization occurring between the ages of 6 and 12.

As a survivor of childhood rape and molestation, Hannah was traumatized by these events. Due to societal pressure, she never reported these violent acts against her to authorities. She shamefully admitted, “We are in the [19]50s… [during] that time you did not say things.” She carried the burdens of her unreported and untreated assaults with her into adulthood. She shared how the ill effects infiltrated into the intimacy of her marriage,
explaining, “One time [my husband] asked me, ‘Why do you feel that you cannot give into me easily?’ It just broke me down…because you don’t know what they will receive and you don’t really want the sympathy.” Hannah’s adult response to intimacy is indicative of her suppression of her response to the rape and molestation of her childhood. She was not provided with an opportunity to heal or to learn to cope with flashbacks and/or feelings of anger and grief.

Michelle was an indirect victim of violence against children. The sexual molestation of her daughters by her husband, their stepfather, put her in the unenviable position of parent of survivors. Her job as a now-single mother was magnified by the responsibilities of assuring her daughters’ emotional state and future wellbeing were intact, as well as processing her own emotional reaction to the molestations. She earnestly made efforts to be open and frank with her daughters about what happened to them and to affirm with them they were not to blame. She coached them and tried to absolve them of self-blame and to manage her own feelings. She outlined her approach, saying, “He molested my girls…On one hand my marriage is done…and my husband is gone and now my children are hurt. So…take your ass to jail! But I’m also trying to make sure they heal as well.” Michelle’s reaction is consistent with the findings of studies conducted with the mothers of sexual abuse survivors. Mothers may have varying responses to the abuse of their children; however, they remain the cornerstone to successful treatment for their children (Finkelhor, 1986; Hubbard, 1989).

Childhood sexual abuse has potentially detrimental effects on the overall wellbeing of victims later in life. Studies have demonstrated that female victims of sexual abuse have a higher risk of revictimization (Barnes, Noll, Putnam, & Trickett, 2009), self-harm (Tunnard et al., 2013), and co-morbidity of physiological and psychological stress (Mendle,
Turkheimer, & Emery, 2007). Long after the physically traumatic episode has passed, the long-term effects linger and can be manifest as a variety of problems, including obesity (Noll et al., 2007), depression, sleep disturbances, eating disorders, poor self-esteem, ability to form interpersonal relationships, and stigmatization (Mendle, Turkheimer, & Emery, 2007). Hannah’s story illustrates how these disturbances can lie in the recesses of the mind and later awaken to infiltrate interpersonal relationships and negative sexual functioning. Michelle’s awareness of these potential impacts on her daughters played a major role in how she helped them cope with the assaults by her ex-husband, particularly during the critical phase of adolescence.

**Living in Poverty**

US Census data from 2014 revealed that there were 10.8 million (26.2%) Blacks living in poverty. Women living in poverty consistently outnumbered men, with six out of 10 poor adults being female—equivalent to 18 million women (16.1%). Among African-American women, the poverty rate is more highly concentrated, with 26.2% of all African-American women living in poverty; this increases to 30.6% if the African-American woman is the head of the household (US Census Bureau, 2015). Pearce (1978) coined the term *feminization of poverty* to reflect the overrepresentation of women among the poor. Additionally, there has been an increased recognition of poverty incidences among “female-dominated groups such as carers” (Lister, 2004. p. 56). As a primarily female profession centered on caring, nursing is impacted by feminization of poverty. Knudsen (1969) found that the percentage of female workers in an occupation had a direct inverse relationship with the amount of pay. Yet nursing can be a route out of poverty for women, and such was the impact of nursing on the lives of the RNs in this study affected by poverty.
Living in poverty is not exclusive to single-headed households. It can also have impacts on traditional nuclear families. Rose was raised in a home with parents who could be described as working poor. Her parents both worked but struggled to meet the family’s basic needs. *Working poor* is a term used to describe families that remain below the official poverty level even though the adults are gainfully employed or actively seeking employment for at least 27 weeks (US Department of Labor—Bureau of Labor Statistics, 2014b). Although Rose did not report official income levels for her parents, growing up, she was aware of the financial difficulties her parents encountered. Rose described the financial situation of her parents; she stated, “They were having financial trouble” all the time.

**Poverty and violence.** Researchers have found that being socioeconomically disadvantaged increases the risk of any type of violence. Hannah was raised in impoverished conditions with her maternal grandmother working as a part-time domestic, cleaning homes and “taking in laundry.” Her upbringing alone predisposes her to an increased risk of sexual assault that poverty exposes women and children to. It is well documented that being socioeconomically disadvantaged also increases the risk of violence crimes. Bassuk, Browne, and Buckner (1996) found that homeless mothers reported more incidences of physical and sexual assault across their lifetimes than low-income housed mothers.

Jackie was raised in an environment where she developed a desensitized perspective of the violence she witnessed. Whether she was grieving the death of family and friends, walking through her neighborhood and seeing someone had been shot, or experiencing the violent stabbing attack involving her sister, she had become numb to the violence. In a study by Buka, Stichick, Birdthistle, and Earls (2001), youths from low-income neighborhoods witnessed significantly more severe violence, such as murders and stabbings, than youths
from middle- and upper-income neighborhoods. Additionally, women who lived in households with income less than $10,000 annually had a four times greater risk of experiencing violence than women who reside in wealthier households (Browne, Salomon, & Bassuk, 1999). Being poor, African-American, and living in an urban area is yet another example of triple jeopardy she was exposed to. As a high school dropout, Jackie used welfare as a means to qualify for affordable housing. She explained, “I got a decent apartment for little to nothing a month because I really didn’t have an income.” She and Eleanor both found welfare as a means to supplement their income during the early stages of living on their own. Eleanor worked diligently to get off welfare, because she did not want her young daughter “to know that we were on welfare.” A few years later, Jackie was trying to support her family on a part-time job making approximately $15,000 annually for a family of four, soon to be five. Her family was struggling below the poverty level: $18,810 a year for a family of four in 2003 (US Census Bureau, 2003). The National Center for Children in Poverty (NCCP) indicates that families need approximately twice the amount listed as the poverty level just to cover basic expenses (NCCP, 2014).

**Overcoming Educational Obstacles**

The American education system has a long history of discrimination and perpetuating inequality. Differences in spending exacerbate the inequalities among schools. The US property tax system supports this inequality by linking the level of investment in schools to the wealth of the community (Biddle & Berliner, 2002; NCES, 1998a). The quality of education and access to resources offered to children in poorer districts is not equivalent to that offered to their counterparts from wealthy districts (Anyon, 1997; Noguera, 2003). Children in poorer districts are subjected to class-based forms of language proficiency determination, limited availability of advanced placement courses, and standardized testing
as the gateway to higher education (Berg, 2010). Hochschild (2003) argued that these students were often worse off and had poorer academic outcomes. This is coupled with the US history of racial segregation resulting in ghetto schools for African-American and Hispanic children confined by poverty in areas that are separate and unequal in resources and lead to poor student achievement, resulting in inequity in education (Ayon, 1997; Kozol, 1991). A study conducted by Orfield and Yun (1999) found that schools are increasingly more segregated by race and poverty. They described these schools as *apartheid schools*, indicating that these students are detached from the rest of society and are exposed to profound inequality in education. The educational inequity in these communities predisposes students from these schools to underpreparation for higher education (Barnes et al., 2007; Borman & Maritza Dowling, 2008). Michelle’s K-12 education exemplified how this funding pattern can affect a child’s educational experience. Because of her parents’ divorce, she moved back and forth between a primarily White suburban school system and a mostly Black urban school system. She noted the rich contrast as she remarked how the suburban schools were “predominantly White… [and] in Detroit it was the opposite.” She also shared how the courses the schools offered were not equally aligned, later adding that she “had to take a summer school course that I could graduate on time.”

Schools oppress by race, gender, class, and culture (De Lissovoy, 2008). Race and class inequalities are not the same; however, both have a cumulative negative effect on a child’s college and future career. There are many factors that impede access and success in higher education for disadvantaged children and result in alienating and unjust experiences for students, particularly students of color (Lipman, 1998). Racial, gender, and cultural identifiers are often used to categorize students and guide the expectations and interactions
with teachers and other students (Giroux, 2006). These same identifiers can also shape how a student perceives oneself, including feelings of belonging in college, fear of what to expect, self-doubt, and negative thoughts associated with perceived expectations. Steele (2010) labeled this as stereotype threat. African-American students are not born with lesser capabilities but are hindered by stereotypical societal views that make Blackness synonymous with being less than capable (Delpit, 2012).

Social class also affects access and opportunity in education. Parental education level has been linked to student access and success in higher education. Parents who have access to resources and knowledge for navigating the educational system are better able to access support their students need for success. Bowles and Gintis (1976) referred to this as intergenerational inequality, when reproduction of social and economic position is passed on from one generation to the next. Other factors such as high-stakes testing, admission requirements, use of technology for college applications, inadequate guidance counseling, limited opportunities to take advanced placement courses, low teacher expectations, racial oppression, and dropouts before graduation also serve as barriers to accessing higher education for minority students (Museus, Palmer, Davis, & Maramba, 2011).

Marginalization of African-American students often results in student disengagement. Disengagement can be attributed to numerous factors and has been linked to linguistic mismatch and lack of cultural understanding (Fine, 1991; Noguera, 2003). Students who do not feel a part of the dominant culture find themselves on the margins. Exclusion of nonconforming students results in persistent educational inequality. African-American students are marginalized through overrepresentation in special education, higher rates of suspension and expulsion, and higher dropout rates (Noguera, 2003; Orfield & Frankenberg,
Educators often attribute the student’s disengagement to their intellectual ability and other deficit-based attributes. However, it is critical to know each student and to have an understanding of that student’s reality. A student’s current situation may have no relationship to her ability to perform academically but can have long-lasting implications on her future successes.

Jackie and Eleanor were both high school dropouts. Eleanor dropped out because she was pregnant. She explained how she rationalized her decision, saying, “[I had] eighty absences. One semester I had all F’s…I got pregnant. Dropped out of high school and went on welfare…Ended up going on…actual food stamps.” Jackie dropped out of high school as well. She stated this was because of her own apathy and disinterest in school. Both were decent students who were overcome by life circumstances. Jackie ended up graduating from high school two years after her class. She explained her thinking at the time: “I couldn’t tolerate some things in my life at that time. I left [School 1] and went to [School 2] and still didn’t finish…I didn’t end up graduating until ‘99… [from] the adult high school…on the Eastside.” Finishing high school under special circumstances put them at an academic disadvantage when it came to nursing. Not only did Eleanor fail the Nurse Entrance Test twice, but she also struggled with the copious amounts of reading and comprehension that was expected of nursing students. Like others, she started nursing school with a built-in disadvantage grounded in her early educational experience. She lamented, “Of course with me skipping a lot of classes my comprehension and reading speed that type of thing, I had a deficit in those areas and I had to build those areas up.” Yet she, like Jackie, knew she could “do the work.”
**Academic Preparation and Nursing Education**

If admitted to nursing education programs, the African-American nursing student often suffers the collateral effects of inadequate academic preparation during her primary and secondary education. This is exacerbated if a student hails from a poorly funded urban school district. These districts often suffer from infrastructure issues that do not foster a positive learning environment, such as overcrowding, lack of textbooks, building issues, uncertified teachers, and a deficit-focus pedagogy (Gutierrez, Asato, Santos, & Gotanda, 2002). Data from the National Center for Education Statistics (2013) indicate that African-American students are not meeting the same benchmarks as White students in nearly every category of academic achievement. The results of inadequate academic preparation are manifested in higher course failure and attrition rates among the disadvantaged population, and academic struggles add to the disadvantaged nursing students’ efforts for inclusion (Robert Wood Johnson Foundation, 2012). Minority nursing students have a significantly higher course failure and attrition rate than non-minorities, with reported ranges between 15% and 85% (Gardner, 2005a; Loftus & Duty, 2010; Seago & Spetz, 2005). African-American students also expressed feeling comparatively inadequately prepared compared to their White counterparts (Jeffreys, 2004; Kirkland, 1998; Sweet, 2012). The design of nursing curriculum further complicates the road to success. Nursing courses build cumulatively, and a student cannot progress in a program until she successfully completes each course in a stair-step fashion. Course failures can disrupt this entire process and add additional financial burden and feelings of self-doubt. Additionally, all nursing courses are not offered every term. Failures can be costly, as students have to sit out and wait for a failed course to cycle around again. There is then the additional cost to repeat a course and the cost of lost potential wages in the delay of acquiring a job as an RN. The additional time and expense can be enough to
deter African-American nursing students from continuing. Stokes’s (2013) qualitative study findings indicated the African-American RN participants employed a variety of strategies, such as effectively defying border crossing, biculturalism, and reading the environment, to help them be successful and resilient while circumventing their negative experiences of nursing school. However, be it Julia’s lack of basic English skills, Eleanor’s reading comprehension, or feeling they had to work “twice as hard” to keep up, like Rose and Grace, the participants in this current research study did not focus on the so-called deficits resulting from their K-12 education as they embarked upon their nursing dream.

Finally, many African-American nursing students are first-generation college students. A first-generation college student is a student with parent(s) who have never enrolled in post-secondary education and whose highest level of education is a high school diploma or less (NCES, 1998b). First-generation college students do not have college-experienced parent(s) to help them navigate the higher education network and teach them what to expect when they step onto a college campus. These students are lacking valuable parental advice regarding how college works and how to be successful, and they often have feelings of not being adequately prepared for or belonging in college. Carnevale and Strohl (2013) reported that African-American and Hispanic students (34%) whose parents had less than a high school education drop out of college more than Whites (27%), and even if their parents had a bachelor’s degree, African Americans and Hispanics were still twice as likely not to attend college as Whites from similar family backgrounds. Reid and Moore (2008) found that lack of adequate academic preparation was not limited to nursing students. Their study with 13 first-generation students from an urban high school found that the students perceived they were not adequately prepared to be successful academically in college.
Triangulation of Violence, Living in Poverty, and Overcoming Educational Obstacles

African-American women continue to experience the ongoing effects of social injustice, exclusion, and marginalization (Hine, 1989, 1994). The women in this study clearly represent the impacts of the intersection of violence, living in poverty, and educational obstacles. These themes were central to their stories as their lives are explored before, during, and after nursing school on their journey to become a registered nurse. The multigenerational aspects of living in poverty and violence, regardless of the type, were also illuminated in their lives. The challenges experienced were often disruptive to their continuation on a path of success. However, these challenges were not unfamiliar to them because they had often existed as their frame of reference from their family of origin. Each of these women understood the value of a nursing education as a means to remedy poverty and expressed a sense of urgency to complete the nursing education program and improve her and her family’s life station. These RNs faced life disruptions and tensions among family responsibility and educational pursuits that often interfered with steady, consistent progress toward their educational goal. These future nurses were critically aware of the barriers they encountered, and the path to higher education was not always smooth. Lack of access to higher education cultivates the cycle of poverty faced by many women, especially women who are single heads of household. Nursing education and a career as a professional RN was viewed as an avenue out of poverty and a pathway to a better standard of living. Research has shown that women with higher education have higher earnings (Jones-DeWeever & Gault, 2006; Tally, 2002). Jones-DeWeever and Gault’s findings indicated that the median hourly earnings of women with degrees was $13.14 per hour as compared to merely $7.50 for the study participants without a degree; this translates to a nearly 75% differential. This is consistent with recent data from the US Department of Labor—Bureau of Labor Statistics
(2015) for adult women over age 25. These data reveal median weekly earnings for women with a high school diploma at $578 and women with a bachelor’s degree at $1049—nearly 100% greater earning power.

Interestingly, income has been shown to be a powerful determinant of college attendance. Students who live in low-income households are less likely to attend college, even if they are high academic achievers. Fox, Connolly, and Snyder (2005) reported that findings in a 12-year longitudinal study of students beginning in the eighth grade, conducted by the Department of Education, revealed some eye-opening results regarding the differences in college completion and the power of socioeconomic status. To summarize, students with the lowest academic performance from the higher income families completed college at the same rate as the highest academic performers from the lowest income families. Each of these groups had a 29% likelihood of completing a bachelor’s degree, compared to a 74% degree completion rate for high-achieving students from higher income families. Although students were high performers academically, the fact that they were from low-income households put them at risk for not completing college. Roy (2005) concluded that this should be a call to arms for those lobbying for policy change, especially since there is a link between job options and level of educational accomplishment.

A college education can be cost-prohibitive for disadvantaged students, particularly for those who are raised in poverty and have parents with little to no financial capabilities of helping them with just the basics of tuition. Conversely, a career as a registered nurse can also change the financial outlook for women who are trying to lift themselves out of poverty. Although poverty disproportionately affects women and children, higher education has been linked to reducing poverty for women (Jones-DeWeever & Gault, 2006). These participants
saw a brighter economic and independent future if they could successfully complete nursing school. Higher education provides African-American nursing students with a hope for a better life; however, both tangible and invisible barriers affect higher education access and success of this population. Freire’s (1970) concept of banking education is an invisible barrier that students hailing from impoverished communities may face, where they are essentially given only what the educators feel they need to know and not the tools to reach their maximum capabilities. African-American students who are raised in poverty may have challenges meeting the financial requirements of nursing school. College is costly for a generic degree, and students in nursing education programs have to incur additional costs for uniforms, laboratory fees, transportation, and insurance.

The triangulation of violence, living in poverty, and educational obstacles can create insurmountable barriers for African-American women seeking higher education. Exposure to violence adds risk to student success, and attending school in an urban low-income setting compounds the risk. Being raised in a home at or below the poverty level exacerbates the complex relationship of domestic violence, poverty, and academics. Dyson (1990) conducted a study with six Black children exposed to violence and found that exposure to violence was reflected not only in behavior problems, but also in poor school performance of children.

Poverty disproportionately affects African-American women and children. According to the US Census Bureau (2010), 38.2% of Black children were living in poverty, compared to 12% of non-Hispanic white children. Poverty rates were even higher for households led by single African-American women. With the triple burden of being raised in poverty, exposure to violence, and educational obstacles, plus the added factor of being African-American, these women are especially vulnerable. The risk factors of poverty, absent fathers, educational
failure, and violence combine to form a formidable barrier to a healthy and fulfilling life (Garbarino & Sigman, 2010). The lived experiences shared by these women exemplify the strength of their character in being determined to succeed despite the proverbial hand they were dealt. The statistical data would lead one to believe that these women were predisposed to fail and remain what Eleanor referred to as a “statistic.” However, these women were determined to do better than the generation before them. They wanted to break the cycles of domestic violence, poverty, and academic failure. Their voices shared in this study are evidence that women can succeed with desire, will, determination, and a little bit of help.
Chapter 7: Trials and Triumphs

Chapter 7 features an analysis of additional themes emerging from the participants’ life history interviews that emerged as trials and triumphs: paying for nursing school; social isolation, perceived discrimination, and lack of diversity; support/lack of support; paying it forward; and grit and tenacity. This chapter will highlight the higher education access issues for the RNs in this study and further explicate the barriers to higher education and professional development for this population. Although some of these issues highlight the negative experiences of their nursing education and professional careers, each woman revealed her underlying grit as she navigated through schooling and her professional career. Narratives of the RNs featured in Chapters 4 (Eleanor, Rose, Jackie, and Hannah) and 5 (Michelle, Julia, and Thelma) are included. Additional voices from the life history narratives of Eliza, Sarah, Grace, Angelica, Laura, Elizabeth, and Hillary are used to supplement the emerging themes in Chapter 7; see Appendix F (pp. 288–299) for their participant profiles.

Although this was not a sampling criterion, all the women in this study can be classified as disadvantaged as defined by the US DHHS (n.d.) and National Institute of Health (2011). They came from either a low-income family or a background that placed in their path obstacles to enrolling or graduating from nursing school. US DHHS Health Resources and Services Administration provides this definition for nursing schools to use to determine eligibility for government-funded nursing scholarships made available to support students from disadvantaged backgrounds. Most importantly, disadvantaged students are those who do not have the same level of opportunity to access higher education. This is particularly applicable to health careers, such as nursing, that are experiencing a shortage as well as a lack of diversity in the profession. Disadvantaged nursing students face a variety of barriers that impede their ability to successfully complete a nursing degree. The participants
in this study all fit into this category in at least one of the criteria. The nurses’ voices are featured as the central focus of the discussion regarding how the intersection of race, gender, and class affect their status as disadvantaged and how they became registered nurses.

**Paying for Nursing School**

In addition to the theme of being raised in impoverished conditions, the theme of paying for nursing school emerged as students were entering nursing school. A nursing education can be cost prohibitive. Financial burdens and responsibilities have been cited by African-American nursing students as a reason for not finishing or even entering nursing school (Goff, 2011; Loftus & Duty, 2010). As far back as the 1930s, African-American nurses cited cost as a factor limiting access to nursing education. In her autobiography, First Lieutenant Prudence Burns Burrell (1997) shared how the $108 fee for the three-year diploma program at Kansas City General Hospital No. 2 prohibited her from entering the program. Even after working three years in a variety of service and domestic jobs, she was unable to save the money to pay for the program. Students in nursing education programs not only have the financial burden of higher education, but they also incur the additional costs for uniforms, laboratory fees, transportation, insurance, and other regulatory requirements for learning in the healthcare setting. Finances are a common barrier cited by many African-American nursing students as a reason for not finishing nursing school. Like other low-income students, many minority nursing students reported having to work at least part-time to meet the financial responsibilities of their families in addition to the costs of nursing school while enduring the rigor of nursing education (Amaro et al., 2006; deRuyter, 2008; Goff, 2011; Loftus & Duty, 2010; Seago & Spetz, 2005).

Financing nursing education was a different experience for each of the RNs. At some point during the discussion of their nursing education experience, participants voiced concern
about the financial considerations of pursuing a degree or diploma in nursing. A college education is costly enough. A nursing education adds additional costs. Each RN acknowledged paying for nursing school as a factor in completing her nursing degree. Some had to postpone entering college while they worked to earn tuition money. Hannah (Chapter 4) and Grace (Appendix F) financed their nursing education this way. Grace had been double-promoted in elementary school. Instead of heading to college as a 16-year-old high school graduate, Grace worked in the post office post-graduation. Grace shared the sentiment of this subgroup of RNs who had working as their only option. She stated, “[I] didn’t have no money to go to school, so I could work a little, save a little, and take some classes part-time.” Hannah decided to work to help her grandmother with her younger brother and save money for college when she could.

Other participants had to work while attending nursing school, often combining work with grants, scholarships, and loans to make ends meet, because their families did not have any money to pay for college. These women also felt a sense of responsibility to help out the family. Rose (Chapter 4), Jackie (Chapter 4), and Eliza (Appendix F) were prime examples of student nurses balancing these aspects of life. Eliza’s story typifies this group of students. Her father died suddenly when she was entering ninth grade and her older sister was entering college. Her sister’s college education exhausted the family reserves, and she was hit with the realization that she would have to figure out a way to get the money she would need to attend college. Rose shared how they struggled with trying to meet the demands of family and nursing school: “I thought your parents took care of that…I took out a huge amount of loans. That first year it was like $17,000…it was really expensive.”
After her father died unexpectedly, Eliza knew she had to find a way to pay for nursing school. She explained, “I was…trying to figure out how I was gonna get…scholarships…My sister…had eaten up a lot of money…I was always thinking…how can I help my mom?…So when I leave and go to college I’m gonna have to figure it out.” Eliza’s decision to attend the college she selected was driven by the amount of scholarship and grant money she was offered. She still had to enroll in the federal work-study program to make ends meet. So she had to find that delicate balance between working enough hours and being able to meet the academic standards of a four-year nursing program. She explained:

The lady in the College of Nursing…She tried to mess me up to the point where I would have failed. The schedule she gave me, it was like you do know I work 30 hours, ‘cause I had to do work-study…I just felt like she didn’t understand the demographics I was in. I didn’t have mommy and daddy paying for school. But for somebody to take 16 credits and working 30 plus hours, it was not happening.

Conversely, Michelle (Chapter 5) exemplified the non-traditional student who was fortunate enough to not have to worry about paying for nursing school. Although she was balancing being a wife, mother, and student, she did not have to work during nursing school. She was able to focus her time on her studies because her “husband…was paying out-of-pocket for me to go to nursing school.”

There were some who would be considered traditional students in this study as well. Students who had parents who were able to pay for college had a contrasting financial perspective. This permitted them to avoid the additional responsibility of employment while in nursing school, with their tuition paid in a timely fashion without financial holds and/or special waivers. Although paying for nursing school was not a problem for them personally,
Angelica, Hillary, and Sarah (Appendix F) were aware that many of their classmates suffered and worried about finances constantly. Hillary described their sentiment:

My mom and dad paid for my entire undergraduate college experience. Even after I switched [from dentistry after three years]. They paid for my apartment, new car, anything I needed. Never had an issue with finances as far as financing school, even after I switched.

She understood this were not the circumstances for many nursing students who had to use federal financial aid, loans, and work to make ends meet. She explained:

To listen to them tell me, “I have 50, 60 thousand dollars in loans.” I had to be quiet ‘cause I’m like, sorry. You know, like, I was fortunate enough to have parents to finance my tuition as well as my sister’s at the same time. That was helpful.

There were some special programs that offered financial support to minorities entering in nursing as far back as 1960s and 1970s. Grace, Elizabeth (Appendix F), and Thelma (Chapter 5) were the beneficiaries of such programming and used these programs to offset the costs of nursing school. Grace benefitted from a program called *Project Rebound*. This program was established to promote diversity in nursing education. Grace recalled how there was funding for a “certain number of Black students” to enroll in the diploma nursing program free of charge. Grace was fortunate to be included in that number. Elizabeth and Thelma participated in a similar program, except their program was designed for entry level working adults who wanted to become RNs. They were participants in a multi-layered benefit program, *The Professional Nurse Education Program* (PNEP), to support them while they attended nursing school in return for corresponding years of service to the sponsoring hospital after becoming an RN. The PNEP did not provide tuition but helped the student
nurses manage some of the intangibles that could be barriers to their success. Thelma described the PNEP:

The PNEP program was very influential to me. Prior to getting into that…I worked 40 hours a week. The PNEP allowed me to cut my hours to 20 hours and keep my full-time benefits, and they also provided me with this computer and that $200 stipend…$200 a month is nothing, but it becomes everything when you working part-time.

Elizabeth also benefitted from the PNEP, and she clearly articulated how significant this was in contributing to her success: “I was also worried about housing. How am I going to pay for everything that I had, car loans and everything?” She finally got the break she so desperately needed, when the approval for Section 8 subsidized housing and the acceptance letter into PNEP both came within days of each other. This made a major difference in her ability to pay for nursing school and provide for her family.

Financial concerns are common for minority nursing students. However, many minority nursing students are willing to take the risks and assume the debt to obtain a nursing degree. It is not uncommon for nursing education and a career as a professional RN to be viewed as an avenue out of poverty and a pathway to a better standard of living. Bullough (2004) found that the nurses in her study chose nursing as a “means to upgrade their earning capabilities” (p. 164). The cost of nursing education will only become magnified as the profession moves toward the Bachelor of Science in Nursing (BSN) as the entry level of practice for nursing (AACN, 2012). Many nursing students struggle with the cost of an Associate’s Degree in Nursing (ADN) program in spite of its lower tuition rates and a shorter timeframe to complete the degree requirements. A BSN takes four years to complete, with no
stop-outs, and it can cost double the amount of an ADN, even though the entry salary for both degrees is typically the same. Financial aid for nursing programs often comes in the form of unsubsidized student loans that accrue interest while the student is still in school and take many years to repay. Even with loans to pay tuition and fees, the additional costs incurred during nursing education remain challenging for many minority students (Crosnoe, Mistry, & Elder, 2002; Jeffreys, 2007; Loftus & Duty, 2010).

Consistent in the research findings for nursing students is the need for financial support in the form of grants and scholarships, which would allow students to reduce their workload outside nursing and make the pace and rigor of the NEP more manageable (Loftus & Duty, 2010). Kirkland (1998) conducted a mixed-method study with 23 African-American BSN students who reported their primary sources of stress as finances, interpersonal relationships, and academics. A more recent study by Gipson-Jones (2009) discovered that African-American nursing students found balancing work, family, and school challenging, so much that students reported leaving nursing because of family needs. Financing a nursing education continues to be a longstanding issue with African-American students pursuing nursing.

**Lack of Diversity**

The lack of diversity in nursing is characterized by the lack of admission of underrepresented and disadvantaged students and the dearth of minority representation among nursing faculty and administrators (AACN, 2014). The profession of nursing is confronted with two major issues: feminization and Whiteness. Statistics indicate that the nursing profession is composed of more than 87% Whites and 93% females, with African-American nurses composing 5% of the total nursing population (National Sample Survey of Registered Nurses, 2008). The US is experiencing a fast-paced change in its population
demographic makeup and associated cultural changes. The Census Bureau predicts there will be a new minority majority by the year 2044, with over half the US population being from a minority background (Colby & Ortman, 2014). With these population changes, nurses will be asked to provide quality nursing care to an increasingly diverse population, and the nursing workforce should be more reflective of the general population of the US. Being low-income, minority, and female are factors that unequally affect lives, creating a unique situation of “multiple jeopardy” that influenced their opportunities to be successful in nursing (Wilson, 2007, p. 148).

The success of African-American women in nursing can be beneficial on many levels. These women, who are often low-income, could benefit from higher education to improve one’s life station and help build a diverse nursing workforce. Simply put, higher education through nursing education could be a route out of poverty for many African-American women while serving to meet the needs of an ever-diversifying population. However, for this to occur, alleviating barriers and improving access to higher education for this population needs to be a priority. Jones (2013) stated, “There are simply not enough African-American nurses that resemble the African-American population…moreover, there are not enough black nurses equipped to provide the cultural sensitivity, patience, and understanding that are essential to providing quality care to minority populations” (p. 67). Furthermore, Hunn (2014) suggests that retention of African-American nursing students at predominantly White nursing education programs can be adversely affected by environment and pedagogy lacking cultural sensitivity. Summarily, disproportionate representation of African-American nursing students in nursing education programs continues to nurture this deficit.
Sarah’s experience in nursing school and in her professional career is exemplary of the lack of diversity surrounding nursing. She described her nursing cohort, the faculty at the nursing school, and the RNs she worked with on her first job. Regarding her cohort, she stated, “[There were] not very many African-American students…that…got to the nursing program part of it,” later adding, “There were only five of us [African Americans] in my cohort [of 100].” She went on to add that the lack of diversity extended to the nursing faculty: “I had one African-American professor in my whole four years at university.” The profound lack of diversity continued as she moved into her professional career. She shared, “There were only two Black nurses on the floor, me and Lisa.” Angelica also tried to quantify the lack of diversity in her nursing education program (NEP). She recalled, “I was one of ten out of 150 [students].” In Eliza’s case there were “only 10 African Americans that got admitted into that cohort—out of 80.”

In addition to the lack of diversity in numbers, Thelma felt that most faculty lacked a general understanding of diversity and cultures. She had to deal with this on almost a daily basis. She recalled how one instructor tried to cite her ethnically-based hairstyle as a dress code violation, pointing out the “way I wore my hair in cornrows” as a violation of the school’s “uniform according to the policy.” The instructor’s lack of understanding may have been threatening to some students, but Thelma was able to educate the instructor; she explained, “I actually pulled the policy…I wasn’t out of uniform!” It is critical to increase cultural competence among nursing at all levels—students, faculty, administrators, and the nursing profession. Increasing diversity in nursing requires more than recruiting students from diverse backgrounds. It requires a multi-dimensional approach that includes increasing cultural competence among nursing faculty to help students from diverse cultural
backgrounds stay in school and graduate (Bednarz, Schim, & Doorenbos, 2010; Ume-Nwagbo, 2012).

The lack of diversity in nursing has also been linked to the ongoing healthcare disparity (IOM, 2003). Grace recognized this gap in healthcare among Blacks and Whites in her work as a quality surveyor. She emphatically stated that the “Caucasian population has better access to healthcare. They get in sooner. They are not as sick.” Unfortunately, the non-Caucasian patients are inundated with healthcare providers who “don’t look like them, really can’t identify with them, they are stereotyped and perceived as drug seekers.” She expressed that the lack of diversity in nursing is not a new phenomenon and it adversely affects how African Americans respond to accessing healthcare and healthcare providers: “If I have someone who can identify with me and the issues that I face…they…will help me heal, seek better care, seek care sooner, [but]…They don’t look like them, they don’t trust them and they treat them differently.”

Elizabeth shared similar reflections of her lived experience working with African-American patients. The lack of diversity and disparity in healthcare became evident to her as well. Staff would unfairly label patients as non-compliant without investigating the cause for the behavior. She testified, “A lot of times the patients didn’t do what they was supposed to do. It was based on their choice of getting…something to eat [or] getting…medication.” She also observed inequity based on race, ethnicity, and income in the ordering of tests and procedures for patients with similar conditions. She added, “I seen physicians that did not utilize the resources for the Afro-American or Hispanic or Asian nationalities as much as they would offer it to the Caucasians that were more well off.” Elizabeth’s observations are consistent with the findings of the IOM (2003), which concluded that although there are
many contributing sources to ongoing disparities, the human element of healthcare provider bias, prejudice, and stereotyping were found to contribute to differences in care, including consistent findings that minorities were less likely than Whites to receive needed services and clinically necessary procedures. Healthcare disparities are pervasive in all aspects of healthcare, and the lack of diversity is reflective of the historical nature of the nursing profession. It also revealed some subthemes that arose from the Whiteness of the NEP, the primarily White faculty, and professional workforce.

**Social Isolation and Perceived Discrimination**

Social isolation and perceived discrimination emerged from the lack of diversity. Unless opting to attend a historically Black college or university, African-American women have little choice in NEP except those that are populated by predominantly White students. Even those who attend NEP in predominantly Black cities, like Detroit, are often among the minority. Eleanor (Chapter 4) and Julia (Chapter 5) both described their inner city NEPs as having a population that was “50-50” with Black and White students. Almost all the participants reported having no more than one Black faculty during their entire nursing schooling. The NEP environment predisposes Black students to incidences of microaggressions. Pierce (1988) argued that microaggressions occur frequently in interracial encounters, causing psychological distress and feelings of invisibility and marginalization among Blacks. Minority nursing students have expressed experiences of perceived discrimination, racism, lack of support, and microaggressions from faculty, peers, hospital patients, and staff. Studies indicated that nursing faculty and peers had a negative bias against minority students (Amaro et al., 2006; Coleman, 2008; Gardner, 2005a; Mills-Wisneski, 2005). Students reported feeling socially isolated and excluded from classroom and social
activities, while faculty concurred with the need for support for minority nursing students (Baker, 2010; Coleman, 2008; Gardner, 2005a; Frances et al., 2004; Mills-Wisneski 2005).

School culture plays an important role in student success. The culture of NEP can promote student engagement or foster failure. The Whiteness associated with NEP has not changed since the inception of the first formalized NEP, and the sociopolitical climate of nursing remains grounded in White privilege (Schroeder & DiAngelo, 2010). The norms associated with White as the dominant culture remain embedded in many NEPs. The nursing culture educational environment is challenged to work to alleviate bias and prejudice while retaining all students to completion. Adjusting to college is challenging enough; adjusting to college culture, norms of the dominant culture, and rigor of nursing education compounds the complexity of the learning environment. The experiences of the RNs in this study reflect their adjustment to the predominantly White NEP culture and the White world of the professional RN.

In addition to being a racial minority, the RNs felt they always had to work harder, be smarter, or prove themselves more so than their non-African-American peers. Frequent microaggressions were part of their lived experiences. Microaggressions are “subtle, innocuous, preconscious, or unconscious degradations, and putdowns” experienced by victims based on their race or gender (Pierce, 1995, p. 281). Researchers have found that exposure to microaggressions can have negative impacts on how well African Americans perform. Steele (2010) has shown that African Americans and women perform worse academically when they are pre-informed with stereotypes about their race or gender. If women were told that women do poorly in math, they performed worse on math tests. Additionally, Sue, Capodilupo, and Holder (2008) conducted a focus group with 13 African
Americans—all either graduate students or employed in higher education—to discuss their perceptions and reactions to microaggressions. Study participants shared feelings of not belonging, being watched suspiciously in stores, and being extra vigilant about their work as they felt their footprint would affect those who followed them. During the interviews for this dissertation study, RNs expressed sentiments in concert with those of the study participants when they shared how they felt because of their race. Angelica explained how she felt when she arrived on campus and was placed in an environment where she found herself as a member of the minority for the first time: “In Detroit…I was always the majority. So, I felt isolated.” Angelica shared how she felt White students made assumptions about her because of “how [I] looked… [my] color… [my] race.” Steele’s (1997, 2010) research on stereotype threat in educational settings examines this phenomenon of threat, of being judged, and how that can become self-fulfilling, ultimately affecting academic performance.

Several RNs expressed feeling a disparity in how White nursing students and Black nursing students were treated by the faculty and by their own classmates. Sarah felt there was a double standard for the students based on race. She explained, “There would be White nurses that kind of just skated by… It was tougher on me… I knew that I had… better not falter.” Grace reported similar feelings about the inequity in treatment of Black and White students, saying, “You got ridiculed… You got the worst patients… They accused us of cheating… We had to sit in the front… You don’t have no rights… [later adding] They were prejudiced. It was just straight up prejudice!” Eliza was succinct in her summation of her experience with nursing faculty and peers; she lamented, “Being the only Black in your clinical group was not easy.” Hillary had a similar incident with her NEP faculty. She felt ignored and later shared how she felt the subjective nature of the clinical grading was used
against her: “Every time I walked in the classroom, this instructor never spoke to me…I spoke every class…10 times that I walked in this class, this lady did not speak to me.” She later added her thoughts about her grades on her clinical performance. When it came to her clinical performance, there was more subjectivity involved and she received a substantially lower grade than her counterparts or what she felt she deserved. While others were routinely getting near perfect 4.0s, she shared, “I’m the only person in the class that got a 3.4—out of everybody in the entire class.” Similar findings emerged from previous studies with African-American students. Students shared incidences of faculty failure to acknowledge them, feeling unwelcomed, and a perception that faculty treated them differently (Coleman, 2008; Dapremont, 2011; Love, 2010).

Laura (Appendix F) offered a contrasting viewpoint. She credited her experience in a diverse K-8 school setting with helping her cope with the lack of diversity and the majority culture in the NEP setting. She described her experience, saying, “It wasn’t as difficult for me to now immerse myself or mingle with the other cultures. I did have friends that were African-American in nursing school, but I had a lot of friends that weren’t.” Nursing was a second career for Laura and many of her classmates. She believed that the commonality of the struggle to successfully complete the NEP brought all of the students together, regardless of color, and created a sense of camaraderie. She laughingly stated, “We all knew we were in the same struggle together.”

Race is a sensitive social construct and lends itself to double standards and double meanings. African Americans are sometimes put into situations where they are on the margins of their own race and the majority race. As a student in a program that targeted “at-risk” Black students for diversifying nursing, Project Rebound (PR), Grace felt she was
considered a double minority—an African American and a special student who did not deserve to be there. She recalled how even the other African-American students admitted into the program via the traditional process did not want to be associated with the PR students. She frustratingly shared, “We were treated different by the students, not just the instructors, but by the students; you were different. There was one Black person in the regular program, but she did not identify with us at all, not one bit.” She laughs as she shared how they are the best of friends now, but when they were in school, “she did not want to be associated with students she thought she was better than…she was ashamed to be associated and affiliated with us.” Black on Black discrimination is not uncommon. Hine (1994) posited that it is based in classism. Studies have shown that Blacks who hail from dissimilar backgrounds will reject the outsiders. Johnson and Kaiser (2012) found that socioeconomic status and racial identity were intertwined. Blacks shunned those who were presented as wealthy and perceived them to be “weakly racially identified” (p. 176). Additional research conducted by Torres and Massey (2012) found that students from affluent, integrated backgrounds felt they had little in common with students from segregated backgrounds.

Conversely, Angelica noted that the few Black faculty who were present on campus during her undergraduate NEP related to the African-American student experience. Her encounters with a sympathetic Black faculty member proved valuable to her. She explained, “She treated us better…We saw this African-American woman in leather overalls, a leather beanie, doctorally-prepared—keeping it real…She would talk to us individually…give us a word of encouragement…and I appreciated her for that.” Mills-Wisneski’s (2005) mixed-method study with 71 African-American BSN students found that 51% indicated that a lack of African-American faculty was very important. The students voiced concerns with the lack
of role models, lack of representation at the university, and the discriminatory assumptions they felt were made based on their race. Kezar and Maxey (2014) noted the amount of time and the quality of relationships students have with faculty can effectively decrease dropout rates. Additionally, Orduña (2009) shared findings from a phenomenological research study with 11 African-American RNs who shared their perceptions of prejudice, isolation, and faculty attitudes as their concerns. Thomas’s (2009) dissertation included eight African-American graduate voices. These graduates shared their perceptions of feeling invisible, differentness, unfairness, condescension, and the perception that at no one cares about them.

These feelings are contextualized in research conducted by Steele (1997) regarding how stereotypes shape intellectual identity and performance, and reinforced by the work of Sue et al. (2007), revealing the experience of microaggressions in everyday life. Hillary echoed this as she relived her experience in the workplace at her first job as an RN where she perceived she was treated unfairly because of her race. She explained, “[I] experienced some harassment and discrimination issues. So, I filed multiple complaints, had to follow action with grievance committees, chief of staff, things of that nature. Myself, along with 12 others left at the same time.” Angelica intimated how feelings and perceptions related to being Black carry over into the professional and academic life of Black RNs even today: “I…always wonder when I go into a patient’s room, what do they think, what are they wondering…When I go into a classroom…when I do my research, it always makes me think…what is this person thinking?”

Social isolation, perceived discrimination, and lack of support in the educational community have been linked to lack of student persistence and have been shown to be integral in these women’s journeys to becoming RNs. Tinto’s Model of Institutional
Departure (1993) depicts multi-faceted student integration into the educational community as key to student success. Feelings of belonging are at the core of African-American student success. Love (2010) and Amaro et al. (2006) found that a significant number of minority students did not feel faculty recognized them as individuals, nor did faculty have an understanding of their culture, which is consistent with the RNs in this study. The women in this study used the feelings of marginalization as motivation. These findings, coupled with the rigor of the NEP, can be paralyzing to African-American nursing students and affect their path to success. The RNs in this study were relentless in their pursuit of academic and professional excellence to “prove wrong” assumptions based on the low expectations of them as African Americans and found a way to manage their feelings and succeed in their NEP.

Difficulty with institutional and social integration into the dominant culture of college and nursing presents an additional barrier for African-American nursing students. There are invisible acts perceived by African-American nursing students that interfere with successful completion of nursing education programs. African-American nursing students report perceptions of feeling marginalized because of their skin color, unfavorable racial climate, difficulty socializing with peers, lack of support from faculty, and feelings of loneliness and isolation as some of the barriers to nursing program progression (Gardner, 2005a; Godfrey, 2005; Love, 2010). Although not physically measurable, these intangible environmental characteristics can profoundly affect a student’s performance and retention and are indicative of the ongoing nursing education program culture grounded in Eurocentric pedagogy and lacking support for non-majority nursing students. African-American students shared their feelings of exclusion and stereotyping in their educational experiences by the White students and by faculty (DeAngelis, 2009; Frances et al., 2004; Solórzano & Yosso, 2002). The
reported lack of diversity and feelings of social isolation are rooted in racism and discrimination (Yosso, 2005).

Social isolation and lack of faculty support compounded the challenges of nursing school for Eleanor. Her social circle was small, and she migrated toward two older African-American women in the program. She shared, “Those were the two people that I kind of stuck with...I really don’t remember anyone else in the program except for us. It was just us.” Eleanor had two faculty members in particular whose support and encouragement were pivotal in her success. One took the time to share a note-taking and study strategy, and the other was an African-American clinical instructor who pulled her aside and implored Eleanor to do better, because she “sees a lot of the Caucasians make it and she wants to make sure that we [African-American students] make it too.” Otherwise she was a bit of a loner who “went to school and came home…I never went to anyone else.”

Coleman (2008) conducted a study with 14 African-American nursing students at a primarily White institution who reported themes of difference, coping, and race as factors in their nursing school experience creating a feeling of institutional abandonment and otherness. These feelings are not exclusive to students in nursing programs. Levin, Van Laar, and Foote (2006) found that African-American students in general felt segregated and discriminated against in college. Tinto’s (1993) Model of Institutional Departure contextualizes students’ success as they progress through the nursing education programs. This model addresses the processes students experience in college in three phases: separation, transition, and incorporation. Each phase is part of a student’s integration into formal and informal academic and social systems. This model helps to situate each participant’s experience as she negotiates through the academic and social network of her nursing program. Tinto’s
pioneering seminal theory points out the critical element of feelings of belonging as integral to the college success of minority students. However, numerous critiques of Tinto’s model point out its lack of generalizability to non-traditional students and the fact that it does not account for the student’s intrinsic characteristics and background variables, such as parental support, parent education, pre-college academic success, and other extended support groups (College Student Retention, n.d.). Additionally, critical race theorists challenge Tinto’s argument regarding the three major sources of student departure: academic difficulty, unresolved educational goals, and failure to integrate into the academic and social life of the institution without any consideration of underlying racism. Tinto does not account for the student who battles the stereotypes and institutional racism to become a successful RN. The truth may lie somewhere in between, such as the case with the participants in this study, which included traditional and non-traditional successful students.

**Support/Lack of Support**

Support comes in many different forms. This study’s participants agreed that support was a critical component to their success in their NEP. Whether the support came from family, friends, peers, or faculty, all agreed that support was an important factor in their journey to become an RN. The discussion of the value of support for African-American women in nursing is not new. Goldstein (1960) conducted an ethnographic study examining the integration of 23 African-American nurses into three Midwest hospital settings. He concluded that the lack of support in their roles forced African-American nurses to deal with discrimination alone. Support can be revealed in many fashions and at various points along the educational and professional journeys. A successful nursing student needs support from the academic, financial, family, faculty, and social/peers realms (Baker, 2010; Jeffreys, 2007). This is particularly challenging when the student has multiple roles to fulfill. Some
families have an established expectation of college success. These students carry the weight of their parental expectations for success in college and their career. Laura received emotional and financial support from her family, but she also carried the burden of the expectation in her family to be a successful college graduate. From her grandparents, parents, siblings, and cousins, she felt pressure to adhere to the family norm of completing college and being successful: “We were always going to someone’s graduation…In high school I’m seeing my middle sister graduate from college and my older sister…going back to get her master’s…it was just what you do…You went to college…and that’s what we did.”

In a rigorous academic program such as nursing, academic support can be a large contributor to student success. Diagnosed with dyslexia during third grade, Laura credited the additional support and learning strategies from her Individual Education Plan (IEP) with helping her achieve in school. However, when she returned to school as an older, nontraditional student for her diploma in nursing, her IEP was outdated, and she received no academic support from the nursing program administrators and no additional financial support due to exhausted financial aid. She reflected on the administrator’s response, saying, “They were like, ‘well you have to get retested.’ I’m like ‘okay, but this is not something that comes and goes, you know, you have it or you don’t.’” Unable to afford the cost of retesting to confirm her dyslexia diagnosis, Laura had to manage on her own without the benefits of the additional academic support afforded with an IEP throughout her entire nursing degree.

Other study participants had multiple roles such as spouse, parent, and employee. Some expressed incredible tension between educational pursuits and feelings of family responsibilities, while others offer credit to special programs and people in helping them to be successful. Each RN had unique experiences and support manifested in many ways from
family, faculty, and peers, while others had unbelievable battles trying to find support and balance their lives. A study conducted by Gibbons and Woodside (2014) revealed the importance of support among first-generation college students from families with low education levels. Their study had three themes emerge: the role of the father, expectations about career, and expectations about college. Along with family support, the students perceived pressure to attend college that came from their fathers (or other family members), like Laura. The pressure to succeed in college was levied as a gateway to a better career, as it was for the women in this dissertation study. Several of the participants shared how mentors, favorite teachers, and family members served as important parts of their support system. Finally, the participants in Gibbons and Woodside’s study expected that college would help them further their families and influence others family members to get an education. The participants in this dissertation study also expressed similar familial expectations for success and expectations of how college can alter one’s life trajectory. RNs exemplified how support from others and special programs helped them to maintain focus during their NEP.

Elizabeth credits the “positive women” in her life with supporting and encouraging her. She, Thelma, and Grace also took advantage of special programs directed toward increasing diversity in nursing or targeting disadvantaged students. Grace recalled the reassurance offered her by Mrs. Green, the coordinator of Project Rebound, when she failed the first nursing program: “She told me not to worry…a new program was available for Blacks.” Eliza and Angelica attended four-year university nursing programs. These institutions had wrap-around services in place, but students had to seek them out. Eliza’s advisor was inspirational to her because she was “our voice for the minority students and kind of looked out for us.” The campus Office of Multicultural Affairs [OMA] filled this gap
for Angelica; she stated, “It [the OMA] was for anybody who felt marginalized, but it always ended up being Blacks.”

Conversely, lack of support created an unpleasant learning environment for some of the participants. Eliza and Grace encountered faculty who were less than supportive and discouraged them from pursuing nursing. The rigor of a nursing program is a challenge in itself, and to have a faculty cast doubt on your abilities can be especially distressing for a young student. Bourdieu and Passeron (1990) posited that such domination through academic proficiency is manifested by funneling students perceived as smart to higher-level careers and tracking others to lower-level jobs. Dealing with the entanglement of multiple roles and expectations created a complex web of physical demands, time constraints, and role responsibility. Eliza was a classic example of a student trying to balance multiple roles while maintaining success in the NEP. As a self-pay student, she “had to work” and try to keep up with her coursework. She was surprised and disappointed in the lack of understanding and negative talk from some of the nursing school faculty. She responded, “I’m 19 years old. I’m working 30 hours a week….stressing out and this chick’s [the nursing faculty] telling me, ‘I don’t think you’re going to make it as a nurse’…I’m…just trying to figure…why are you pointing me out?’” She perceived a pervasive lack of support and neglected at times. She shared how she felt she had “to work twice as hard because she would not assist me during clinical. I always just had to figure it out on my own.”

Grace had a similar encounter and shared how the faculty tried to steer her to the licensed practical nursing program: “[The Dean] told me I was not RN material and if I wanted to be a nurse I needed to go to LPN school.” Support is integral to success in NEPs. The faculty remarks were discriminatory and not supportive of student success. Eliza and
Grace used these negative comments from faculty as motivation to be successful in their respective nursing programs. These faculty responses contradicted the findings in previous studies regarding the role of faculty and support for minority nursing students. Previous studies have found that minority students feel ostracized in the classroom, and faculty have expressed an awareness of the need for support services for minority nursing students to provide a nurturing learning environment (Baker, 2010; Coleman, 2008; Gardner, 2005a; Frances et al., 2004; Mills-Wisneski, 2005).

Angelica attended nursing school as a traditional student as well. She recognized two areas of support she felt were integral in her success. One was the University Office of Multicultural Affairs, and the other has been a variety of mentors in her personal, academic, research, and professional life. From her mother, a retired nurse who was her first mentor, to the current mentors in her life, she has found value added toward her success by being mentored by other professional nurses. She shared, “I…remember [my mother]…having a great work ethic and sharing patient stories…In undergrad…my first mentor…I still keep in touch with her. She…really has my best interest and saw something in me that I didn’t see in myself.” Wraparound support services and a welcoming culture are essential elements that promote an environment of success for all nursing students and professionals but are particularly needed to assist in growing the number of successful African Americans entering the nursing profession.

Support can also come from being a part of a group. Belonging to a group can create a sense of camaraderie that can be uplifting to an individual. Other group members can model behaviors and exemplify what is required to become successful. Eliza was inspired by the members of Chi Eta Phi Sorority, Inc. Chi Eta Phi Sorority, Inc. is a professional
organization for registered nurses and student nurses from many cultures and diverse ethnicities, both male and female. A chance meeting with an African-American RN, who was a member of Chi Eta Phi Sorority, Inc., and who recommended Eliza for a sorority scholarship, sparked the relationship with the sorority for Eliza. When she went to accept the scholarship she marveled at what she saw: “When I got the scholarship and I just saw all these Black nurses…I was like, oh my God!...I want this to come to my school.”

Having a network of Black student nurses and RNs made a major difference for Eliza and the other African-American student nurses in her NEP. The Chi Eta Phi Sorority, Inc., Mission statement speaks to these core values:

- Encouragement of the pursuit of continuing education
- Recruitment programs for health careers
- Stimulation of close and friendly relationship among members
- Development of working relationships with other professional groups
- Identification of a core of nursing leaders who affect [sic] social changes at the national, regional, and local levels. (Chi Eta Phi Sorority, Inc., n.d.)

Eliza succinctly shared how the Chi Eta Phi Sorority, Inc. chapter on campus helped her and other Black nursing students “meet each other and we helped each other,” living up to the mission of the sorority group.

**Paying it Forward**

The success of African-American nursing students is important to the future of a diverse nursing profession. Minority nurses are needed at the bedside, in academia, and in leadership positions. Many of the study participants expressed the desire to “pay it forward.” The RNs in this study all have some measure of success in their nursing career, except Laura, a new graduate, who had not secured her first RN job at the time of this study. Aside from
the retirees, the study participants hold positions as nurse leaders, researchers, faculty, and advanced practiced nurses, and some are exceptional staff nurses. Each offered her perspective of her future in nursing and the impact she can have on the future of other African-American RNs. Jones (2013) posited that more African Americans are needed in the profession of nursing to “teach future nursing students how to provide care for a multicultural society, for baby boomers who are aging well and living longer as a result of technological advances, for patients with complex health conditions, and how to influence health care policy” (p. 68).

Hillary was concerned with the lack of diversity in her traditional NEP and the lack of support for the undergraduate nursing student. She felt that as a young professor, age 25 at the time, she could make a difference in the lives of African-American students. Hillary chose her teaching assignments carefully and wanted to be present during the early stages of the African-American nursing students’ development to provide some of the support she felt they needed. She explained her rationale, saying, “I picked those classes intentionally. I felt like I got cheated, basically, and I felt like I need to give these students everything that I know.”

Angelica honestly expressed how much the high number of African-American nursing student failures bothers her. Her personal experience makes this a particularly sensitive matter for her. She said, “I am starting to see a lot of students now, not pass forward from the first try. African-American ones, which bothers me. I am one, though. I didn’t pass forward on the first time, but I know that it’s a lot of people who don’t.” She has a strong belief in the power of mentoring from her own personal experience and has shared herself as a mentor to others and has several mentors in her circle who serve a variety of purposes in
her life. She passionately shared her belief in the power of mentoring, saying, “I wouldn’t be who I am and where I am if I didn’t have really good mentors…It is very reciprocal…I find time to mentor.” She values mentoring because it is her way to help the next generation of registered nurses and to continue to pay it forward. Several researchers in nursing literature have found the significance of mentoring relationships in nursing (Allen, 1998; Boyle & James, 1990; Dunham-Taylor, 2000; Peltz & Raymond, 2016; Vance, 1995). However, there is limited research on mentoring and the African-American nurse experience. One significant study was conducted by Hill, Del Favero, and Ropers-Huilman (2005). Hill et al. conducted a two-stage mixed method study with 47 African-American nurses to explore the role of mentoring in the development of African-American nurses leaders in baccalaureate and graduate nursing programs. In general, Hill et al. found that having a mentoring relationship was influential in leaders pursuing positions and career advancement. Nugent, Childs, Jones, and Cook (2004) implemented the Mentorship Model for the Retention of Minority Nursing (MMRMS). The MMRMS was developed to augment the retention and graduation rates of minority baccalaureate nursing students. The goal of the MMRMS was to create an educational environment supportive to the needs of minority students. The overarching feature of this model is faculty and institutional awareness to create a culturally sensitive and supportive environment in the areas of academics, financial, professional leadership, and self-development to improve retention. The MMRMS project used faculty, other students, and minority nurse leaders as mentors. The first year of this program yielded a 100% retention rate for African-American students and an 81.3% graduation rate. The students who did not graduate remained with the program repeated it and graduated.
Finally, nursing has provided Grace with a very comfortable life financially. She tries
to do her part to actively promote nursing as a profession among Black people and shares her
wealth generously in hopes of inspiring and unburdening others. She and her husband, who is
also a nurse, have helped others finance their nursing education because they know how
challenging it can be, and they give generously to many causes in the community. She
earnestly stated how important it is for her to share her good fortune and to pay it forward to
others, saying, “I have been blessed [so I] and share and give to others. I’m very generous
with family. I’m very generous at church, because if it wasn’t for God’s blessing I wouldn’t
have it to give. It’s not just for me.” Having mentors and role models that, according to
Thelma, “look like me” has been inspiring to many of the participants in this study. Race
issues form barriers that can be counterproductive to success. Critical race theorists (CRT)
argue that this is due to “how the social construct of race shapes university structures,
practices, and discourses” (Yosso et al., 2009, p. 663). These same constructs are evident
throughout an African-American student’s educational experience and are sometimes
founded in the racial majority, but also exist minority to minority.

A variety of barriers have a cumulative effect on a student’s future success. Most
research studies are not limited to finding one singular barrier to success in nursing. The low-
income African-American woman who is a first-generation college student and a single
parent faces a multitude of obstacles to accessing and succeeding in higher education.
Previous research reveals that support was identified in many forms by students, nurses, and
faculty. Amaro et al. (2006) identified positive support from teachers, peers, and ethnic
nursing student associations as measures to promote student retention. Studies by Baker
(2010) and Gardner (2005a) revealed support from faculty and approachable, empathetic, and caring educators, respectively, as one of the factors for student persistence.

In her book, *Rock My Soul: Black People and Self-esteem*, bell hooks (2003) shared the impact that lack of faculty support can have on students:

> When I was a college student most of the black students I knew were striving to excel. At times crippling self-doubt, often engendered by the way we were treated by unenlightened professors, white and nonwhite, chipped away at self-esteem, and students…began to falter and fail. (p. 16)

Other studies have shown that African-American students value peer and faculty support, faculty encouragement, and financial support. Buchanan (1999) conducted groundbreaking qualitative research with 10 African-American BSN students. These students reported a preference for support as important to stress reduction. The students went further to express a preference for mentoring from someone they could identify with. These feelings were echoed in a more recent study by Dapremont (2011) with 18 African-American ADN and BSN graduates. The participants in this study indicated that whether support was from family, faculty, or peers, it was vital to their success. These participants also identified faculty encouragement as an important contributor to their success. Qualitative studies conducted to illuminate student voices continually identified faculty support and encouragement as an important contributor to success (Kosowski, Grams, Taylor, & Wilson, 2001; Leroy, 2008).

Strategies that support students in all domains have been shown to be effective. Dapremont (2011) suggested these types of strategies are effective because “It takes a community to create a nurse” (p. 254). Gordon and Copes (2010) developed and implemented the Coppin Academy for Pre-Nursing Success (CAPS) as a model for
recruitment and retention of minority nursing students at the Coppin State University Helene Fuld School of Nursing. CAPS targeted high school students from disadvantaged backgrounds with an interest in a nursing career and placed them in a year-round pre-entry baccalaureate preparation program. CAPS graduates are exceeding expectations in retention and licensure exam pass rates. Programs like CAPS reach students early and promote student success. Gilchrist and Rector (2007) shared strategies to recruit and retain a diverse nursing student population. Other programs have implemented strategies to connect with students as early as middle school, supporting students through the application process, provide buddies, tutors, and mentors (Beacham, Askew, & Williams, 2009; Brown & Marshall, 2008; Condon & Miller, 2011; Dapremont, 2011; Manney & Fonza-Thomason, 2010). Swinney and Dobal (2008) employed a more comprehensive approach to retention and nursing workforce diversity. Their “Embracing the Challenge” (ETC) project used a three-pronged approach: recruit students to nursing, support and retain students in nursing, and provide stipends and scholarships.

There is scant research directed at the concept of “paying it forward” among nurses. Rather, there is copious research on mentoring and the benefits thereof, and buried in that research is the idea of “paying it forward.” In a more recent study conducted by Payton, Howe, Timmons, and Richardson (2013), students shared their feelings about the importance of role models, having someone who looks like them and someone to teach them the tricks of the trade. Hill et al.’s (2005) study exemplified the idea of being mentored and those mentors mentoring someone in the next generation of nurses. One of the participants in their study represented the thinking of many nurses who mentor and help others unsolicited; Tiffany stated, “They blessed me, and I bless someone else” (p. 351).
Grit and Tenacity

A persistent person has been described as having “staying power” to attend to a goal or a task, and resilience indicates the ability to bounce back from an adverse circumstance. Persistence and resilience have been studied throughout educational literature and are often referred to synonymously. In nursing research, persistence and resilience are qualities found to be possessed by successful nursing students to help them through a transient situation (Jeffreys, 2007; Newton, 2008; Saucier, 1994; Welhan, 2000; Williams, 2010). The participants in this study incorporated episodic moments of persistence and resilience in pursuit of their goal to become an RN. Academic resilience has been researched by many educational researchers at the K-12 (American Psychological Association, 2008; Floyd, 1996; Griffin & Allen, 2006) and higher education levels (Brown, 2008; Castro, Garcia, Cavazos, & Castro, 2011; Howell, 2004; Lepage-Lees, 1997; Morales, 2008; Morales, 2010; Morales & Trotman, 2004; Morales & Trotman, 2011). Resilience has also been studied by other disciplines, including nursing, psychology, and sociology. Much of the research in this area pools all minority students together or focuses on the historically at-risk African-American male. The seminal work in resilience theory was grown out of the work by Garmezy (1973) with the antecedents of children with schizophrenia, indicating that a person has the ability to adapt to an adverse circumstance and continue to function. Higgins (1994) examined resilience from the perspective of 40 adults who had survived less than desirable experiences in their early lives and lead fulfilling lives as adults. More recently, Harper’s (2010, 2012) research seeks to explain resilience and persistence by contradicting the widespread assumption that Black males are incapable, unintelligent, and perpetually at risk. Stokes’ (2013) study adds to this discussion as it explored strengths and attributes of “successful” African-American nurses using principles of Harper’s Anti-Deficit
Achievement Framework as opposed to the historical focus on deficits of African-American students.

Nursing education programs (NEP) are academically rigorous and demanding. However, some African-American nursing students manage to persist to success. Persistence is the quality that drives someone to maintain continual effort even though a task may be difficult. Resilience, on the other hand, refers to the ability to “bounce back” after an untoward event (American Psychological Association, 2014; Southwick, Douglas-Palumberi, & Pietrzak, 2014). Although often used as synonyms, these terms are quite different. For example, persistence is required for degree attainment, while some students may never have to exercise resilience. Educational studies have attributed African-American student success to educational resilience: the ability to overcome challenging life circumstances and succeed academically (Bryan, 2005; Kim & Hargrove, 2013; Wang, Haertel, & Walberg, 1997). Whether resilience, persistence, or a combination of non-cognitive traits, sustenance to degree attainment is an important component of breaking the intergenerational cycle of poverty, of post-secondary success, and of improving one’s life station (Jones-DeWeever & Gault, 2006).

Some nursing researchers have explored the theme “determination to succeed.” This research includes findings regarding resilience, persistence, determination, perseverance, motivation, and overcoming. Consistent among these studies are the findings that participants who exhibited persistence and resilience did not necessarily describe themselves in such a way, but offered descriptors indicating resolve (Amaro et al., 2006; France et al., 2004; Gardner, 2005a; Jordan, 1996; Mills-Wisneski, 2005). Sweet (2012) conducted research with 11 African-American BSN students at a predominantly White religious university, examining
their persistence to graduation. This study’s findings concur with research regarding students’ feelings of discrimination and lack of support. More importantly, the participants in the Sweet study identified things that assisted them to persist to graduation, including support from faculty and peers—particularly other minority students—and a strong sense of faith; students also reported that other factors included not wanting to disappoint family or become another African-American statistic. It is important to note that African Americans are often included in research studies examining minorities as an aggregate with other racial and/or ethnic groups outside the social majority, such as Asian, Latino/a, and Hispanic without differentiation. In nursing research, minority aggregate groups often include males as well. Even so, the research often circles back to barriers identified even when designed to measure factors contributing to success.

It is fair to speculate that nursing student success is more likely related to a combination of non-cognitive traits: persistence, resilience, perseverance, determination, tenacity, and grit. The seminal research of Duckworth, Peterson, Mathews, and Kelly (2007) examined grit among college undergraduates, West Point cadets, and Scripps National Spelling Bee champions. Duckworth et al. define grit as “maintaining effort and interest over years despite failure, adversity and plateaus in progress” (pp. 1087–1088), or simply “perseverance and passion for long-term goals” (p. 1087). Their findings indicated that individuals with a high level of grit have unwavering determination, effort, and motivation over long periods, despite experiences with setbacks or adverse conditions. The measure of grit is determined using an 8- or 12-item self-report Grit Scale developed by Duckworth. Grit is a non-cognitive construct that is viewed as essential to achievement as intelligence. The interest in non-cognitive skills is a growing area of research. Current research by Duckworth
(unpublished) in a Gates Foundation-funded study examines the relationship between grit and persistence to college completion of urban charter school students. Preliminary findings indicate that college completers have higher levels of grit than those who do not complete college. The next area to explore is whether grit can be learned. Wilson (2007) conducted a study highlighting the lived experience of 13 African-American RNs. Although not specific to grit, using semi-structured interviews and a focus group, the participants described how they wanted to fulfill a dream of becoming an RN and felt a sense of surviving and perseverance in achieving that goal. However, there is no research specific to examining the construct *grit* among African-American nursing students or nurses.

Another non-cognitive personality trait is tenacity. In addition to having grit, the nurses in this study were tenacious. Even when faced with challenging life moments, these women were undeterred as they sought to fulfill their desire to become registered nurses. The RNs in this study demonstrated tenacity time and again when faced with adverse circumstances; they found a way to achieve their goal. Their desire to become RNs superseded anything they perceived as an obstacle to their goal attainment. Their tenacity was unaffected by their situation regardless of how dire things may have seemed. For this study, *grit* is conceptualized as the feelings and internal fortitude of the women, while *tenacity* is conceptualized as the actions exhibited. Elizabeth described it best as she spoke about the obstacles in her life while trying to finish nursing school, surviving domestic violence, recovering from a nervous breakdown, and being a single mother of two. She resolved to finish the NEP for herself, her children, and for the mentors in her life who believed in her. She took a year of preparatory courses to strengthen her college skills, and she was able to compartmentalize better and allowed herself to make her education her
priority. She explained her approach to completing nursing school, saying, “I did not allow anything to come in front of what I was trying to obtain. I was determined…I just gave everything I had…That was the hardest, to try to overcome all those obstacles.” Elizabeth’s story illuminates the tenacity and grit necessary for some to complete nursing school.

Nursing students not only have to cope with the transitions and integration issues of the typical undergraduate, but also are faced with a variety of anxiety-producing situations in the patient care setting. The added stress from these experiences has been linked to high attrition rates (Dreary, Watson & Hogston, 2003). Although Stokes (2013) offers a look into the lived experiences of African-American RNs who attended primarily white institutions and the positive attributes of study participants, there is no nursing research study specifically examining tenacity and grit as character traits for success among African-American nursing students and RNs. Most nursing student success research studies have been conducted addressing minority nursing student resilience, self-efficacy, and persistence as learned characteristics of successful nursing students (Hodges, Keeley & Troyan, 2008; McAllister & Lowe, 2011).

**Self-efficacy.** Grit and tenacity combined to help these nursing formulate their self-efficacy. Integral to their success in completing nursing school is the belief that they could do it. In his formative paper, Bandura (1977) coined the term *self-efficacy* to describe this belief, where behavior, environment, and personal/cognitive factors come together to garner a belief that an individual possesses the power to complete a task. One of the fundamental elements to strengthening the development of self-efficacy is *vicarious experience*—having a person to model after. Although African-American nurse role models were limited, the encounters with such role models were powerful. Seeing someone else model and perform a task
increases one’s own belief in the ability to do the same. Angelica and Eliza intimated this in their emphasis on the impacts that mentors and role models made in their lives; observing a “Black nurse with a PhD” in her undergraduate program and seeing a “room full of Black nurses” at her first Chi Eta Phi Sorority, Inc. meeting, respectively, motivated each of them. The vicarious experience of success provides a foundation for belief in one’s own capability—a sense of agency (Bandura, 1997). Bandura postulated that having someone to model after increases a person’s feelings of self-efficacy: If they can do it, so can I. The never-quit attitude of the nurses in this story is exemplary of their self-efficacy. Whether it was Rose, who “knew there had to be a better way to live,” or those who overcame repeated failures like Michelle, Eliza, and Elizabeth, or even those who experience hostile learning environments like Grace—their sense of agency combined with grit and tenacity helped them to develop self-efficacy and use it to achieve their goals.

The RNs in this study are characterized by more than one singular personality quality. Each experience was unique, but each showed grit and tenacity in achieving her goal to become an RN. In the cases of Elizabeth, Julia, Thelma, Eleanor, Hannah, Jackie, Michelle, and Rose, they sustained their tenacity in a variety of incidents of violence against girls and women. Grace, Eliza, and Sarah were each told by a nursing faculty person they were not RN material. Each used this verbal assault as motivation to propel herself to be successful in her NEP. Others displayed their tenacity while enduring academic failure or dire financial situations. Many of the participants remained tenacious to endure a combination of negative life events.

Angelica’s challenges are indicative of the academic barriers students faced. Angelica had always been a good student. She did very well in the nursing classes, but the support
courses at times proved formidable to her. She found inspiration from her advisor in the Office of Multicultural Affairs, without which she likely would have failed. Studies have shown that academic and interpersonal support have helped African-American students’ success through graduation and the RN licensure exam (Buchanan, 1999; Coleman, 2008). She failed statistics and found out “two days before graduation” that she was missing two additional required courses. As with many minority nursing students, academic failure derailed her plan for graduation. This affected her emotionally, socially, and financially. Stop-outs in nursing school can have a tremendous effect on progress due to the sequential nature of nursing course; not all courses are offered every term. Furthermore, she was embarrassed, frustrated, and could not start the job she had already lined up post-graduation. Angelica was determined to finish her nursing degree. She was steadfast and determined to take these courses during the shortened summer term. Her grit and tenacity were displayed as she completed the graduation requirements simultaneously and graduated the next term despite all odds.

**Passing the NCLEX-RN.** With her learning disability, nursing school was not easy for Laura. But she had her mind set on a goal, and she was not going to be moved from it. Her grittiness was evident as she remembered, “I did have tunnel vision …I’m trying to get to this goal…it wasn’t one time it was like…I can’t do this…I figured out a way…I felt like that is my biggest success…because of my disability and I did it.” Successful completion of an accredited NEP is the first step in becoming an RN. All NEP graduates must then pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN) before they can begin practicing as an RN. The pressure to pass the NCLEX-RN can be overwhelming. Laura exemplified the challenge some graduates face when trying to pass this exam.
Unfortunately, she failed the NCLEX-RN the first two times. After each failure of NCLEX-RN, the state has a mandatory 45 days one has to wait between retakes. Although the NCLEX-RN failures took a toll on her mental state, Laura was not deterred. She ended up getting prescribed anti-anxiety pills to help her cope. With each failure, the stakes are higher and become seemingly insurmountable. After three failures, testers must complete a Board-approved educational program before they are approved to take the NCLEX-RN up to three more times (State of Michigan Department of Licensing and Regulatory Affairs, n.d.). Like others, Laura did not have that kind of time or money to invest in becoming an RN. With diligent preparation, including review courses, study groups, and numerous practice exams, Laura’s grit and tenacity paid off, and she passed the NCLEX-RN on her third try.

Eliza had a similar experience with the NCLEX-RN exam. Because of the need to help her mother financially, Eliza went to work as a graduate nurse less than a week after graduating from nursing school. Working full-time interfered with her study time to prepare for the NCLEX-RN exam, and she failed. Eliza wanted to be an RN, but the pressure to work and help her mom “with the bills” was ever present. She desperately needed the increased RN wage, but opted to work as a dialysis technician for almost a year while she took time to prepare to retake the NCLEX-RN. After nearly a year of study prep, she passed the exam and began working as an RN.

As Eliza’s and Laura’s cases demonstrates, completing a nursing program does not guarantee success on the NCLEX-RN. The National Council of State Boards of Nursing (NCSBN; 2015) reported through the third quarter of 2015 that 83% of all RNs pass the NCLEX on the first try, and 39% of repeaters pass the NCLEX on the second attempt. The NCSBN does not present data broken down by race, gender, or ethnicity. In efforts to
improve their chances at passing the NCLEX-RN, nursing students take on the additional rigor of review courses, study groups, and other test preparation aids. First-time pass rates are also important to nursing program accreditation by the governing bodies. Current trends show nursing programs are recommending review courses and sometimes include them as part of the program curriculum. Even with all these fail-safes in place, the impacts for African Americans and other ethnic minorities are still inequitable. However, several researchers have found that African Americans and other ethnic minorities have higher attrition rates and lower first-time failure rates than their White counterparts (Crow, Handley, Morrison, & Shelton, 2004; Haas, Nugent, & Rule, 2004; Jeffreys, 2007; Seago & Spetz, 2005; Yocom & Scherubel, 1985).

Conclusion

The RNs in this study chose nursing for a variety of reasons. Nursing was chosen as a career because of restrictive factors, attractive factors, and internal motivation factors (Grainger & Bolan, 2006; Mooney, Glacken, & O’Brien, 2008; Seago & Spetz, 2005; Zysberg & Berry, 2005). Some had experiences with illness or inspiring care of loved ones—attractive factors; some elected to pursue nursing over medicine, and some had a need to provide for their family—restrictive factors; others felt called to nursing or had a desire to be in a helping profession—internal motivation factors. However, the overriding dominant motivation for the RNs in this study was to use education as a route to a sustainable and independent life. Education as a route out of poverty and a means to a better life strikes a chord in each of these stories. The desire to have a better life can inspire students to employ their grittiness and tenacity to overcome the most adverse circumstances, take calculated risks, and live in less-than-desirable situations as part of a means to an end. A major benefit
of higher education is the reduction in the risk of poverty, and this is particularly applicable to African-American women. Jones-DeWeever and Gault’s (2006) study of women in poverty supports the idea that higher education “had a host of positive financial, social, and emotional effects on low-income women and their children” (p. v). They found that 94% of the respondents in their study indicated their educational experience had changed their lives for the better. The RNs in this study from a low-income background were all seeking a way out of poverty. The other RNs were raised to believe education was a way to be independent, and that going to college was their only option after high school. All the RNs exhibited tenacity and grit as they visualized how a nursing career via higher education would allow them to provide a bright future for themselves and their families. Jackie reflected the participants’ overall general sentiment when she said, “I was just so determined to become a nurse…I don’t remember a time when I ever wanted to quit.”

This chapter analyzed the narratives of the women in this study who faced a variety of challenges as they sought to become registered nurses. The RNs in this study sought to become RNs across decades from the 1970s–2014; however, the themes were consistent across generations. As African-American women they expressed feelings of social isolation and perceived discrimination during their nursing school and professional experience. They described feeling as if they had to work harder than their White counterparts, were being left out of social events or study groups, and were graded unfairly, all contributing to their feelings of marginalization. By contrast, some found support and encouragement from diverse peers and faculty during their nursing education program and camaraderie founded in a common goal. These supportive relationships were influential in the success of many of the RNs and helped them to cultivate their grit and tenacity. Finally, these nurses expressed a
concern for the lack of diversity among nursing faculty and in the profession. They shared how the lack of diversity has impacts on patient care and is often demonstrated in disparity in healthcare.
Chapter 8: Conclusion, Implications, and Recommendations

The need for registered nurses in the United States has created a demand for nursing education programs to produce more quality RNs for the professional workforce. Nursing remains characterized by a lack of diversity among nursing students, the workforce, nursing faculty, and administrators (AACN, 2011). As the US population continues to diversify, there is a need for nursing to reflect the general population. As a result, the need for an educated and diverse nursing workforce is magnified. In September 2012, the American Association of Colleges of Nursing (AACN), American Association of Community Colleges (AACC), Association of Community College Trustees, National League for Nursing (NLN), and the National Organization for Associate Degree Nursing issued the Joint Statement on Academic Progression for Nursing Students and Graduates to promote academic progression in nursing with the common goal of preparing a well-educated, diverse nursing workforce (AACN, 2015b). Not only is there a call for an increase in the number of registered nurses in the workforce, but there is a concurrent call for nurses who are bachelor’s and master’s degree-prepared (IOM, 2010). The success of minority nursing students is critical to the future of the nursing profession and to meeting the demand for more minority nurses and faculty.

Scant research exists specific to the African-American registered nurse. Much attention has been focused on determining the barriers affecting minority nursing student success. There are many barriers to higher education for minority nursing students, the most notable of which is the financial burden associated with higher education. Structural barriers also exist. In recent years there has been a slow yet steady increase in the numbers of applicants to NEPs, but that has not been matched by an increase in the diversity of the nursing workforce. NEPs are routinely faced with more applicants than they are able to enroll, and acceptance rates are on the decline because there are just not enough seats to
accommodate all of the qualified applicants. According to AACN (2015c), from 2010 to 2013, at least 52,000 qualified applicants have been turned away from entry-level NEPs. This same report cites a shortage of faculty, limited clinical placement sites, and funding as primary barriers to accepting all qualified applicants to nursing programs. This presents a challenge for nursing education program administrators.

As the largest minority group in nursing, African-American nurses are key to improving diversity in the healthcare workforce and could greatly contribute to improving the health of the community and creating a pathway to address healthcare disparities among the ever-changing US population. Hine (1989) asserted that African-American nurses are critical to improving the health of the African-American community by influencing and urging access to mainstream healthcare and abandoning home remedies. Hine also found that African-American nurses are more willing to work in underserved communities. Several of the nurses in this study chose to work only in communities with high concentrations of African Americans for this same reason. When sharing about the patients she sees, Elizabeth echoed this sentiment, “When I actually became an RN and I…was like—No! I need to be right there in the inner city.”

The focus of this study was to examine the lived experiences of African-American women who have become registered nurses. This study presented the voices of these women to illuminate the strategies and tactics employed on their path before, during, and after becoming RNs. The nurses in this study did not perceive themselves as at-risk or disadvantaged, even though they all met the criteria to be classified as such at some point in their lives. Nurses in this study attended nursing school in each decade since 1970 and shared similar experiences of lack of diversity, faculty support, and financial, and social and
academic struggles across the span of time. The participants shared a determination to become an RN in spite of the perceived odds stacked against them.

In this study the participants’ pathways to higher education were not always easy—they were traumatic at times—and the road through nursing education was not always smooth, but these women exemplify the grit and tenacity necessary to demystify the odds and become RNs. As early as 1960, Goldstein’s ethnographic study at three Midwest hospitals revealed how African-American nurses are often on the margins of organizational culture and are left to deal with discrimination without support. Other studies have attempted to summarize the experiences of Black nursing students in nursing education programs serving primarily White students for factors contributing to the success of African-American nursing students. Current literature specific to the African-American nursing student experience at primarily White NEPs remains limited. Stokes’s (2013) dissertation researched this population and adds to this discourse. Stokes’s study with successful African-American RNs found that these nurses employed a variety of strategies to foster their success and resilience in the face of incidences of racism, discrimination, and isolation. White and Fulton (2015) conducted an integrative literature review specific to this population spanning the years 1998–2013 and found 12 peer-reviewed research articles and five dissertations related to this topic. Themes from these studies included lack of diversity (struggling with isolation and wanting to belong), importance of faculty for student success, and the need for academic and interpersonal support. The narratives of the nurses in this study indicate that not much has changed. Using a life history approach gave a look into the life of each African-American woman and what it was like to be her (Berteaux, 1981). Counter-storytelling revealed narratives that were compelling, illuminating the lived experience of being an African-
American female and the manifestation of inequality at the intersection of race, gender, and poverty. Additionally, the counter-narratives give voice to the African-American female registered nurse (Delgado, 2000).

**Black Feminist Thought and Critical Race Theory Implications**

This study used Black feminist thought to frame African-American women as vehicles of power and knowledge. The counter-storytelling is used to contradict the assumption of oppression and marginalization based on race, gender, and class. Collins (1990) asserted that placing Black women’s experiences at the core of theoretical analysis allows for a fresh viewpoint and conceptual lens with which to view the triangulation of race, gender, and class. Using African-American women to share the African-American female experience for this research study offered the opportunity to highlight the oft-muted voice. Pairing BFT with critical race theory (CRT) strengthens the theoretical framework for this study by acknowledging the Eurocentric legacy of discrimination and racism in the US (Bell, 1992; Delgado, 1995). The RNs in this study shared multiple experiences of overt and covert racism, including microaggressions. They also shared a lack of surprise at the treatment they received. This is a marked indication of the embedded nature of race and racism in our society. The existing literature frequently features the word perception when referring to students’ responses to racism or stereotyping. In this case, each woman’s perception is her reality. This emphasizes the complex relationship of race, gender, and class. Being female in a patriarchal society carries certain stereotypes and societal notions. However, being Black and low-income brings forth a whole new set of issues. The intersection of race and class compounds the inequality in higher education and is a key factor in societal experiences and higher education access. Income and racial stratification exist. The two together make it “difficult to clearly mark the point where racial discrimination ends and economic
deprivation begins, but the evidence is clear that both negatively affect educational and economic opportunity and are most powerful in combination” (Carnevale & Strohl, 2013, p. 14). CRT and BFT allowed for the lived experiences of the women in this study to be contextualized in their own space and spoken from their voice, revealing counter-stories demonstrating persistence, grit, determination, and tenacity to become RNs despite the circumstances of life experienced. Nurses were eager to share their stories to serve as inspiration to others and to contradict the dominant voice being presented about African-American women. As Eleanor stated:

The biggest thing is that getting my story out there. Getting the story [out for] African Americans to see…It doesn’t matter if you have one child or five children; if you are in an abusive relationship or not…there should be no reason why you can’t do what it is that you want to do.

Julia felt compelled to share her story to inspire others. She shared:

People need to know that it’s not easy out here but you know if you put your mind to it you can do it. Especially if you have support…just put your mind to it. If it’s something you want to do then you can do it.

This dissertation seeks to add to the discussion and identify success strategies from the narratives of African-American women who have become RNs, and illuminate the possibilities for future RNs and educators.

**General Findings and Implications**

The findings are significant to nursing because this study adds to the body of research specific to the lived experiences of African-American female registered nurses before, during, and after matriculating at predominantly White nursing education programs. This study also contributes to the body of literature on social determinants of health, specifically
social interactions and relationships (types of violence and discrimination), quality of schooling, economic stability, and the impacts on the lived experiences of the nurses (Healthy People 2020, 2014). It is unique because it not only identifies barriers encountered but also shares participants’ strategies for success in their journey to become RNs. The participants’ experiences before nursing school included poverty, inadequate K-12 educational preparation, and the unexpected theme of violence. During nursing school, the themes of lack of diversity, paying for nursing school, and support/lack of support emerged. Their experience in the professional nursing world included the additional theme of paying it forward. The theme of grit and tenacity was embedded throughout the participant experiences.

The participants adverse lived experiences affecting their education and professional development. Grit and tenacity are two character traits employed by the participants to circumvent any barrier or perceived deficit and are woven throughout their lived experiences. Additionally, the field of nursing can benefit from these findings as it works to develop and implement strategies to promote recruitment, retention, and graduation of African Americans (and other minorities) into nursing. This will in turn help to address other needs in the nursing workforce, such as the nursing shortage and increasing diversity.

The findings of this study are also significant to education at the primary, secondary, and post-secondary levels. Each of the participants in this study attended public school for at least part, if not all, of her K-12 education. Children who have a quality K-12 education can have greater access to higher education, which leads to improved employability (higher income) in their adult life. The bottom line is that education can be described as the cog that turns the wheel. Success is gained through education. It is a fairly simple formula: higher
education leads to higher income. In addition to higher income, collateral benefits of higher wage earning power are better health, better housing—living in safer neighborhoods—healthier food, and access to improved medical care (Cutler & Lleras-Muney, 2010; Freudenberg & Ruglis, 2007; Ross & Wu, 1995). College graduates have higher earning power, pay more taxes to help build a stronger economy, support social programs, and reduce the need for social assistance. Improved employability of college graduates provides an opportunity to secure a job with a full complement of healthcare and dental benefits to allow for a healthier lifestyle for one’s family and future generations. Higher education creates an intergenerational connection for future opportunity through quality education and improved health and income. The educational implications for this study can help raise awareness of the impact of the historical patterns of inequity in policy and practices in K-12 public education, such as the aforementioned tax-based funding for public education. Thelma shared her experience moving from an urban K-12 school system to a suburban system for her last year of high school. She shared: “I had never gone to school with White kids before ever in my life…I couldn’t believe how different it was.” Several of the participants shared feelings of inadequacy when they got to nursing school and particularly when they compared themselves to their White counterparts.

The implications for higher education are to create an inclusive environment for all students. Students need to feel supported, valued, and included in the educational setting. Hassouneh and Lutz (2013) found that faculty of color were key in promoting a culture and climate of inclusion. Their study results suggested a unique nature to the relationship among students of color and faculty of color. They concluded that faculty of color play an important role in mentoring and transmission of knowledge regarding navigating nursing academia.
These relationships were described as a major contributor in the success of students and faculty of color.

**Culturally Relevant Pedagogy**

Achieving a multicultural education system requires transformation in three dimensions: self, schools, and society (Gorski, 2013). The first level is self-examination. Teachers and educators need to reflect and transform themselves. This is not a one-time snapshot of *Who am I?* but a continuous, reflective, critical self-examination of stereotypes and biases that have impacts on student interactions and a paradigm shift in their pedagogy.

The next level is the examination of schools and schooling to deconstruct the traditional pedagogy and create a learning environment that is culturally relevant and student-centered. In a recent dissertation study by Hawkins (2014), students shared how their education was “disrupted” in the learning environment that was disengaging and non-supportive to them academically, socially, and emotionally (p. 170). Hawkins found that students were marginalized emotionally and structurally by the disciplinary policies that led to exclusion from school and language barriers in their learning environment.

Currently, the lack of cultural relevance in pedagogy is so embedded in the US education system that one does not even blink an eye to the relevance of reading *Snow White* to a group of preschoolers, middle-school math story problems lacking linguistic inclusion, social studies textbooks that lack a diverse representation of the world, or nursing faculty teaching assessment skills from a White middle-class patient paradigm. Certain aspects of history are ignored, or current events affecting the student population go undiscussed. African-American students need to feel valued, and leaders in education have to be responsive to the students they are responsible for educating. Ladson-Billings (1995) has been a leader in the effort to establish culturally relevant pedagogy (CRP) as the approach to
teaching students in urban schools. CRP contradicts the traditional, dominant pedagogical strategies and instead concentrates on developing a classroom environment and learning experiences that acknowledge student diversity and include their pluralistic backgrounds and lived experiences (Ladson-Billings, 2001).

Nursing school administrators have to explore pedagogical strategies that can engage the entire student body. After conducting a literature review of studies of African-American students at primarily White institutions, Hunn (2014) suggested a pedagogy that is deliberate, culturally sensitive, and includes careful use of team-based learning as an effective retention strategy to counter the adverse effects of NEPs. Culturally relevant pedagogy is a strategy that incorporates multicultural education to promote learning among minority students (Irvine & Armento, 2001; Ladson-Billings, 1995). Culturally relevant pedagogy (CRP) is a teaching methodology that has been found to be effective with African-American students and puts the student at the center of the educational experience. In this strategy, teachers use students’ culture to overcome the negativity of the dominant culture by incorporating culturally-based teaching. This positively promotes students’ knowledge, skills, and attitudes. Values, beliefs, practices, and experiences a student brings to school, regardless of where the student comes from, can be an integral part of a student’s successful academic experience (Delpit, 1995; Sato & Lensmire, 2009; Ladson-Billings, 1994). This is not limited to the classroom level, but these strategies of cultural pluralism need to be incorporated into teacher preparation programs (Cochran-Smith, 2008). The dominant pedagogy should be replaced by a more inclusive pedagogy such as legitimate peripheral participation. Lave and Wenger (1991) described this learning as a situated activity process where students become “a full participant in a sociocultural practice” (p. 29). Learning should integrate principles of a
learning environment that is student-centered as opposed to teacher-centered. Bednarz et al. (2010) argued that increasing cultural diversity across many dimensions calls for nursing educators to shift from traditional pedagogy—how adults teach children—to andragogy aimed at adult learners.

Emdin (2016) is doing groundbreaking work in this area with his work promoting the theory of Reality Pedagogy. In *For White Folks Who Teach in the Hood…and the Rest of Y’all Too*, Emdin shared the principles of his educational approach, reality pedagogy. Reality pedagogy features include using culturally relevant strategies, embracing and respecting each student’s culture, and engaging students as experts in their own learning. Emdin encourages an approach to education rooted in using the intellectual capabilities demonstrated within hip-hop music and call-and-response to educate young people. #HipHopEd is a social media movement grown out of this pedagogical approach. Emdin and his team are meeting the students where they are and trying to teach from a perspective that is relevant to the students they encounter. They seek to understand the student’s world and try to meet them in it to assist them to learn and realize their potential.

Finally, a multicultural education system, with a culturally sensitive pedagogy, will lead to a transformation of society where each student has equal opportunity to excel. Educators with a social justice lens begin to identify systemic inequities in the educational system laden with policies and practices that favor some student groups and lobby for social change to create equity. In addition to classroom strategies, policies that perpetuate inequity in education need to be eradicated to offer every student the opportunity to achieve his or her full capabilities.
Nursing Education Implications

African Americans make up the largest minority subgroup in nursing schools and in the nursing profession, yet nursing education programs are still challenged with improving efforts in recruiting, retaining, and graduating African-American nursing students. African-American nursing students are often disadvantaged upon entering nursing school as a result of deficit-modeled K-12 urban school systems and deficit-minded educators. Urban schools are often situated in low-income, predominantly minority neighborhoods (Books, 2004; Kozol, 1991). Educational under-preparation is not automatically equated with lack of intelligence. Rose (1989) posited that students can be stalled by their educational history and changes need to be made to education to level the playing field for all students to advance their education. Students coming from these types of schools are disadvantaged when it comes to academic preparation and admission to secondary education and even more so when it is time to determine who qualifies for the coveted seats in the NEP. The findings of this study indicated that these African-American nurses felt academically underprepared, had to work harder than their White counterparts to keep up, and were almost uniformly affected by academic failure during the nursing education program.

In addition to the state of urban public education, minority nursing students face barriers to higher education associated with the Whiteness and feminization of nursing. Whiteness, feminization of nursing, and poverty form a triad that contributes to the exclusion of African-American students. Living in poverty predisposes women to living in inequality, lack of access to education, discrimination, and barriers preventing achievement of educational goals (Books, 2004; Gault, 2012; Hess et al., 2015). A college degree in nursing has the potential to lessen the effects of poverty and break the intergenerational cycle of poverty for women and their families (Gault, 2012; Hess et al., 2015; Jones-DeWeever &
Gault, 2006; Lyter, 2002). Kane and Rouse (1993) conducted a study using data from a longitudinal study with youth and found that for each year of college, earning power increases by four to nine percent. Inequity in access to college education is counterproductive to improving one’s life station. It violates basic human rights and erects obstacles to future opportunities and successes. Polakow (2007) posited:

Unequal life circumstances and the lack of fundamental social and economic rights entrap poor women and entangle their lives in a web of resource deficits that diminishes their own development as human beings, and profoundly alters their own children’s life chances. (p. 185)

A national initiative to combat educational inequity has been set forth. The White House (2014) has issued a call to action to increase college opportunity for low-income students by “partnering with colleges and universities, business leaders, nonprofits and others to…support more college opportunities for students across the country” (Paragraph 2). Partners committed to expanding college opportunity are committed to action in connecting more low-income students to colleges that are right for them; providing additional science, technology, engineering and mathematics (STEM) full-tuition, four-year scholarships for students from diverse, urban backgrounds; waiving fees for college applications for eligible students; better supporting students in need of remediation; and employing recruitment and retention strategies to improve outcomes for low-income students.

Nursing has multiple points of entry—diploma, associate’s degree, or bachelor’s degree—to allow flexibility in meeting the needs of the aspiring student. Whichever entry point is chosen, the highly competitive admission process used by many NEP applies hierarchical metrics to determine which applicants are most suited for admission. These
metrics often include grade point average, essay, or standardized test scores, and create another barrier for African-American applicants. Eleanor encountered such a barrier as she had to repeat the Nurse Entrance Test (NET) to score high enough to meet the admission requirement for the NEP. It has been noted that nursing schools use the NET to aid in selection of students deemed suitable to matriculate through their programs with greater likelihood of success on the NCLEX-RN. The NET and other admission requirements exemplify what Gramsci (1971) described as the bias evidenced in the hegemony of the education system. Standardized testing and admission requirements are structures that contribute to the disenfranchisement of people of color (Ladson-Billings & Tate, 1995, Museus et al., 2011). Repeating the NET adds cost and adds another layer to the structural barriers experienced by the study participants.

The institutional pressure for nursing program administrators to prepare graduates to pass the NCLEX-RN on the first attempt is one driver of the restrictive admission criteria for nursing programs. First-time pass rates of graduates are among the criteria for continued accreditation of nursing programs and are enticing to attract future students. It is also one way to evaluate and compare nursing programs (Seldomridge & DeBartolo, 2004). There is an ongoing debate about the merit of academic-based-only nursing admission policies and practices. The accreditation of nursing schools is jeopardized when increasing numbers of students fail the NCLEX on their first attempt. Here, again, is a structure that encourages the school administrators to create hurdles to protect the accreditation of the NEP but that ultimately negatively affect the students’ opportunities. Freire (1970) argued that these types of structures are created by the dominant elite and perpetuate an environment of exclusion and marginalization for the group being dominated.
Laura and Thelma encountered the barrier of limited seats in nursing programs. With the glut of applications for the limited number of available seats in NEP, the admission process has become very competitive. NEP administrators use materials traditionally biased against women and minorities as the tools to determine the order of admission: standardized tests (Micceri, 2009; Zwick, 2002). The merit of entrance exam scores as admission criteria is arguable. In a dissertation study, Roat (2008) found portions of the Nurse Entrance Test to have some correlation with NCLEX-RN success, but there is a dearth of research on the merit of entrance exams and early success in NEP. Because of the competitive state of the current nursing admission processes, minority students are often left on the margins.

Additionally, nursing school can be costly, creating yet another barrier for some students. The cost for completing a nursing degree at a four-year public institution ranges from $40,000-$100,000 as opposed to $6,000-$20,000 at a two-year program (CostHelper, 2015). Students who elect to complete prerequisites for a Bachelor’s of Science in Nursing (BSN) degree program at a community college are disadvantaged in some admission processes. Some post-secondary institutions offer additional “points” to applicants who complete their prerequisites at the institution to which they are applying. For applicants trying to save costs and complete prerequisites at an outside institution, this can be a disadvantage before they are even considered for the NEP. Bell’s critical race theory (1992) indicates that such policies and practices continue to feed the inequity among African Americans and nourish social structures that feed inequality (Ladson-Billings & Donnor, 2005). Eleanor, Elizabeth, Hannah, Jackie, and Julia elected to complete their associate’s degrees first and returned to school later to complete their bachelor’s degrees. Partnering
these challenges with exposure to the subpar K-12 educational systems, African-American applicants are operating at a deficit before they are even considered for enrollment.

Thelma and Laura exemplified the nursing student applicant who has actually completed the admission requirements but faced another barrier of having to be waitlisted for admission to the nursing program due to a glut of qualified applicants and scarcity of available seats. Freire (1970) labeled these type of conditions as “limit situations,” conditions that constrain the ability of an individual to reach one’s potential. Freire argued that individuals must take part in finding solutions to the limitation that is the source of oppression and pursue creative ways to respond to such situations or conditions that can limit individual achievement of their potential. Both Thelma and Laura took the lead in the process of transforming their own future. Thelma shopped around for a program that would admit her right away. She had a sense of personal urgency as an older student and single mother and “could not afford” to sit on a waiting list for a year. Laura’s sentiment was similar; she was waitlisted at all the nearby nursing programs for which she qualified. She opted to move to another state so she could enroll in an NEP immediately.

Nursing education programs (NEP) are challenged to bridge the gap between students’ K-12 education and future success in nursing school. NEPs are faced with regulatory guidelines and curriculum dictated by accrediting bodies that are often not diverse or relatable to diverse student populations. The RNs in this study shared experiences of poor quality K-12 education and the challenges it created for them as they entered their NEP. Julia shared how she graduated from high school and could not write well enough to pass the college English course that was prerequisite to the nursing courses. Eleanor shared how she struggled to keep up with the large amount of reading and comprehension required for
nursing school, and Rose shared how she felt inferior and less confident in her foundational knowledge than her White peers. Rose described how the majority of the White students “just knew more.” Students entering NEPs unequally yoked and with a different cultural, language, and life experience are at a disadvantage in a Eurocentric-based educational program.

Nursing can be the answer for many African-American women, but as it stands, nursing education needs to provide an educational experience conducive to all of its students’ success. The attrition rate for African-American nursing students has to be addressed. Lack of diversity among nursing faculty and lack of feeling of inclusiveness among African-American students is an ongoing concern for nursing school administration. The Whiteness of nursing is very real. The majority of the students are White, along with the faculty and nursing workforce. The participants in this study felt isolated by the students and generally unsupported by the faculty. Rose shared how she felt as if she did not exist and how the “White students didn’t talk to me.” Additionally, many students, like Sarah, felt isolated because they were one of few Blacks, if not the only one in their cohort. Sarah explained the lack of diversity among the nursing faculty, saying, “I only had one Black instructor the whole time. The whole four years there.” As the dominant culture, Whites often are unable to conceptualize what the minority is experiencing. Kozol (1991) explained how belonging to the dominant culture can shade one’s understanding of those who are not members, resulting in discounted feelings of otherness. Black feminist thought as a contextual framework adds clarity to this study’s participants’ sense of otherness and authenticates their feelings of marginalization (Alinia, 2015; Collins, 1990). CRT’s counter-storytelling strategy used in this study amplified the voices of African-American women, a marginalized group who often
do not have opportunity to tell their stories from their perspectives in their own voice (Bell, 1992).

Nurse educators, decision-makers, and administrators have to be self-reflective and self-critical in examining how they approach students of color and educate themselves on how to engage all students in an inclusive educational process. This is not a simple process, as members of a hegemonic society are often unaware of the subtle nuances that have infiltrated their daily lives. To establish a multi-cultural approach to education and a culturally relevant pedagogy, educators have to acknowledge and address the uncomfortable topics of race and racism. According to Bonilla-Silva (2014), this would be difficult because Whites have developed a new racial ideology called “colorblind racism.” The premise of colorblind racism is that Whites believe that race does not matter; in all reality, racial discrimination exists on many levels and infiltrates our daily lives and interactions. Reflecting upon and discussing race is a good start to awareness of the perspective one holds and to open dialogue regarding inclusiveness. This is challenging to do with such an uncomfortable topic, but it is critical if faculty and administrators are going to promote an inclusive and culturally competent educational setting.

Nursing education programs need to offer multi-dimensional support for students. Students need a supportive academic environment that provides strategies for test-taking, study skills, note-taking, and assimilation into the processes for nursing education. Students need to understand what is expected of them academically and that their grade will be based conjointly on what they know and how they implement this knowledge into practice. Financial support will relieve the burden of having to work while going to school. Nursing school is innately rigorous, and having to work takes away from valuable study time and
removes students from opportunities to socially integrate. Students also need social support to integrate into the learning environment and create a sense of belonging. These types of supports can augment the learning experience and serve to improve success in nursing programs (Fletcher et al., 2003; Gardner, 2005b; Sutherland, Hamilton, & Goodman, 2007).

Last, as seen in this study, support does not end after graduation. The first year of nursing after graduation can be challenging, if not disheartening, for new nurses. Adjusting to the role and responsibilities of a registered nurse without the safety net of the clinical instructor leads to high turnover and attrition among new nurses. Nurses have reported unfriendly workplaces, emotional distress associated with patient care, fatigue, and exhaustion as factors contributing to leaving nursing (MacKusick & Minick, 2010). A project implemented by Banister, Bowen-Brady and Winfrey (2014) was designed to help nursing students smoothly transition into the RN role. These authors developed the Clinical Leadership Collaborative for Diversity in Nursing to provide career nurse mentors to support minority nursing students and facilitate their transition to practice. This academic-service partnership paired experienced minority nurses with students and helped to guide them through the junior and senior year of nursing school and the first year of employment. This project was successful in retaining 100% of its participants (N = 64) from 2007–2012. Similarly innovative support programs need to be more broadly implemented in nursing.

**Nursing Practice Implications**

The gross disparities in health among minorities and non-minorities underscore the critical need to increase the number of minorities in nursing practice. The Sullivan Commission Report (2004) indicated that healthcare based on knowledge and sensitivity to cultural differences will contribute to decreasing the healthcare disparities. As the US
becomes more diverse, the need for religious, linguistic, sexual, and gender-based sensitivity in healthcare becomes more prevalent. Studies have found that minorities are not comfortable seeking care within a healthcare setting where there are a limited number of healthcare providers who are members of ethnic minorities like themselves (Love, 2010; Wong et al., 2008). Minorities are leaders in morbidity and mortality rates, and the “lack of minority health professionals is compounding the nation’s persistent racial and ethnic health disparities” (Sullivan Commission Report, 2004, p. 2). The belief is that minorities are more likely to enter a healthcare system to seek care from providers available to provide culturally sensitive care. Nurses as the frontline healthcare providers are integral to combating the ongoing healthcare disparity. Increasing the diversity of the nursing workforce in practice can have significant impacts on the associated healthcare disparity. This is meaningful to the African-American population, as African-American nurses are more willing to serve in underserved communities (Collins et al., 2002; NHDR, 2007). The impacts are two-fold: to help mitigate the nursing shortage and to decrease the healthcare disparity, resulting in a culturally competent and sensitive nursing workforce. A pilot study by Harris et al. (2013) found that even a one-hour course in cultural competence curriculum led to a statistically significant difference in self-reported feelings of cultural competence at three and six months post-education. Improving diversity and cultural competence among healthcare providers is one strategy to improve patient outcomes and access to healthcare (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007; Harris, 2010). A classic example of lack of cultural competence is shared in The Spirit Catches You and You Fall Down, in which Fadiman (1997) chronicled the clash of the culture of the traditional medical-model healthcare system and the traditional beliefs of a Hmong family in the treatment of their
young daughter, Lia’s, seizure disorder. Although both her parents and her doctors wanted what was best for Lia, the collision of two worlds, combining a lack of understanding and inability to effectively communicate, resulted in Lia tragically ending up in a vegetative state for over 25 years until her death. Providing cultural competence education is one strategy to better equip healthcare providers to care for patients like Lia from diverse populations. Some of the collateral benefits from a reduction in healthcare disparities are decrease in healthcare costs, increased longevity, and improved general wellbeing of minorities. Bull and Miller (2008) supported the idea that the commonality of lived experiences between African-American patients and caregivers can be enough to promote improved use of healthcare services and contribute to the reduction in healthcare disparity.

It is clear that the nursing profession is in need of minorities, as the nursing demographic is not keeping pace with the changing US racial demographic (Carthon, Nguyen, Chittams, Park, & Guevara, 2014). AACN (2011) reports that 17% of the nursing profession is minority, and only 5% of those are African Americans (the largest minority subgroup). The need for first-level providers who speak the language and have an awareness of religious practices and cultural and societal norms can improve trust, build rapport, and expedite quality care. Strategies for recruitment and retention of a diverse nursing population will be critical to serving the aging and increasingly diverse population eligible for healthcare, particularly with the implementation of the Affordable Care Act (Harris, Rosenberg, & O’Rourke, 2014).

The transformation of nursing education is a precursor to creating a diverse nursing workforce and transforming nursing practice. Transformations to address the lack of diversity in healthcare providers need to be implemented in conjunction with addressing the “outdated
and ethnocentric educational strategies” (Lancellotti, 2008, p. 179). Nursing needs a sustained effort to attract more minorities to nursing as a career choice and to increase the number of minority amongst faculty. Success of minority students is vital to the future of the nursing profession’s goal of providing culturally sensitive care and meeting the healthcare needs of an increasingly diverse population.

Nursing needs to introduce diverse student populations in urban areas to nursing school during middle and high school. This can be accomplished through developing partnerships with community schools involving faculty, administrators, and current nursing students to develop bridge programs for minority students interested in nursing. Generating early interest in nursing offers nursing educators the opportunity to recruit a diverse student population more representative of the US population. Early intervention creates partnerships among nursing education programs and the community to prepare diverse students to meet the admission criteria for program admission. Nursing programs located in urban communities can take the initiative to invest in the education of students from the community through partnerships, identify students interested in nursing, and help prepare them academically and socially. Additionally, these nursing programs should apply for funding to offer financial support to economically disadvantaged students. Increasing admission of minority populations is not enough. Once admitted, in lieu of changing the behavior of the minority student to fit the dominant culture of nursing, theories such as Leininger’s culture care theory should be employed to provide a nursing educational framework and culture that recognizes individual students’ cultural beliefs, practices, and values, thus promoting a learning environment that is structured but conducive to individuality (Lancellotti, 2008). Combining these strategies can offer significant contributions to minority student admission,
retention, and success in nursing education programs and subsequently influence the diversity of the nursing workforce in practice.

None of these individual strategies can be successful without development of an increased cadre of minority nursing faculty and faculty preparation to teach diverse populations. Lack of minority faculty has been found to be a barrier to recruitment and retention of diverse nursing students (Baker, 2010; Mills-Wisneski, 2005; Robinson, 2005; Zajac, 2011). Promoting and fostering development of minority faculty can have many benefits to the education and practice of nursing. Minority nursing faculty can offer valuable contributions to education and research and help to mitigate the connection among healthcare providers and the end-users. Rowsey, Kneipp, and Woods-Giscombe (2013) developed a program to increase the diversity of faculty, researchers, and leaders in nursing. The Careers Beyond the Bedside (CaBB) program targets underrepresented ethnic minorities in undergraduate nursing and is designed to prepare these students for doctoral programs within one year of graduation. CaBB offers students pre-entry into the nursing program, academic enrichment, educational seminars, financial support, mentoring by nursing faculty and graduate students, and other activities designed to prepare students for graduate school. Programs such as this are integral to increasing diversity and contributing to reducing healthcare disparities.

Ultimately, nursing practice is linked to transformation of nursing education. Nursing literature is consistent in findings regarding the barriers to nursing student success and retention. A variety of barriers to success have been identified among minority nursing students. The barriers consistently flow in the vein of support. These barriers to minority success in NEP have been explored from many angles. Researchers have found that barriers
to nursing student success have been consistently attributed to finances, academics, family support, and support of peers and faculty (Gardner, 2005a; Jeffreys, 2007; Loftus & Duty, 2010; Newton & Moore, 2009).

Changing nursing practice is inexplicably linked to minority student success. To assist with increasing the diversity of nurses in practice, some NEPs are proactively trying to promote African-American student success by instituting new types of support programs. Colleges and universities are using summer bridge programs, mentoring, and tutoring as support structures for underrepresented students. Summer bridge programs introduce students to the campus and provide for early assimilation and engagement while also fostering support systems with other students before the challenge and rigor of the NEP is introduced (Harper & Quaye, 2009). Many schools focus on the academic support of the students, while others offer programs for “disadvantaged” students that include academic and social support. Along with academic support, social support has been found to be key to the success of disadvantaged students. Kosowski et al.’s (2001) research with African-American nursing students revealed the value students and faculty place on being placed in care groups for support, role modeling, and a safe environment to dialogue and share. This is critically important in nursing education, where the barriers that African-American students face are not solely based on human capital but also on invisible barriers, such as marginalization and microaggressions. African-American student reports of unfavorable racial climate, difficulty socializing with peers, lack of support from faculty, and feelings of loneliness and isolation are barriers perceived to affect success in nursing education (Gardner, 2005a; Love, 2010). Hillary recalled repeated challenges with the faculty at her NEP, explaining, “People grow up and make stereotypes and generalizations about race, it bothers me that people can’t be as
culturally diverse and competent…That was a big challenge for me throughout the nursing program…all the way to the end.” Nursing education administrators’ adoption and implementation of strategies to support marginalized students will help meet the demand for RNs and contribute to closing the healthcare disparity gap. This is of particular importance, as minority providers are more likely to serve in urban communities, resulting in improving access and increasing use of the healthcare system by minorities (Love, 2010; Wong et al., 2008).

The barriers to success for minorities in nursing are well documented. Current NEPs are integrating relevant support structures to improve the success of disadvantaged and underrepresented students. Three levels of support are available to promote student success. At the federal level, NEP administrators can apply for grants through the US DHHS (n.d.) to increase nursing education opportunities for individuals who are from disadvantaged backgrounds (which includes underrepresented minorities) by providing scholarships, stipends, and other retention activities. NEPs have to apply for these grants directly. These types of programs can alleviate some of the financial burden for nursing students. At the university level, programs offer students scholarships, grants, and stipends to pursue degrees in high demand fields. These types of programs also offer support in mentoring, tutoring, and peer support. Finally, at the NEP level, students need individual support from faculty and peers and strategies for NEPs to recruit, retain, and graduate minority nursing students to meet the needs for a future diverse nursing workforce.

**Study Limitations and Recommendations for Future Research**

The purpose of this qualitative research study was to explore the lived experiences of African-American female registered nurses. This dissertation included a small, purposeful sample of women from a small radius in the Midwest. Yet some compelling narratives...
emerged from the lived experiences of these women, and the findings of this study speak to the broader issues of exclusion, marginalization, violence, and poverty. Limiting this study was the participants’ ability to recall historical events. Varying amounts of time had elapsed since the nodal events had occurred, and the accuracy of recollections could have been affected. Conversely, the variance in the amount of time since the critical event of nursing school added value to the historical contextualization of the study, as personal experiences were aligned with specific timeframes in society and history.

This study was also limited to the voices of African-American female registered nurses from a relatively segregated portion of the Midwest that has a long history of educational inequity, economic disparity, and racial discrimination. This limitation could be explored further by continued research involving other groups. There are other minority groups whose experiences were not addressed, as well as those who are marginalized based on gender, income, religion, or sexuality. Opportunity for further exploration with comparative groups would allow for exploration of multi-collinear variables to examine a multidimensional perspective of lived experiences before, during, and after nursing school.

Although focusing on one racial group offers limitations, additional qualitative research could be conducted featuring African-American women from similar backgrounds, such as single mothers or second-career seekers, or in different geographic regions of the US. Critical race theorists posit that race and racism are a normal part of US society, and marginalized groups tell stories from a different perspective (Bell, 1992). Knowing this, what would the lived experiences of African-American RNs in the South, where history has been laden with segregation, inequality, and oppression, be like compared to those in the West where diversity is comparatively embraced? Additionally, research exploring the experiences
of other racial and ethnic groups could add to the discourse. For example, some questions for future research that emerged after completing this study are: What are the experiences of other minority groups in nursing? As a gender-based minority group, what are the lived experiences of African-American men in nursing? Hine (1989, 1994) has explicated the rich history of African-American women living with social injustice, exclusion, and marginalization that are reflected in the oppressive conditions of work and education, particularly in nursing. The voices of men and other minority groups in nursing can add to the discourse regarding exclusion and marginalization for those not a member of the dominant group. What are the experiences of women who are poor but not minorities? How do the experiences of African-American women in poverty compare to those from higher income levels? The experiences of non-minority poor women is of particular interest considering the findings of the Institute for Women’s Policy report tracking the experiences of a mostly minority group of single mothers as they pursued higher education as a means to a better economic life for their families (Jones-DeWeever & Gault, 2006). The economic impact for the women in the Jones-DeWeever and Gault report showed a remarkable increase in income (92%) for women with a four-year degree compared to women with a high school degree. Pearce (1978) argued that some women “are poor because they are women” (p. 28). It would be intriguing to explore the lived experiences of poor, non-minority women to see if findings would be similar to those of the African-American women in this study. With the growing familiarity of technology, future research could also incorporate the use of smartphones as a mechanism for data collection.

This study also offers potential for larger scale quantitative research regarding African-American women and nursing education and professional experience. It would be
intriguing to assess the self-reported quality of grit among underrepresented groups of nursing students and professional nurses using the established *12-Item Grit Scale* (Duckworth et al., 2007). Other quantitative studies could seek to determine what, if any, predictive variables are indicative of success in NEP and how can those data be used to help everyone who wants to become a registered nurse achieve success.

Qualitative research could also be used to explore the impacts of mentoring on retention. An additional gap in the literature exists in exploring the experiences of students who failed or stopped out and never returned to nursing school. It would be compelling to examine what happened to these former students: at what stage did they drop out, why they chose not to return to nursing, and what are they doing instead. It would also be of interest to explore the experiences of African-American women who attended a historically Black college or university, or a religious school, or even a single-gender institution of higher learning. Another question to explore would be to conduct research with RNs categorized by highest degree attained. *What would the experience of a BSN graduate be like? Would that experience be comparable to an ADN graduate?* Finally, a longitudinal study to track this group in real time would be a great way to capture the lived experiences at or near the point of occurrence and gather responses. *Would these groups have similar experiences and perceptions?*

**Final Thoughts**

As I began this qualitative research study, I wanted to examine the lived experiences of African-American female registered nurses with the purpose of sharing their experiences to help others. Barriers to success for African-American (minority) students had been researched, and my focus was going to be to delve into their strengths and success strategies they found meaningful prior to and following pursuit of their nursing degree. I did not
suspect that these women would open my eyes and mind to so many new “stories.” As I explored these lived experiences, I gleaned more than a mere paradigm shift in thinking. Their narratives were more than a simple laundry list of challenges and successes highlighting “this is what worked for me, and this is what was not as helpful.” I became immersed in the world of oppression, where race, class, and gender intersect and reveal inequity, violence, the complex web of social ills, educational challenges, family responsibilities, and more. It awakened me with clarity to recognize that when students sit in those chairs for their first nursing class they come with many unique elements to their life stories that were established well before the students’ first day of nursing school. They arrive at nursing school for a variety of reasons: some were natural caregivers, others used nursing as a vehicle to change their life’s path, and some decided to pursue nursing instead of medicine because of the time commitment or personal fit. Nonetheless, NEPs have a powerful role in maximizing human potential and changing the demographic of the nursing profession. Administrators are challenged to increase the number of African Americans as nurse leaders, decision-makers, stakeholders, and students to analyze and implement policies and programs to support success of persons from disadvantaged and diverse backgrounds.

The results of this study suggest it is critical for nursing educators, administrators, and faculty to acknowledge the complex nature of African-American students and the complexity of social inequities that each individual carries; that students who may seem to have it all together still have to live with the embedded overt and covert microaggressions that occur daily in life and in nursing school, even if they seem well-adjusted. We all need to remember we are more than the sum of life events and experiences from which we came. Yet all students do not have an equal opportunity to reach their maximum potential. However,
some do succeed in spite of what may appear to be insurmountable odds. In order to improve educational opportunities for all students, a deficit-oriented focus needs to be eradicated from the US public education system, including higher education. Multicultural education is a counter-strategy that will benefit groups traditionally oppressed because of race, income, or gender. Stakeholders need to embrace multicultural education as a social justice strategy toward educational equity to establish a framework that will provide students choices and support their strengths. It starts when a student enters school, and it probably begins even before that, when we are “socialized” to our families and communities.

As educators on the front line, we need to create a learning environment where girls, if they so choose, can take advantage of opportunities in science, technology, engineering, and math (STEM) that are usually reserved for high-achieving boys, and boys can gain opportunities in careers that allow them to express their interest, not just their *manliness*. Multicultural education is an essential component of the movement to effect social change and elimination of oppression and injustice; this benefits all children and fosters the overall public good (Gorski, 2013). However, social change is not without its challenges. This change needs to be addressed at many levels. It starts with each of us as we teach children, work with our colleagues, sit on committees, conduct research, establish policies and procedures, and determine where funding is best allocated. The sharing of the lived experiences of these African-American women offers insights to pathways and strategies that stakeholders, policy-setters, and decision-makers can implement to improve access and support success of underrepresented students. *Quality education matters!* Nelson Mandela (2003) stated it best when he said, “Education is the most powerful weapon which you can use to change the world.”
References


Cumming v. Richmond County Board of Education, 175 U.S. 528 (1899).

doi:10.3928/01484834-20110317-03.


doi:10.1177/1532708607310794


http://doi.org/10.1111/cdep.12038


doi:10.1016/j.nedt.2005.06.004


doi: 10.1377/hlthaff.27.2.413.


Mandela, N. *Lighting your way to a better future*. Planetarium, University of Witwatersrand, Johannesburg, South Africa. 16 July 2003. Address given at Launch of Mindset Network.


League for Nursing. (2010). Executive summary: Findings from the annual survey of
Disorders and Stroke. Retrieved from
http://www.ninds.nih.gov/diversity_programs/definitions.htm
survey of schools of nursing academic year 2009–2010. Retrieved from
http://www.nln.org/docs/default-source/professional-development-
programs/exec_summary_0910.pdf?sfvrsn=4
National League for Nursing (NLN). (2013). Annual Survey of Schools of Nursing, Fall
and families. Retrieved from http://nwlc.org/resources/national-snapshot-poverty-
among-women-families-2014/
Nettles, M. T. (1990). Success in doctoral programs: Experiences of minority and white
Newton, S. (2008). The impact of community college transfer on entry-level baccalaureate


doi:10.4097/NNE.0b013e31821fdb9d


University of Pennsylvania School of Nursing. (n.d.) *Nursing through time: Nursing history and health care.* Retrieved from http://www.nursing.upenn.edu/nhhc/Pages/timeline_1700-1869.aspx?slider1=1


http://www.nursing.upenn.edu/nhhc/Pages/AmericanNursingIntroduction.aspx


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Appendix A: Recruitment Flyer

Approved by the Eastern Michigan University Human Subjects Review Committee
UHSRC Protocol Number: 670017-2
Study Approval Dates: 10/30/15 – 10/29/16

Dissertation Research Study
An Exploration of the Life Histories of African-American Registered Nurses

Eastern Michigan University
Department of Nursing

Seeking Participants
A qualitative research study to explore the life histories of African-American female registered nurses.

Who is Eligible?
- African-American female registered nurses
- Ages 18 and over
- Currently licensed to practice or retired from nursing practice
- Attended a primarily White nursing education program
- Living in the United States

What will you be asked to do?
- Participate in up to 3 confidential interviews with the investigator
- Tell the story of your life
- Complete a basic confidential demographic data profile

Compensation
You will receive no compensation for your participation in this study.

If you have any questions or are interested in participating, please contact: Investigator: Marva Brooks @ (248) 320-8320 or Email: mbrook25@emich.edu
Appendix B: Consent Form

An Exploration of the Life Histories of African-American Registered Nurses

Informed Consent Agreement Information

Study Overview
I am a PhD candidate in the Educational Studies – Nursing Concentration at Eastern Michigan University. My dissertation research is an interview-based qualitative study in which I explore the life histories of African-American female registered nurses. The Study involves up to three audio-taped interviews of approximately one hour in which I will ask you questions about your background and perceptions and experiences related to childhood education, nursing education, and working within the nursing profession. Participation in the study is completely voluntary and your identity will be kept confidential if you choose to participate.

Benefits and Risks of Participation
The results of this study will contribute to the body of research regarding African-American women in nursing. The benefits to you as participant may be an opportunity to reflect on your own perceptions about and experiences across your lifespan as you describe them in the interview process. There is no financial compensation for participation. There are no foreseeable risks to participating in the project.

Dissemination of Results
Findings from the research study will be shared as part of the requirements of the PhD in Educational Studies – Nursing Concentration at Eastern Michigan University. If you would like to see the final dissertation, a copy will be made available to you. The findings may be written up for presentations at Eastern Michigan University, or used in later professional presentations at Conferences or submitted for publication. Any dissemination of findings will be anonymous, your name will not be identified in the dissertation or any papers or presentations of this data.

Inclusion Criteria
- African-American female registered nurses
- Ages 18 and over
- Attended a primarily White nursing education program
- Currently licensed to practice or retired from nursing practice
- Living in the United States

If you would like to participate in the research study, please read and sign the consent form on the following page.
An Exploration of the Life Histories of African-American Registered Nurses

Informed Consent Form

I agree to participate in one or more interviews conducted by Marva Brooks as part of a dissertation research study about the life histories of African-American registered nurses. I understand that an interview will last approximately 60 minutes and that the interview(s) will focus on my background and perceptions; educational experiences in childhood and nursing school; and nursing professional career. I will be asked questions about my background; childhood and nursing school educational experiences and professional experiences as a registered nurse. I may be invited to complete up to 3 interviews to allow time to cover the identified content. I understand and agree to audio-recording of the interviews. I also agree to complete a confidential basic demographic data profile.

I understand that my participation in the interview(s) is completely voluntary; that I may choose not to answer certain questions, and that I may withdraw and discontinue participation at any time with no negative consequences, no penalty, nor loss of benefits. I further understand that my confidentiality will be protected at all times, and that any identifying characteristics about me, my family, or workplace will have a fictitious name(s) assigned to assure my confidentiality. The transcripts of the tapes will be assigned a numerical code and kept in a locked file cabinet and in a password protected computer file. I further understand that if I decide at any point after the interview that I do not wish to participate, my tapes and transcripts will be destroyed and no material will be used from the interviews.

I agree to allow these research findings from my interview(s) to be anonymously disseminated with my confidentiality fully protected at all times, in doctoral dissertation, in Eastern Michigan University presentations and/or disseminated in future publications, conferences, and professional settings. I understand that no identifiers will be used in the presentation of the results.

If you have any questions about this project and your participation in this study, please feel free to contact myself, Marva Brooks, or my dissertation chair, Dr. Raymond using the below listed contact information. This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee (UHSRC) for use from October 15, 2014 to October 15, 2015. If you have questions about the approval process, please contact the UHSRC at human.subjects@emich.edu or call 734-487-0042.

Interview Respondent’s Name: ____________________________________________________
Signature:  ________________________________   Date: ______________________________

For further questions or concerns, please contact:            OR            Contact the Doctoral Committee Chair:
Marva Brooks                                           Dr. D. Marty Raymond
10211 Dartmouth St.                                       Doctoral Program in Educational
Studies                                                  School of Nursing
Oak Park, MI 48237                                       332 Marshall
(248)320-8320                                             Eastern Michigan University
Email: mbrook25@emich.edu                                Ypsilanti MI 48197
                                                        Tel: (734)487-2054
                                                        Email: draymon3@emich.edu
Appendix C: Approval Letter

RESEARCH @ EMU

UHSRC Determination: EXPEDITED CONTINUING REVIEW APPROVAL

DATE: October 26, 2015

TO: Marva Brooks, RN, MN
Eastern Michigan University

Re: UHSRC: # 670017-2
Category: Expedited
Approval Date: October 30, 2015
Expiration Date: October 29, 2016

Title: An Exploration of the Life Histories of African-American Registered Nurses

Your research project, entitled An Exploration of the Life Histories of African-American Registered Nurses, has been approved in accordance with all applicable federal regulations.

This approval includes the following:

1. Enrollment of 20 subjects to participate in the approved protocol.
2. Use of the following study measures: Demographic Data; General Script/Sample Questions
3. Use of the following stamped recruitment materials: Dissertation Research Study: An Exploration of the Life Histories of African-American Registered Nurses - Eastern Michigan University Department of Nursing Seeking Participants - A qualitative research study to explore the life histories of African American female registered nurses.
4. Use of the stamped: An Exploration of the Life Histories of African-American Registered Nurses Informed Consent Form

Renewals: This approval is valid for one year and expires on October 29, 2016. If you plan to continue your study beyond October 29, 2016, you must submit a Continuing Review Form by September 29, 2016 to ensure the approval does not lapse.

Modifications: All changes must be approved prior to implementation. If you plan to make any minor changes, you must submit a Minor Modification Form. For any changes that alter study design or any study instruments, you must submit a Human Subjects Approval Request Form. These forms are available through IRBNet on the UHSRC website.

Problems: All major deviations from the reviewed protocol, unanticipated problems, adverse events, subject complaints, or other problems that may increase the risk to human subjects or change the category of review must be reported to the UHSRC via an Event Report form, available through IRBNet on the UHSRC website.

Follow-up: If your Expedited research project is not completed and closed after three years, the UHSRC office requires a new Human Subjects Approval Request Form prior to approving a continuation beyond three years.

Please use the UHSRC number listed above on any forms submitted that relate to this project, or on any correspondence with the UHSRC office.
Good luck in your research. If we can be of further assistance, please contact us at 734-487-3090 or via e-mail at human.subjects@emich.edu. Thank you for your cooperation.

Sincerely,

Jennifer Kellman Fritz, PhD
Chair
University Human Subjects Review Committee
Appendix D: General Script/Sample Questions

General Script/Sample Questions

Introduction: In order to ensure you are giving informed consent, I would like to share some information about myself and this study. I am a PhD candidate in the Educational Studies – Nursing Concentration at Eastern Michigan University. My dissertation research study is to explore the life histories of female African-American registered nurses. This qualitative study involves me conducting interviews with study participants. You will have up to three interviews. Interviews will be approximately one hour long. I will ask you questions about your background and childhood; education; and nursing professional experiences. I will also ask that you complete a basic demographic profile. The results of this study may contribute to the body of research regarding African-American women in nursing. Results will only be shared in a confidential manner. Participation in this study is voluntary. If you choose to participate, you will be assured of complete confidentiality. You may choose to withdraw from this study at any time. Now, I would like to give you time to read the informed consent agreement, ask any questions you may have, and if you choose to participate, please sign the consent agreement as indicated.

Childhood, Family and Education

- I am interested in learning about you, your childhood, family and early education.
  
  *Tell me about your background.*
  
  *What was your childhood schooling like?*
  
  *How would you describe yourself?*

Nursing Education Experience

- Now, I am interested in your reflection on your nursing education experience.
  
  *Why did you decide to become a registered nurse?*
  
  *Share with me your experience during nursing school.*
  
  *What support services did you utilize during your nursing education?*

Professional Experiences

- I would like for you to tell me about your professional life experiences as an RN.
  
  *How do you define success?*
  
  *How do you see yourself fitting into that definition?*
  
  *What type of work experience(s) have you had?*

At the close of the interview I will provide my contact information and a flexible timeframe for further contact and scheduling of follow-up interviews to clarify information and ask additional questions.
Appendix E: Demographic Data Form

Please answer all questions to the best of your ability.

1. Age_____ 

2. Relationship status
   ○ Single, never been married   ○ Married   ○ Divorced   ○ In a relationship   ○ Widow(er)

3. What type of nursing program did you complete?
   ○ Associate’s degree
   ○ Diploma program
   ○ Bachelor’s degree

4. What is your highest level of degree attained?
   ○ Diploma
   ○ Associate degree
   ○ Bachelor’s degree
   ○ Doctorate
   ○ Other non-nursing degree
   (please describe) _________________________

5. Did you ever fail a nursing course?
   ○ Yes   ○ No
   If yes, which nursing course(s) did you fail? _________________________

6. What was your college cumulative grade point average? ________

7. What was your high school grade point average? ___________

8. Were you employed while in nursing school?
   ○ Yes   ○ No

9. If employed, how many hours per week do you work? ______
   ○ Not applicable

10. Father’s highest education level:
    (Mark one)
   ○ Less than 8th grade
   ○ Some high school
   ○ GED
   ○ High school diploma
   ○ Some college
   ○ Associate degree
   ○ Bachelor’s degree
   ○ Master’s degree
   ○ PhD or EdD (Doctoral degree)

11. Mother’s highest education level:
    (Mark one)
   ○ Less than 8th grade
   ○ Some high school
   ○ GED
   ○ High school diploma
   ○ Some college
   ○ Associate degree
   ○ Bachelor’s degree
   ○ Master’s degree
   ○ PhD or EdD (Doctoral degree)

12. Did your family of origin qualify for any of the following? Select all that apply.
   ○ Food stamps/EBT card
   ○ Childcare vouchers
   ○ Subsidized health care
   ○ Subsidized housing
   ○ Free/reduced lunch
   ○ Other______________

13. What is your expected household income from all sources before taxes for this year?
   ○ None
   ○ $50,000 - $74,999
   ○ $75,000 - $99,999
   ○ $100,000 - $124,999
   ○ More than $125,000

14. _______
Appendix F: Registered Nurse Participant Profiles

This study profiled 14 registered nurses (RN) currently residing in the Midwest. The sample consisted of one retired RN; 12 actively practicing RNs; and one newly licensed graduate whom had not secured her first RN position as the time of this study. Two of the RNs were graduates of diploma programs; one was an Associate Degree in Nursing (ADN) graduate; seven held their Bachelor of Science in Nursing (BSN) degree; four had earned a Master’s of Science in Nursing degree (MSN); and one had her PhD. Each of the RNs shared the experience of matriculating through a nursing education program where they were among the minority. Cases of seven participants are included in Chapters 4 and 5. The thematic analysis Chapters 6 and 7 includes supporting narrative from all the participants. The following section features a synoptic summary of each RN participant. Participants appear in this appendix in alphabetical order.

Angelica. Angelica is a 40-year-old pediatric nurse practitioner and nursing faculty. She has been married for 12 years to a local politician and has no children. She is the only participant in the study with a PhD. Born and raised in Detroit, Angelica is the only child of her mother and the sixth child of her father. She had an upper-middle-class upbringing in a two-parent home. She received her K-8 education at a private Catholic school and attended public high school. For college, she enrolled in the nursing program at a PWI located in a distant suburb of Detroit. She always knew she wanted to be a nurse because of the influence of her mother; who is also a nurse, had in her life. She also felt nursing provided her with a career where she could do everything that she wanted to do. When she started college, Angelica had never attended school with White students. Financing her college education was never a problem for Angelica—her parents provided everything she needed. The biggest issue for Angelica was being one of very few Blacks in the nursing education program
(NEP); she struggled to fit in and felt like she always had to prove herself. Angelica also had some academic issues during nursing school. She had to spend an extra semester in college to meet the BSN graduation requirements. In addition to her PhD, Angelica holds both a BSN and MSN degrees. Her professional career includes work as a pediatric staff nurse, intensive care unit, Sickle Cell clinic, and pediatric nurse practitioner. She is currently a proud member of Chi Eta Phi Sorority, Inc.

**Eleanor.** Eleanor is a 44-year-old married mother of two adult daughters. She and her husband were both raising young daughters alone and joined their families in 1998. Eleanor is the youngest of four children born and raised in Detroit in a middle-class family. Her father, an electrician, was the provider and her mother stayed home and managed the household. Her father was emotionally and verbally abusive to her mother. Her parents divorced when she was in the eighth grade. Eleanor began to skip school, run with a gang, and made a series of poor choices; eventually she dropped out of high school. At 17 years old, she became pregnant and moved out on her own, supporting herself with public assistance. Eleanor returned to finish her high school diploma and soon thereafter completed medical assistant training. Her boyfriend was mentally and physically abusive to her. She threatened to leave him, and he became distraught and attempted suicide. He survived and his threats to Eleanor and her daughter continued until he went to jail for a drug-related murder he committed. She decided to pursue a degree in nursing because as a single mother, becoming a registered nurse was the quickest route to earn money to support herself and her daughter. Plus, she absolutely love helping, so it was a plus for her to be able to do both. Eleanor has earned her ADN, BSN, and MSN degrees. She is currently working as a part-
time cardiac catheterization nurse and full-time nursing faculty at a local community college, while working toward completing her PhD.

**Eliza.** Eliza is a 39-year-old nurse educator. She is single and has no children. She has been an RN since 1997. Eliza spent her entire youth growing up in a suburb bordering the north side of Detroit. Her nuclear family of origin included her parents, an older sister, and a younger brother. Eliza was educated in a strong public school system. Her father, an autoworker was the ultimate provider, and her mother was an educator. Eliza’s parents always stressed the importance of college. Her life dramatically changed when her father had a massive heart attack and died suddenly. Everything changed for the worse. The family’s finances went into a tailspin. Eliza knew there was no money for her to go to college. When it was time to go to college Eliza selected a public primarily White institution (PWI) close to home. She knew she wanted to be a nurse since she was nine years old. Eliza was a sickly child and knew she wanted to help the sick. She combined her love for science with what she felt was her calling. Eliza had her first encounter with racism in nursing school at the PWI she attended and struggled academically through nursing school. Eliza compounded her academic challenges because she had to work 30–40 hours a week to pay her way through college and help her mother with home expenses. She started to work in nursing less than a week after graduation. However, once she failed the nursing licensing exam she elected to spend a year working as a dialysis technician and studying for the retake of the RN licensing exam. She passed the exam on her second try. Her career has included staff nursing and education. She is currently working as an educator while completing her MSN.

**Elizabeth.** Elizabeth is a single mother of two children. She is 44 years old and has never been married. She and her two brothers were raised by a single mother and attended
Detroit Public Schools for grades K–12. Her mother had a well-paying job at a soda company and provided a middle-class upbringing. This comfortable lifestyle came to an abrupt halt when her mother lost her job for coming to work under the influence of alcohol. The family began to move a lot and her mother drank excessively and used crack. Her mom was also verbally and physical abusive. When Elizabeth was a senior in high school, her mother beat her severely and kicked her out of the house. Her paternal grandmother became her source of support. Elizabeth graduated high school and began working at a fast food restaurant. Then she got pregnant, and had an abortion, and decided to change her life. She began to take college classes and became a medical assistant. Elizabeth had her first child with her long-term boyfriend when she was 21, and he was 17. Her relationships with both her children’s fathers were marked by verbal and physical abuse. She discovered her passion for nursing while working as a medical assistant. Elizabeth felt nursing would allow her to use her natural gifts to touch and change lives. She made two attempts at nursing school, overcoming financial and academic challenges, a nervous breakdown, family tension, and social isolation. She finished her ADN in 2005, and recently completed her BSN. She has worked as a cardiac intensive care nurse, a nursing instructor, and as faculty for a patient care technician program.

Grace. Grace is 62 years old. She is the youngest of three children raised by a single mother in Detroit. She did not know her father until she became a young adult. Her mother struggled tremendously to provide for her family, but she always encouraged Grace to go to college. An excellent student, Grace attended her neighborhood public schools and was double-promoted during elementary school. She was inspired to become a nurse by participating in the Future Nurses Club in high school and watching her older sister serve on
the Nurse’s Guild at church. With no money for college, she went to work at the post office after high school. Grace was eventually able to attend nursing school on a special program implemented in the 70s that provided tuition for underserved students. Nursing school in the early 70s had little support for Black students, and Grace noticed a disparity in the number of Black students failing as compared to White students. She also experienced discrimination and prejudice at the hands of nursing faculty. Grace began her nursing career as a diploma graduate in 1973 and after practicing a few years returned to complete her BSN and MSN. She and her husband were living the dream life together when their second child was born with multiple birth defects and lived just one day, putting an incredible strain on their marriage. They worked through their grief and have made a very comfortable standard of living for themselves and their children. Grace is currently an administrative executive for a healthcare system and her husband is a certified registered nurse anesthetist. She is an active member of Chi Eta Phi Sorority, Inc.

**Hannah.** Hannah is a 67-year-old retired RN. She is divorced and has no biological children. Hannah was raised in a small town in Kentucky. She is the oldest of four children born to her mother, and the only girl. Hannah and her oldest brother were raised together by her maternal grandmother. Her two younger brothers were raised by two other families in the community. Her grandmother provided laundry services for White families to support the three of them. Hannah attended the local public school for Black children. When in the third grade she was raped by two teenage boys. Soon thereafter in the fourth grade an uncle began to sexually molest her. She carried the emotional scars from these events with her into adulthood. When integration came, her mother enrolled her in the White junior high school, where she was the only Black student. Hannah was an excellent student and wanted to go to
college, but instead, after high school she worked to help her grandmother and saved money toward the licensed practical nurse (LPN) program tuition. After completing her training as an LPN, she decided to become an RN because of her desire to increase her scientific knowledge and enhance her opportunities to care and help a diverse group of people. She completed her ADN and soon followed with her BSN degree. She has been an RN since 1978. Since retiring in 2011, Hannah spends her time educating the community as a Type II diabetic and colon cancer survivor. She is active in her church and works with the homeless community in her hometown.

**Hillary.** Hillary is a 29-year-old family nurse practitioner at a rural clinic. She has been an RN for six years. Hillary is the youngest of three girls raised in a comfortable upper-middle-class home by both parents. She is a Detroit native and an excellent student. She spent her K–8 years at a Catholic school and attended a reputable high school in Detroit for grades 9–12. Unfortunately, in high school, Hillary found out she had scoliosis and could not participate in the sports she loved. She delved into her academics and completed all of the available advanced placement and honors courses available by her junior year. She had also met all of the requirements for a State of Michigan high school diploma, so she elected to finish high school via an online home school program. Her academic acumen earned her a full scholarship to Vanderbilt University. Hillary started out as a dentistry major, but after three years, switched to nursing because she did not like the internship portion of dentistry. Money was never an issue for Hillary during college, her biggest issue in nursing school was feeling marginalized simply because of her race. She felt picked on, unsupported, and frustrated as she watched many African-American students fail out of the nursing program. Hillary finished her BSN in 2009 and immediately started working on her double MSN,
which she completed in 2013. Her work experience includes manager of a children’s’
institution and part-time nursing faculty. She is engaged and she and her future husband are
also co-owners of a family business.

**Jackie.** Jackie is 35 years old. She and her two siblings were raised in the projects of
Detroit by a single mother on government aid. In the neighborhoods surrounding her home
Jackie witnessed many violent acts growing up, including her sister stabbing a girl with a
pocket knife on the front porch of their family home. Growing up she was a good student and
a dedicated member of the marching band. However, Jackie became disenchanted with
school, and at 17, she dropped out of high school and moved out on her own. At 19, she
returned to an adult education alternative school to complete her high school diploma. Jackie
has been married for nine years; she and her husband were high school sweethearts. They
have three children, ages 14, 12 and 10. Jackie began her healthcare career as an emergency
medical technician (EMT). She initially wanted to become a pediatrician but felt nursing
better fit her personality. She loved the way nurses spent more time with the patients and
nursing also fulfilled her desire to take care of people. She started nursing school when she
was four months into a high-risk pregnancy with her youngest child. During nursing school
she was forced to manage a high-risk pregnancy, two toddlers at home, and her husband’s
loss of his job. In spite of these life challenges, Jackie completed her ADN, BSN, and was
recently accepted into a Nurse Midwife program. Jackie has been the sole source of regular
income for her family since 2006. Her husband has difficulty securing employment because
of a felony gun charge. Jackie works full-time and carries the benefits for her family. She is
currently working in the ER at a Detroit hospital.


**Julia.** Julia is a 48-year-old nurse practitioner (NP) for an insurance company. She is the single mother of three adult children. Her life began in the impoverished section of Highland Park, MI. Julia was the middle child of seven children raised in poverty by both of her parents. She attended the public school system for grades K–12. Her father was a drug abuser, and also emotionally and physically abusive to her mother. At the age of 18, Julia married her high school sweetheart and moved to Germany for his first military instillation. Soon after arriving in Germany her husband became violent and began to physically abuse her. She divorced her husband shortly after returning stateside, but he did not stop harassing her until he eventually succumbed to a self-inflicted gunshot. Julia began her work career in a low-wage job as a housekeeper in a hospital. She viewed nursing as her ticket out of poverty. Julia also wanted to become a nurse because she was fascinated by the human body and wanted to make a difference while helping people. She started in healthcare as a licensed practical nurse (LPN). Since then, Julia has earned her ADN, BSN, and MSN. Julia was confronted with perceived discrimination throughout her nursing education. She was also challenged and sidetracked by the needs of her children, in particular, a violent altercation between her two daughters and the ongoing mental health issues of her youngest daughter.

**Laura.** Laura is a new graduate. She is 33 years old and single, and finished a diploma nursing program in May 2015. Nursing is a second career for Laura. She already holds a bachelor’s degree in psychology. She had been working as a paraprofessional in a suburban public school system when she decided to go to nursing school. As the youngest of three daughters, Laura felt a bit of pressure from her family to be successful like her sisters. Growing up in a two-parent home, her parents emphasized college as the only option. Her parents provided her with a middle-class upbringing in an integrated neighborhood. She
attended public school for grades K–12 in a diverse public school system in the suburbs of Detroit. In the third grade, a savvy teacher recommended Laura for testing for learning disabilities, and it was found that Laura had dyslexia. Laura got an Individual Education Plan (IEP) and did well through high school and her first college degree with the added support. Laura was inspired to become a nurse after she witnessed firsthand the care provided to her grandmother by the hospice nurses, coupled with her love for science. Nursing school presented a whole new challenge for her, academically, emotionally, and financially. Due to waitlist in Michigan nursing schools, Laura went out of state to attend nursing school. Laura struggled through the nursing program without the benefits of an IEP. Additionally, she had exhausted her financial aid while pursuing her first college degree, so she struggled to make ends meet. The toughest and most stressful hurdle for Laura was passing the nursing licensure exam. She failed the first two times she sat for it. On the third try, she passed. Today, Laura is seeking her first job as a registered nurse—in Michigan.

Michelle. Michelle has been an RN for 16 years. The oldest of three children born in Detroit, she spent her early formative years being raised by her college-educated parents. After her parents’ divorce, she split her time between her father in Ann Arbor and her mother in Detroit, matriculating in both public school systems. Michelle is 45 years old and initially dreamed of becoming a pediatrician, but she put those plans on hold when she became a mother at age 18. Subsequently, she became a single mother of two before age 20. She was stuck in a series of dead-end jobs, being supplemented by public assistance. She decided to become a nurse to make a better life for her children. For Michelle, nursing was a relatively quick way to secure a stable and flexible career where she would always have a job. Michelle failed out of nursing school twice before successfully completing her Associate Degree in
Nursing (ADN). Michelle was married to her first husband for seven years. She divorced him when it was discovered that he had been sexually molesting her daughters. Michelle is currently married to her second husband and is working as a contingent emergency room RN. She is working on completing an ADN to Master’s program while her husband is pursuing his ADN. Michelle was a participant in my 2012 pilot study.

**Rose.** Rose is a 30-year-old family nurse practitioner. She has been married since 2007 and has two young daughters. Rose earned her BSN in 2007 and her MSN immediately afterwards. Born in Detroit, her nuclear family consisted of her parents and a younger brother and sister. Her family of origin was a working-class poor family. Rose attended public school for grades K–12. Her family moved to a nearby suburb when Rose started middle school. Rose began to run with a gang and her grades deteriorated. Her parents tried desperately to control Rose with threats and physical beatings. Rose’s behavior put her in a situation that lead to a traumatic event when she was 16 years old and too inebriated to make decisions for herself. This event served as a turning point for Rose. She began to apply herself in school, strengthen her faith, and was able to graduate with her class. She applied and was accepted to a historically Black College out-of-state. As a first generation college student, Rose had little advice from her parents. After a year, she moved back home and enrolled in a local university nursing program. Her initial dream was to become a podiatrist, but the reality of the time and cost to become a doctor led her to realign her goals. While earning her BSN and MSN, Rose accumulated a major nursing student loan debt exceeding $90,000. Rose also acquired a $200 thousand mortgage while in college, trying to help her parents after their home was foreclosed. She and her husband have slowly recovered from some of the debt, and have been able to purchase their first house in a suburb east of Detroit.
**Sarah.** Sarah was born in West Africa. She is 39 years old and has been in the United States (US) since she was three years old. Her father emigrated from West Africa to complete his studies as a librarian, and settled his family in Ohio. Sarah is the middle child of three girls. She did not speak English when she arrived in the US. Her parents enrolled Saran and her sisters in school and gave their daughters American names to help with assimilation. Education holds high value for Sarah’s parents. Both of her parents have multiple college degrees. All three girls were educated in primarily White Catholic school for grades K–8. When it was time for high school, their parents enrolled them in the more ethnically diverse public school system. Coming from a family of healthcare providers, Sarah knew she wanted to be a nurse by her junior year in high school. Nursing allowed her to care for people and be close to the patient and family. Sarah knew after high school she would begin working on what her parents refer to as her “first degree.” She enrolled in a nursing school in Ohio that only had two minorities, Sarah and one other student. Nursing school presented an academic challenge for Sarah. She failed courses and was told by one instructor that she was not nursing material. She remained determined and completed her BSN in 2008. She worked her way into a management position at an urban hospital and currently holds the position of nurse manager of one of the largest internal medicine clinics in Detroit.

**Thelma.** Thelma is a 45-year-old divorced mother of two adult children. She began her healthcare career as a unit clerk, progressed to medical assistant (MA), and has been an RN since 2002. A Detroit native, Thelma’s family of origin included her mother and five siblings. Her parents divorced when she was about seven years old. Her mother remarried, and Thelma and her siblings enjoyed a stable working class upbringing. Thelma attended Detroit Public Schools. In high school she became rebellious and began to run with gangs.
The gang activity involved fighting and gun violence. Her mother was not pleased and moved Thelma to Cincinnati to finish high school. She was accepted to a historically Black college in Ohio. She could not afford to continue to pay for college and had to drop out after one year. On welfare and needing a career to support herself and her son, she became a medical assistant (MA). She married her son’s father and entered into a physically abusive relationship. The marital stress affected her mental well-being and she suffered a nervous breakdown and was on antipsychotic medications. At 32, she divorced her husband and started classes toward a nursing degree. For Thelma, a nursing career would allow her to provide for her family. However, finances and course failures slowed her progress in completing nursing school. Thelma felt discriminated against and also had some anxiety issues that affected her academically. Thelma has worked with her current employee for the past 26 years. She is currently working on a team to integrate an electronic medical record system.
Appendix G: Summary of Types of Violence, Living in Poverty, and Educational Obstacles of Seven Featured Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Type of Violence</th>
<th>Living in Poverty</th>
<th>Educational Obstacles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor</td>
<td>Father emotionally abusive to mother</td>
<td>Pregnant teen mother—moved out on her own at age 17</td>
<td>High school dropout</td>
</tr>
<tr>
<td>44-year-old Married Mother of 2</td>
<td>Boyfriend emotionally, psychologically, economically and physically abusive; suicide attempt;</td>
<td>Welfare</td>
<td>Graduated one year late</td>
</tr>
<tr>
<td>Jackie</td>
<td>Community/environmental</td>
<td>Raised in housing projects by single mother on welfare</td>
<td>High school dropout</td>
</tr>
<tr>
<td>35-year-old Married Mother of 3</td>
<td>Multiple loved ones murdered</td>
<td>Moved out at 17; welfare sole provider</td>
<td>Adult education</td>
</tr>
<tr>
<td>Rose</td>
<td>Physical—parents spanking, slapping, punching</td>
<td>Parents poor; living paycheck to paycheck</td>
<td>Family responsibilities</td>
</tr>
<tr>
<td>30-year-old Married Mother of 2</td>
<td>Emotional—Verbal abuse</td>
<td>Childhood home foreclosed; family mortgage in her name</td>
<td></td>
</tr>
<tr>
<td>Hannah</td>
<td>Sexual abuse—childhood rape and molestation</td>
<td>Raised in poverty by grandmother</td>
<td>Only Black child in her school</td>
</tr>
<tr>
<td>67-year-old Divorced No children</td>
<td></td>
<td>Mother received welfare</td>
<td>Jim Crow era</td>
</tr>
<tr>
<td>Michelle</td>
<td>Sexual abuse—Daughters sexually assaulted by her husband</td>
<td>Teen mother</td>
<td>Attended five schools in grades 6-12</td>
</tr>
<tr>
<td>45-year-old Married Mother of 2</td>
<td></td>
<td>Welfare</td>
<td>Failed nursing class 3 times</td>
</tr>
<tr>
<td>Thelma</td>
<td>Physical—Intimate partner violence</td>
<td>Welfare</td>
<td>Poor high school Performance</td>
</tr>
<tr>
<td>45-year-old Engaged Mother of 2</td>
<td></td>
<td>No money for college loan payoff</td>
<td>Failed nursing course</td>
</tr>
<tr>
<td>Julia</td>
<td>Physical—Father abusive to mother; Intimate partner violence, economic</td>
<td>Family of origin poor</td>
<td>Poor K-12 education</td>
</tr>
<tr>
<td>48-year-old Single Mother of 3</td>
<td>Husband suicide</td>
<td>Dad stole from family for drugs</td>
<td>RN program shut down</td>
</tr>
<tr>
<td></td>
<td>Daughter stabbed other daughter</td>
<td></td>
<td>LPN program rigor</td>
</tr>
</tbody>
</table>