Development of aMindfulness-Based Cultural Intelligence Model

Applications in Health Care Organizations

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Extended Abstract

The early twenty first century work environment is characterized by increasing cultural diversity. The ability of individuals to work together despite differences in cultural values, beliefs, and norms is critical for organizational success.

Academics from a range of disciplines,including international business, psychology, and communication, have contributed to our understanding of needed adjustments for successful cross-cultural interactions(Black, Mendenhall &Oddou, 1991; Mendenhall &Oddou, 1985; Morley &Cerdin, 2010; Caligiuri, 2000; Ones &Viswesvaran, 1999; Phillips & Gully, 1997). Both the international business and inter-cultural communication literature tend to examine cultural differences from the perspective of national origin,values,and language, thus categorizing individuals on the basis of country level cultural dimensions (e.g. Hofstede, 1980; House, Hanges, Javidan, Dorfman, & Gupta, 2004). There is to some extent, a presumption of cultural homogeneity within a given country, which can be misleading given the growing movement and interactions of people across countries that increases exposure to values and socialization from different backgrounds (Tung &Verbeke, 2010). There are also intersecting subculturesthat are related to different communities of interest (both virtual and physically located communities) that contribute to cultural diversity in a given setting (Schim, Doorenbos, Benkert, & Miller, 2007). Overall, demands of interacting with individuals across cultures, whether virtual or physical will only increase in the years ahead as corporations cross country borders in search of business opportunities. This increase in demand for cross-cultural interaction skills points to the importance of having a framework to conceptualize cultural competencies. Unfortunately, a review of the literature across international business, workplace diversity, and intercultural communication domains, showed a still lacking conceptualization of such competencies (Johnson, Lenartowicz, and Apud, 2006).

In an effort to develop a possible cross-cultural competency framework, Earley and Ang (2003) introduced the concept of cultural intelligence or "CQ." CQ is a multidimensional construct that is grounded in the theory of multiple loci of intelligence (Sternberg &Detterman, 1986). CQ could be broadly described as an ability to assess an unfamiliar cultural environment and adapt oneself for success in that environment. Ang and colleagues (2007) argued that CQ addresses several gaps in the existing literature as it is conceptually distinct from personality traits, and other types of intelligences or specific cultural competencies. CQ was posited to have four dimensions and is an applicable framework regardless of specific cultures. CQ could also take a broader perspective of culture – one that encompasses not only different nationalities and

cultures but also different gender, religions, races, and ethnicities that could be related to workplace diversitycharacteristics. Thomas and Inkson (2009) called this broader perspective an individual's "psychological fingerprint": education, socio-economic background, and professional background (including both functional background and organizational and departmental experience).

This broader characterization of culture is consistent with that which is used in the U.S. health care sector. Here, the definition of cultural competence is framed in the context of workforce diversity,which refers to cultural subgroup classifications by gender, age, ethnicity, race, religion, and sexual orientation (Johnson et al., 2006). Thus, the broad conceptualization of CQ is not only relevant for examining across-country differences, it is also relevant for cultural differences that are related to workforce characteristics. Johnson and colleagues (2006) noted the need for institutional support in developing cultural competence of healthcare workers because of the diverse patient interaction requirements due to patients coming from all walks of life and cultural roots. It was therefore not a surprise that TheJoint Commission on the Accreditation of Healthcare Organizations ("JCAHO" or the "Joint Commission") whose accreditation is considered the gold standard in the health care sector defines cultural competence as "the ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the healthcare encounter. Cultural competence requires organizations and their personnel to do the following: 1) value diversity; 2) assess themselves; 3) manage the dynamics of difference; 4) acquire and institutionalize cultural knowledge; and 5) adapt to diversity and the cultural contexts of individuals and communities served" (Joint Commission, 2010, p. 91). The health care literature has examined several models of cultural competence, including Leininger's seminal model of transcultural nursing care (Leininger& McFarland, 2006), Campinha-Bacote (1999, 2002)'s model, Purnell (2000)'s model, and Schim and colleagues' (2007) model. These different models have been used in different health care agencies to assess and develop cultural knowledge, skills, and awareness. While these healthcare-rooted models have been useful in various settings, they tend to be specific to the healthcare industry's unique needs. In contrast, the CQ model by Earley and Ang (2003) is a more general model that provides a novel and useful framework which could be applied in both the healthcare as well as business sectors.

Earley and Ang (2003) initially defined CQ as a three-facet construct: cognitive CQ, motivational CQ, and behavioral CQ, a system of interacting abilities whereby each of the three facets is integral to CQ, with each facet reinforcing the other two, and interacting together to produce the CQ model. Thomas (2006) examined this three-facet CQ model and argued that mindfulness could be a possible replacement of the motivational construct and one that serves as a metacognitive link between knowledge and behavior. Out of the mindfulness literature, three qualities have been consistently identified as essential facets of mindfulness. These three qualities of mindfulness are: using empathy, using all senses, and viewing situations with an open mind (open-mindedness) or from multiple perspectives (Brown & Ryan, 2003; Langer, 1989; Langer &Moldoveanu, 2000). The review of the literature also showed these three qualities to be clearly distinguishable along three different domains: internal logic (for empathy), kinetic senses (for using all senses), and type of approach or angle (for perspectives) (Brown & Ryan, 2003; Langer, 1989; Langer &Moldoveanu, 2000). Arising from the literature review, this study proposes an expanded Thomas' (2006) CQ model that includes three sub-components (empathy, open-mindedness, and using all senses) in the mindfulness construct.

The purpose of this study is twofold: first, to explore the role of mindfulness in cultural intelligence (CQ) with the development of a CQ mindfulness model that builds on the CQ and mindfulness literature, and second, to test the model's ability to predict culturally congruent patient care. This research study builds on both Earley and Ang's (2003) and Thomas' (2006) theories by exploring the facets of mindfulness in the CQ framework. The CQ mindfulness model is then tested with registered nurses from various health care settings to determine the model's ability to predict practices recommended by the Joint Commission in order to meet the new accreditation standards of culturally competent, patient- and family-centered care.

Data was collected in a large metropolitan University in the Northeast of the U.S. from 215 graduate nursing students, nursing faculty, and alumni who work for a variety of health care organizations in a highly culturally diverse urban environment. This provides a new disciplinary setting for CQ research, i.e. health care, in contrast to the majority of empirical studies to date that have been conducted with business students and professionals.

Hypotheses were tested using a combination of several existing instruments with demonstrated validity and reliability in international business (from the CQ literature) and in psychology (from the mindfulness literature), as well as a new scale developed with actual statements from the Joint Commission's accreditation standards and recommendations for effective communication, cultural competence, and patient-and family-centered care (Joint Commission, 2010).

Prior to testing the hypotheses, exploratory factor analysis was used to examine the factor structure of Mindfulness and culturally congruent patient care. Confirmatory factor analysis was then used to assess the convergent validity and discriminant validity of the Mindfulness measurement model. The hypotheses were tested using structural equation modeling in AMOS (Version 21.0).

The study results support the presence of three essential and distinct facets of mindfulness: empathy, open-mindedness, and using all senses, and the key role played by mindfulness in cultural intelligence. The data indicate strong relationships between mindfulness and total mental CQ (cognitive CQ and metacognitive CQ), and between mindfulness and behavioral CQ. Study results also support the significant influence of mindfulness on culturally congruent patient care and the influence of behavioral CQ on culturally congruent patient care.

These findings contribute to the management literature by adding to the growing CQ research on antecedents of CQ and interactions amongst different CQ facets. Its unique contribution is the demonstration of mindfulnessas a suitable replacement for motivation in the CQ framework, and showing the validity of mindfulness subconstructsof empathy, open-mindedness, and using all senses. This study also contributes to the cultural competence literature in health care with the introduction of the CQ mindfulness model as well as a new instrument to measure culturally congruent patient care. This research on CQ and mindfulness in health care proposes a novel insight as to why some nurses may be more effective than others at providing culturally congruent patient care. Findings offer timely managerial implications for health care organizations.

The study results help inform management practice in health care agencies and in other culturally diverse organizations. The ability to better understand what makes individuals more culturally intelligent has important implications for hiring, developing, transferring, and promoting staff in culturally diverse organizations. By identifying three key facets of mindfulness and developing a valid instrument to measure these facets, individuals will be able to focus on specific areas of self-development using training strategies geared

towardsstrengthening each of these three facets. In order to encourage the development of individuals' CQ in an organization, the findings suggest that management should encourage the development of empathy, open-mindedness, and the use of all sensesin training programs.

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