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# The Lived Experiences Of Clinical Adjunct Dental Hygiene Faculty

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THE LIVED EXPERIENCES OF CLINICAL ADJUNCT DENTAL HYGIENE FACULTY

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A DISSERTATION

Presented to the Affiliated Faculty of

The College of Graduate and Professional Studies at the University of New England

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2019

## THE LIVED EXPERIENCES OF CLINICAL ADJUNCT DENTAL HYGIENE FACULTY

### ABSTRACT

Clinical education is an integral part of a dental hygiene student's education. Clinical adjunct dental hygiene faculty primarily teach in the clinical setting. Clinical adjunct dental hygiene faculty are often hired for their clinical expertise and may lack teaching experience. The transition from clinical practice to academia raises concern about the adequacy of support and preparation clinical adjunct faculty receive as they begin their new role as educators. The purpose of this interpretative phenomenological analysis was to explore clinical adjunct dental hygiene faculty members' experiences of preparedness as they transitioned from clinical expert to novice educator. Six clinical adjunct dental hygiene faculty who participated in this study were interviewed. Interviews were audio-taped and transcribed. Transformative learning and identity theories were the conceptual frameworks utilized for this study. The data were analyzed and resulted in four key themes. These themes were support and mentorship, orientation, teaching facilitators, and educational methodology development. The recommendations are to provide novice adjunct faculty members with a formal mentorship, extensive support, a formal orientation to the college and the department, and additional professional development opportunities related to teaching methodologies. Establishing a more supportive environment for new adjunct members can help increase belongingness, connection, and create professional identities as educators.

University of New England

Doctor of Education  
Educational Leadership

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## DEDICATION

For my mother, Pamela. I hope I have made you proud.

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## **CHAPTER ONE**

### **INTRODUCTION**

During their career, there are some dental hygiene clinicians who choose to take on another role and teach. For these newcomers, the world of academia can be quite different from clinical practice. As such, new faculty must learn to navigate new terrain and adapt to their new roles. This study identified the perceived needs and necessary support of clinical adjunct dental hygiene faculty as they enter the field of education. The purpose of this study was to explore clinical adjunct dental hygiene faculty members' experiences of preparedness as they transitioned from clinical expert to novice educator. It is this researcher's intention that the results from this study will inform the educational training and support of clinical adjunct dental hygiene faculty. This research study employed an interpretive phenomenological approach within the framework of transformational learning and identity theories. Six participants were purposefully selected to participate in 45-minute interviews. Thus, this phenomenological research approach will help better understand the perceived needs and necessary support for clinical dental hygienists to feel prepared to teach as clinical adjunct faculty in academia.

This chapter is organized into the following sections: background and context, statement of the problem, purpose of the study, research questions, conceptual framework, rationale and significance, and definition of terms. Lastly, a conclusion is provided which highlights key points and sets the stage for Chapter Two.

#### **Background and Context**

Dental hygiene educators, similar to other allied health educators, often transition from working in clinical practice to teaching in academia. While some clinical dental hygiene educators teach full-time, the majority teach part-time and maintain other employment

(American Dental Education Association, ADEA, 2017; Fagan-Wilen, Springer, Ambrosino, & White, 2006; Roberts, Chrisman, & Flowers, 2013). Full-time dental hygiene faculty teach in both the classroom and the clinic. Full-time faculty are provided with numerous professional development opportunities (Elder, Svoboda, Ryan, & Fitzgerald, 2016; Forbes, Hickey, & White, 2010; Paulis, 2011). However, adjunct dental hygiene faculty do not share the same experiences as their full-time counterparts (CODA, Commission on Dental Accreditation, 2017; Elder et al., 2016; Forbes et al., 2010; Paulis, 2011). Faculty development programs are often centered around the needs of full-time faculty (CODA, 2017; Forbes et al., 2010). Similar to adjunct nursing faculty, the majority of clinical adjunct dental hygiene faculty teach only in the clinical setting (Davidson & Rourke, 2012). Furthermore, most clinical adjunct dental hygiene faculty are hired because of their experience in patient care and have no formal training in the educational process (McLeod, Steinert, Meagher, & McLeod, 2013; Paulis, 2001; Schönwetter, Lavigne, Mazurat, & Nazarko, 2006). While clinical adjunct faculty have extensive clinical skills, their teaching practices are often based on their past experiences as students or as clinicians, rather than on guided practices as teachers (Paulis, 2011; Scanlan, 2001).

Rogers, Dunn, and Lautar (2008) postulated that merely wanting to be a teacher is not enough. Given the vital role that clinical dental hygiene educators play in the education process, it is essential they are familiar with teaching methodologies. Moreover, student satisfaction with clinical education is important because of the impact that this component of the curriculum has on the success of the new graduate. New dental hygiene graduates are expected to be competent beginner clinicians, ready to enter the workforce and meet the demands of evidence-based practice (Higgs & McAllister, 2007). Therefore, effective clinical teaching is essential for student learning.

In an effort to standardize faculty and establish consistency, the American Dental Association's (ADA) Commission on Dental Accreditation (CODA) issued a common accreditation standard in 2015 (Standard 3-7) requiring all dental hygiene faculty to have training in teaching methodology courses (ADA, 2016). The Standard was revised in 2017. The following is an overview of CODA Standard 3-7:

All dental hygiene program faculty members must have background in current education theory and practice, concepts relative to the specific subjects they are teaching, clinical practice experience and, if applicable, distance education techniques and delivery. Faculty who supervise students' clinical procedures should have qualifications which comply with the state dental or dental hygiene practice act. Examples of evidence to demonstrate compliance may include: faculty curriculum vitae with recent professional development activities listed and/or evidence of participation in workshops, in-service training, self-study courses, on-line and credited courses, attendance at regional and national meetings that address education, mentored experiences for new faculty, scholarly activity, and maintenance of existing and development of new/and or emerging clinical skills. (ADA, 2019, p. 32)

Coursework should include pedagogical methods, assessment techniques, working with adult learners, and teaching with technology. All institutions wishing to become reaccredited and maintain accreditation status must adhere to the new regulations (ADA, 2019). Although faculty are required to take educational coursework related to the discipline they teach, there are no formal guidelines specifying the contact hours, the frequency, or the specific content for this coursework (ADA, 2019). Department chairs must make their own interpretation of this standard. Therefore, there is no continuity in how faculty fulfill these requirements.

This issue has become increasingly important as the dental hygiene profession is experiencing a shortage of educators and the shortage is predicted to increase (American Dental Education Association, 2017). According to the American Dental Education Association's Allied Director's 2016 Survey, approximately 50% of the dental hygiene workforce is over the age of 50 (ADEA, 2017). To cope with the shortage, many institutions are increasing the numbers of part-time faculty, increasing the workload of current faculty, and hiring faculty with less than preferred credentials (ADEA, 2017). The fate of the profession is tied to the qualifications of the educators. As part of ensuring the quality of clinical education, universities need to be involved in the education and support of clinical educators (Higgs & McAllister, 2007).

As demonstrated in Chapter Two, a review of the literature reveals a gap regarding how clinical faculty obtain a teaching foundation. A study conducted by Wallace and Infante (2008) on the impact of clinical teaching workshops indicated that "most of the participants identified a need for professional development related to clinical teaching" (p. 1171). Therefore, professional development with the focus of teaching could assist the clinical educator to become a more effective teacher and subsequently improve the clinical experience for the students.

### **The Institute**

The study took place in an institution, herein called "The Institute," located in a suburban community in the Northeast. The Institute opened in 1912 and has become a four-year comprehensive college in art and sciences. The Institute is comprised of 30 buildings and spans across 380 acres. The school's mission is to deliver exceptional academic and applied learning outcomes through scholarship, research, and student-engagement (The Institute, 2018).

Today, The Institute is one of the largest colleges of technology, with over 9,600 students enrolled (The Institute, 2018). Students are enrolled in 37 baccalaureate, seven associate, and most recently, one master's degree program in its Schools of Arts and Sciences, Business, Engineering Technology, and Health Sciences (The Institute, 2018). The majority of students (93%) are commuters, 30% are minority, the male/female ratio is 56% to 44%, and the admissions are increasingly selective with only 49% of applicants accepted (The Institute, 2017). The Institute has experienced an average annual enrollment increase of 4% per year since 2008 (The Institute, 2017). There are 736 faculty and 1,177 additional employees (The Institute, 2018).

The Institute is accredited and offers many specialized accredited programs in the areas of healthcare and engineering (The Institute, 2018). The degree programs have been developed with the aim of fulfilling the need for applied science and technology graduates and fill a niche that is in demand and adds strength to the local economy (The Institute, 2018). The college continues to seek opportunities to strengthen its relationship with the local community and surrounding areas (The Institute, 2018).

**Dental Hygiene Program.** One such successful program with strong ties to the community is the dental hygiene program. The program began in the 1946 and is one of five dental hygiene programs in the area. Dental hygiene graduates earn an associate's degree in applied science degree (A.A.S.) and receive a dental hygiene license upon successfully passing their written and clinical board exams. The Institute also offers two opportunities for students to obtain their baccalaureate degrees in dental hygiene. The first is the degree completion option. In this situation, students can enroll in bachelor's level classes after they receive their A.A.S. degree. The second option is the straight bachelor's program, which began in the fall of 2017 and is a



four-year program. These students began by taking their general coursework during the first year and went on to take their clinical coursework during the following three years.

The department of dental hygiene at The Institute currently employs 12 full-time and 25 adjunct faculty. To become a dental hygiene educator at The Institute, one is required to have a master's degree in addition to a state dental hygiene license. In addition, faculty must have a minimum of five years clinical practice experience, certification in local anesthesia, a current Cardiopulmonary Resuscitation (CPR) certification for healthcare professionals, and must be a member of the American Dental Hygienists' Association (ADHA). The majority of faculty hold adjunct positions, as most of the positions in the dental hygiene department are clinical positions. Adjunct faculty can only work a maximum of eight hours per week, and as a result, part-time faculty often have multiple jobs. A significant draw to teaching part-time at The Institute is the benefits. Part-time faculty can receive both health and retirement benefits after teaching six hours per semester. The limited number of dental hygiene programs in the vicinity and the central location of the institution also makes The Institution an ideal place to work.

**Dental Hygiene Faculty.** As mentioned previously, a master's degree is required to teach in the dental hygiene program at The Institute. However, there is no requirement for the degree major. A number of faculty have master's degrees in public health, dental hygiene, education, science, arts and business administration. Therefore, faculty at the college have varying levels of teaching skills, consistent with the research finding that most faculty transition from clinical practice to academia with little or no teaching experience (Davidson & Rourke, 2012; McLeod et al., 2003; Paulis, 2011; Schönwetter et al., 2006). While clinical adjunct faculty are considered to be clinical experts, they have a limited understanding of the practice of clinical teaching (Franz & Smith, 2013; Scanlan, 2001). The "teaching needs" of clinical educators depend on

their knowledge of the adult learning process (Rogers et al., 2008, p. 41). The challenge for health care programs is to provide a strong network of clinical teachers for applied training for students (Rogers et al., 2008).

There are a number of concerns raised by having an increasing number of clinical adjunct faculty. Some of these reasons include: clinical adjunct faculty do not go through the traditional full-time hiring procedures, they are not interviewed by a search committee, and they often do not receive a formal orientation (Schönwetter et al., 2006). For the purpose of this study, orientation is defined as the formal or informal process by which new faculty are informed of their role, clinical responsibilities, and the institution or department's policies and procedures (Roberts, Chrisman, & Flowers, 2013, p. 298). Furthermore, clinical adjunct faculty may not have prior experience teaching and little to no background in adult education (Davidson & Rourke, 2012). Trends in allied health education suggest teaching style impacts student learning outcomes (Wallace & Infante, 2008).

Finally, in 2015, the profession's accrediting body, the American Dental Association Commission of Dental Accreditation (CODA), issued a new standard (Standard 3-7), which was revised in 2017, requiring all dental faculty to take teaching methodology courses. Specifically, all full-time and part-time faculty must have background in and current knowledge of the specific subjects they teach and the educational theory and methodology consistent with their teaching assignment (ADA, 2019). This is an important standard, which helps to ensure quality assurance. Educators must maintain current and relevant teaching skills.

### **Statement of the Problem**

Clinical education plays a large role in the training of a dental hygienist. As such, dental hygiene programs rely on the clinical experience and expertise of clinical educators to instruct

students in the clinical setting. According to the 2016 ADEA Survey of Program Directors, 65 percent of faculty teaching in dental hygiene programs are part-time (ADEA, 2017). Due to the sheer number of clinical adjunct dental hygiene faculty, much of the responsibility of clinical teaching falls on them. Clinical adjunct dental hygiene educators are expected to prepare students to be competent dental hygiene clinicians. Clinical educators are simply not born that way, becoming a clinical educator is a developmental process (Higgs & McAllister, 2007). However, most clinical adjunct educators have limited or no training as educators (Franz & Smith, 2013). Dicke, Hodges, Rogo, and Hewett (2015) purported that clinical adjunct dental hygiene faculty often have varying backgrounds, education, and levels of experience which can lead to faculty taking different approaches to instruction. Students are negatively impacted by a lack of consistency in faculty teaching (Dicke et al., 2016). For example, Dicke et al. (2015) described students becoming distracted by instructor variation. Furthermore, some students reported altering their clinical performance to satisfy individual instructors (Henzi, Davis, Jasinevicius, & Hendricson, 2007). In an effort to improve calibration efforts, CODA implemented a new Standard, 2-24, requiring dental hygiene programs to have a “defined mechanism to calibrate dental hygiene faculty” (ADA, 2019, p. 28). To demonstrate compliance, dental hygiene programs are required to show documentation of calibration exercises (ADA, 2019). The profession of dental hygiene requires experienced, qualified and dedicated educators to help make the profession successful.

While there is extensive information on effective teaching and student learning in many disciplines of higher education, there is limited literature on effective clinical teaching in dental hygiene (Schönwetter et al., 2016). The clinical setting is very different from the classroom or laboratory. Teaching in the clinical environment occurs during direct patient care, therefore

effective clinical teaching is an essential component of dental hygiene education. Clinical instructors help bridge the gap between theory and practice. Clinical instruction often has an instructor to student ratio of approximately one to five (ADA, 2019). Moreover, clinical instructors work in closer proximity to their students, which allows for a closer rapport. Schönwetter et al. (2016) purported that clinical instructors can have a potentially greater influence on dental and dental hygiene students' learning in clinic rather than in classroom settings.

Schönwetter et al. (2016) concluded that instructors should be provided with formal pedagogical training to improve teaching effectiveness. CODA strives to improve the education of dental and dental hygiene students by imposing requirements on the faculty and within the curriculum. As a result, there is a growing concern for quality assurance for maintained accreditation status. Educators must be competent in not only the content of what they teach, but in how they teach it. While new full-time faculty are provided with strategies to assist in the transition from clinical practice to academia, adjunct faculty are not afforded the same opportunity (Forbes, Hickey, & White, 2010).

### **Purpose of the Study**

The purpose of this study is to (a) examine the lived experiences of clinical adjunct dental hygiene faculty as they transitioned from clinical experts in their respective fields to novice educators; (b) explore clinical adjunct dental hygiene faculty member's perceived level of preparation as they transitioned from clinical practice to academia, and lastly, (c) identify perceived clinical adjunct faculty needs of support to maintain the practice of teaching.

Although clinical adjunct dental hygiene faculty may also teach in the classroom and online, this

study addresses only clinical adjunct dental hygiene faculty who teach dental hygiene students within the clinical setting.

### **Research Questions**

This study seeks to answer the following research questions:

1. What is the lived experience of clinical adjunct dental hygiene faculty in their teaching role as they transitioned from clinical setting to academia?
2. What is the experience of receiving support and mentoring as clinical adjunct dental hygiene faculty?
3. What professional development do clinical adjunct dental hygiene faculty need to successfully teach in the clinical setting?

### **Conceptual Framework: Transformative Learning and Identity Theories**

According to Chi and Glaser (1998), expertise in one's field is reached after approximately 10 years of practice. Dreyfus and Dreyfus (2005) described a five-stage skill acquisition which includes novice, advanced beginner, competency, proficiency, and expertise. According to the authors, to be considered an expert, one has to make immediate and unreflective decisions (p.779). The researchers further postulated, "intuitive judgement is the hallmark of expertise" (p. 779). Thus, Dreyfus and Dreyfus (2005) do not place a specific time value on becoming an expert, as it is an individualized event. During this time, professional identities are constructed and are matured through ongoing exposure to practice and continued professional development. A professional identity allows better understanding of one's role within his or her area of practice (Rasmussen, 2015). However, when clinicians decide to enter academia, they must reframe their professional identities. This experience may prove daunting for some.

Mezirow's (1998) transformative learning theory addresses the various factors that affect the way adults learn and create meaning in their lives. According to Mezirow (1996), "learning is understood as the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one's experience in order to guide future action" (p.162). It is in this vein that transformative learning and phenomenology are similar, as they both account for not only the personal experience, but also the interpretation of experience, which leads to a change in mindset, behavior, or beliefs. Mezirow (2000) used the term "frames of reference" to describe a person's new experience along with his or her original views, habits, or mindsets (p. 17). Thus, critical reflection is a crucial element in Mezirow's (2000) transformative learning theory. According to Mezirow (2000), transformative learning requires both individual experience and critical reflection. Specifically, in this study, transformative learning theory will be applied to the perspective of the individuals who share the phenomena or experiences of transformation.

Illeris (2014) built upon transformative learning theory. According to Illeris (2014), learning of any kind is dependent on interaction and acquisition. Interaction is between the individual and the environment. Acquisition is connecting of new knowledge through interaction (Illeris, 2014). Illeris (2014) takes the approach to learning a step further to include the development of identity. Identity is formed by self-perception. For Illeris (2014), identity is, "how one wants to be experienced by others" (p. 37). Identity development and change are conceptualized through transformative learning. According to Illeris (2014), "identity is the adequate concept for what transformative learning is related to and transforms" (p. 38). The literature supports the challenges many clinicians face as they transition from expert clinician to novice educator (Anderson, 2009). Using the theoretical frameworks of transformative learning

and identity theories, this study aimed to uncover the challenges clinical adjunct dental hygiene faculty face as they adapt to their new role.

These two theories provide concepts which help understand the lived experience of clinical adjunct dental hygiene faculty. One such concept is learning as belonging. Illeris (2014) discusses Wenger's (1998) social theory of learning, in which learning is the result of social participation. Another concept is the work identity. According to Illeris (2014), for most people work occupies a considerable amount of a person's time. Therefore, work identity is more or less integrated with personal identity (Illeris, 2014). Finally, Illeris (2014) posited that for transformative learning to take place at the workplace, one requires guided learning, mentoring, coaching, and networking. These concepts were used to frame the study's findings.

### **Rationale and Significance**

There is an abundance of literature on classroom teaching in higher education, however teaching and learning in the clinical setting is very different (McLeod et al., 2003; Ramani & Leinster, 2008; Schönwetter et al., 2016). According to Ramani and Leinster (2008), there are challenges in the clinical setting that are not seen in the classroom environment. There are time constraints, patient-related challenges, and the physical clinical environment can be non-conducive for teaching.

In addition, all dental and dental hygiene faculty are now required to take methodology coursework related to their teaching. While full-time faculty are required to provide evidence of methodology in their annual reports, adjunct faculty are only required to provide such information upon each new accreditation cycle, which is every seven years (ADA, 2019). Moreover, the Standards do not delineate how often the coursework should be completed, nor do they specify how many credit hours are required. Consequently, clinical adjunct faculty may

take the necessary coursework only when required to do so. Given the number of and reliance on adjunct dental hygiene faculty as compared to the number of full-time faculty, and the importance of experiential learning in the clinic setting, studies devoted to exploring adjunct dental hygiene faculty preparation and experience in teaching are necessary. In this researcher's experience, clinical adjunct faculty may delay their fulfilment of methodology coursework until the time of the next accreditation cycle. This is reflected in the course dates provided in their bibliographical sketch, or BioSketch. BioSketches are limited versions of curricula vitae and are required for each faculty member at the time of accreditation (ADA, 2018). They are used to highlight each individual's qualifications.

It is plausible that faculty postpone taking methodology coursework because of a lack of opportunity to do so. A recent Internet search for educational coursework for clinical dental hygiene educators yielded limited results. Some of the coursework required the participant to travel long distances and also included high tuition fees. While some colleges provide financial support of professional development for adjunct faculty, others do not (Forbes et al., 2010).

Due to the growing number of adjunct faculty employed by the institution, it is important to understand faculty's perceptions of their teaching effectiveness and what preparation each faculty member takes in preparing for his or her role as educator. In addition, little literature exists that identifies clinical adjunct faculty teaching needs from their perspective (Santisteban & Egues, 2014). Furthermore, review of the literature revealed a lack of existing literature on the needs of adjunct clinical dental hygiene faculty as they entered academia. This research offers a voice to adjunct clinical dental hygiene faculty to explore their narratives of how they adjusted both in their professional capacity and in their professional identity as they entered the academic workforce.



### **Researcher's Perspective**

The principal researcher's experience as a clinical dental hygienist and, subsequently, as an educator, plays an integral role in this study. After fourteen years in private practice and obtaining a master's degree in business administration, this researcher made the journey from a clinical dental hygienist to the role of an adjunct clinical dental hygiene educator. With little experience in education, this researcher shadowed more seasoned faculty. Although she muddled through and found her way, the experience begged the question, "How do clinical adjunct dental faculty prepare for their role as clinical educators?" It was the researcher's intention through this research study to identify dental hygiene adjunct instructors' needs as they transition to their new roles as clinical faculty.

### **Definition of Terms**

#### **Accreditation**

Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction, which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards.

Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest (CODA, 2017).

**Adjunct Faculty**

A non-tenure track, part-time teaching faculty. This individual teaches and is compensated on a per term basis with no guarantee of being rehired for the next academic term (Leslie & Gappa, 2002).

**Clinical Education**

The education provided in a clinical health setting, involving the application of theoretical and technical knowledge in practice with a real-world view of patients (Ramani & Leinster, 2008).

**Commission on Dental Accreditation**

The Commission on Dental accreditation (CODA) is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related allied health disciplines.

CODA serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

CODA has an obligation to the public, the profession, and prospective students to assure that accredited dental education programs provide an identifiable and characteristic core of required education, training and experience (American Dental Association Commission on Dental Accreditation, 2016).

**Professional Development**

Professional development is defined as the continuous learning that professionals need to pursue throughout their careers to maintain, enhance, and broaden their professional competence.

Academic institutions refer to this activity as faculty development (Rogers, 2008, p. 41).

**Standards**

A rule or basis for a criterion, used for comparison. Dental education programs leading to the D.D.S., D.M.D., or R.D.H. degree must meet the required standards to achieve and maintain accreditation (CODA, 2016).

**Assumptions, Limitations, and Scope**

The use of one-on-one interviews may intimidate some of the participants, which may skew their responses. In addition, some of the participants may feel uncomfortable answering questions truthfully. Lastly, the participants included in this study represent only a limited geographic area in the United States.

**Conclusion**

The dental hygiene profession is facing changes: many dental hygiene educators are approaching retirement and institutions are increasing their number of adjunct faculty. Clinical adjunct dental hygiene faculty are often employed because of their clinical expertise, but lack a formal teaching foundation. As a result, new adjunct faculty must learn to navigate their new roles and identities. A problem exists in that clinical adjunct faculty are not being offered the resources that full time faculty receive (CODA, 2017; Forbes, Hickey & White, 2010; Paulis, 2011). Ongoing faculty development and support is a requirement to improve teaching and learning, to enhance job satisfaction of faculty, and to increase student satisfaction (Schoening, 2013). It is important to identify clinical adjunct dental hygiene faculty needs to help improve teaching and learning in the clinical setting.

Chapter Two will provide a review of the literature. It includes the theoretical framework, literature on adjunct faculty, and the importance of clinical dental hygiene education. It also includes a comparison of adjunct clinical faculty from other health disciplines.

## CHAPTER TWO

### LITERATURE REVIEW

The purpose of this study is to explore the lived experience of clinical dental hygienists as they transition to clinical adjunct educators and to identify clinical adjunct faculty needs as they actualize their new role in teaching. Currently, clinical adjunct faculty comprise the majority of dental hygiene faculty (ADEA, 2017). Most adjunct faculty teach the clinical component of dental hygiene. Clinical education is an essential component of dental hygiene education as it is practical education applied in a real-life situation. Therefore, clinical educators play a significant role in teaching the newest members of the profession.

Clinical teaching is the heart of a dental hygiene curriculum. Students begin with a semester of preclinical instrumentation, in which they work on partners. The following semesters they are working on live patients and rely on faculty to guide them each step along the way. Clinical faculty bring with them the skills, efficiency, and clinical “tricks.” Students have an opportunity to work with a diverse faculty who have the ability to teach things not found in a textbook.

Clinical educators are considered experts in their respective fields and are most often hired for their expertise (Paulis, 2011; Schönwetter et al., 2006). Although clinical educators are skilled clinicians, they do not always have a background in education (Paulis, 2011; Scanlan, 2001). Variations in faculty backgrounds can lead to issues with faculty calibration when it comes to teaching (Dicke, Hodges, Rogo, & Hewett, 2015). Faculty calibration is both standardized instruction and standardized assessment of student performance (Casa, 2015). In the dental hygiene clinic, students are instructed by numerous faculty, many of whom are adjunct faculty. Casa (2015) postulated that attaining clinical instructor calibration is difficult due to

minimal adjunct training. Furthermore, Casa (2015) posited that because adjuncts do not have mastery in educational principles, adjuncts rely solely on practical experience, complicating calibration further. Student learning may be negatively impacted when there is variation in both assessment and clinical judgement among different faculty (Dicke et al., 2015).

Dicke et al. (2015) posited that reducing faculty variation could also help meet accreditation standards. In addition, institutions and educators would benefit from providing a formal pre-employment orientation to department/institution policies and procedures, specific training in teaching methodologies, and support for novice adjunct clinical faculty to improve the quality of teaching done by adjuncts (Paulis, 2011). By using the theoretical lenses of the transformative learning theory and identity theory, this study explores the transition of the clinical practitioner to educator to help identify ways to strengthen their teaching abilities.

This integrative literature review explores the characteristics of adjunct faculty and compares and contrasts clinical teaching versus classroom teaching in an effort to document ways to improve teaching performed by clinical adjunct dental hygiene faculty. The author conducted a review of the literature, published 2000-2019, using major research databases (PubMed, ProQuest, ERIC, Google Scholar). The search terms included variations of the following key words: dental hygiene, adjunct faculty, part-time faculty, allied health educator, and clinical education.

This chapter is organized into four sections. Part one discusses both adjunct faculty and the role of adjunct clinical dental hygiene faculty. Part two addresses the importance of clinical teaching and learning in dental hygiene education. Part three is a literature review of adjunct clinical faculty needs in similar disciplines. Part four introduces the theoretical framework of transformative learning and identity theories.

### **Characteristics of Adjunct Faculty**

As college enrollment has steadily increased over the years (National Center for Educational Statistics, 2018), the composition of the faculty has changed. Whereas full-time faculty was once the majority, part-time faculty members now represent the “largest and fastest growing segments of the postsecondary instructional workforce in the United States” (Snyder & Dillow, 2012 p. 6). According to a 2015 review of postsecondary education by the National Center for Education Statistics, almost half (49%) of faculty members are adjunct or part-time faculty (National Center for Education Statistics, 2015). The Coalition on Academic Workforce (CAW) conducted a study in 2012 on part-time faculty in higher education in the United States. That study compiled the following information: a) The salary for a standard 3 credit course was anywhere from a low \$2,235 at two-year colleges to a high of \$3,400 at four-year colleges; b) Part-time faculty did not receive wage increases based upon their credentials, as compared to other disciplines, nor did they receive higher compensation after several years of work; c) Part-time faculty did not receive professional support and they were not included in academic decision making. The study also noted that the presence of a union had a positive impact on wages. Furthermore, 40 percent of the study’s participants reported receiving retirement benefits through their institution and only 23 percent reported having access to health benefits through their academic employer; these statistics are higher among public institutions, which may be the result of having a union (Snyder & Dillow, 2012, p. 13).

There are some union contracts that prohibit the hiring of adjunct faculty (Edwards & Tolley, 2018). The CAW (2012) report also noted that despite adjunct faculty dedication to teaching, few institutions provided them with professional development support, “another

indicator that institutions are not investing in maintaining and improving the quality of instruction” (p. 15).

There are a number of reasons why institutions are increasingly hiring part-time faculty. One reason is budgetary constraints. Institutions are the first to suffer from budgetary cuts (Fagan-Wilen et al., 2006). The utilization of adjunct faculty provides a cost savings for institutions. Adjunct faculty are often hired to meet the demands of enrollment. By only hiring faculty as needed, based on enrollment, institutions can save money. In this way, part-time faculty provide flexible staffing options for institutions experiencing sudden growth or decline (Kezar & Maxey, 2013). As a result, there is no guarantee of continued employment for adjunct faculty (Forbes et al., 2006). In addition, some institutions do not offer adjunct faculty benefits, thereby providing institutions with another cost incentive to utilize adjunct faculty (Kezar & Maxey, 2013). Another reason institutions hire more part-time faculty is because of an inadequate supply of full-time faculty (Fagan-Wilen et al., 2006). Finally, adjunct faculty are hired because they offer a unique experience and specialties in their respective occupational fields.

Adjunct faculty do not share the same advantages as full-time faculty (Elder et al., 2016; Forbes et al., 2010). In addition to receiving a lower compensation and a lack of benefits, adjunct faculty often do not have the time to plan and prepare for their new roles as they can be hired days before the semester begins (Fagan-Wilen et al., 2006; Forbes et al., 2010). Additionally, adjunct faculty do not have office space, which decreases the likelihood of meeting with students outside of the classroom or clinic (Kezar & Maxey, 2013). In addition to a lack of office space, adjunct faculty may not have access to a computer or telephone (Carrol, 2001). As such, adjunct faculty may be faced with the decision to give out their personal phone numbers.

Research suggests that the increase in the number of part-time faculty, along with their lack of support, can have an adverse impact on various measures of student success, such as poor retention, lower grade point averages, and graduation rates (Kezar & Maxey, 2015).

Meixner and Kruck (2010) conducted a study on the needs and satisfaction of part-time faculty. Their definition of part-time faculty correlates with this study's definition of adjunct faculty. The authors identified mentoring, socialization, and working space as important themes in their study. West, Borden, Bermudez, Hanson-Zalot, Amorim & Marmion (2009) purported the idea that adjunct faculty who do not feel supported or appreciated for their contributions will experience self-doubt and not perform well. According to West et al. (2009), "not being educationally prepared for a teaching role resulted in participants doubting their abilities as educators, which led to lowered self-confidence in their role as teacher" (p. 307). Furthermore, Milliken & Jurgens (2008) postulated dissatisfaction among adjunct faculty could lead to reduced faculty retention. In an effort to support and retain adjunct faculty, colleges should aim to recognize, nurture and develop adjunct faculty (Elder et al., 2016; Meixner & Kruck, 2010; West, 2009).

While a number of accrediting agencies differ in their definitions between full-time and part-time employees, their purpose is the same: to advance the quality of higher learning.

According to the Middle States Commission on Higher Education,

Employment policies and practices for part-time faculty "should be as carefully developed and communicated as those for full-time faculty." The greater the dependence on such employees, the greater is the institutional responsibility to provide orientation, oversight, evaluation, professional development, and opportunities for integration into the life of the institution. (American Association of University Professors, 2018, para. 11)



## **Dental Hygiene Adjunct Faculty**

Most dental hygiene programs reside in community colleges, where the majority of faculty are part-time (ADEA, 2017). According to the 2016 American Dental Education Associations' (ADEA) Survey of Directors, part-time faculty comprise 65% of the overall workforce (ADEA, 2017). Moreover, that trend is expected to continue due to the retirement of an aging workforce and a limited number of full-time faculty (ADEA, 2017). Trends suggest that vacancies will continue to be filled by adjunct faculty (ADEA, 2017). Furthermore, it is expected that the demand for dental hygiene services will continue. According to the Bureau of Labor, employment for dental hygienists is projected to grow 19% from 2014 to 2024, much faster than the average for all occupations (Bureau of Labor, 2016). Another reason for the increase in part-time faculty is an inadequate supply of full-time instructors. As stated earlier, the minimum requirement for full-time status is a bachelor's degree, however in some institutions, a master's degree or a doctorate degree is required. This can be a deterrent for potential faculty.

Adjunct instructors most often are full or part-time clinical dental hygienists who continue to work in a variety of clinical settings while teaching on a part-time basis. Therefore, these faculty have other commitments and are only present at the institution on a limited basis. Fagan-Wilen et al. (2006) demonstrated that time constraints were most often cited as a limiting factor in the separation of adjunct faculty from full-time faculty.

Clinical adjunct faculty are hired based on their clinical experience and have little or no formal teaching preparation (Davidson & Rourke, 2012; Scanlan, 2001). Kelly (2007) posited that clinical instruction requires both clinical and pedagogical knowledge, however adjunct faculty often only have the former. Moreover, a lack of formal knowledge in teaching means

instructors teach as they were taught (Krautscheid, Kaakinen, & Warner, 2008; Paulis, 2011; Scanlan, 2001).

Adjuncts often struggle to adapt to their new role (Forbes et al., 2010). Scanlan (2001) demonstrated that part-time clinical nursing educators learn clinical teaching “on the job” (p. 243) and through “trial and error” (p. 245). New clinical faculty reported seeking guidance from more seasoned faculty to find their way (Scanlan, 2001). Adjunct faculty have reported feelings of isolation and being left out of the information loop from the full-time faculty and the overall school environment (Fagan-Wilen et al., 2006). Furthermore, studies have demonstrated that grade inflation is often common among adjunct clinical faculty (Dicke et al., 2015; Fagan-Wilen et al., 2006; Forbes et al., 2010). Adjunct faculty tend to be more lenient when assessing students. Fagan-Wilen et al. (2006) suggested one reason adjuncts give higher grades is the need for higher student evaluations, which may positively impact term-to-term rehiring.

### **Quality Assurance**

As discussed in Chapter One, the Commission on Dental Accreditation (CODA) accredits dental hygiene programs. CODA mandates that dental hygiene clinical instructors demonstrate coursework in educational methods (ADA, 2019). However, when new clinical faculty are hired, they may only have clinical experience. As Schönwetter et al. (2006) stated, “An individual with superior clinical skills is not necessarily proficient at teaching those skills” (p. 6).

Another part of the Standards for Clinical Dental Hygiene Practice requires dental hygiene programs to consistently strive to improve instruction and assessment methods in an effort to better prepare new dental hygiene graduates (CODA, 2016). Improving the teaching abilities of adjunct faculty could potentially help meet those standards (Dicke et al., 2015; Forbes et al., 2006). Clinical adjunct dental hygiene faculty are primarily hired because of their

expertise in the clinical setting, however, a faculty member with exceptional clinical skills is not necessarily a qualified teacher (Paulis, 2011; Schönwetter et al., 2016). Studies on the effectiveness of adjunct faculty teaching are varied (Beitz & Wieland, 2005). Denial, Nehmad, and Appel (2011) suggested factors measuring clinical learning are complex due to the diverse influences to which students are exposed. For example, students are evaluated on their treatment of live patients. However, because patients are all different in regard to their past/present medical history, oral health needs, and treatment plans, the students' learning experiences will differ as well. This results in a subjective faculty assessment and may contribute to increased faculty variation in grading. Dicke et al. (2015) reported on considerable variation in assessment and clinical judgment among health care faculty. Thus, a lack of calibration among faculty may also interfere with providing quality dental hygiene education. Research demonstrates clinical instructors with less experience exhibit higher levels of variation in teaching and assessment (Dicke et al., 2015; Park, Howell, & Karimbux, 2009; Paulis, 2011). A similar study by Wallace and Infante (2008) yielded similar results. Clinic coordinators reported concerns about differing philosophies and values among faculty during teaching and evaluation sessions.

### **Clinical Dental Hygiene Education**

Clinical education differs qualitatively in both the content and the student-teacher interaction as opposed to the classroom (Higgs & Mcallister, 2007; McLeod et al., 2003; Schönwetter et al., 2006). It takes place in an environment where students can apply the theory learned in didactic courses to practical situations. The clinical educational environment supports cognitive, psychomotor, and affective learning (McLeod et al., 2003). Students must apply theory and content-based knowledge, while demonstrating hands-on skills (McLeod, 2003; Ramani & Leinster, 2008; Scanlan, 2001). For example, in the clinic the focus is on the affective

when the student actively listens to a patient; the cognitive is employed by using sound information to create a treatment plan, and the psychomotor ability is the correct use of an instrument in a patient's mouth. Additionally, students must develop communication, critical thinking, and related patient care skills. Clinical learning is experiential; therefore, clinical pedagogy is dependent on the interaction of the students, instructors, and the patients (Ramani & Leinster, 2008).

According to Denial et al. (2011), "All clinical environments share a common challenge to provide the highest level of patient care while maintaining the highest level of education for the students" (p. 36). Clinical dental hygiene education plays a large role within a dental hygiene student's education. As stated by Rogers, Dunn, and Lautar (2008), "It is the clinical supervisor who engages students in the clinical portion of the education process and assists students in crossing the bridge from classroom preparation to competently performing at the entry level of their field" (p. 40). During the course of their education, dental hygiene students spend more time with their clinical instructors than with their didactic faculty (Paulis, 2011; Schönwetter et al., 2006).

Students experience encounters with patients where they need to develop interpersonal skills, psychomotor ability, and decision-making capacity (McLeod et al., 2003). As such, dental hygiene students rely heavily on adjunct clinical faculty. As stated by Roberts, Chrisman, and Flowers (2013), "The marriage of skills and knowledge that occurs in the clinical setting can either be positively or negatively affected by these novice educators" (p. 295). The role of the clinical faculty is to provide supervision, support, and role modeling for the dental hygiene student (Wallace & Infante, 2008). Clinical teaching takes place in a more intimate setting, with a closer proximity of instructor to student (Paulis, 2011). In addition, the instructor-student ratio

is much smaller in the clinic. Thus, clinical teaching style is different than in the classroom. Furthermore, clinical faculty must demonstrate clinical competence and positive professional behavior. Because the welfare of patients is at stake, clinical teaching carries a higher weight of responsibility that creates impediments to teaching and learning that do not exist in the classroom (Mlyniec, 2012). Because dental hygiene students are not licensed, clinical faculty must assess the individual student's level of autonomy to determine how much support is required. In addition, the clinical experience of the student depends upon the knowledge and competence of the clinical educator (Parslow, 2008). Therefore, clinical education plays a central role in dental hygiene education.

Research strongly suggests students prefer qualified instructors. In a 2011 study by Paulis, dental hygiene students rated educational guidance in teaching clinical skills as most important for clinical instructors. In a similar study by Schönwetter (2006), dental and dental hygiene students identified the following categories as important for effective clinical teaching: individualized rapport (friendly, approachable), organization (punctual, clear), enthusiasm (motivating), learning (knowledgeable), group interaction (fair, accountable), and breadth (relevance) (p. 631). The literature supports the direct impact clinical instructors have on student learning. Rogers et al. (2008), purported the importance for institutions to provide preparation and support for their clinical faculty.

### **Adjunct Clinical Faculty: Lessons Learned from Other Disciplines**

Professional education in other disciplines, including social work and law (Fagan-Wilen et al., 2006), and other health disciplines such as physician assistants, ophthalmology, and nursing, also hire part time instructors based on clinical expertise rather than on teaching experience (Davidson & Rourke, 2012). Similar to the dental hygiene profession, adjunct faculty

from these other professions also identified challenges in their transition to academia and impediments to maintain efficacy in their teaching role (Davidson & Rourke, 2012). Research from other professions has yielded a number of suggestions to aid training clinical experts to become educators, help in role transition, and to support the recruitment and retention of novice faculty. These suggestions include: mentorship, orientation, support, professional development, socialization, collaboration, and connection.

### **Mentorship**

In a 2013 study by Frantz and Smith of allied health professionals who transitioned from clinicians to educators, the authors identified both formal and informal mentoring as a facilitator for successful transition. Mentoring, as defined by Zellers, Howard, & Barcic (2008) is, “a reciprocal learning relationship characterized by trust, respect, and commitment in which a mentor supports the professional and personal development of another (the mentee) by sharing his or her life experiences, influence, and expertise” (p. 555). Many clinical faculty continue to work in their clinical areas while teaching and may find it difficult to balance their careers. Hessler and Richie (2006) posited a formal or informal guidance program would help ease their transition and decrease some of their anxiety. The authors suggested that mentoring could be formal, in which newer faculty are paired with more seasoned faculty and goals and objectives are developed, or it could be informal, in which teaching strategies and tips are offered as necessary. Mentors could also serve as role models of the successful transition into the educator role.

New faculty may bring with them new ideas to make a meaningful contribution to the profession. It is important to provide newer faculty the tools they need to make a successful transition into academia. A lack of proper training may lead to job dissatisfaction and

resignation (Carr, Ennis, & Baus, 2010; Milliken & Jurgens, 2008). To ensure academic success of new faculty, they must have collegial support within the department (Doran, 2017).

Mentoring can enhance the experience of incoming faculty members. Mentoring can create future academic leaders, prepare new faculty for leadership roles, and help new faculty gain the necessary skills to make them successful (Stolberg, 2015). Research on the role of mentoring in academic medicine and nursing has long documented positive effects on career success (Bagramian, Taichman, McCauley, Green, & Inglehart, 2011; Bland, Taylor, Shollen, Weber-Main, & Mulcahy, 2009; Gwyn, 2011). Furthermore, findings from a 2004 study by Barnes indicated a positive association between career satisfaction and length of mentor relationship among dental hygiene program directors.

### **Orientation**

Roberts et al. (2013) defined orientation as “the formal and informal process by which new adjunct faculty are informed of their role, clinical responsibilities, and policies/procedures to be followed when carrying out that role” (p. 298). Therefore, orientation can be described as pre-employment preparation. Orientation should also include the faculty evaluation and promotion process. Unfortunately, not all institutions host orientation for adjunct faculty, while others provide a brief, basic overview (Roberts et al, 2013). A lack of orientation may not only leave adjunct faculty feeling excluded from networking activities, but also less informed of the institution’s goals, practices, and policies (Kezar & Maxey, 2016a). Parslow (2008) reported participants feeling unprepared and ill equipped for the role of teaching because of a lack of orientation to the responsibilities of the adjunct clinical faculty role. Parslow (2008) stated, “several participants went into the adjunct clinical faculty role feeling excited and confident but soon realized the complexity of clinical teaching and all that was required of them” (p. 97).

## **Support**

Support, as defined by Roberts et al. (2013), are “people and/or processes that actively guide the development of the adjunct clinical faculty role” (p. 299). New adjunct faculty require support from their peers, the chairperson, and the administration. Support includes advice, the sharing of resources, and an assigned mentor. Fagan-Wilen et al. (2006) reported an increase in the support and training universities are providing for adjunct faculty. While the focus among these varies, common practices were around teaching methodologies including the components for effective teaching instruction and adult education theory, curriculum development, adjunct committees, office space, adjunct recognition, such as “Adjunct Appreciation Day,” (Fagan-Wilen et al., 2006, p. 43) and teaching awards. Some authors have identified resources to increase information sharing among the department and the university such as adjunct instructor reference manuals and Web-based information repositories. Additionally, new adjunct faculty may require technological support, especially as more and more of patient documentation moves into electronic formats. Furthermore, a number of institutions are recording student grades electronically. The foundations for support are to assist adjunct faculty in adapting to their new roles and to assimilate adjuncts into the broader academic community (Fagan-Wilen et al., 2006).

## **Socialization**

According to Hessler and Ritchie (2006), socialization is an important part of developing relationships for new faculty. The authors suggested establishing monthly faculty meetings to discuss questions or concerns as well as share ideas and build relationships (p. 151). Furthermore, Bland, Taylor, Shollen, Weber-Main, & Mulcahy (2009) asserted that mentoring facilitates the socialization of the protégé into the institution’s culture, fosters relationships and network building, and promotes professional growth for both mentors and mentees. Neese



(2003) surmised that formal strategies to bring new faculty into meetings and events is necessary for long-term success. Neese (2013) stated, “preparation for and socialization into the educator role is essential to the success of novice educators and their students” (p. 261).

### **Professional Development**

Unfortunately, some schools continue to hire novice educators, yet have no systematic plan for orienting, training, or mentoring these clinical experts (Davidson & Rourke, 2012). Research on nursing programs identified the need for adjunct clinical faculty members to have reliable educational practices to support student success (Davidson & Rourke, 2012). One suggestion is to provide clinical adjunct instructors with faculty development programs to address the education gap that exists between expert clinician and clinical instructor (Davidson & Rourke, 2012; Hewitt & Lewallen, 2010). In a 2001 study of clinical physical therapy instructors, participants who completed a continuing education program related to educational methods reported feeling more confident in their abilities of goal setting, conflict resolution, and organization (Kettenback, Grady, Herning, & Wilson, 2001). In another study by Behar-Horenstein, Garvan, Catalanotto, and Su (2016), participants rated professional development and skills as their highest unmet faculty need. Items within this category included learning better student-teacher dialogue, enhancing small group teaching, teaching methodology, updating technology skills, and assessment methods. Furthermore, the authors posited that faculty development programs have been reported to enhance participants’ feelings of belongingness. Therefore, adjunct faculty professional development can benefit both faculty and students alike.

### **Collaboration**

Hessler and Ritchie (2006) purported collaboration between new adjunct faculty and full-time faculty can be beneficial. Full-time faculty and more seasoned part-time faculty can take a

team-teaching approach to submerge the newer adjunct faculty into the teaching philosophies of the institution and to provide a starting point from which the adjunct faculty could expand. Providing faculty with opportunities to enroll in methodology or course related classes with colleagues could foster meaningful work relationship and collaborations, factors that may increase job longevity.

### **Connection**

Connection is defined as, “the experience by an adjunct clinical faculty of being invited to participate in college-related activities” (Roberts et al., 2013, p. 299). In the 2010 study by Forbes et al., clinical adjunct nursing faculty stated isolation was a common complaint among respondents. Behar-Horenstein et al. (2016) purported that faculty development programs could enhance the “participants’ sense of belongingness” (p. 53). Integrating adjunct faculty into the institution’s full-time faculty activities, meetings, and events can help promote a sense of identity among adjunct faculty.

### **Conceptual Framework: Transformative Learning and Role Identities**

When clinical adjunct dental hygiene faculty transition from clinical practice to academia, they experience a role transition process from their identities as clinicians to their identities as instructors (Davidson & Rourke, 2012; Schoening, 2013). While dental hygiene clinicians are considered to be experts in their field, they generally have little to no formal training in education or in the pedagogy of effective student learning (Davidson & Rourke, 2012; Schoening, 2013). As such, novice clinical educators may find themselves overwhelmed by their new responsibilities. Boyd and Lawly (2009) found that novice nurse educators tended to hold on to existing identities as clinical practitioners rather than embrace new identities as academics. New roles require developing a new set of values and norms as well as a new identity (Anderson,

2009). Many adjunct faculty work in multiple roles, and subsequently, must learn to manage many identities. Therefore, it is fitting to apply both identity theory and transformative learning as frameworks to this study.

Work role transition, as described by Anderson (2009), is “the human experience associated with entering a new community of practice. It is a dynamic, developmental process to assume the new identity, values, and knowledge base of the new role” (p. 203). A lack of role identity is one factor that creates job dissatisfaction for adjunct clinical instructors (Forbes et al., 2010). Finn, King, and Thornburn (2000) stated that clinical faculty members frequently feel insufficient in the new educator role due to a lack of information, which creates feelings of inadequacy. Forbes et al. (2010) reported that adjuncts could feel “marginalized” and “disempowered” because of disconnectedness with full-time faculty (p. 117).

In addition to a new identity, novice faculty must expand their knowledge. New faculty need to learn new knowledge and how to make sense of their new role. Mezirow’s (1978) transformative learning framework postulates how adults learn in different circumstances. The concept goes beyond the acquisition of new knowledge; it also includes individual experience, critical reflection, and dialogue (Taylor, 1998, in Mezirow & Taylor, 1998). These three elements are interdependent and shape the way adult learners make sense of and form perspective. A number of scholars debated the theory of transformative learning as lacking. Kegan (2000) posed the question, “what form transforms?” To answer this question, the following terms have been offered: the person (Jarvis, 2009); the personality (Illeris, 2014); and the self (Rogers, 1951). However, Illeris (2014) expanded on Mezirow’s (1998) transformative learning theory to suggest it is the individual’s identity that is transformed. Illeris (2014) stated that identity is created, developed, and changed through transformative learning. Identity theory

is comprised of three elements: content, incentive, and interaction. Content is what is learned; incentive is motivation and engagement of the learner; and interaction occurs with other individuals and is situational. Learning is an individual process that is created through the interplay of prior learning, experiences, situations, and attitudes. Mezirow's (1998) transformative learning theory and Illeris' (2014) identity theory are used as the frameworks to evaluate how adjunct dental hygiene faculty both make meaning of and develop a professional identity as clinical educators.

Illeris (2014) employed a phenomenological study of part-time clinical nursing faculty. The following themes were identified as having a part in identity formation as instructors: relationships with other instructors, the motivation to be better instructors, and the need for support and training. Overarching themes identified from the participants were feelings of isolation from the main campus; the value of having a mentor to help learn pedagogical skills, roles and responsibilities; and role ambiguity.

Schoening (2013) found similar results in a study examining the transition from nurse to nurse educator. Among the four phases identified was disorientation, which was characterized as role ambiguity. Disorientation results from having previously been an expert in another role and then reverting back to novice in a new role. Participants described a lack of formal orientation, mentorship, and formal preparation in pedagogical strategies in teaching (p. 169). In the final stage, identity formation, participants reported learning how to integrate their dual identities.

Ramage (2004) described the transition from clinician to educator as "negotiating multiple roles as disassembling the nursing identity and rediscovering and realizing the new self as educator" (p. 292). Novice faculty recreate their identity by learning new knowledge, engaging with students, and interacting with other faculty. Moreover, adjunct faculty have

reported experiencing role conflict. Although they were recognized as skilled clinicians, some adjuncts felt that their role as clinical educator was temporary, born out of necessity, and therefore they were not a true faculty member (Roberts et al., 2013).

Higgs and McAllister (2007) purported, “the journey of growth and development as a clinical educator requires active learning approaches coupled with reflection on one’s practice as a clinical educator” (p. e51). McAllister (2001) developed a model to help train clinical educators. The model consists of the following six dimensions, which require the educator to: a) develop a sense of self, b) develop a sense of relationship with others, c) develop a sense of being a clinical educator, d) develop a sense of agency as a clinical educator, e) seek dynamic self-congruence, and f) grow and develop.

Successful professional identity formation occurs for individuals when they develop attitudes, beliefs, and behaviors, and learn the knowledge and skills that support the roles and responsibilities of being that professional (Johnson, Corwin, Wilson, & Young, 2012). Therefore, to support adjunct faculty in their successful transition to educator identity, faculty must receive adequate orientation to policies and procedures, mentoring, socialization, support, connection, collaboration, and ongoing professional development. As a result, it is fitting to apply both identity theory and transformative learning as frameworks to this study.

### **Conclusion**

Chapter Two provided a review of the literature pertaining to this study. Clinicians moving into education not only have to become familiar with a new environment, culture, and expectations, but also have to demonstrate their educational development (Franz & Smith, 2013). Supporting adjunct clinical instructors by including them in academic programs and decisions enhances their sense of belonging. Additionally, interacting with full-time faculty creates

opportunity for mentoring and support that is needed for their role development (Forbes et al., 2010). Faculty professional development provides needed support and knowledge for part-time instructors and is a key factor in job satisfaction and retention (Davidson & Rourke, 2012; Forbes et al., 2010). Dental hygiene students depend on optimal clinical learning experiences to become competent clinicians. The intention of this study is that the insights gained from this research could impact approaches to clinical education. It would behoove institutions to provide a formal orientation on effective clinical teaching to new faculty.

Chapter Three will focus on the methods of the study. A description of the research design, participants, and the rationale will be presented. This chapter will also focus on the research design and approach of the study.

## CHAPTER THREE

### METHODOLOGY

This study explores the phenomenon of being a clinical adjunct dental hygiene faculty member in college environment. An interpretive phenomenological approach was employed to study the lived experiences of clinical adjunct dental hygiene faculty teaching in academia. A qualitative method afforded the opportunity to gain an understanding of the perspective of the participants. This research will contribute rich detail to the community of practice about the professional experiences of clinical adjunct dental hygiene faculty. This study sought to answer the following research questions:

1. What is the lived experience of clinical adjunct dental hygiene faculty in their teaching role as they transitioned from clinical setting to academia?
2. What is the experience of receiving support and mentoring as clinical adjunct dental hygiene faculty?
3. What professional development do clinical adjunct dental hygiene faculty need to successfully teach in the clinical setting?

Chapter Three will outline the research design used to research the lived experience of adjunct clinical faculty in dental hygiene. The framework of the interpretive phenomenological approach will be described. Chapter Three is organized into the following sections: phenomenology, setting, participants, data, analysis, participation rights, and limitations.

#### **Phenomenology**

Phenomenology is considered a disciplinary field in its own right, or an extension of the field of philosophy. Philosophers Husserl and Schultz introduced phenomenology in the 20th century. As stated by Patton (2015), “by phenomenology Husserl (1913) meant the study of how

people describe things and experience them through their senses. His most basic philosophical assumption was that we can only know what we experience by attending to perceptions and meanings that awaken our conscious awareness” (as cited in Merriam & Tisdale, 2016, p. 9). Phenomenology is an approach to qualitative research that focuses on the lived experience of a phenomenon within a particular group. Researchers are concerned with how individuals make sense of the world and make meaning of their life experiences.

Another phenomenologist of the same era, and also an assistant for Husserl, was Martin Heidegger. Heidegger introduced hermeneutics, or the art of interpretation. For Heidegger (1962), “the meaning of phenomenological description as a method lies in interpretation” (p. 61). Therefore, the interpretive phenomenological approach acknowledges both the participants’ interpretation and the subjective nature of the researcher’s role in the interpretation of the phenomenon.

The dental hygiene profession is considered an allied health profession, and is directly related to the everyday concerns of people’s lives. Thus, in trying to improve one’s practice, research is best approached through a qualitative research design (Creswell, 2012).

Phenomenology uncovers “how human beings make sense of experience and transform experience into consciousness, both individually and as a shared meaning” (Patton, 2002, p. 104).

Moustakas is considered the father of phenomenological research. Moustakas (1994) viewed the experience of the phenomena and behavior of the person as intertwined. As such, interviews provide first-hand knowledge of the experience (Moustakas, 1994). Because this researcher sought to gain an understanding of the “lived experience” of adjunct clinical dental hygiene faculty, an interpretive phenomenological approach was used.



### **Setting**

In seeking to understand the experiences of adjunct clinical faculty in dental hygiene, it is important to understand their lived experience within the setting of academia at The Institute. Therefore, the setting of this study takes place at the dental hygiene department at the college. The Institute is a four-year college located in the northeast. There are approximately 9,600 students enrolled in various degree programs in its Schools of Arts and Sciences, Business, Engineering Technology, and Health Sciences. Within the School of Health Sciences are the nursing, medical laboratory technician, and dental hygiene programs. The dental hygiene department has 12 full-time and 25 adjunct faculty. There is only one male faculty member. There are currently 77 students matriculated in the applied associate degree program, 50 enrolled in the bachelor completion program, and 30 students enrolled in the entry level bachelor's program.

After receiving IRB approval and permission from the chair, an email with a letter attached was sent to all dental hygiene adjunct faculty within the department. The attached letter introduced the researcher, the purpose of the study, and requested participation in the study. In addition, the researcher provided her contact information so that potential interviewees could ask questions.

### **Selection of Participants**

This study employed purposive sampling to enlist participants who have actually lived the experience being studied. According to Bloomberg and Volpe (2016), "the logic of purposeful sampling lies in selecting information-rich cases" (p. 148). One form of purposeful selection is criterion-based sampling. Bloomberg and Volpe (2016) posited, "criterion sampling works well when all the individuals studied represent people who have experienced the same

phenomenon” (p. 148). The criterion used for this research is to study adjunct clinical dental hygiene faculty who have been teaching in the clinical setting at The Institute for a minimum of one to three years. This criterion is important as this specific group shares similar experiences.

Phenomenological research is often conducted on small sample sizes. The researcher interviewed six clinical adjunct dental hygiene faculty members. The exact number of interviews was determined when saturation was reached. Saturation is defined as the point where all major themes have been identified and there is no new information (Creswell, 2014). This researcher was seeking the following specific criteria: a) clinical adjunct dental hygiene faculty with a minimum of one to three years of experience of clinical teaching at The Institute and b) a willingness and availability to participate in the interview process.

### **Data Collection**

The preferred method of collecting data in phenomenological research is in depth interviewing. As postulated by Brinkmann and Kvale (2015), a research interview “is a conversation that has structure and a purpose” (p. 5). Thus, the interview is a focused conversation that focuses on components of the research questions. Interviews were conducted one-on-one, where the researcher elicited information from the interviewee. Interviews lasted approximately 45 minutes to one hour. The researcher introduced herself, the purpose of the study, and requested verbal consent. Written consent was obtained prior to scheduling the interviews. The interview began with some icebreaker questions about the participant’s interests to set a comfortable setting where the conversation flowed freely. The phenomenological aspect was employed to gain an understanding of the subjective perception experienced by the participants. To accomplish this, a set of semi-structured, open-ended questions was used when interviewing participants to guide the interview and reconstruct the experience. Follow-up

questions were used to probe for more detailed information. At the end of each interview, the researcher thanked each participant for their time. Each individual interview was audio taped and transcribed by the researcher. Merriam and Tisdell (2016) postulated that transcribing the data oneself offers the benefit of becoming more familiar with the data. Interviews took place at off site locations such as at diners, coffee houses, and interviewees' homes to ensure convenience, comfort, and privacy. Interviews were scheduled for mutually convenient times. Follow-up interviews were scheduled approximately three weeks later to complete any missing information or to clarify ambiguous statements. At this time, participants were provided with the transcripts for member checking. Member checking was used to ensure that there is no misinterpretation of views and comments.

### **Analysis**

The simple definition of qualitative research is that it uses words as data (Braun & Clark, 2013, as cited in Merriam & Tisdell, 2016). Recorded interviews were transcribed using a transcription service and the researcher reviewed each transcript for accuracy. According to Patton (2015), "the experience of different people are bracketed, analyzed, and compared to identify the essences of the phenomenon" (p. 116-117). By bracketing, Patton is requiring the researcher to "bracket" any prior beliefs or preconceptions about an experience. This act of temporarily putting aside any assumptions allows the researcher to approach the experience objectively (Merriam & Tisdell, 2016). During analysis, data was analyzed for specific statements and coded for overarching themes. Coding was accomplished by following the six-step process as defined by Smith, Flowers and Larkin (2009). They were as follows: (a) read and re-read the transcript, as well as listen to the audio recording a number of times, (b) take notes on the descriptive, linguistic, and conceptual comments, (c) develop emergent themes, (d) search for

connections across themes, (e) move to the next case and, (f) look for patterns across cases. It is important to ensure that all qualities described have equal weight, a process described by Moustakas (1994) as “horizontalization” (p. 27). The end goal of a phenomenological study is to describe the “essence” of the phenomenon.

### **Participants’ Rights**

Participation in the study was voluntary; participants were informed of their options to withdraw at any time. Participants were required to sign an informed consent form (Appendix A) . In the consent form, participants were informed of the purpose, risks and benefits of the study, along with the measures taken to ensure confidentiality. Participants were notified that all transcripts will be stored in a locked file cabinet at the researcher’s home. Pseudonyms were used instead of the participants’ actual names. In addition to written consent, participants provided verbal consent. All data, such as audio recording and notes, that were collected pertaining to this study will be stored in a locked file cabinet in the researcher’s home office to which only the researcher has access. Records will be stored for ten years post initial publication. Ethical issues are important in research and researchers must take action to ensure research is conducted in an ethical manner.

### **Limitations**

Interviews using only a small number of people are limited in that the results cannot be generalizable. Moreover, interviewing only faculty from The Institute limits the study further. In addition, Merriam and Tisdell (2016) postulated that the interviewer-respondent interaction is “a complex phenomenon” because “both parties bring biases, predispositions, attitudes and physical characteristics that affect the interaction and the data elicited” (p. 130). Response bias

may pose a limitation as the interviewees have a relationship with the principal investigator. Therefore, it is important to take a step back, act respectful, and place all assumptions aside.

### **Conclusion**

Chapter Three provided the methodology of the study. The intent of the study was to explore the lived experience of adjunct clinical dental hygiene faculty, therefore a phenomenological approach was the most appropriate method. In addition, this chapter addressed confidentiality, data recording and storage, and participants' rights. The findings of this qualitative study will be presented in Chapter Four.

## **CHAPTER FOUR**

### **DATA ANALYSIS AND KEY FINDINGS**

This chapter will discuss the research design, analysis of the data, and key findings. The purpose of this study was to explore clinical adjunct dental hygiene faculty members' experiences of preparedness as they transitioned from clinical expert to novice educator. This research study sought to answer the following research questions:

1. What is the lived experience of clinical adjunct dental hygiene faculty as they transitioned from clinical setting to academia?
2. What is the experience of receiving support and mentoring as clinical adjunct dental hygiene faculty?
3. What professional development do clinical adjunct faculty perceive they need to develop and maintain their clinical teaching skills?

The approach used to gather data was qualitative. The researcher employed an interpretative phenomenological approach. Potential participants received a recruitment letter to explain the purpose of the study and to gauge interest in participation (Appendix B). The researcher received a positive response. Permission to conduct the study and collect data on faculty participants was obtained prior to the study. The Institutional Review Board (IRB) at the University of New England approved this study as exempt (Appendix C). Prior to the start of each interview, an informed consent was reviewed with each participant (Appendix D). The informed consent included the option to withdraw from the study at any time. The participants were provided with an opportunity to ask questions. None of the participants requested to opt out of the study and none of the participants objected to being audio taped. Each of the faculty participants was provided with a copy of the signed informed consent. All participants were

asked not to discuss their enrollment in the study with anyone. The researcher assured each participant that privacy and confidentiality would be maintained throughout each step of the research process.

Interpretive phenomenological analysis (IPA) is a qualitative approach which aims to uncover how participants make sense of their world through their experiences and perceptions (Smith & Osborn, 2003). Smith and Osborn (2003) maintained the best way to collect data for IPA is through the semi-structured interview. Therefore, the researcher conducted interviews to gain an in-depth understanding about the participants' experiences. The purposeful sample consisted of six clinical adjunct dental hygiene faculty members. By interviewing faculty participants, this researcher sought to paint a rich picture of real-world clinical dental hygiene education. Interviews lasted approximately 45 minutes to one hour each. To obtain clear and accurate information, the researcher asked follow-up questions and restated the participant's response. The semi-structured interview was comprised of 19 open-ended questions. Interview questions can be found in Appendix B.

Participants were assigned a pseudonym to protect their confidentiality. Data from the interviews with the six clinical adjunct dental hygiene faculty were transcribed and analyzed for themes. The remainder of the chapter will include a description of the selected participants, the data collection and the analysis process, and a description of the emergent themes as per the methodological process of coding. The findings reported in the chapter include four major themes. These themes were: support and mentorship, orientation, teaching facilitators, and educational methodology development.

### **Profile of the Participants**

Participants were clinical adjunct dental hygiene faculty from a single dental hygiene program in a four-year college in the Northeast. All of the participants were female and Caucasian, which mirrors both the gender and race distribution of the dental hygiene profession (ADEA, 2016). Their ages ranged from 33-61 years. All had backgrounds in clinical practice before entering academia. However, participants in the study came from a broad diversity of educational backgrounds. While all the participants had master's degrees, as required for employment at the institution, there was variation among the degree major. Three participants had master's degrees in public health, one participant had her master's degree in community health education, one participant had her master's degree in dental hygiene, and another had her master's in education. In addition, at the time of the interviews, two participants were enrolled in their doctoral studies and one participant had recently applied to a doctoral program. Participants' level of clinical experience was between eleven and forty-three years. Clinical teaching experience ranged from five to thirty-five years. Demographic information can be found in Table 1.

In addition to teaching as clinical adjunct dental hygiene instructors, participants were employed in other positions. All the participants maintained their clinical positions in addition to teaching. Three of the participants worked in more than one dental office. In addition to working as a dental hygienist in a private practice and teaching, one of the participants also worked for a dental manufacturing company.



Table 1

*Profile of participants*

Participant (Pseudonym)	Education	Years as a Dental Hygienist	Years Teaching as a Clinical Adjunct Instructor
Francesca	Master of Public Health	11	7
Gail	Master of Community Health Education	43	35
Tricia	Master of Public Health Administration	11	5
Diane	Master of Education	22	15
Kim	Master of Dental Hygiene	36	30
Brenda	Master of Public Health	17	8

**Data Collection**

Interviews were conducted with six clinical adjunct dental hygiene faculty. The interviews took place in coffee houses, diners, and in three cases, the participant's home. Participants provided informed consent in both written and verbal form prior to the start of each interview. Interviews were audio-recorded with the permission of each participant. Data collection was derived from the interview questions that asked participants about their experiences and perceptions (Appendix B). The audio-recordings were reviewed and were used to obtain textual data. Initially, the researcher began by hand transcribing the first two interviews. However, after discovering the arduous and time-consuming approach of hand transcribing, the researcher began using the professional transcription service, Temi™. To ensure each transcript would be analyzed in the same manner, the original two hand-transcribed interviews were professionally transcribed by Temi as well. All transcriptions were reviewed

and edited for accuracy. The researcher listened to the recording of the interviews while reviewing the transcripts for accuracy. After each transcript was meticulously checked line by line, individual transcripts were provided to the participants for member checking. Member checking resulted in additional input from participants about the initial themes that appeared to emerge from the data.

### **Data Analysis**

Analysis occurred concurrently with data collection. In an effort to engage with the text, each transcript was reread several times and analyzed individually to identify themes. As purported by Smith and Osborn (2003), “Each reading has the potential to throw up new insights” (p. 67). The researcher followed a step by step analysis provided by Smith and Osborn (2003). First, the left-hand column of the transcript was used to make comments about the text. Comments in this section were made to identify common words or to make meaningful connections. Some of the words or phrases that were common were: lightbulb, rewarding, return back here, lack of competence, unsure, clinical experience, and terminology.

After preliminary notes were documented for each transcript, the author returned to the beginning of the transcript and utilized the right margin to identify emerging themes. According to Smith and Osborn (2003), the other margin is used to capture the “essential quality” (p. 68) of what was identified in the text. These themes are of higher order thinking and attempted to create theoretical connection beyond what the participant actually said (Smith & Osborn, 2003). The author attempted to group themes together using like terms and interrelating, interconnected groupings. Most themes clustered together naturally. Interpretive phenomenology analysis is iterative, meaning the researcher must always check their own sense making against the words

and statements from the participant. After reviewing the data collected from the six participants, no new information had emerged, suggesting saturation had occurred.

### **Presentation of Results**

The findings from the data answered the research questions. The data were categorized based on similar patterns or groupings. Four major themes were identified. These themes were support and mentorship, orientation, teaching facilitators, and educational methodology development. The following details the thematic findings from the data analysis process. These themes contain contextual support, which include significant words, phrases, or ideas gleaned from the transcript data and are used to answer the research questions.

#### **Research Question # 1:**

#### **What is the lived experience of clinical adjunct dental hygiene faculty as they transitioned from clinical setting to academia?**

Participants mostly reported positive experiences related to their first decision to teach in the clinical setting. Reasons for wanting to teach varied. To protect the privacy of the participants, only pseudonyms have been used.

**Diane.** Diane reported working long hours, five days a week in clinical practice when she first began her career in 1997. A few years later, The Institute began their bachelor's program. Diane made the decision to go back to school because she knew she did not want to continue to practice clinical dental hygiene full-time any longer. In 2004, Diane was among one the first cohorts to graduate from The Institute's Bachelor's of Dental Hygiene Program. After completing her practicum at the college, she was offered a position teaching in the clinic the following semester.

**Tricia.** Tricia also remembers working many hours in clinical dental hygiene. Tricia recounts, “I was working full-time, ten-hour days nonstop and it [clinical practice] was burning me out.” Tricia felt encouraged to go back to school and further her education by her former faculty. Tricia stated, “I kept in contact with some of my faculty who took a liking to me. It was suggested that I continue my education as it would open more opportunities to me.” Tricia went on to receive her bachelor’s degree in dental hygiene in 2008 and continued on to get her master’s degree in 2011. While she was in her master’s program, she was not sure which path to take in her career, so she asked the chair if she could come into clinic to shadow the faculty there. Shortly after that experience, Tricia was hired as a clinical adjunct faculty member.

**Francesca.** Similar to Tricia, Francesca went on to receive her bachelor’s degree immediately after receiving her associate’s degree in 2008. Francesca reported loving clinical dental hygiene, but knew she wanted more from her career. She had a special place in her heart for The Institute after having spent a significant amount of time studying there. As soon as Francesca earned her bachelor’s degree in 2009, she sent her resume to the chair of the dental hygiene department, inquiring about a teaching position. She was initially asked to come in to shadow for a few months, after which she was hired. Francesca enjoyed teaching, but having only a bachelor’s degree, she was required to go back to school and earn her master’s degree. Francesca graduated with her master’s degree in 2017. It is important to note that upon initial hiring, Francesca had the least amount of clinical experience, less than four years.

Two participants, Gail and Kim, knew early in their careers that they “wanted more” and thought that teaching would satisfy that desire. These two faculty members have acquired a significant number of years teaching clinical dental hygiene. They have each worked for a

number of different dental hygiene chairs and because they were hired around the same time, they share a unique and similar perspective.

**Gail.** Gail graduated with her associate's degree in dental hygiene in 1976. While working full time as a clinical dental hygienist, Gail went on to earn her bachelor's degree in dental health education in 1978. At that time, Gail wasn't sure if she wanted to go on to dental school to become a dentist, or become a dental hygiene educator and teach. According to Gail, "It was the 70's and a turning point for women in the workforce." After speaking with a guidance counselor, she decided to head in the direction of becoming an educator. Gail earned her master's degree in community health education in 1979. Gail then moved to Mexico and worked in a dental school. She also provided community health education to various elementary schools in Mexico. After two years, Gail moved back to the United States. In 1984, Gail applied and was hired for a position teaching a didactic course, dental health education, at The Institute. The chairperson at the time asked if Gail wished to teach in the clinic as well. Although Gail was interested in the opportunity, the chairperson asked to meet with Gail in her office. The chairperson asked for Gail to demonstrate her fine motor skills and coordination by picking up a dental instrument and using it correctly on a typodont (an anatomically correct, plastic set of teeth with rubber gums). One semester later, Gail was offered a clinical teaching position. Interestingly enough, Gail was the only faculty participant who was given a hands-on interview.

**Kim.** Kim had an equally long history in teaching dental hygiene. Kim received her dental hygiene license and her bachelor's degree at the same time, in 1983, as she attended an institution that offered a four-year program. After working for a year as a full time clinical dental hygienist, Kim returned back to her alma mater to obtain her master's degree in dental hygiene in 1988. During this time, Kim was fortunate enough to be hired by the institution to

teach sophomore dental students periodontology. As a result, Kim received her master's degree tuition free. The program required Kim to do an internship in her final semester, so she was sent to The Institute for a semester to shadow a faculty member in the dental hygiene clinic. Immediately after her graduation, Kim was offered a clinical teaching position and has been teaching at The Institute ever since.

**Brenda.** The remaining participant found herself in education by chance. Brenda recalled sustaining an injury that required her to take a leave of absence from her job as a clinical dental hygienist. Unable to work, she went back to school to earn her baccalaureate degree in dental health education. Shortly after, when a clinical teaching position became available, Brenda was offered the job. Initially, Brenda turned down the opportunity, as she had a passion for public health and planned to take that route. However, the chair of the dental hygiene department at the time asked her, "How do you know you do not want it [teaching] until you try it?" Brenda ended up taking the position and realized quickly her love for teaching.

### **Motivation to Teach**

There are various reasons adjunct faculty chose to teach. Some of the factors included in the literature were financial incentives, knowledge in subject matter, a desire to contribute to their community or profession, and leadership (Dolan et al., 2013). In another study of adjunct faculty who taught non-traditional learners at a private institution in the Midwest, the author identified the sharing of knowledge, students, and intrinsic value as the most important contributing factors to their motivation to teach (Williamson, 2014). All of the participants interviewed identified as having a strong commitment to teaching. This finding correlates with the findings from a study by Allison, Lynn, & Hoverman (2014). Allison et al. (2014) explored adjunct faculty motivations for teaching. The authors reported 73% of the adjunct faculty

surveyed felt passionate about teaching. Furthermore, the participants in the study were motivated to help the students succeed and frequently engaged in uncompensated extra time to work with the students (Allison et al., 2014). Several of the faculty participants of this study have been involved in student projects outside of the clinic on a volunteer basis. Francesca took pride in volunteering her time whenever she could. She has been active in all community outreach activities and has mentored both associate and bachelor level students. Tricia, Gail, Brenda, and Kim have all volunteered their time to mentor students during their summer research projects. Diane has volunteered for every Give Kids A Smile Event ever hosted at The Institute. The Give Kids A Smile Event is a community outreach event to provide preventive dental hygiene care to children of lower socioeconomic backgrounds (ADA, 2019). Adjunct faculty members' commitment to the students is evidenced by volunteering their time outside of what is required of them.

**Research Question # 2: What is the experience of receiving support and mentoring as clinical adjunct dental hygiene faculty.**

Support and mentorship was a large area of focus for the novice clinical adjunct faculty. Participants spoke at length of their experiences of having an informal mentor when they first began teaching. They expressed a great need for a mentor with whom to find support and guidance. This area seemed to play a large role in the first experiences of teaching for the new clinical adjunct faculty. As mentioned above, new faculty entered teaching from a variety of backgrounds and thus, turned their attention to those seasoned faculty to help show them the ropes. Therefore, the first theme identified was support and mentorship.

## **Theme 1: Support and Mentorship**

The first theme that emerged was support and mentorship. All of the faculty participants interviewed in this study reported having some level of support and mentorship. Although support and mentorship are interrelated, as mentoring is a form of support, they are discussed individually, as subgroups.

**Support.** Support for adjunct faculty members varies from institution to institution. Support is necessary, not only to ensure that adjunct faculty teach to the best of their ability, but to improve faculty morale and inclusion. Support can be found on many levels: departmental, collegial, and college-wide.

**Department support.** All of the faculty participants interviewed felt supported by the department. Francesca felt that she could ask anyone for guidance and they would provide it. Gail and Kim had worked for different chairs throughout their teaching careers and both felt that the current chair is excellent at keeping them informed. In addition, all the participants felt that the chair was approachable and supportive. As Kim reported, “There are a lot of emails that go out. I feel like it keeps me in the loop.” Furthermore, the participants all felt appreciated and recognized by the chair. However, three of the participants felt as though they were treated differently than the full-time faculty. Tricia stated that sometimes she felt as though her ideas did not matter. She mentioned that she has refrained from speaking up at faculty meetings. Kim felt that some of the full-time faculty think less of the adjuncts. Diane expressed that sometimes she feels excluded from the full-time faculty, but she attributed it to the frequency with which the full-time faculty interact with each other.

**Collegial support.** One of the more seasoned faculty members, Kim, felt intimidated when she first started teaching because she was both new and younger than all of her peers.



However, Kim did feel supported and comfortable asking questions. The majority of the participants described their belonging to a “work family.” The majority of adjuncts have worked together for years and have developed close knit relationships with each other. The adjunct faculty interviewed appeared to genuinely enjoy working with one another. These adjunct faculty seek social encounters with each other outside of the workplace, making the Department of Dental Hygiene at The Institute a unique place to work. The social relationships were reportedly cultivated through self-initiated involvement. There are two faculty meetings per year. Aside from those meetings and sporadic community service events, adjunct faculty would not have the opportunity to socialize unless it was initiated by the faculty themselves. Brenda confided that she had fewer social interactions outside of work, but that it stemmed from her lack of effort to be more involved.

*College-wide support.* When asked about college-wide support, all of the participants felt that this was an area that had improved a bit over the years, but that unless the dental hygiene chair forwarded the information along, they were uninformed in terms of college-wide events. Much of the college-wide workshops and seminars are geared to full-time faculty. Information for these can be found during governance meetings and in the form of flyers which are often placed in the library or other administrative buildings. Due to the time constraints, they face and lack of perceived need, adjunct faculty do not visit these other buildings on campus.

Gail stated, “It wasn’t until twenty years later, that I received a tour of the college.” Brenda added, “There is really no reason to leave our building.” The majority of the participants admitted to receiving email communications about college-wide events, but did not receive communications by any other means. Francesca mentioned, “as far as the main college, I’m not really sure what they do or what they offer.” Brenda mentioned that she had not been diligent

about keeping her work email active, as passwords are required to be changed every four months, and she often forgets to change hers. This results in being temporarily locked out of the work email account until the college technology support team is contacted and the problem is fixed.

Furthermore, clinical adjunct faculty are less frequently on campus when compared to full-time faculty. Clinical adjunct faculty often hold other employment elsewhere and are contracted for less hours, thereby limiting their presence on campus. Gail mentioned she was aware of on campus courses that were offered from time to time. However, Diane felt that these were only offered at certain times and during certain days. The majority of the adjuncts are only on campus a maximum of eight hours per week and some are only there in the evenings.

**Mentorship.** Participants all reported their preparation for teaching was developed through shadowing more seasoned faculty. All of the participants recalled having a mentor to aid them in the transition to their new role in teaching. However, most of the interviewees described having a casual, informal mentor, rather than a formal mentor. The length of mentorship varied for each participant, but none of the participants had longer than a semester to shadow. Francesca, Diana, Tricia, and Brenda reported coming in and shadowing seasoned faculty on their own time, non-paid, and prior to being formally hired. Despite having this experience, Tricia felt uncertain of her teaching ability when she first began. Tricia stated, “In the beginning, I felt competent in my clinical skills, but I felt like I missed a lot of teachable moments with the students.”

Francesca explained that although she had an informal mentor prior to her official employment at the college, she had another experience with a different mentor years later. Francesca’s experience observing another faculty member was more beneficial than her own

informal experience. Francesca described observing a senior faculty member who was mentoring a bachelor's student doing her practicum in clinical education. "I kind of shadowed a seasoned colleague of mine in terms of mentoring someone else for the bachelor's program practicum. Listening to her and shadowing her teach another student helped make me a better mentor and educator."

Brenda shadowed a senior faculty member for a short period of time, but was then "tossed in with her five to six students." Brenda recalled, "I had my go-to people if I needed them, but for the most part, I was on my own." Brenda remembered asking a lot of questions and always checking with other faculty if she did things correctly. Brenda described herself as a rule-follower. "I try and follow the rules word for word. I feel like it helps me navigate my role as an educator."

Gail was provided with a mentor for her didactic course, but remembers having an informal mentor in the clinical setting. Gail felt comfortable asking any of the faculty on the floor for help. "There were times when I wasn't sure about something. I would ask the other faculty for their opinion. I found the feedback from other instructors most helpful in situations like that." Gail also discussed how she would seek help from other faculty with a difficult student. "If I hit a roadblock with a student, I would stop, because it's not a teachable moment. And then I would ask another instructor if they could guide that student differently." Gail remarked, "Even all these years later, I still handle situations like that the same way."

While Tricia was grateful to have had an informal mentor during her transition into clinical teaching, she also felt like she needed more.

The downside was that it [the mentor] was very here and now support. It was confined to the walls of the clinic. I would have liked to have additional support. I'm ten semesters in and there are still things I don't feel comfortable with.

Tricia mentioned feeling uncomfortable when she needed to ask the more seasoned faculty for guidance. "It made for an awkward situation when the students would see me go and ask another faculty member a question. I felt like the students would lose trust in me."

Kim recalled "casually" following a mentor when she first started teaching. "I remember feeling intimidated by the more seasoned, superior faculty back then. It makes me very conscious of the younger faculty now and I always try and make them feel welcome and encourage them to ask questions."

**Access to resources.** Although the participants felt well-informed of college and departmental resources, some faculty members reported that access was intermittent. Gail mentioned that there used to be campus lunch and learn courses offered several semesters ago, but she had not heard of any recently. Brenda said she remembered hearing about some courses offered to faculty on campus, but it was a while ago and it was only offered during the time she teaches, so it was not particularly helpful. The faculty participants disclosed that they do not have access to an adjunct faculty workspace, computer, or phone, should they need to meet with the students outside of clinic. Half of the faculty did not feel this was a necessity, however three of the participants felt it would be nice to have.

## **Theme 2: Orientation**

Orientation is defined as "the formal and informal process by which new adjunct faculty are informed of their role, clinical responsibilities, and policies/procedures to be followed when carrying out that role" (Roberts et al., 2013, p. 298). At this time, the new faculty member is

made aware of the institution's vision and mission, as well as institutional policies surrounding grading and evaluation (Danaei, 2018). A lack of orientation may lead to a new faculty member being unequipped to follow the institution's policies and procedures. In addition, the new faculty member may experience anxiety, confusion, a misalignment of expectations, and the inability to fully identify with their new role (Owens, 2018). Thus, a lack of orientation may lead to disorientation.

None of the faculty participants reported having a formal orientation to the department or college. At the time of their hiring, the participants were sent over to human resources to complete the necessary paperwork. Gail recalls first having received a tour of the college campus after 20 years of teaching there. Brenda admitted she is still unsure which building is for what.

In addition, the participants were all made aware of a clinic manual that is available at each unit in the clinic. The manual is used by both faculty and students and describes the department's policy and procedures. Although the clinic manual addresses certain expectations of the faculty and students alike, it does not provide teaching objectives and strategies and thus, is not a replacement for teaching methodologies and pedagogies, formative and summative evaluations, and effective student to instructor communication.

### **Theme 3: Teaching Facilitators**

The term facilitator is defined by the Merriam-Webster dictionary as someone or something that facilitates something, or makes something easier (Merriam-Webster, 2019). Therefore, teaching facilitators were described to the participants as ideas or events that helped them, as novice clinical adjunct dental hygiene faculty members, teach in the clinical setting. Faculty were asked if they had experienced an event that created a change in the way they teach.

The following subthemes incorporate the participants' responses: educational background, clinical experience, and transformative learning.

**Educational background.** Half of the participants (n=3) reported having formal education coursework, which helped them prepare for their role as clinical educators. Formal education coursework is defined as taking college level courses that teach students how to be teachers. Courses can include lesson planning, curriculum development, or student assessment. Two of the more seasoned faculty interviewed reporting having early experiences in didactic teaching prior to teaching in the clinical setting, which they attributed as beneficial to their overall teaching. Teaching dental hygiene didactic courses proved advantageous for these faculty members, as some of the teaching skills translated into the clinical setting. Gail felt her didactic teaching experience helped teach to different learning styles. She recounted, "Teaching in the clinic is similar to teaching in the classroom. You have to teach to different learning styles in both settings. Some students are auditory learners, while others may be more of a visual learner. It doesn't matter which setting you are teaching in." Kim had a similar experience. While studying for her master's degree, Kim taught periodontology to dental students. In addition, Kim also did her master's degree practicum in a dental hygiene school clinic. This early teaching practice gave Kim rich experience and proved opportune, as she was hired as a clinical adjunct professor immediately after.

Diane gained an educational foundation after years of teaching in the clinical setting, when she earned her master's degree in education. Diane described her experience, "In my master's program, we developed a learning contract in which you put down things you wanted to learn. I wanted to learn how to communicate with students...how to describe how to do things. It

was great, they sat us down and taught us those tools.” Thus, Diane’s master’s degree provided her the tools to “teach.”

The remaining participants reported having no educational background in pedagogy or adult education. Tricia stated, “I do not have an education in education. I always felt that something was lacking amongst the adjuncts, because sure we can do our job, but can we teach what we do?” Diane remembered initially feeling uncomfortable teaching in the clinic. “The first time I sat with a student, I said ‘give me the scaler, this is how you do it’ because I was unable to verbalize the steps. Demonstrating was easy, but describing was hard.” When asked about her educational background and experience, Brenda replied she had little to none. Brenda recounts her early days teaching, “I would not say I felt competent, not by any means and not for a long time.”

**Clinical experience.** Adjunct clinical dental hygiene faculty are hired primarily for their clinical expertise (Paulis, 2011; Schönwetter et al., 2006). According to Ramani and Leinster (2008), one of the hallmark skills that make clinical teachers excellent is clinical competence. In a 2011 national study of future dental hygiene faculty needs, Coplen, Klausner, and Taichman (2011) identified clinical dental hygiene skills as most important (99%) followed by educational skills (97%), technological skills (94%), and research (53%). Adjunct clinical faculty often teach part-time and continue to work as clinicians. As such, these faculty share their current, real-world knowledge with their students in the educational setting. Owens (2018) conducted a study on part-time nursing faculty. The participants identified both past and present clinical practice experience as necessary in maintaining their clinical knowledge and skills. As stated previously, all the faculty participants reported beginning their careers as clinicians and maintaining that role while transitioning into teaching. All of the participants maintained employment in one or more

private practice setting. When asked about how they developed their teaching skills, the participants all discussed using their clinical expertise as a springboard. A central theme for all participants was utilizing their practical experience to teach dental hygiene students in the clinical setting. Their experience provided a means to maintain their clinical skills as well as served as a knowledge base.

Each participant valued their clinical experience and each viewed their ongoing clinical experience as an advantage. Tricia and Brenda posited that years of communicating and teaching different patients helped give them the skill of communicating with different people. Tricia elaborated that applying the real life work situation in clinic helps open the students' eyes to what life will be like for them after graduation. Francesca pointed out that her strong clinical skills make her a role model for her students. When certain situations arise in the clinic, she can explain to the students how she handles them in her day-to-day private practice. In addition, Francesca felt that her practical experience makes her invaluable to student learning. She feels students are engaged when she describes how her clinical responsibilities mirror those of the students in the clinic. Kim stated, "I won't stop working in private practice as long as I'm teaching because I feel like that makes me a better educator." Kim stated, "I practice what I teach."

**Transformative learning.** The transformative learning theory posited how adults learn in different circumstances (Mezirow, 1997). Transformative learning occurs when an individual encounters a disorienting event that disrupts their views and ways of thinking to make them more open to another perspective and may result in adapting another viewpoint (Mezirow, 1997). Thus, one must first encounter a "disorienting dilemma" (Mezirow, 1991, p. 94). Transformative



learning is believed to be the highest level of deep learning (Ileris, 2014). Furthermore, for transformative learning to occur, the individual must critically reflect.

One of the interview questions asked if the participants encountered transformative learning. The researcher defined transformative learning for the participants as any situation or event that resulted in a change to their viewpoints, beliefs, or attitudes. According to Cooley (2013), “transformative learning improves one’s teaching practice whereby one learns to enhance the teaching learning situation for all its members” (p. 34). Several of the faculty interviewed (n=4) felt that their experience teaching in freshman clinic helped them improve their teaching skills and was therefore, transformative. Teaching in freshman clinic is very different than teaching in sophomore clinic. In freshman clinic faculty must first prepare for teaching by reading the same textbooks required for the students. Faculty who teach in freshman clinic must put aside their clinical experiences and teach only the basics. Faculty reported that learning what freshman learned first-hand, as well as the terminology used to explain procedures, helped promote consistent instruction in the clinical environment. Therefore, teaching in freshman clinic created a change in the participants’ habits of mind and frames of reference, suggesting transformative learning took place (Mezirow, 1991). Brenda remembers an “enlightening experience:”

After teaching for several semesters in sophomore clinic, it was suggested that I be put in freshman clinic. Wow! That was eye-opening. Some of the material came back to me from when I was a student, but some I felt like I needed to relearn. It was so helpful to hear how the material was being taught to the students. It was the best experience for me.

I suggest all new faculty be required to go through freshman clinic.

Gail described how her experience teaching in freshman clinic helped her:

I would write down the terminology that they [the freshman faculty] would use. I typed up these scripts, on how to explain things. I kept them in my locker. Then when someone new would start teaching, I would go to my locker and give the new person a copy. You should see my locker. I have tons of folders in it.

**Research Question #3: What professional development do clinical dental hygiene faculty perceive they need to develop and maintain their clinical teaching skills?**

Researchers Whitelaw, Sears, & Campbell (2004) conducted a study to determine whether involvement in professional development facilitates a transformation in their teaching philosophy and practice. The authors identified that when faculty worked directly alongside of professional development course developers, faculty experience transformation as their needs for personal and professional development are met. The authors contended that by allowing the faculty members the opportunity to engage as active members in course development, participants were able to reframe their references, question their perspectives, and open up new ways to look at their practice (Mezirow, 1991). Moreover, Whitelaw et al. (2004) reported half of the participants surveyed had a major change to their pedagogical style, while another 25% experienced a minor change as a result of a professional development program created for their specific needs. One of the questions for this study asked the interviewees about their level of professional development. These findings helped in the creation of the fourth theme, educational methodology developments.

**Theme 4: Educational Methodology Developments**

When asked about professional development opportunities, all of the faculty participants felt that they were provided with a plethora of course offerings through emails via the department chair. However, when the researcher differentiated between coursework related to

dental hygiene compared to those geared strictly to educational methodology, the conversation changed. Francesca pointed out, “We get plenty of continuing education course offerings, but the methodology courses are hard to come by. I’ve been trying to find them and it’s not easy.” In a similar study of nursing clinical adjunct faculty, Owens (2018) identified the need for pedagogical skills as most critical when clinical nurses transitioned into the role of educators.

**Opportunities.** Gail admitted that she enjoys taking educational methodology coursework and tries to take advantage of online courses when the dental hygiene department chair sends them via email. Diane said she had taken almost every methodology course given by ADEA, but did not know of any others being offered. Kim felt there were limited opportunities to take educational methodology courses related to teaching in the clinical setting and thought it odd given the number of clinical programs located all over.

As mentioned previously, both full-time and adjunct faculty are required to demonstrate evidence of educational methodology coursework. The researcher inquired how often and how many credits of educational methodology coursework participants were required to take. Although some of the faculty participants admitted to guessing, no one knew the exact answer, indicating that this is an area that should be clarified by CODA.

**Needs.** A needs assessment can help to individualize support for adjunct faculty. Therefore, one of the interview questions inquired about clinical adjunct dental hygiene faculty member’s professional development needs. When asked about what additional knowledge or skills the faculty participants would like to acquire related to teaching, responses ranged from how to better communicate with students to how to approach a difficult student.

When asked about her most challenging issues teaching, Francesca replied, “learning how to teach to different learners and learning how to communicate better with students, such as

what words to use to communicate better.” Gail wanted to learn how to handle challenging students, such as students she could not help. Tricia wanted to learn how to better help a struggling student, how to identify when a student is having difficulties and how to help them. Diane wanted to learn how to teach to different learning styles. Kim stated that she was excited to learn anything new pertaining to clinical dental hygiene and education. Kim feels that being an educator is ever evolving and one should always continue to grow. The responses of the faculty participants in this study are in line with the results of the 2008 study by Wallace and Infante. The authors identified that clinical faculty wanted additional professional development related to clinical teaching and educational methodologies.

### **Summary**

In this chapter, the findings from the study were presented. The researcher told the narratives of the faculty participants’ experiences through their voices. Four themes were identified using the transcripts from the interviews. The themes were support and mentorship, orientation, teaching facilitators, and educational methodology development. In Chapter Five, a discussion of the findings, suggestions, and recommendations will be provided.

## CHAPTER FIVE

### RECOMMENDATIONS AND CONCLUSIONS

The purpose of this study was to explore clinical adjunct dental hygiene members' experiences of preparedness as they transitioned from clinical expert to novice educator. Chapter Five includes a discussion of the findings and provides recommendations and a conclusion of the study. The findings are related back to the conceptual framework using transformative learning and identity theories.

The results of the findings of the study were synthesized into four major themes. These key themes can be found in Table 2. The first major theme was mentorship and support. Mentorship was described as either formal or informal. Support was identified as collegial, department, or college-wide. The second theme was orientation. Orientation was described as the formal or informal process by which faculty are introduced to an institution's policies and procedures. The third theme that emerged from the data was identified as teaching facilitators. Faculty members described their background or, in some cases, lack thereof, in formal education, their clinical experience, and their encounter with transformative learning. The fourth theme stemmed from the general perspectives of the participants regarding their perceptions about educational methodology coursework.

Table 2

*Summary of Four Major Themes*

Theme 1:	Mentorship and Support
Theme 2:	Orientation
Theme 3:	Teaching Facilitators
Theme 4:	Educational Methodology Development

## Interpretation of Findings

The following subsections contain discussions of the findings. The conceptual frameworks selected for this study were transformative learning and identity theories. The findings of the study will be discussed through the lens of these two theories. The organization of the subsections will be in the order in which the major themes have emerged.

### Theme 1: Mentorship and Support

**Mentorship.** As novice educators begin their new journey as educators, they might ask themselves, “who am I as an educator?” Mezirow’s transformative learning theory can inform professional identity formation (Watkins, Davis, Callahan, 2018). The definition of professional identity has been adapted from the Watkins et al. (2018) study of clinical therapists. Professional identity is the foundation of one’s beliefs and convictions that informs one’s teaching approach, style, values, philosophy, and effectiveness of practice (Watkins et al., 2018). It is this researcher’s position that the adjunct faculty interviewed for this study identify as clinicians, rather than as educators. Novice educators begin with inexperience and limited, or the absence of, teaching knowledge. It is at this point the new faculty member requires training, support, and self-reflection to evolve into their new role. Mentorship can help guide the mentee into this new role.

The benefits of mentoring are numerous (Bland et al., 2009; Fountain & Newcomer, 2016). The mentor benefits by entering into a “reciprocal learning relationship” (Fountain & Newcomer, 2016, p. 484), the mentee receives assistance and support during career development, and the student benefits by receiving useful feedback from the faculty members (Fountain & Newcomer, 2016). Additional benefits include: the recruitment, retention, and professional advancement of faculty (Bland et al., 2009; Gwyn, 2011), the socialization of the

protege into the academic culture, (Bland et al., 2009), and the increase in collegiality, networks and relationships among novice faculty (Danaei, 2018). Mentoring has also been cited as a method for training and orientation for new faculty (Mullen & Forbes, 2000). Owens (2018) purported the value of having a mentor while new faculty learn pedagogical skills, roles and responsibilities.

As stated in Chapter Four, although the participants all reported a level of informal mentoring, or the opportunity to shadow a more seasoned faculty member, none of the participants reported being assigned to a formal mentor. Furthermore, the length of time for the informal mentorship varied for each faculty member. This finding is similar to previous research studies. According to Jacks (2009), “programs frequently pair new and seasoned faculty to assist with the transition, but that may not be enough. A more formal mentoring relationship between seasoned and new faculty will increase the effectiveness of integration into the program” (para. 7). Furthermore, mentees require time to both develop a relationship with their mentor and to self-reflect.

**Support.** As discussed in Chapter Four, support was required for new adjunct faculty on many levels. According to Boice (1991), a key marker of highly effective instruction is that the instructors actively network and seek teaching information from colleagues. The majority of faculty participants spoke about support that they solicited, however support needs to reach beyond what is self-initiated. Due to the limited number of hours adjunct faculty spend on campus, especially when working at more than one institution, faculty interaction, socialization, and collaboration was often difficult. The majority of faculty participants found ways to interact and socialize with each other outside of the college. In this manner, the adjunct faculty at The Institute are a unique group of people. The clinical adjunct faculty that were interviewed

described themselves as a family. Gail stated, “We’ve become a family over the years. We invite each other to personal events and travel together. What we have, it’s very special.” Moreover, because the faculty felt well-informed, through the dental hygiene chairperson, of all the ins and outs of the main college, they felt fully supported.

Strong peer relationships are not always the norm. In a study by Specht (2013) on novice nursing faculty, the instructors reported experiencing incivility from senior instructors. These new faculty reported experiencing belittlement, humiliation, and rejection from more seasoned faculty. As a result, new novice nursing faculty members’ negative experiences impacted their ability to adapt to their new roles (Specht, 2013). Dunham-Taylor et al. (2008) purported the term “horizontal hostility” (p. 338) to describe peer hostility when describing novice nurse experiences. Such hostility included criticism, verbal abuse, bullying, harassment, and intimidation from established nursing faculty towards new employees. Another term used to describe negative attitudes towards new faculty is professional hazing (Mason, 2001). Such experience can cause faculty attrition, as they are unable to handle the additional stress of their work-life (Dunham-Taylor et al., 2008). Therefore, peer support is necessary for faculty morale and retention.

Three of the faculty members interviewed felt they were treated differently than their full-time counterparts. Kezar and Maxey (2016b) argued that far too often adjunct faculty are marginalized. The authors suggested that this viewpoint comes in part from the institution’s administration. Because of their part-time status, lesser presence on campus, and lower levels of involvement, they are never fully included in the core faculty of the institution. As stated by Kezar and Maxey (2016b),



Although these individuals are not considered for tenure and may not be required or permitted to participate in the full range of teaching, research, and service tasks of tenure-track faculty, they are still faculty members. The work they do is tremendously important for the teaching and research mission of the institution. (p. 5)

When adjunct faculty feel marginalized in terms of personal recognition and significance, they may feel as though they are lesser members of their institutions and never fully identify as members (Doran, 2017; Forbes, et al., 2010). Illeris (2014) stated that for transformative learning to take place, learning must be something more than the acquisition of new knowledge or skills. Rather, Illeris (2014) selected the term identity to describe what transforms when transformative learning takes place. The learner's identity becomes integrated with the interaction of the world. As stated by Illeris (2014), "the concept of transformative learning comprises all learning that implies changes in the identity of the learner" (p. 40). Professional identities are formed when the new employee acquires the "attitudes, behaviors, and knowledge necessary to participate as an internal organization member" (Fleming, Goldman, Correll, & Taylor, 2016, p. 544-555). Furthermore, an individual's professional identity continues to evolve with reflection, dialogue with peers, and problem-solving in the workplace (Hammond, Cross, & Moore, 2016). Yet, forming a professional identity may be a difficult task. Adjunct faculty may have difficulty establishing a professional identity when organizational resources, support, and guidance are limited (Doran 2017). By understanding how new adjunct faculty form their professional identities, institutions can provide the necessary support to help faculty members successfully take on their new roles.

Furthermore, research has shown that adjunct faculty who feel unsupported or underappreciated for their contributions may experience self-doubt and not perform well (Elder

et al., 2016; West et al., 2009). Support strategies include improved access to teaching resources, teaching advisement such as mentors, and orientations from both the department and the college. To be successful, new adjunct faculty require support from the college, the department, and from their peers.

### **Theme 2: Orientation**

Orientation is a formal or informal process of introducing new faculty to the process and procedures of the institution. It is the period of time that occurs between the initial hiring of the employee and the start of the academic term (Vance, 2018). Orientation programs should provide basic information in addition to teaching resources. Vance (2018) posited that orientation is even more essential for novice adjunct faculty, as these faculty spend less time on campus, and therefore, have less experience and professional networks than their full-time peers. In addition, orientation can facilitate the formation of a professional identity (Vance, 2018). According to Haiduck-Pollack (2015), adjunct faculty may lack professional identity as a result of feeling underrepresented and lacking a voice among their full-time faculty cohort. In a study by Meixner and Kluck (2010), the authors identified the majority of part-time faculty surveyed regularly received contradictory information about services, programs, and orientation. Approximately 50% of the faculty surveyed were not invited to an orientation and nearly one quarter were unable to attend due to scheduling conflicts. The findings of this study echoed that of Meixner and Kluck, as all of the participants reported never having a formal orientation to the college. Without an orientation, the participants had to learn their new role while working in it and by seeking information from peers or relying on experiences they had when they were students.

### **Theme 3: Teaching Facilitators**

As postulated by Mezirow (2003), “transformative learning is learning that transforms problematic frames of reference - sets of fixed assumptions and expectations (habits of mind, meaning perspectives, mindsets) - to make them more inclusive, discriminating, open reflective, and emotionally able to change” (p. 58). The researcher inquired whether the participants experienced teaching facilitators that transformed their teaching. Faculty participants identified the following as teaching facilitators, or events that helped change the way they teach: having a background in education, having on-going clinical experience, and having the opportunity to work in the preclinical course with the freshman students. These findings are similar to a study by Mann and De Gange (2016) on the experience of novice clinical adjunct nursing faculty. The authors interviewed nine novice clinical nursing faculty. The participants identified the following as facilitators in the transition from clinical work to academia: taking graduate school courses in adult education; teaching and learning theories; prior work experience; assistance from peers; mentors and supervisors; having an orientation program; familiarity with the facility they are teaching in; and attending continuing education conferences. As far as teaching barriers, four of the participants also identified the area they wished to work on as the challenge of how to respond to different student situations.

All of the faculty participants perceived themselves to be expert dental hygiene clinicians. As a result, their professional identity was first and foremost as dental hygienists. Instructor identity was developed through their experiences, learned roles, and responsibilities. As educators, they valued providing direct patient care with their students. Faculty participants saw themselves as role models, coaches, motivators, and problem-solving agents. They expressed the importance of sharing their clinical practice experience with their students.

#### **Theme 4: Educational Methodology Development**

According to a study on adjunct faculty members in Maryland, authors Dolan, Hall, Karlsson, & Martinak (2013) identified that adjunct faculty most desired recognition for their professional statuses, teaching expertise, and that they wanted to become better educators through professional development opportunities. Dental hygienists are required by law to take a certain amount of continuing education credits to maintain their license. The exact number of credits and timeframe is determined by each state. In addition to continuing education coursework related to content, dental hygiene educators, both full-time and adjunct status, must show evidence of coursework in teaching methodology as per CODA. Although the participants interviewed in this study felt that they were provided with ample professional development opportunities relative to dental hygiene continuing education courses, the majority of faculty participants did not feel that those opportunities were as plentiful when it came to educational methodology coursework. A factor of this limitation is the limited hours adjunct faculty spend teaching. Adjunct faculty often hold multiple jobs and only spend a short time on campus. Another factor is the limited number of courses offered both locally and on line.

Adjunct faculty members require ongoing professional development, specifically in the area of teaching. Moreover, educational methodology is a requirement of the dental hygiene accrediting body, CODA (2018). Three of the faculty participants (Francesca, Tricia, and Brenda) mentioned that their teaching skills developed from their experience teaching their patients. The literature supports this idea. As adjunct instructors lack expertise in the educational environment, they are more likely to revert to traditional methods of education and familiarity, such as how they were taught when they were students (Webb et al., 2013). Moreover, Schriener (2007) posited, “not being educationally prepared for a teaching role

resulted in participants doubting their abilities as educators, which led to lowered self-confidence in their role as teacher” (p. 148).

### **Implications**

Mentorship takes time and resources, neither of which may be freely available to institutions. However, Dunham-Taylor et al. (2007) posited that it is significantly less money to provide a mentorship program to new faculty members than it is to replace one. Institutions may have inadequate resources to support adjunct growth and development, which leaves adjuncts to fend for themselves. According to Berschback (2010), although reliance on adjunct faculty is high, adjunct faculty must learn about teaching and develop institutional awareness without the pay and benefits afforded to full-time faculty. However, not taking these necessary steps to help new adjunct faculty assimilate to their new role may have deleterious effects on faculty retention, motivation, and student learning outcomes.

### **Recommendations for Action**

The first step before any plan is developed is to determine the needs of the new faculty as well as the culture and mission of the institution and the department. Faculty needs assessments should be ongoing to understand their experiences and requirements. The recommendations provided below stem from the thematic analysis that emerged from this study. Suggestions are provided based on the findings of the key themes.

#### **Mentorship**

As purported by Dunham-Taylor et al. (2007), “mentorship can be the single most influential way to help in the successful development and retention of new nursing faculty, not only for the initial purpose of filling a vacant position but also for the long-term maturation of nurse faculty members” (p. 337). Although Dunham-Taylor et al. (2007) were referring to new

nurse faculty members, the same holds true for new dental hygiene faculty members, as the dental hygiene profession is modeled from the nursing profession. Fountain and Newcomer (2016) postulated that while mentoring has been frequently utilized as a training method for new faculty in higher education, adjunct faculty were typically excluded.

The literature suggests that compared to research on mentoring, there is little research on the mentoring of adjuncts (Thomas, Lunsford, & Rodrigues, 2015). Moreover, in dentistry, research on mentoring is scarce (Bagramian et al., 2011). Studies have shown that when expert nursing clinicians are transitioning to academia, mentoring can aide in that transition (Green & Jackson, 2014; Mijares & Bond, 2013). Mentoring has been shown to help teach, encourage and retain educators (Dunham-Taylor et al., 2008; Green & Jackson, 2014).

In addition to the benefits of mentoring, CODA now requires new faculty to have a mentor (ADA, 2019). Therefore, it is advised that institutions employing adjunct faculty adopt a formal mentorship program. Programs should include: a clearly stated purpose and goals; support from leadership, administration, and faculty; alignment of organization goals and objectives; adequate resources; strategies for matching of mentors and mentees; orientations for both mentors and mentees to introduce the program; and evaluation for continuous improvement (Fountain & Newcomer, 2016). It is necessary to begin with an institutional culture that supports mentoring. Ongoing institutional and departmental support is crucial to sustain the program. Bagramian, Taichman, McCauley, Gren, and Inglehart (2011) postulated that it is equally important to recognize the mentor for their participation with rewards and recognition.

Furthermore, Dunham-Taylor et al. (2007) posited that, “mentoring is a process that should not cease after a few weeks or months” (p. 339). Rather, the mentorship should last until

the novice faculty member becomes fully integrated into the academic community. A more formalized mentoring program can help align adjuncts with their full-time counterparts. Mentors can share their knowledge and skills and help integrate new faculty into the culture of the college.

The faculty interviewed for this study experienced what they described as an informal mentorship. It appeared that mentor-protégé relationships were formed based on convenience i.e., observing another faculty member teaching in the clinic at the same time as the new member. While the participants received some benefit from this experience the majority of the faculty participants would have preferred more.

It is recommended that new adjunct faculty members be paired with the more seasoned, full-time faculty member and that both parties be assigned to teach in the same clinical session (Bland et al., 2009; Jacks, 2009). This will help the newest member learn to navigate his or her new role, while having a role model and support within the setting and will ensure mentor availability should any challenges or questions arise. Furthermore, mentoring aids in socialization, with the mentor acting as the “socializing agent” (Dunham-Taylor, 2007, p. 339) and collaboration, as the mentee and mentor are each working toward the same goal, to graduate competent and prepared dental hygiene students.

Dunham-Taylor et al. (2008) posited that new faculty learn their new roles through socialization. Mentoring is a form of planned socialization (Dunham-Taylor et al., 2008). This socialization helps the new faculty member to understand his or her assigned roles and responsibilities, while establishing long-term relationships within the program (Dunham-Taylor et al., 2008). Furthermore, new faculty members may feel stress or anxiety as they learn their

new position. Bagramian et al. (2011) postulated positive social support can help when individuals are coping with stress.

Mentoring programs can be used in conjunction with other formal training processes, such as orientations. The mentor-mentee relationship can help foster innovation in teaching and learning. A mentoring paradigm may help the new faculty member reflect on their experiences. Cranton (1996) purported that critical reflection was the heart of transformative learning. For transformative learning to take place, the adult learner must move beyond the acquisition of new knowledge and skills and self-reflect (Cranton, 1996). Self-reflection is an individual's consideration of the meaning and the implications of an experience or action (Branch & Paranjape, 2002). A mentor can offer new insights and perspective, thus challenging the new faculty member to examine their core beliefs.

### **Support**

As stated previously, the faculty members in this study felt supported by the department and their peers, but not necessarily by the college. Department support was provided via opportunities sent via email. Peer support was described as self-initiated as there were limited opportunities to socialize on campus.

Support of new adjunct faculty is essential. For new adjunct faculty to be successful in their new roles, support must be provided on college-wide, department-wide, and peer-wide levels. Kezar and Maxey (2016a) posited that supporting adjunct faculty may positively impact student learning outcomes and graduation rates. Vance (2018) suggested that adjunct faculty may be less familiar with the institution's student support services and thus, may be unable to best support those students requiring additional help. Institutions should provide new adjunct faculty with a series of orientations and informational sessions to apprise the members of all the



college has to offer. For faculty only teaching in the evening, access to support may be limited or non-existent (Kezar & Sam, 2010). Colleges should provide extended hours of support for those teaching evenings only, while simultaneously fostering feelings of inclusion and professional value. For those newer faculty who have fewer years of teaching experience, support is even more essential (Fagen-Wilen et al., 2006). Therefore, providing adjunct faculty with additional support can help them identify first and foremost as educators.

New adjunct faculty can be introduced to their collegial network of peers through these orientations and preterm workshops as well as through their mentorship. Improving adjunct faculty belongingness can help promote a strong sense of institutional affiliation, which may increase faculty retention, job performance, satisfaction, and student learning outcomes (Vance, 2018). In addition, institutions can utilize centers for teaching and learning to develop and promote professional networks of support (Vance, 2018). Finally, asking new adjunct faculty members to participate in decision making, such as textbook offerings, materials, and guest speakers, has been shown to support newer faculty (Fleming et al., 2016). All of the faculty in this study answered positively to wanting to be more involved with the program. Several of the faculty members (Gail, Kim, Brenda, Tricia, and Francesca) reported that their experiences mentoring dental hygiene students during their summer research projects was a rewarding experience and they would welcome additional opportunities to work with students outside of the clinical setting. Diana mentioned she had some ideas about bringing in some newer technology into the department to offer students other ways to treat patients. The faculty all reported having a vested interest in both the program and the success of the students.

## **Orientation**

None of the faculty participants interviewed in this study experienced an orientation. When asked how the participants learned the policies and procedures for both the college and the department, the participants responses were: help from mentors and peers, the clinic manual, the chair of the department, and trial and error. Three faculty members also added it helped that they graduated from the program and therefore had a foundation of the policies and procedures.

In an effort to aid new adjunct faculty in their understanding of department or college-wide opportunities, institutions should provide both college-wide orientations and department-wide orientations. In the event that institutions do not offer adjunct faculty an orientation program, it is even more pertinent that departments provide one to their adjunct faculty to help inform new faculty of their roles. Establishing an orientation process for new adjunct faculty may help ensure that new members are familiar with policies and procedures, new role expectations, and may promote a better sense of inclusion (Vance, 2018). Moreover, new faculty orientation is when the new member forms his or her professional identity (Vance, 2018). Vance (2018) purported, “Orientation is especially important for new adjunct instructors, who may have less time and experience on campus to form professional networks than their full-time, tenure-track peers” (p. 1). These faculty may miss opportunities to engage in collaborative discussions surrounding teaching methods.

Dunham-Taylor et al. (2008) posited orientation should introduce the teaching role in general. Moreover, “mere tours and a brief discussion are not adequate” (p. 342). Vance (2018) suggested orientations take place in a one-on-one setting with department leadership. The intimate process may foster more a relaxed conversation. Moreover, the leader can clarify

the role expectations for the new faculty, along with addressing any questions or concerns the new employee may have (Vance, 2018).

Furthermore, orientations may help foster relationships by increasing collegiality among the faculty. Faculty who are excluded from orientation activities may become less acclimated to their institution, may have insufficient knowledge about the policies and procedures of the institution and or the department, and feel alienated (Kezar & Maxey, 2016a). As posited by Vance (2018), “a lack of proper orientation and support many hinder adjuncts’ ability to meet student needs or contribute to their institutions” (p. 10). Vance (2018) postulated, “having a formal pre-semester plenary session that takes into consideration the diverse needs of both returning and new faculty would help to deepen newcomers’ connections to the culture of the institution and department” (p. 159). Lastly, an instructional pre-service orientation, in the form of an in-service workshop, should be offered to adjunct faculty, who may be limited in prior teaching experience (Danaei, 2018).

### **Teaching Facilitators**

The faculty interviewed in this study reported various circumstances that they felt helped them develop and maintain their teaching abilities. Those teaching facilitators were listed as having formal educational coursework, maintaining employment as clinical dental hygienists, and having the experiences of teaching in freshman clinic. Therefore, it is beneficial that new faculty be required to have a background in education, maintain ongoing clinical practice, and be provided with similar experiences in freshman/preclinical courses.

These suggestions are in line with the mandates from CODA. As mentioned previously, CODA requires faculty to have a background in current education theory and practice and clinical practice experience (ADA, 2019). Not all of the faculty began their teaching with a

background in education. Therefore, it is suggested program leaders seek individuals with a formal background in education to fill clinical adjunct positions. In addition, CODA requires teaching faculty to have clinical experience, however there is no specification for the required number of years. It is recommended that faculty continue to practice in the clinical setting while simultaneously holding teaching positions to offer students the most current and relevant clinical information.

Finally, over half of the faculty reported their experiences teaching in freshman/preclinic clinic as transformational to their teaching. In freshman clinic/preclinic, the faculty could not rely on their clinical experiences alone to teach. Rather, faculty had to start at the beginning and follow the steps outlined for the new students in their textbooks. These experiences required more preparation of the faculty, as they had to learn to speak differently to the students and teach the basics first. The faculty found this experience helpful and beneficial when they taught the more advanced students in sophomore clinic. Dental hygiene department chairs should rotate new faculty through freshman/preclinical classes to help improve faculty teaching and to calibrate all faculty. Ideally, only one new faculty member should be introduced into freshman clinic at a time as not to disrupt student learning.

### **Professional Development**

Literature on faculty development initiatives identified that novice faculty are often excluded (Edwards, Sandoval, & McNamara, 2015). In a Maryland study by Dolan et al. (2013), the authors identified adjunct faculty as having a lack of professional development when compared to their full-time counterparts. In the same study, 72% of the survey respondents felt that faculty development should be more available, accessible, and frequent. It is unfortunate, given novice faculty tend to need teaching support the most (Edwards et al., 2015). “In college

and university settings, professional development should be offered for professionals in various positions (Darling-Hammond & McLaughlin, 2011). Educational institutions have an obligation to provide adjunct faculty with effective professional development (Morton, 2012). When providing professional development for adjunct instructors, the program facilitator should consider faculty needs. Adjunct instructors are often experts in their respective fields, but that does not guarantee them success as instructors (Webb et al., 2013). Professional development offerings must incorporate best practices. Adjunct instructors often have second jobs and do not have the time to devote to improving and building upon their educational practice. A suggestion is to provide presentations online or through meetings on WebEx or Skype. Courses can also be recorded so that faculty can review them during their own time.

As mentioned earlier, dental hygiene educators must take continuing education credits to maintain their dental hygiene license. However, dental hygiene educators must take additional coursework in teaching methods. Participants felt that they received adequate professional development opportunities related to their professional continuing education course requirement for their dental hygiene license. However, the faculty members who participated in the study reported having difficulty finding appropriate educational coursework to fulfill their requirements as dental hygiene educators. One suggestion is to advise faculty to broaden their search requirements when seeking methodology coursework. Although general methodology may not be geared to clinical coursework, it may provide pedagogical best practices for teaching to various learners. In addition, because much of the methodology requirements are left to the interpretation of each program's dental hygiene chair, setting the number of credit hours along with a timeline, such as a minimum of two credits a year, will help faculty adhere to a goal of completing their requirements.

### **Additional Suggestions**

In addition to the suggestions captured from the thematic analysis in this study, the literature offers additional recommendations to help make adjunct faculty member's transition to teaching successful. By bringing adjunct faculty into the institution's culture, faculty will have a greater sense of belonging and loyalty to the institution. Additional suggestions are to strengthen the hiring process for clinical adjunct faculty, increase adjunct faculty recognition, incorporate them into decision making, and to support them in leadership roles.

**Adjunct hiring process.** As mentioned in Chapter Two, adjunct faculty do not encounter the same hiring process as full-time faculty. Often the hiring of adjunct faculty bypasses the detailed hiring protocol employed for full-time faculty members (Christensen, 2008). Generally, full-time positions require a national search followed by a series of interviews. Search committees are utilized to conduct the interviews. Candidates may be asked to prepare a short presentation. Interviews include pedagogical questions as well as other questions specific to the position. On the other hand, adjunct faculty are hired on an as-needed basis. The institution may or may not utilize a search committee to screen applicants. Therefore, the process of hiring an adjunct faculty member may not result in the most ideal candidate. Moreover, because the process is faster, the new faculty member is not provided with an orientation to the institution. A suggestion would be to change the qualifications for initial hire. A search committee should be used to identify potential candidates and the interview process should mimic that of a full-time position. By employing a more formal search, candidates with a background in educational methodology could be identified. These efforts should help in the hiring of the best possible candidate for the position.

**Ideas for additional support.** The literature provides additional measures to aide in new adjunct faculty support. Faculty participants reported receiving their information via emails from the chair. A suggestion to effectively manage communication and distribution of information for new adjunct faculty within the department, is create a faculty handbook, as well as a Web-based repository for information. This would prevent the need to scroll through emails to locate information. Other ideas include the creation of a faculty newsletters, adjunct faculty committees, access to learning management systems for didactic course syllabi, textbook input, and an Adjunct Faculty Appreciation Day (Fagan-Wilen et al., 2006), to honor their contributions and efforts. As suggested earlier, adjuncts could be given the opportunity to provide input on course development and material selection. Elder et al. (2016) suggested including adjunct in leadership and in decision making about issues important to their role. Lastly, The Center for Community College Student Engagement (2014) suggested providing adjuncts with access to a shared office space to meet with students and network with other faculty as well as access to technical resources.

### **Recommendations for Further Study**

Due to the nature of the study in interviewing faculty members from one institution, the results may be limited and not generalizable to all dental hygiene programs. Therefore, the next step should be to survey clinical adjunct dental hygiene faculty at other institutions to build upon this research study. A quantitative study surveying all dental hygiene programs nationwide may provide additional information on adjunct faculty members' needs.

### **Conclusion**

New faculty members are often skilled and dedicated instructors who may bring fresh perspectives from various fields of practice. This makes adjuncts invaluable to institutions. In

higher education, where dental hygiene programs are found, reliance on adjunct faculty is high. Transition from the dental hygiene clinical setting to academia requires support. In an effort to support clinical adjunct faculty, institutions should build a supportive environment; provide formal mentorship programs; strengthen orientation; and increase adjunct faculty members' knowledge about institutional resources and professional development activities, such as educational methodology coursework opportunities. In addition, institutions should foster a sense of belonging and provide recognition for adjunct faculty work and contributions to increase a sense of professional identity. Because adjunct faculty hold many of the institution's teaching positions, the success and integrity of the institution is tied to adjunct faculty. For adjunct faculty to be successful, they need to feel invested in and part of institution's mission. Therefore, adjuncts need to be provided with the support and professional development that they deserve (Juszkiewicz, 2016). Juszkiewicz (2016) further purported that providing adjunct faculty with supports such as professional development and mentoring may help students. Leaders should motivate adjunct faculty to engage faculty contributions to the program and to the curriculum.



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## APPENDIX A: SAMPLE RECRUITMENT LETTER

Dear Clinical Adjunct Faculty Member,

I am a doctoral candidate at University of New England. I am interested in the experiences of clinical adjunct dental hygiene faculty. There is little information about what is helpful in preparing clinical adjunct dental hygiene faculty to teach and this 60-90 minute interview will provide you the opportunity to share the experiences you have had in transitioning from clinical expert to novice educator.

Participation involves approximately a 60-90 minute interview. The interview will be kept confidential and will be set up at a time and a place that is convenient for you. The interview will be audiotape-recorded; however, your name will not be recorded on the tape. Only a pseudonym will be used to protect your identity. Your name and identifying information will not be associated with any part of the written report of the research. All of your information and interview responses will be kept confidential. After the recorded tapes have been transcribed, the tapes will be deleted. Data will be stored in a locked cabinet in the researcher's home for 10 years. You may notify the researcher at any time that you would like to stop the interview and your participation in the study. There is no penalty for discontinuing participation.

While there are no direct benefits to the participants of this study, the results of this study may assist dental hygiene programs in supporting future clinical adjunct dental hygiene faculty. There are no risks associated with participating in the study beyond what one would experience in their everyday life. Findings from this study will be shared with the participants.

I hope you will consider joining me in helping to learn more about clinical adjunct dental hygiene faculty needs.

Sincerely,

Susan Vogell, RDH, MBA

(917) 359-3404  
svogell@une.edu

## APPENDIX B: INTERVIEW QUESTIONS

1. Tell me about yourself and your dental hygiene career (e.g. education, years of experience, areas of specialty, length of teaching, currently working).
2. How and why did you choose to become an adjunct clinical faculty?
3. Describe your experience as an adjunct clinical faculty member teaching in the clinical setting.
4. Is your experience as an adjunct clinical faculty member different than what you expected? If so, how?
5. What is your experience or education in the field of adult education? How and where did you develop your teaching skills?
6. Describe your orientation and mentorship as an adjunct. Did you (Do you) feel prepared and competent to teach clinical dental hygiene?
7. What type of guidance did you find most helpful in developing competence as a dental hygiene educator?
8. In what ways are or were you supported as an adjunct clinical faculty?
9. What do you perceive were facilitators as you transitioned from clinician to educator?
10. What do you perceive were barriers to your transition from clinician to educator?
11. What knowledge, disposition, or skills do you feel you brought to the college?
12. Have you experienced any events that have transformed your teaching practice? If yes, please describe them.
13. Do you feel the students relate to you differently than if you were a full-time clinical teacher? If so, how?
14. What are the rewards of being an adjunct clinical teacher?

15. What are your most challenging issues related to teaching?
16. What additional knowledge and skills would you like to acquire related to teaching?
17. Describe how/ or how are you are included as a member of this department.
18. Upon beginning your teaching career, were you provided with
  - a. a mentor?
  - b. an orientation to the College and the department regarding policies and procedures?
  - c. support?
  - d. socialization?
  - e. professional development?
  - f. collaboration?
  - g. connection?
19. Describe suggestions for how your department or College can include/involve adjunct faculty members.

Is there anything else you would like to add that we haven't already addressed?

## APPENDIX C: IRB



Institutional Review Board  
Mary DeSilva, Chair

**Biddeford Campus**  
11 Hills Beach Road  
Biddeford, ME 04005  
(207)602-2244 T  
(207)602-5905 F

**Portland Campus**  
716 Stevens Avenue  
Portland, ME 04103

To: Susan Vogell  
Cc: Carey Clark, Ph.D.  
From: Liam Harrison, M.A., J.D. CIM  
Date: January 4, 2019

Project # & Title: 19.01.02-003 The Lived Experiences of Clinical Adjunct Dental Hygiene Faculty

The Institutional Review Board (IRB) for the Protection of Human Subjects has reviewed the materials submitted in connection with the above captioned project, and has determined that the proposed work is exempt from IRB review and oversight as defined by 45 CFR 46.104(d)(2).

Additional IRB review and approval is not required for this protocol as submitted. If you wish to change your protocol at any time, including after any subsequent review by any other IRB, you must first submit the changes for review.

Please contact Liam Harrison at (207) 602-2244 or wharrison@une.edu with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Liam Harrison", is written over a light gray rectangular background.

William R. Harrison, M.A., J.D.  
Director of Research Integrity

IRB#: 19.01.02-003  
Submission Date: 12/21/18  
Status: Exempt, 45 CFR 46.104(d)(2)  
**Status Date: 01/04/19**

## APPENDIX D: INFORMED CONSENT

**UNIVERSITY OF NEW ENGLAND  
CONSENT FOR PARTICIPATION IN RESEARCH**

**Project Title:** The Lived Experiences of Clinical Adjunct Dental Hygiene Faculty

**Principal Investigator(s):** Susan Vogell

**Introduction:**

- Please read this form. You may also request that the form is read to you. The purpose of this form is to give you information about this research study, and if you choose to participate, document that choice.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

**Why is this research study being done?**

The purpose of the study is to explore the lived experiences of adjunct clinical dental hygiene faculty in an effort to identify support needed for faculty to maintain and improve their teaching skills.

**Who will be in this study?**

Approximately four to ten clinical adjunct dental hygiene faculty will participate in this study.

**What will I be asked to do?**

If you decide to participate in the research, you will be asked to participate in an interview where you will be asked about your thoughts, opinions, and experiences on what it means to be an adjunct clinical dental hygiene faculty member. Interviews will be audio-taped, however your name will not be on the tape. Your participation should take approximately 60-90 minutes.

**What are the possible risks of taking part in this study?**

There are no physical, emotional, or social risks associated with this research beyond what one would experience in their everyday life.

**What are the possible benefits of taking part in this study?**

While there are no direct benefits to the participants in this study, results from the study may help future clinical adjunct dental hygiene instructors.

**What will it cost me?**

This research study will not cost you anything.

**How will my privacy be protected?**

Only pseudonyms will be used to disguise your identity and when describing your responses in the study. The individuals who will have access to the data include: Susan Vogell, principal researcher. In addition, the principal's dissertation committee, as well as the University of New England IRB may review the data.



**How will my data be kept confidential?**

The confidentiality of data will be maintained by using pseudonyms when collecting and reporting the data. After the audiotapes have been transcribed, the audiotapes will be deleted. All data will be stored in a locked cabinet in the researcher's home for 10 years.

**What are my rights as a research participant?**

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University.
- Your decision to participate will not affect your relationship with Susan Vogell.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.
  - If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You will be informed of any significant findings developed during the course of the research that may affect your willingness to participate in the research.
- If you sustain an injury while participating in this study, your participation may be ended.

**What other options do I have?**

- You may choose not to participate.

**Whom may I contact with questions?**

- The researchers conducting this study are: Susan Vogell
  - For more information regarding this study, please contact: Susan Vogell (917) 359-3404.
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact: Susan Vogell (917) 359-3404 or Dr. Carey Clark (707) 239-6738.
- If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

**Will I receive a copy of this consent form?**

- You will be given a copy of this consent form.

**Participant's Statement**

**I understand the above description of this research and the risks and benefits associated**

**with my participation as a research subject. I agree to take part in the research and do so voluntarily.**

\_\_\_\_\_  
Participant's signature or  
Legally authorized representative

Date

\_\_\_\_\_  
Printed name

Researcher's Statement

**The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.**

\_\_\_\_\_  
Researcher's signature

Date 1/3/19

Susan Vogell  
Printed name