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by

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A DISSERTATION

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For the Degree of Doctor of Philosophy

Major: Human Sciences
(Leadership Education)

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This purpose of this explanatory sequential mixed methods study was to examine the intercultural sensitivity development process of faculty and staff at a health sciences college in the Midwest. In the quantitative phase, this study investigated changes in intercultural sensitivity over a three year period, along with the relationship between developmental level of intercultural sensitivity (as measured by Intercultural Development Inventory [IDI] [Hammer, Bennett, & Wiseman, 2003]) of participants and Psychological Capital (PsyCap, a multidimensional construct consisting of hope, efficacy, resiliency, and optimism [Luthans, Youssef, & Avolio, 2007]). In the qualitative phase (Case Study) data collection and analysis further explored the link between changes in intercultural sensitivity and helped to further explain the quantitative results. Quantitative results indicated that the faculty and staff of the college experienced significant growth in Developmental Orientation (DO) and that there was not a significant quantitative relationship between PsyCap and the changes in DO. However, the findings from the qualitative phase of this study enhanced the understanding of the quantitative results in that high PsyCap supported growth in developmental level in several ways:
1. Key leaders with high PsyCap and relatively high developmental level created environments and initiatives that encouraged the development and growth of others in the organization.

2. Leaders with high PsyCap and relatively high developmental levels who directly supervised individuals with high PsyCap, were described as having a positive impact on direct reports’ developmental levels.

3. Individuals with low PsyCap experienced developmental gains if they were in close working relationship with others with high PsyCap.

These results along with implication for future research and application to the field are discussed.
DEDICATION

This study is dedicated to the memory of my father, Hamzeh Ali Abdali Soosan. Saying goodbye to you time and time again (when you took us to England, then later United States, then after your last visit with us) was profoundly difficult, but not nearly as difficult as it was watching you in the hospital bed after your stroke. The way the nurse treated you that one day, was the turning point in my career. I decided that we must prepare healthcare providers differently. She didn’t know you or us, yet her bias toward foreigners evidenced by her hateful words was like daggers piercing my heart. I am not proud of the way I acted that day, Dad. I know you wouldn’t have wanted me to talk to anyone the way I did to that nurse.

I know this work, won’t change the past, and I also know the long hours and years to get here are nothing compared to the immense sacrifices you and Mom made for us to have an education and a future; I do hope this work will bless others so that they may never have to experience what we did.

Not a day goes by that I don’t thank God for you, Dad. I love you and I miss you.
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“...Love one another. In the same way I loved you, you love one another. This is how everyone will recognize that you are my disciples—when they see the love you have for each other.” John 13:34-35 MSG

Pursuing a PhD is no easy task, and getting to this point would certainly not happen without the support of family, friends, mentors, scholars and mostly God. There are so many who have loved me in this journey.

I wouldn’t be here if it weren’t for the incredible love of God. Thank you Lord for listening to me, for holding me when I could no longer stand, for loving me, and for showing me that the best is yet to come.

My darling Scott, if I was Mary you would be my Joseph: Quiet strength, persevering love, deep faith in me! All of that has helped me feel secure in your love. There aren’t enough words to thank you for the sacrifices you have made to keep your promise to my Dad. He is proud of you, I know it. You are by far my favorite human being. I look forward to getting older and grayer with you my darling.

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ways that has made me a better teacher, scholar and researcher. I am eternally grateful that God brought you into my life. I am so looking forward to our future collaboration together.

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

This explanatory sequential mixed methods study examined the intercultural sensitivity development process of faculty and staff at a health sciences college in the Midwest. Specifically, this study investigated the relationship between developmental level of intercultural sensitivity (as measured by Intercultural Development Inventory [IDI] [Hammer, Bennett, & Wiseman, 2003]) of participants to their Psychological Capital (PsyCap, a multidimensional construct consisting of hope, efficacy, resiliency, and optimism [Luthans, Youssef, & Avolio, 2007]), while exploring the approach to development. Consider the following story which provides a real-life example of the importance of cultural competence in healthcare:

A 12-year-old boy, hit by a truck while riding his bike in his small town neighborhood, was flown by helicopter to the closest trauma medical center 50 miles away. Upon arrival at the hospital, the parents were notified that things didn’t look good. The young boy’s heart had stopped several times and his brain was showing no activity, indicating that the boy was brain dead. Eventually, the family was approached with the question of organ donation. Several hours later, the family informed the chaplain that they were ready to remove the life support and would agree to organ donation if the hospital allowed a family member to be present in the operating room at the time of the harvesting of the organs. The family explained that in the faith traditions of their Native-American tribe, they believed the spirit of their son rested in his heart. They wanted a family member to be present to observe that the heart was allowed to fully stop beating and that time was given for the spirit to be freed before the harvesting of organs so that the spirit was not trapped. The chaplain listened, empathized, and communicated his appreciation of the importance of this request. The chaplain shared this newfound information with the hospital decision makers. After an intense and politically and emotionally charged dialogue between the various hospital representatives and verifying that there were no legal issues with meeting this request, the hospital agreed to allow a family member to observe the harvesting of the
organs in the operating room. Later, the Nebraska Organ Retrieval System notified the hospital decision makers that this was the first time in the 25-year history of organ donation in the state that a Native-American family had agreed to organ donation.

This story is based on actual events during the time the researcher headed up the Diversity and Cultural Competence Initiatives at the stated health system (that includes the health sciences college). This event is an example of how the developmental level of intercultural sensitivity of the leaders and decision makers can powerfully influence outcomes in critical situations. While in hindsight the solution to this dilemma may seem obvious, during the actual events “doing the right thing for the right reasons” was extremely unclear. This was because in a hospital there are highly specialized duties, and differences exist in the training, background, and motivations of the parties involved in conducting the duties. Culturally competent care is delivered when professionals operate from a developmental level of intercultural sensitivity that supports their growth in cultural knowledge and skill to enable them to effectively care for culturally diverse patients and work with culturally diverse colleagues.

The publication of the Institute of Medicine (IOM) Report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (2003), generated an increase in research and government initiated requirements for the healthcare delivery system to eliminate the gap in access and quality of care for ethnic and racial minority populations. The IOM study identified providers’ bias, stereotyping, and uncertainty as a major part of the reasons for unequal treatment. The call to organizations and schools was to develop “cultural competence” as a core competence for all current and future healthcare providers (IOM, 2003). The information in this chapter is laid out as follows: (1)
overview of the issues, (2) statement of the problem, (3) purpose of the study, (4) delimitations and limitations of the study, and (5) significance of the study.

**Overview of the Issues**

In 1998 the U.S. Department of Health and Human Services Office of Minority Health (OMH), in conjunction with the Agency for Healthcare Research and Quality (AHRQ), sponsored a study to examine how cultural competence affects healthcare delivery and health outcomes. The study resulted in the development of national standards for culturally and linguistically appropriate services (CLAS) in healthcare (Fortier & Bishop, 2003). In August 2000, President Clinton signed Executive Order 13166 which instructed all federal agencies to draft plans to “improve access to federally conducted or federally assisted programs for persons who, as a result of national origin, are limited in their English proficiency” (Executive Order No. 13,166, 2000). According to the OMH website (2013):

Cultural competency is one of the main ingredients in closing the disparities gap in healthcare. It’s the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, healthcare services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes. Culture and language may influence:

- health, healing, and wellness belief systems;
- how illness, disease, and their causes are perceived; both by the patient/consumer and
- the behaviors of patients/consumers who are seeking healthcare and their attitudes toward healthcare providers;
- as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the healthcare delivery service industry in this
country. The provider and the patient each bring their individual learned patterns of language and culture to the healthcare experience which must be transcended to achieve equal access and quality healthcare. (para. 2)

Continued disparities in health outcomes caused Congress to initiate the IOM study (2003) to assess differences in the kinds and quality of care received by U.S. racial and ethnic minorities and nonminorities. Specifically, Congress requested the following:

- Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);
- Evaluate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and,
- Provide recommendations regarding interventions to eliminate healthcare disparities. (IOM, 2003, p. 3)

The findings created a national frenzy. Figure 1.1 represents a visual of the findings.

![Figure 1.1. Visual of Findings by IOM Study (IOM, 2003, p. 4)](image)

The IOM study committee stated in their report, “The committee finds strong evidence for the role of bias, stereotyping, prejudice, and clinical uncertainty from a
range of sources, including studies of social cognition and ‘implicit’ stereotyping, and urges more research to identify how and when these processes occur” (IOM, 2003, p. 178). The recommendations of IOM were that efforts should focus on three broad levels:

1. Healthcare systems changes, specifically legal and regulatory changes
2. Healthcare worker cultural competence to address implicit prejudices, stereotyping, and bias
3. Patient centered care—care that sought to understand appropriateness from the patient’s perspective

Thus a call to change was issued—from government agency reimbursement requirements (e.g., Medicare and Medicaid reimbursements to healthcare agencies and providers), to enhancing standards of quality care for culturally and linguistically diverse populations (e.g., Health and Human Services Standards), to assessment of quality care (e.g., Joint Commission Standards, AHRQ studies), to training and preparation requirements in medical and health schools around the country by accrediting agencies.

Statement of the Problem

The call to change is really a call to transform—transforming the healthcare delivery system to a new system that has not existed before. This is a difficult—and some would argue impossible—call. I would say it is difficult, yet not impossible. Transformation of a large system (such as the healthcare delivery system) will require transformation of multiple organizations and smaller systems (Bass & Avolio, 1994). These organizational transformations will not come to fruition without individual transformation; individual transformation will be necessary to bring forth organizational transformation (Bass & Riggio, 2005). Individual transformation in worldview is
typically a product of growth and development (Hammer et al., 2003). As individuals grow in their understanding of the complexity of human behavior and how culture influences beliefs, attitudes, and biases, they are able to develop in intercultural sensitivity (Bennett, 1993).

Development requires intentionally taking a deep dive and evaluating one’s beliefs, values, biases, stereotypes, and assumptions held as truths on multiple levels: macrocultural level (national and/or regional), microcultural level (organization or educational institution), and individual level (familial). This developmental work takes time, can be painful, and involves a willingness to accept ambiguity with the ever-changing patient population (Gardenswartz, Cherbosque & Rowe, 2010).

Historically, much of the education and training of healthcare providers’ cultural competence has focused on having cultural knowledge and gaining cultural encounters with a variety of cultures that the provider may encounter (Campinha-Bacote, 2002; Leininger & MacFarland, 2002; Papadopoulos, 2003). Even though the IOM researchers stated that disparities in health outcome is partially due to provider discrimination, bias, stereotyping and uncertainty, there have been few empirical studies that have identified a process for development (Altshuler, Sussman, & Kachur, 2003; Huckabee & Matkin, 2012); explicitly, studies that are seeking to answer how the developmental level of intercultural sensitivity of healthcare educators affect the development of future healthcare providers in a measurable way. This has created a gap in effectively preparing healthcare providers for caring for patients in the 21st century.

In order to become culturally competent, healthcare providers need to be educated in environments that have created a climate of respect for diversity—a climate where
faculty and staff, as well as students, are recruited with their differences viewed as assets
to be integrated to enhance organizational effectiveness rather than issues to be detached
in order to be assimilated into the organization (Douglas et al., 2011). Future healthcare
workers are not able to develop this level of cultural competence unless they are taught
and led in the process in colleges, and by faculty and staff who are developmentally able
to teach and engage students in a process of growth and development that is
transformational in nature (Campinha-Bacote, 2002; Long, 2012).

**Purpose of the Study**

The purpose of this sequential explanatory mixed methods study was to examine
the intercultural sensitivity development process of faculty and staff at a health sciences
college in the Midwest. Specifically, this study investigated how the developmental level
of intercultural sensitivity (as measured by IDI) of participants (faculty and staff of the
college) was linked to PsyCap, a multidimensional construct consisting of hope, efficacy,
resiliency, and optimism (Luthans, Youssef et al., 2007), while exploring the approach to
development.

Sequential explanatory mixed methods design is a two-phase design. The “overall
purpose of this design is that qualitative data helps explain or build upon initial
quantitative results” (Plano-Clark & Creswell, 2007, p. 71). This design was well suited
for this research because we were looking to obtain information through qualitative
interviews that will helped us understand the results we saw in IDI developmental
changes. Figure 1.2 is a visual of the explanatory design.
In the quantitative phase, the data explored the relationship between faculty and staff developmental level of intercultural sensitivity and psychological capital by obtaining quantitative results through the administration of two assessments: the IDI which is a measure of the developmental level of intercultural sensitivity (Hammer et al., 2003); and PsyCap which is a multidimensional construct consisting of hope, efficacy, resiliency, and optimism (Luthans, Youssef et al., 2007). The guiding question for the quantitative phase of the study was:

1. Is there a relationship between growth in intercultural sensitivity and PsyCap?

In the qualitative phase, the case study (Yin, 2009) provided the opportunity to gain an “in-depth understanding of the case” (Creswell, 2013, p. 98). In this situation, the case study boundaries were the faculty and staff of a college of health sciences’ process of intercultural sensitivity development. Most often a case study is utilized when studying a current real-life situation (Creswell, 2013). This was accomplished by conducting semistructured interviews with purposefully selected participants. Using maximum variation sampling to select participants was utilized to obtain different perspectives (for analysis of the data) to obtain greater interpretation of the quantitative data gathered in the first phase (Creswell, 2013). Therefore, the purpose of this qualitative case study was to understand what happened that led to changes in developmental level of intercultural sensitivity for each participant. The questions that drove this study were:
1. What did the participants experience in their personal and professional life?

2. How did they make sense of those experiences?

3. How do they describe their efforts in growing in developmental level of intercultural sensitivity?

4. What challenges did they experience in the process of developing intercultural sensitivity?

5. What do they consider to be the impact of the diversity and cultural competence initiative at the college?

Ultimately the process of collecting quantitative data, analyzing it, selecting participants for the qualitative inquiry, and interviewing them to identify themes enabled the researcher to obtain information that were merged together to provide answers to the following mixed methods questions:

1. How does the qualitative case study create a more complete explanation of the changes in IDI developmental scores and the relationship to PsyCap?

2. How does the qualitative case study explain the changes in organizational structures that support developmental growth in faculty and staff?

**Definition of Terms**

*Cultural competence* in healthcare is “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989, p. 28).
Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (U.S. Department of Health and Human Services, 2000).

Intercultural sensitivity, for the purposes of this study, is defined as “the ability to communicate effectively in cross-cultural situations and to relate appropriately in a variety of cultural contexts” (Bennett, 1993, p. 22).

Intercultural sensitivity development, for the purposes of this study, is defined as “development through stages of personal growth on a continuum of increasing sophistication in dealing with cultural difference moving from ethnocentrism through stages of greater recognition and acceptance of difference ethnorelativism” (Bennett, 1993, p. 22).

Intercultural Development Inventory (IDI) is the name of the instrument used for measuring an individual’s developmental level of intercultural sensitivity. It is a valid and cross-culturally reliable assessment (Hammer et al., 2003).

Psychological capital is a:

. . . measure of an individual’s positive psychological state of development and is characterized by: (1) having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (optimism) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and (4) when beset by problems and
adversity, sustaining, and bouncing back and even beyond (resilience) to attain success. (Luthans, Youssef et al., 2007, p. 3)

**Delimitations and Limitations of the Study**

Delimitations of the study include:

1. The study was confined to the faculty and staff of one college. The uniqueness of this study within the specific context makes it difficult to replicate exactly in another context (Creswell, 2013).

2. Participants’ responses were reflections of, and limited to, their personal experiences in their position within the organization.

Limitations of the study include:

1. Because the participants of the study are all in one region of the country, the researcher cannot say with confidence the sample was representative of the population (Creswell, 2013).

2. In the quantitative phase of the study there was, risk of a nonresponse error, such as problems caused by differences between participants who responded and those who chose not to respond, that led to a lower than anticipated response rate (Creswell, 2013).

3. Because of the nature of qualitative research, the information obtained in the second phase of the study may be interpreted differently by different readers.

4. Because of the interpretative nature of the qualitative research, the researcher may have introduced her bias into the analysis of the findings.
5. There is a potential for bias in the qualitative results interpretation, because the researcher was a former employee of the organization and has familiarity with the strengths and weaknesses of the organization.

**Significance of the Study**

This study was the first known study to explore the relationship between growth in developmental levels of intercultural sensitivity (as measured by IDI) and psychological capital (as measured by the cross-cultural PsyCap). The results of this study could have significant impact on the way faculty and staff continue their own growth and development as a process for preparing healthcare workers for clinical practice with diverse populations.

Developing intercultural sensitivity has many benefits to those providing the care and those receiving care. The empirical studies of PsyCap indicate that positive psychological capital is developable (Luthans, Avey, Avolio, Norman, & Combs, 2006; Luthans, Avey, Avolio, & Peterson, 2010). If we are able to show that positive psychological capital aids in growing the developmental level of intercultural sensitivity (as measured by IDI), we can potentially impact the success of cultural competence initiatives in health sciences colleges, and potentially aid in the reduction of the gap in disparities in health of many populations in our nation.

According to OMH, while different stakeholders will study and want different outcomes, it is possible to link together a series of intermediary outcomes that contribute to health status improvements and cost savings. For example:

**CLAS →** better communication (measured by comprehension, satisfaction, etc.) creates
better adherence to medications and lifestyle changes which can lead to
improved health status which will
lower undesirable healthcare use (ER visit, hospitalization, etc.)

The AHRQ states that studying cultural competence and the clinical encounter (e.g., patients, families, and clinical staff) may have more interest in the impact that cultural competence interventions have on what are often called intermediary outcomes (e.g., comprehension, satisfaction, adherence to medication and lifestyle recommendations, appropriate utilization) (AHRQ, 2004). Figure 1.3 represents how this study could fill some of the gap in the literature. Current research studies are represented in light blue, gaps that exist are represented in orange, and a gap which the present study hopes to address is represented in red.

Figure 1.3. Significance of the Study
TABLE 1.1. DISSERTATION MAP
Sequential Explanatory Mixed Methods Design and Procedures

<table>
<thead>
<tr>
<th>Phase</th>
<th>Procedure</th>
<th>Product</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative Data Collection</td>
<td>(N=52)</td>
<td>1. IDI</td>
<td>July-Aug 2013</td>
</tr>
<tr>
<td></td>
<td>• Web based assessment</td>
<td>2. Cross-Cultural PsyCap</td>
<td></td>
</tr>
<tr>
<td>Quantitative Data Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeated Measure Analysis of Variance (ANOVA)</td>
<td>• SPSS quantitative software</td>
<td>Sep-Oct 2013</td>
</tr>
<tr>
<td></td>
<td>• Correlational Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Study</td>
<td>(N=10)</td>
<td>• Case Study</td>
<td>Oct 2013</td>
</tr>
<tr>
<td>Participant Selection</td>
<td>• Maximum variation sampling of participants for case studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualitative Data Collection</td>
<td></td>
<td>• Recorded Interviews Transcribed</td>
<td>Oct-Nov Dec 2013</td>
</tr>
<tr>
<td>Qualitative Data Analysis</td>
<td></td>
<td>• In Vivo Coding of transcription</td>
<td>Jan 2014</td>
</tr>
<tr>
<td></td>
<td>• Semi-structured individual interviews with participants</td>
<td>• Member checking and coding verification</td>
<td></td>
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<td></td>
<td>• Review of college initiative</td>
<td></td>
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<td></td>
<td>• Reviewing open ended statements made by participants in the IDI</td>
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<tr>
<td></td>
<td></td>
<td>• Coding and Thematic analysis</td>
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<td>• Within case and across case theme development</td>
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<td></td>
<td>• Explanation of the meaning of the quantitative results</td>
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<td></td>
<td>• Interpretation of the meaning of cases</td>
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<tr>
<td></td>
<td></td>
<td>• Discussion</td>
<td>Feb-Mar 2014</td>
</tr>
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<td>• Recommendation for future studies</td>
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<tr>
<td>Side-by-Side Mixed Methods</td>
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<tr>
<td>Analysis</td>
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CHAPTER II

REVIEW OF LITERATURE

This chapter begins by exploring research regarding the importance of cultural competence in healthcare. The setting for this study will be presented next, followed by current approaches to cultural competence in healthcare providers, systems, and healthcare educators. Next, the relevant literature regarding the Developmental Model of Intercultural Sensitivity (DMIS) and the IDI will be presented along with research on PsyCap. The two are explored and linked to workplace effectiveness and employee performance. Finally, the chapter will end with gaps in literature, hypotheses for the quantitative phase, and the research questions for both the qualitative and mixed methods phases.

Importance of Cultural Competence in Healthcare

The World Health Organization (WHO) states that nurses are the largest group of healthcare professionals in the world with a total of 19.3 million midwives and nurses (WHO, 2011). The current and future nursing (Registered Nurses [RN]) shortage in the world is a global concern. According to the Global Health Workforce Alliance, the critical shortage of all healthcare workers across the world has been classified as one of the most acute limitations to the achievement of global health goals. In the 21st century, the shortage will worsen, health systems will be weakened even further, and health goals will not be achieved. According to the WHO, the world will be short of 12.9 million healthcare workers by 2035; currently, we are short 7.2 million healthcare workers globally (WHO, 2014).
In a recent news release (WHO, 2013) Dr. Marie-Paule Kieny, WHO Assistant Director-General for Health System and Innovation, stated:

The foundations for a strong and effective health workforce for the future are being corroded in front of our very eyes by failing to match today’s supply of professionals with the demands of tomorrow’s populations. To prevent this happening, we must rethink and improve how we teach, train, deploy and pay health workers so that their impact can widen.

At the Third Global Forum for Human Resources for Health Care, Dr. Carissa Etienne, WHO Regional Director for the Americas, stated:

One of the challenges for achieving extensive health coverage is ensuring access to well-trained, culturally-sensitive and competent health care staff. The best strategy for achieving this is by guaranteeing that the education and training of health professionals is aligned with the needs of the population. (WHO, 2013)

The United States population continues to grow in cultural and ethnic diversity. By 2060 the population will be considerably older and more racially and ethnically diverse (U.S. Census Bureau, 2012). The IOM landmark publication, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (IOM, 2003), identified that widespread healthcare disparities exist for culturally and ethnically diverse populations. Since then, there has been an increased focus on reducing health disparities by multiple agencies: American Hospital Association (AHA), Centers for Medicare and Medicaid Services (CMS), The Joint Commission and AHRQ, OMH, and American Academy of Colleges of Nurses (AACN) (Starr, Shattell, & Gonzales, 2011). The call to change confronting racial and ethnic disparities in healthcare is a call to transform the very vast healthcare delivery system to a new system that has not existed before. This is a difficult task. Transforming a large system will require revamping multiple organizations and
systems (Bass & Avolio, 1994). These important organizational changes will not come to fruition without individual transformation (Bass & Riggio, 2005). In order for a large system to change to a system that has not existed before, individuals leading the transformation will need a new worldview to guide their efforts. Individual shift in worldview is typically a product of growth and development (Hammer et al., 2003). As individuals grow in their understanding of the complexity of human behavior and how culture influences beliefs, attitudes, and behaviors, they are able to shift their worldview (Bennett, 1993).

The Setting of this Study

In 2007, in an effort to enhance their general education course offerings, this researcher was asked to develop and teach a course on cultural competence. The researcher agreed to teach the course, if the researcher could assess the students’ level of intercultural sensitivity at the start and end of the semester using the IDI. At that time the college president agreed and suggested using the IDI as a measure for the college’s strategic initiative to grow their students’ level of intercultural competence from entrance to graduation. Her goal was to use this information to enhance the college’s efforts in course offerings for students and training for faculty and staff. The dean of students, the dean of nursing, and the dean of allied health were instrumental in developing an implementation plan for the college-wide initiative.

As the researcher taught the course and worked with students (using the IDI) to develop their level of intercultural sensitivity, students would repeatedly ask if the faculty and staff were being taught this information. When the researcher responded no, they would ask why not. The researcher shared the students’ concerns with the college
leadership, and they felt that it was important for the faculty and staff to also take the IDI and learn its contents. Therefore, in May 2010, all faculty and staff took the IDI and were required to meet with the researcher in a private meeting to understand their individual results (after attending a group result interpretation) and a process for each person’s individual development was discussed. The dean of students had a strong interest and commitment to intercultural sensitivity development and volunteered to spearhead the initiative. This researcher recommended to the college that several key individuals should go through the IDI training to better understand the instrument and learn how to further their efforts at the college level. The dean of students and two faculty members attended the training which resulted in additional momentum for implementing additional college-wide initiatives (i.e., Diversity Advisory Committee made up of leaders from the community, Faculty and Staff Diversity Council, and increased diversity education requirements for faculty and staff).

Since 2010, the developmental scores (as measured by IDI) of graduating students have increased each year. This connects with other research that indicates individuals (faculty and staff in this case) cannot grow others’ (students at this college) level of intercultural sensitivity to a level they themselves have not reached (Bennett, 2004; Long, 2012).

In May 2013, all faculty and staff took the IDI again. The group results were shared again and those interested met with the researcher to discuss changes in their individual results. The interesting issue that came up was that, while all faculty and staff embarked on the same developmental process, some individuals’ developmental level of intercultural sensitivity (DO as measured by IDI) increased, some stayed the same and
some decreased, which leads us to this research. What happened? Why didn’t everyone experience an increase?

**Approaches to Cultural Competence in Healthcare**

The idea of being culturally competent is not new to healthcare. In fact, Dr. Madeline Leininger, a nurse anthropologist, is thought to be the pioneer of this in relation to nurses. Her work in “transcultural nursing,” which began in the 1950s, is widely used in nursing education and by other fields of healthcare (Allen, 2010). Her efforts were to prepare and train nurses with ways to provide culturally meaningful care (De Leon Sianz & Meleis, 2007). “Transcultural nursing is concerned with comparing differences and similarities between cultures regarding caring values and life practices to predict care needs of individuals and promote culturally fitting care” (Allen, 2010, p. 315).

Transcultural nursing defines culture as “attitudes, values, beliefs and life practices learned and shared by people in a particular social group which are passed on down generations affecting individuals’ thinking and actions” (Allen, 2010, p. 315). Leininger (2002) emphasizes culture-specific care which refers to nurses’ understanding of caring actions, healthcare information and knowledge, including folk healing practices, particular to each culture in order to provide care matching a person’s healthcare needs.

The call to organizations and schools was to develop “cultural competence” as a core competence for all current and future healthcare providers (Betancourt, 2003; Douglas et al., 2011; Giger et al., 2007; IOM, 2003). While cultural intelligence (CQ) is a heavily used model in the business sector, the most heavily used models of cultural competence in healthcare come from the transcultural nursing paradigm. Three models most often cited in healthcare research are (a) Campinha-Bacote’s (2002) model of
cultural competence process, (b) Giger and Davidhizar’s (2002) transcultural assessment model, and (c) Purnell’s (2002) transcultural assessment model. These models similarly focus on cultural competence defined as meaningful and helpful care for people from different cultural backgrounds founded in knowledge of specific cultural beliefs, attitudes, and practices. Further exploration of each model follows.

Campinha-Bacote’s (2002) model focuses on cultural competence as a process. The model “requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent” (p. 181). Campinha-Bacote defines cultural competence as “the ongoing process in which the health care professional continuously strives to achieve the ability and availability to effectively work within the cultural context of the client” (p. 181). The model has five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. Cultural awareness is the process of assessing one’s own biases, investigating professional background, and being aware of discrimination in healthcare. In cultural knowledge, the provider acquires knowledge of worldviews of different cultural and ethnic groups. Cultural skill is the ability of the provider to do a cultural assessment (including physical assessment) of their patient. Cultural encounter promotes face-to-face exchanges with clients from culturally diverse backgrounds. This is to encourage challenging biases about a particular cultural group and to reduce the likelihood of stereotyping. Cultural desire gets at the reason to want to engage in the process of becoming culturally aware, knowledgeable, and skillful in seeking cultural encounters. Campinha-Bacote states:

. . . Cultural desire is an essential component of establishing cultural competence. Without a desire to engage in the process of cultural competence, the process therefore may become fragmented at best. Lack
of cultural desire may impede the ability to meet the cultural needs of others. (Montenary, Jones, Perry, Ross, & Zoucha, 2013, p. e52)

The researcher posits that the process by which one gains the desire is through development. While Campinha-Bacote’s model is a comprehensive model for how healthcare organizations and educational institutions should frame their work of cultural competence, it doesn’t fully explore the developmental readiness (gaining desire) of those in leadership positions to embrace and embark on the implementation of this model in their organization.

Giger and Davidhizar’s (2002) model is mostly focused on assessment of patients as unique cultural beings. The model suggests “that each individual is culturally unique and should be assessed according to six cultural phenomena: communication, space, social organization, time, environmental control, and biological variations” (p. 185). Communication in the model covers every facet of communication and is considered the way culture is shared and continued. Giger and Davidhizar believe that communication (both verbal and nonverbal) is typically the reason for the most significant problems in working with individuals from diverse cultural backgrounds. Space, in this model, refers to the distance between individuals when they interact, recognizing that all communication occurs within space. The authors follow Hall’s zones of interpersonal space: intimate, personal, social and consultative, and public. They believe that rules concerning personal distance vary from culture to culture and that individuals have their own approach to space stemming from cultural norms. Violation of an individual’s space will cause discomfort and could potentially end up in how the individual proceeds with decisions regarding care. Next is social organization, which denotes the way a group
organizes themselves; “Family structure and organization, religious values and beliefs, and role assignments may all relate to ethnicity and culture” (Giger & Davidhizar, 2002, p. 185). The authors’ approach to time is as a component of interpersonal communication. The emphasis in this model is how different cultures approach their communication when it comes to time—either past, present, or future orientation. Recognizing the approach to preventive healthcare, while motivated by future orientation (a particularly Western approach to time), can be a limiting factor in some patients’ approach to life. The model continues with environmental control, which refers to the locus of control. Many people from the United States believe their locus of control is internal, meaning if they want to go to the doctor, they will. Much of the rest of the world believes that there is an external locus of control and, as such, seeking healthcare is viewed as useless because whatever is going to happen, will happen. The last component of the Giger and Davidhizar (2002) model is the idea of biological differences. This component recognizes that there are genetic variations between individuals in different racial groups, while recognition of cultural differences is most often cited:

Less recognized and understood are the biological differences that exist among people in various racial groups. Although there is as much diversity within cultural and racial groups as there is across and among cultural and racial groups, knowledge of general baseline data relative to the specific cultural group is an excellent starting point to provide culturally appropriate care. (Giger & Davidhizar, 2002, p. 187)

In the end, this model is centered on factors that a provider must take into consideration in order to provide care that is culturally relevant. This model “builds on the seminal work of Dr. Madeleine Leininger and others in space phenomena, communication, and anthropology” (Giger & Davidhizar, 2002, p. 187). This model does
not address the underlying developmental readiness of the provider to engage in learning about and using this model for assessment.

Purnell’s (2002) model was originally created as a framework for organizing cultural assessment.

Later, a schematic, the metaparadigm concepts, and the cultural competence scale were added. Because the model has a schematic combined with an organizing framework and because it is applicable to all health care disciplines in all practice settings, it has been classified by some nurse theorists as complexity and holographic theory. (p. 193)

There are 12 domains (each a piece of a pie) that make up the pie-shaped framework. Along with that, there are four rims that encircle the pie-shaped framework: the outer farthest rim depicts the role of the global society, the next rim represents the role of the community, the third rim depicts the role of family, and the last rim is the individual. These rims are considered the metaparadigm concept. Each cultural domain (construct) is represented in one of the 12 pie-shaped wedges. Although the 12 domains and their concepts go from more general to more specific, the order that the provider uses the domains can fluctuate. The following is a brief description of the 12 domains and their major concepts.

**Overview/heritage** includes concepts related to the country of origin, current residence, and the effects of the topography of the country of origin and current residence, economics, politics, reasons for emigration, educational status, and occupations.

**Communication** includes concepts related to the dominant language and dialects; contextual use of the language; paralanguage variations such as voice volume, tone, and intonations; and the willingness to share thoughts and feelings. Nonverbal communications such as the use of eye contact, facial expressions, touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, or future worldview orientation; clock versus social time; and the use of names are important concepts.
Family roles and organization includes concepts related to the head of the household and gender roles; family roles, priorities, and developmental tasks of children and adolescents; child-rearing practices; and roles of the aged and extended family members. Social status and views toward alternative lifestyles such as single parenting, sexual orientation, childless marriages, and divorce are also included in this domain.

Workforce issues include concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, individualism, and health care practices from the country of origin.

Biocultural ecology includes variations in ethnic and racial origins such as skin coloration and physical differences in body stature; genetic, hereditary, endemic, and topographical diseases; and differences in how the body metabolizes drugs.

High-risk behaviors include the use of tobacco, alcohol, and recreational drugs; lack of physical activity; nonuse of safety measures such as seatbelts and helmets; and high-risk sexual practices.

Nutrition includes having adequate food; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used during illness and for health promotion and wellness.

Pregnancy and childbearing practices include fertility practices; methods for birth control; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum treatment.

Death rituals include how the individual and the culture view death, rituals and behaviors to prepare for death, and burial practices. Bereavement behaviors are also included in this domain.

Spirituality includes religious practices and the use of prayer, behaviors that give meaning to life, and individual sources of strength.

Health care practice includes the focus of health care such as acute or preventive; traditional, magicoreligious, and biomedical beliefs; individual responsibility for health; self-medicating practices; and views toward mental illness, chronicity, and organ donation and transplantation. Barriers to health care and one’s response to pain and the sick role are included in this domain.

Health care practitioner concepts include the status, use, and perceptions of traditional, magicoreligious, and allopathic biomedical health care providers. In addition, the gender of the health care provider may have significance. (Purnell, 2002, pp. 195-196)

Purnell (2002) posits that, “The domains do not stand alone; each domain relates to and is affected by all other domains” (p. 195). Along the bottom of the model is “an erose (saw-toothed) line representing the concept of cultural consciousness” (p. 196). The
line depicts movement of the provider (or organization) from unconsciously incompetent to consciously incompetent, to consciously competent and ends with unconsciously competent. Dr. Purnell believes that this model can be applied in a variety of contexts and can guide development of assessment tools.

Multiple studies have looked into developing cultural competency in students using one or more of the above models (Allen, 2010; Bednarz, Schim, & Doorenhos, 2010; Comer, Whichello, & Neubrander, 2013; Douglas et al., 2011; Giger et al., 2007; Long, 2012). Since the focus of education in health science programs has mostly been on preparation for clinical practice, much of the education and training of healthcare providers’ cultural competence has focused on having cultural knowledge and gaining cultural encounters with a variety of cultures that the provider may encounter (Long, 2012). The IOM researchers stated that disparities in health outcome are partially due to provider discrimination, bias, stereotyping, and uncertainty. However, there have been few empirical studies that have identified a developmental process as a necessary piece of the cultural competence education (Altshuler et al., 2003; Huckabee & Matkin, 2012).

Altshuler et al. (2003), believing that intercultural sensitivity is a predictor of the attitude of the provider in intercultural encounters, used the developmental approach to assess pediatric resident trainees’ developmental level prior to and after intercultural training interventions. They discovered that the developmental level of the participants impacted the effectiveness of the type of intervention.

Huckabee and Matkin (2012), in a study of students graduating from a physician assistant program, found that the students were highest in minimization developmental stage, which emphasizes cultural commonality over cultural distinctions. Enhanced
curricular instruction—such as exploring cultural assessment methods and controversies in healthcare differences, combined with increased clinical experiences with diverse cultures—was recommended to help move students past the minimization stage to gain greater cultural competency.

In a study of how nursing students are being prepared, Long (2012) identified that there is little empirical evidence that developing cultural competence, while a goal of accreditation and approval boards of nursing, has been effective. This has created a gap in effectively preparing healthcare providers for caring for patients in the 21st century.

In order to become culturally competent, healthcare providers need to be educated in environments that have created a climate of respect for diversity (Long, 2012). Such a climate is fostered when faculty and staff, as well as students, are recruited whose differences are regarded as assets to be integrated to enhance organization effectiveness rather than issues to be confronted (Douglas et al., 2011). According to Long (2012), future healthcare workers are not able to develop this level of cultural competence unless they are taught and led in the process. Development will need to occur in colleges, and by faculty and staff who are developmentally able to teach and engage students in a process of growth and development that is transformational in nature (Monteny et al., 2013).

As health sciences colleges seek ways to prepare graduates to live in and contribute to an increasingly global society, they are enhancing their efforts on how to effectively teach the constructs of cultural competence (Comer et al., 2013; De Leon Siantz, 2008; Long, 2012). This has created a body of research that shows effective cultural competence needs to start with educators. Therefore, to teach diverse student populations in an effective manner that ensures their success, health sciences colleges
must embark on a comprehensive process for this level of transformation in their faculty and staff (Montenery et al., 2013; Sealey, Burnett, & Johnson, 2006; Starr et al., 2011). According to Long (2012), “The overall goal for any educational program teaching cultural competence is to equip faculty with the needed knowledge and skills to understand ethnic and cultural differences” (p. 103).

Barriers to the provision of culturally competent care have been cited that have little to do with content knowledge and more to do with the provider’s personal beliefs and values. Changing the habitual beliefs and behaviors of adults is difficult when the changes require them to first confront their personal biases, stereotypes and assumptions. (Comer et al., 2013, p. 90)

A few studies have looked at faculty level of cultural competence in healthcare as an antecedent to student cultural competence (Sealey et al., 2006; Wilson, Sanner, & McAllister, 2010). Sealey et al. (2006) identified that faculty should be urged to participate in continuing education programs on cultural competence to improve their knowledge. They stated that the continuing education programs need to be combined with cross-cultural encounters to substantially improve overall cultural competence. The study conducted by Wilson et al. (2010) indicated that cultural competence in faculty is a process and that new knowledge must be part of that process.

While Campinha-Bacote’s (2002) model, Giger and Davidhizar’s (2002) model, and Purnell’s (2002) model are all needed and have merit, none of them looks at the developmental level necessary prior to engaging with people from all walks of life. Campinha-Bacote’s model comes closest, specifically the part of the model that speaks to cultural desire. Even so, to date no studies were found that looked to see if increasing the developmental level of intercultural sensitivity (using the IDI) of faculty and staff (in
health sciences) leads to creating an educational environment that enhances cultural competence of graduating students. While the latter is beyond the scope of this particular research study, the former provides opportunity for a rich study by itself. The developmental level of healthcare faculty and staff will drive their desire to create environments that enhance the students’ ability to grow in cultural competence. The IDI is a valid and reliable measure of developmental level.

**Developmental Model of Intercultural Sensitivity**

According to Bennett (1993), intercultural sensitivity is the extent to which an individual internalizes differences as a way of managing interactions with diverse others, reaching an understanding that cultures vary profoundly in the way they shape worldviews. “The underlying assumption of [intercultural sensitivity development] is that as one’s *experience of cultural difference* becomes more sophisticated, one’s competence in intercultural relations increases” (Bennett & Bennett, 2004, p. 152).

Milton Bennett’s DMIS (1986) assumes that as intercultural challenges cause one’s experiences of cultural difference to become more complex, one’s ability to be sensitized to difference increases in intercultural encounters. Bennett’s model was based on observations and interactions with individuals as they learned to become more competent communicators in environments with multiple cultures. The model identifies culture as any group with a set of similar constructs. Therefore, the intent of the model is not limited to racial, cultural, and ethnic diversity. Rather, all forms of diversity and differences among individuals may be included in this definition.

The six stages of the DMIS represent an ordinal scale in which each stage is characterized by increasing sensitivity to cultural difference. As one’s experience of
cultural difference becomes more complex, one’s competence in intercultural relationships is strengthened. In Bennett’s (1986) model the first three stages are ethnocentric (e.g., one’s own culture is experienced as central to the understanding of others). The second three stages are ethnorelative (e.g., one’s own culture is experienced within the context of other cultures). Bennett conceptualizes intercultural sensitivity as a continuum ranging from an ethnocentric perspective to a more ethnorelative worldview.

While Bennett’s (1986) DMIS is seminal to understanding development and growth in intercultural sensitivity and Hammer et al.’s (2003) IDI expands it by creating a valid and reliable assessment for measuring developmental levels, “it does not assume that progression through the stages is one-way or permanent” (Bennett, 1993, p. 7).

Bennett (2004) states that:

The most basic theoretical concept in the DMIS is that experience (including cross-cultural experience) is constructed. This is the central tenant of cognitive constructivism, which holds that we do not perceive events directly. Rather, our experience of events is built up through patterns or categories that we use to organize our perception of phenomena. (pp. 72-73)

Therefore, meaning-making of experiences happens at the developmental level of the individual (Bennett, 1993).

Ayas’ (2006) mixed method study of third-year medical students found that while there was no relationship between international experience and changes in perceived developmental levels of intercultural sensitivity, participants agreed that active participation, reflection and dialogue, and open mindedness were a few of the factors related to effective intercultural experience. Lundgren’s (2007) study, exploring the developmental process of teachers, indicated that professional development experiences
are enhanced through cohorts of learners, especially school-based cohorts with administrative support. Moodian’s (2009) study found that participants’ developmental levels of intercultural sensitivity actually declined from the second time to the first time. Moodian explained that the potential correlation between stress and decreased intercultural sensitivity could have been a factor in the participants’ developmental level. In another study by Li (2010) with a group of Canadian healthcare executives, while the executives were highly motivated leaders, they were not able to make progress in intercultural sensitivity development on a personal or organizational level. After further investigation, she found that the executives actually accumulated more fear after IDI assessment and training.

While experience is a valuable teacher, it is not just experience that leads to intercultural sensitivity development, but rather how meaning is given to the experience. As an individual continues to grow in intercultural sensitivity development, they recognize the complexity of culture and how deeply rooted it is in their own life. The ability to create meaning from experiences with diverse populations progresses as the developmental level increases (Bennett, 1986). Development is therefore not marked by what one thinks about an intercultural situation; it is indicated by how one thinks about that experience. Christopher and Hickinbottom (2008) stressed that individuals must be aware of their own cultural assumptions, otherwise they will be “doomed to being narrow and ethnocentric as long as they remain unaware of the cultural assumptions underlying their work” (p. 565). An appropriate measure of developmental level of intercultural sensitivity is the IDI (Hammer, 2009; Hammer et al., 2003; Paige, Jacobs-Cassuto, Yershova, & DeJaeghere, 2003). The IDI is based on the DMIS theoretical framework. It
is a 50-item inventory created to measure individuals’ orientations toward cultural differences. In creating the IDI, Hammer et al. (2003) believed that “the crux of the development of intercultural sensitivity is attaining the ability to construe (and thus to experience) cultural difference in more complex ways” (p. 423).

This study used Milton Bennett’s (1993) developmental model of intercultural sensitivity for the following reasons: (a) development requires intentional introspection comprising of evaluating one’s beliefs, values, biases, stereotypes, and assumptions held as truths on multiple levels (Comer et al., 2013); (b) individual transformation is an antecedent to organizational transformation, further individual transformation in worldview is typically a product of growth and development (Bass & Riggio, 2005; (c) development will need to occur in colleges, and by faculty and staff who are developmentally able to teach and engage students in a process of growth and development that is transformational in nature (Long, 2012); (d) Bennett, together with Hammer and Wiseman (Hammer et al., 2003), designed a survey instrument to empirically measure an individual’s intercultural sensitivity development consistent with Bennett’s understanding of that process. The IDI facilitates the examination of the developmental gains of concern in this study.

Bennett’s DMIS is seminal to understanding development and growth in intercultural sensitivity, and Hammer et al.’s IDI expands it by creating a valid and reliable assessment for measuring developmental levels. Neither addresses the underlying psychological state necessary for an individual to grow along the continuum.
Psychological Capital

Luthans, Youssef et al. (2007) “use the term *psychological capital* to represent individual motivational propensities that accrue through positive psychological constructs such as efficacy, optimism, hope, and resilience” (p. 542). They begin by expanding on the work of positive psychologist Csikszentmihalyi who stated (as cited in Luthans, Youssef et al., 2007) that:

. . . positive psychological state is a capital that is developed through a pattern of investment of psychic resources that results in obtaining experiential rewards from the present moment while also increasing the likelihood of future benefit . . . When you add up the components, experiences and capital, it makes up the value. (p. 542)

Luthans, Youssef et al.’s (2007) formal definition of psychological capital (or PsyCap) is:

. . . an individual’s positive psychological state of development that is characterized by: (1) having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (optimism) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (resilience) to attain success. (p. 3)

Each of the four states of PsyCap, which Luthans, Youssef et al. (2007) describe, has a theoretical basis.

1. Self-efficacy is founded on the work of Albert Bandura and his social cognitive theory. PsyCap self-efficacy is defined as the “individual’s conviction . . . about his or her abilities to mobilize the motivation, cognitive resources, and courses of action needed to successfully execute a specific task within a given context” (p. 38).
2. Hope based on Snyder’s work, is defined as “a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-oriented energy) and (b) pathways (planning to meet goals)” (p. 66).

3. Optimism is primarily founded in the work of Seligman and Csikszentmihalyi. PsyCap optimism is defined as “two crucial dimensions of one’s explanatory style of good and bad events: permanence and pervasiveness” (p. 91).

4. Rooted in Coutu’s work, resilience in PsyCap is defined as “the capacity to rebound or bounce back from adversity, conflict, failure, or even positive events, progress, and increased responsibility” (p. 112).

Multiple empirical studies have shown that the four components of PsyCap have positive relationships with performance, happiness, well-being, and satisfaction of workers (Avey, Reichard, Luthans, & Mhatre, 2011; Luthans, Norman, Avolio, & Avey, 2008). Employees’ optimism is related to their performance, satisfaction, and happiness (Youssef & Luthans, 2007). Hope is related to employees’ performance, satisfaction, happiness, and retention (Youssef & Luthans, 2007). Resiliency has a positive relationship with employee performance and happiness and satisfaction (Youssef & Luthans, 2007). The literature confirms the importance of workplace PsyCap as a higher-order construct with impact on organizational outcomes such as performance and productivity (Luthans et al., 2010). Further, in a meta-analysis of PsyCap, Avey et al. (2011) found a relationship between PsyCap and both positive and negative workplace measures.

This study sought to also understand the relationship between intercultural sensitivity development change and PsyCap. Luthans’ PsyCap is the other theoretical
model that informed this study. PsyCap is the positive psychological state of development of individuals. It is a higher order construct made up of hope, efficacy, resilience, and optimism. PsyCap has positive correlation with performance and satisfaction (Luthans, Avolio, Avey, & Norman, 2007) and mediates between supportive climate and performance (Luthans et al., 2008).

Pajares (1995) stated that the higher the sense of efficacy, the greater the effort, persistence, and resilience. Self-reflection leads to the development of resilience (Sesma, Mannes, Scales, 2005). Self-reflection increases the likelihood of producing higher developmental levels of intercultural sensitivity (Bennett, 1993). Thus, an individual’s resilience and persistence are strongly related to their efficacy.

Sense-making from life experiences occurs when there is a balance between experiences that personally challenges the present frame of thinking and enough support to encourage reflection (Klein, Moon, & Hoffman, 2006; Merriam & Clark, 1993). To engage in activities that challenge one’s worldview, the individual needs to be optimistic and hopeful that the experiences that they engage in are supported by their organization and will, in fact, benefit them personally and professionally.

**Linking IDI and PsyCap**

Previous research found that higher PsyCap creates a more satisfying workplace which enhances performance and productivity (Avey et al., 2011; Luthans et al., 2008, 2010; Youssef & Luthans, 2007). Research has also shown that higher developmental level of intercultural sensitivity enhances the relationship between leaders and followers (Matkin & Barbuto, 2012) and between faculty and students (Sealey et al., 2006; Wilson et al., 2010). However, to date there has not been any mixed methods research that has
studied the relationship between changes in developmental level of intercultural sensitivity (as measured by the IDI) and PsyCap.

This study explored the impact of a diversity and cultural competence initiative at a health sciences college. Utilizing a sequential explanatory mixed methods approach, the study occurred in two phases. The first phase was the quantitative phase where the following hypotheses were tested:

*Hypothesis 1:* There will be a significant increase in developmental level of intercultural sensitivity of faculty and staff from 2010 to 2013.

*Hypothesis 2:* There will be a positive relationship between PsyCap score and change in IDI DO.

A visual depiction of the hypotheses is presented in Figure 2.1.

The “overall purpose of explanatory mixed methods design is that qualitative data will help explain or build upon initial quantitative results” (Plano-Clark & Creswell, 2007, p. 71). Therefore, based on the findings in the quantitative phase, participants were selected for the second phase.
Phase 2 was the qualitative phase. The central theme was understanding the experiences that led to changes in the developmental level of intercultural sensitivity. The research question was to ask what occurred in participants during 2010 and 2013 that led to changes in developmental level of intercultural sensitivity. The questions that drove the case study were:

6. What did the participants experience in their personal and professional life?
7. How did they make sense of those experiences?
8. How do they describe their efforts in growing in developmental level of intercultural sensitivity?
9. What challenges did they experience in the process of developing intercultural sensitivity?
10. What do they consider to be the impact of the diversity and cultural competence initiative at the college?

During the mixed methods analysis, the data was merged together to provide answers to the following mixed methods questions:

3. How does the qualitative case study create a more complete explanation of the changes in IDI developmental scores and the relationship to PsyCap?
4. How does the qualitative case study explain the changes in organizational structures that support developmental growth in faculty and staff?

The ultimate goal of using this design was to better understand answers to questions that quantitative data alone would not provide. Therefore, participants were selected for a qualitative inquiry, and findings were merged for analysis to see how the qualitative data explains the quantitative results in a more complete and comprehensive
manner. This type of design works best when the researcher is looking through a pragmatist lens, in which the intent is to understand what worked (Plano-Clark & Creswell, 2007). Mixed methods research works well in real-world and practical applications, as was the case in this study—the college’s approach to increasing the developmental level of intercultural sensitivity of its faculty and staff.

This chapter reviewed the relevant literature regarding DMIS and the IDI, along with research on PsyCap. The two were explored and linked to workplace effectiveness and employee performance. Finally, the chapter ended with gaps in literature, hypotheses for the quantitative phase, and the research questions for both the qualitative and mixed methods phases. The next chapter provides an in-depth look at the research methodology, population, data collection, and data analysis.
CHAPTER III

METHODOLOGY

This chapter presents the research methodology for this study. The purpose of this sequential explanatory mixed methods study was to examine the intercultural sensitivity development process of faculty and staff at a health sciences college in the Midwest. Specifically, this study investigated how the developmental level of intercultural sensitivity (as measured by IDI) of participants (faculty and staff of the college) was linked to PsyCap while investigating the approach to development. Since mixed methods research (MMR) uses the pragmatism worldview where the focus is on “what works, real-world, practice oriented approach” (Creswell & Plano-Clark 2011, p. 40), it was the method that best fit the purpose of the study and most suitable for answering the research question posed.

This chapter is organized in the following manner: First, there will be a discussion of why mixed methods, then who the participants are, and why they were selected. Next will be a discussion of the research design, followed by measures used in the quantitative phase and the approach to the qualitative phase. The chapter ends with data analysis and the process used at each phase of the research.

Why Mixed Methods

MMR is an approach for collecting, analyzing, and mixing quantitative and qualitative data during some phase of the research in a single study (Creswell & Plano-Clark, 2011). The reason for integrating both types of data was that neither quantitative nor qualitative method would completely capture what happened during the 3-year period of interest; specifically, the reason for the change in developmental level of intercultural
sensitivity of the faculty and staff. The qualitative case study method utilized in this study was intended to enhance the quantitative data by offering a more complete picture of the changes in developmental level of intercultural sensitivity and the link to psychological capital. By capturing the voices of the faculty and staff, we gained an in-depth perspective that would have been missed by using only quantitative lens or only a qualitative lens. Therefore, the priority (Creswell & Plano-Clark, 2011) in this study was given to the qualitative approach, because it focused on the explanations of the results obtained in the quantitative phase. This involved extensive data collection in the qualitative phase from multiple sources and a cross-case analysis.

This paper has already established the research in PsyCap and much of the research utilizing the IDI has been quantitative. Also, as presented in the literature review, very little research exists involving intercultural sensitivity level of faculty and staff in health sciences colleges. For that reason, the present study not only advances what is known about developing intercultural sensitivity using the IDI in faculty and staff, but also how PsyCap is linked to this process.

**Population**

The dean of students at a health sciences college had a strong interest and commitment to diversity and cultural competence. She volunteered to spearhead their initiative. In May 2010, all faculty and staff were required to take the IDI. The results were presented at an all-college meeting, and the faculty and staff were told that they were to meet with the researcher in a private one-on-one session to obtain and discuss their individual results. At that time, an individualized development plan was also shared with each person. Later, the dean of students and two faculty members attended the IDI
training which resulted in additional momentum for implementing additional college-wide initiatives (i.e., Diversity Advisory Committee made up of leaders from the community, Faculty and Staff Diversity Council, and increased diversity education requirements for faculty and staff).

Since 2008, the researcher had been administering the IDI with all incoming and graduating students. Interestingly, after the faculty and staff took the IDI, the developmental scores of graduating students began to rise. This connects with other research that indicates individuals (faculty and staff in this case) cannot grow others’ (students at this college) level of intercultural sensitivity to a level they themselves have not reached (Bennett, 2004; Long, 2012).

In May 2013 all faculty and staff took the IDI again. The group results were shared again, and those interested met with the researcher to discuss changes in their individual results. The interesting issue that came up was that while all faculty and staff embarked on the same developmental process, some individuals’ developmental level of intercultural sensitivity (DO as measured by IDI) increased, some stayed the same and some decreased, which lead to this research. What happened? Why didn’t everyone experience an increase?

That question led to the creation of this study. All faculty and staff ($N = 75$) were asked to consider participating in this study. Of the 75 faculty and staff, 52 agreed to participate (69% participation rate). Of the 52 who agreed, 33 had taken the IDI in 2010 and 2013. Therefore, the participants for this study are 33 faculty and staff. In agreeing to participate, they agreed to have their IDI results included as part of the study. This information was external data that was approved by the participating college Internal
Review Board (IRB) (Appendix A1) and by the University of Nebraska-Lincoln IRB (Appendix A2). Table 3.1 provides an overview of the participants. Participants were 31 females and 2 males; 19 faculty and 14 staff. All were Caucasian. The majority of participants (20 of 33) had master’s degrees; of the remaining 13, 9 had a Ph.D. or equivalent and 4 had bachelor’s degrees.

Table 3.1. Participant Demographics (N = 33; 19 Faculty, 14 Staff)

<table>
<thead>
<tr>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>33</td>
</tr>
<tr>
<td>Person of Color</td>
<td>0</td>
</tr>
<tr>
<td>Age Level</td>
<td></td>
</tr>
<tr>
<td>31-40</td>
<td>7</td>
</tr>
<tr>
<td>41-50</td>
<td>6</td>
</tr>
<tr>
<td>51-60</td>
<td>13</td>
</tr>
<tr>
<td>61-over</td>
<td>7</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>4</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>20</td>
</tr>
<tr>
<td>Ph.D. or Equivalent</td>
<td>9</td>
</tr>
</tbody>
</table>

Informed consent was obtained as part of the online PsyCap assessment (Appendix C1). All phases of the study were explained to the participants at that time (Appendix D). They were told that they may be selected to participate in Phase 2 and, if that occurred, they would be notified via email at a later date. Incentives were offered for both phases of the study to encourage participation. Everyone who chose to participate in the first phase of the study had their name put into a drawing for two $50 Amazon gift cards. All participants who participated were entered into that drawing (52 faculty and
staff). For Phase 2, qualitative interviews, participants had their name (14 faculty and staff) put into another drawing for two other $50 Amazon gift cards.

**Research Design**

Sequential explanatory mixed methods design is a two-phase design. The “overall purpose of this design is that qualitative data helps explain or build upon initial quantitative results” (Plano-Clark & Creswell, 2007, p. 71). This design was well suited for this research because we were looking to obtain information through qualitative interviews that would help us understand the results we had seen in IDI developmental changes. The strength in applying this design to this study ensured a more complete explanation of the quantitative findings by sharing the participants’ stories and contexts reflected in those findings. Individuals who scored at extreme levels or had unexpected results were of particular interest in this study, whereas in a quantitative study would be considered outliers and deleted from the analysis.

Figure 3.1 is a visual of the explanatory design.

![Figure 3.1. Visual of the Explanatory Design](image)

In the quantitative phase, the data explored the relationship between changes in faculty and staff DO of intercultural sensitivity and PsyCap. This was accomplished by obtaining quantitative data through the administration of two assessments: the IDI which is a measure of the developmental level of intercultural sensitivity (Hammer et al., 2003);
and PsyCap which is a multidimensional construct consisting of hope, efficacy, resiliency, and optimism (Luthans, Youssef et al., 2007). The guiding question for the quantitative phase of the study was: Is there a relationship between growth in intercultural sensitivity and PsyCap?

In the qualitative phase, the case study (Yin, 2009) provided the opportunity to gain an “in-depth understanding of the case” (Creswell, 2013, p. 98). In this situation, the case study boundaries were the faculty and staff of a college of health sciences in the Midwest in the process of intercultural sensitivity development. Most often, a case study is utilized when studying a current real-life situation (Creswell, 2013). This was accomplished by conducting semistructured interviews with purposefully selected participants to obtain greater interpretation of the quantitative data gathered in the first phase. Therefore, the central theme was understanding the experiences that led to changes in the developmental level of intercultural sensitivity. The research question that guided this phase was: what occurred in participants during 2010 and 2013 that led to changes in developmental level of intercultural sensitivity. The questions (Interview Protocol – Appendix F) that drove the case study were:

1. What did the participants experience in their personal and professional life?
2. How did they make sense of those experiences?
3. How do they describe their efforts in growing in developmental level of intercultural sensitivity?
4. What challenges did they experience in the process of developing intercultural sensitivity?
5. What do they consider to be the impact of the diversity and cultural competence initiative at the college?

Ultimately the process of collecting quantitative data, analyzing it, selecting participants for the qualitative inquiry, and interviewing them to identify themes enabled the researcher to obtain information that was merged together to provide answers to the following mixed methods questions:

1. How does the qualitative case study create a more complete explanation of the changes in IDI developmental scores and the relationship to PsyCap?

2. How does the qualitative case study explain the changes in organizational structures that supported developmental growth in faculty and staff?

Measures

IDI

The IDI was the dependent variable in the quantitative phase of this study (Appendix B2). In this phase we were looking to understand if there is a relationship between the change in IDI Developmental Orientation score and PsyCap score. Hammer et al. (2003) developed the IDI based on Bennett’s (1986) DMIS. The IDI is a 50-item survey (taken through the Internet with a secure username and password) that provides perceived orientation score (where the participant places him/herself) and developmental orientation score (where the instrument places the participant based on responses to questions). The assessment also includes five short-answer questions. The responses to these questions were not used in the scoring, but were there to help qualified administrators explain the findings using scenarios given by the participant in the short-answer questions. This information helped in the qualitative phase. Table 3.2 is a
description of the stages of the IDI (Hammer, 2011) and sample statements from the assessment for each stage.

Table 3.2. Description of IDI Stages and Sample Statements for Each Stage

<table>
<thead>
<tr>
<th>Scale Title</th>
<th>Worldview Definition</th>
<th>Sample Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>An orientation that likely recognizes more observable cultural differences yet may miss the deeper cultural differences, and may avoid or withdraw from cultural differences.</td>
<td>“There would be fewer problems in the world if culturally different groups kept to themselves.”</td>
</tr>
<tr>
<td>Polarization</td>
<td>A judgmental orientation that views cultural differences in terms of “us” and “them.”</td>
<td></td>
</tr>
<tr>
<td>Defense</td>
<td>An uncritical view toward own cultural values and practices, but an overly critical view toward other cultural values and practices.</td>
<td>“Family values are stronger in our culture than in other cultures.”</td>
</tr>
<tr>
<td>Reversal</td>
<td>An overly critical orientation toward own cultural values and practices and an uncritical view toward other cultural values and practices.</td>
<td>“People from our cultures are lazier than people from other cultures.”</td>
</tr>
<tr>
<td>Minimization</td>
<td>An orientation that highlights cultural commonality and universal values and principles that may also mask deeper recognition and appreciation of cultural differences.</td>
<td>“People are fundamentally the same despite apparent differences in cultures.”</td>
</tr>
<tr>
<td>Acceptance</td>
<td>An orientation that recognizes and appreciates patterns of cultural difference and commonality in one’s own and other cultures.</td>
<td>“Many times I have noticed cultural differences in how direct or indirect people are in conversation.”</td>
</tr>
<tr>
<td>Adaptation</td>
<td>An orientation that is capable of shifting cultural perspective and changing behavior in culturally appropriate and authentic ways.</td>
<td>“I often act as a cultural bridge between people from different cultures.”</td>
</tr>
</tbody>
</table>

The IDI is now in its third version.

Developing the IDI (v.1., v.2, v.3) involved a number of protocols, including (1) in-depth interviews of 40 individuals from a variety of cultures and preparation of verbatim transcripts of these interviews, (2) inter-rater reliability testing to determine whether the discourse of the respondents reflects core orientations delineated in Bennett’s (1993)
DMIS model, (3) listing of all statements made by each respondent that are indicative of the agreed-upon developmental orientation followed by a review (for redundancy, word clarity, etc.) of these statements by two, cross-cultural pilot groups, (4) rating of the remaining statements (randomly arranged) by a group of seven cross-cultural experts (expert panel review method) in terms of whether the items clearly reflect an identifiable core orientation, (5) submission of the remaining items to factor analysis (IDI v.1) and confirmatory factor analysis (IDI v.2 and v.3), and (6) content and construct validity testing of the IDI with modified versions of the Worldmindedness Questionnaire and an Intercultural anxiety questionnaire. Additional testing found no significant correlations of the IDI with social desirability (Crown Marlow Social Desirability Index) and no significant systematic effects on the IDI in terms of gender, educational level and age. (Hammer, 2010, p. 2)

In developing version 2:

Confirmatory factor analyses (CFA), reliability analyses, and construct validity tests validated five main dimensions of the DMIS, which were measured with the following scales: (1) DD (Denial/Defense) scale (13 items, \( \hat{\sigma} = 0.85 \)); (2) R (Reversal) scale (9 items, \( \hat{\sigma} = 0.80 \)); (3) M (Minimization) scale (9 items, \( \hat{\sigma} = 0.83 \)), (4) AA (Acceptance/Adaptation) scale (14 items, \( \hat{\sigma} = 0.84 \)); and (5) an EM (Encapsulated Marginality) scale (5 items, \( \hat{\sigma} = 0.80 \)). (Hammer et al., 2003, p. 421)

In 2007, a more comprehensive testing of the IDI across culturally different groups was conducted. The IDI was administered to a cross-cultural sample of 4,763 individuals from 11 distinct, cross-cultural sample groups. These individuals came from a variety of sectors, from both for-profit and non-profit international organizations and educational institutions.

CFA of the data enable empirical distinctions to emerge between the Denial and Defense orientations and between Acceptance and Adaptation perspectives, resulting in the following seven scales: Denial (7 items, \( \hat{\sigma} = .66 \)), Defense (6 items, \( \hat{\sigma} = .72 \)), Reversal (9 items, \( \hat{\sigma} = .78 \)), Minimization (9 items, \( \hat{\sigma} = .74 \)), Acceptance (5 items, \( \hat{\sigma} = .69 \)), Adaptation (9 items, \( \hat{\sigma} = .71 \)), and Cultural Disengagement (5 items, \( \hat{\sigma} = .79 \)).

In addition, two composite measures were created. The Perceived Orientation score, computed using an unweighted formula, reflects where the individual or group places itself along the intercultural development continuum (PO, \( \hat{\sigma} = .82 \)). The Developmental Orientation score (DO, \( \hat{\sigma} = .82 \))
.83) is computed using a weighted formula and identifies the main or primary orientation of the individual or group along the intercultural development continuum. (Hammer, 2010, p. 1)

Because the Developmental Orientation is the perspective the individual or group is most likely to use in situations that involve cultural difference, it is the score that is used in this study.

**PsyCap**

PsyCap served as the independent variable in this study (Appendix B1). Luthans, Youssef et al.’s (2007) formal definition of PsyCap is:

> . . . an individual’s positive psychological state of development that is characterized by: (1) having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (optimism) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (resilience) to attain success. (p. 3)

Each of the four states of PsyCap, which Luthans, Youssef et al. (2007) describe, has a theoretical basis.

1. **Self-efficacy** is founded on the work of Albert Bandura and his social cognitive theory. PsyCap self-efficacy is defined as the “individual’s conviction . . . about his or her abilities to mobilize the motivation, cognitive resources, and courses of action needed to successfully execute a specific task within a given context” (p. 38).

2. **Hope**, based on Snyder’s work, is defined as “a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-oriented energy) and (b) pathways (planning to meet goals)” (p. 66).
3. Optimism is primarily founded in the work of Seligman and Csikszentmihalyi. PsyCap optimism is defined as “two crucial dimensions of one’s explanatory style of good and bad events: permanence and pervasiveness” (p. 91).

4. Rooted in Coutu’s work, resilience in PsyCap is defined as “the capacity to rebound or bounce back from adversity, conflict, failure, or even positive events, progress, and increased responsibility” (p. 112).

Implicit measures are believed to tap a more “authentic” psychological construct while at the same time being less susceptible to known problems with self-report measures such as socially desirable responding (Roberts, Harms, Smith, Wood, & Webb, 2006). Harms and Luthans (2012a) developed the Implicit PsyCap (I-PCQ) to serve as an unconscious driver of thoughts, behaviors, and decisions. Because of the established relationship between the researcher and the participants, the I-PCQ was used for the present study. The purpose was to reduce the social desirability factor that may impede in obtaining authentic responses from the participants.

The I-PCQ uses a “semi-projective technique using written prompts that are followed by normal, short questions scored along a Likert scale” (Harms & Luthans, 2012a, p. 591). Three situational prompts (positive, negative, and ambiguous) are presented to elicit implicit schemas related to positivity and PsyCap. Participants are asked to think of someone (not themselves) and generate stories. The stories are not to be written down, but to be imagined. They are then followed by questions related to the person and their psychological state (Harms & Luthans, 2012a).

In a follow-up study, the I-PCQ was shown to have positive correlation:
with the scores on the self-report measure of PsyCap, PCQ (Sample 1 n = 291: \( r = .40, p < .001 \); Sample 2 n = 226: \( r = .43, p < .001 \)) indicating convergent validity of the two scales. The correlations were low enough to indicate discriminant validity of the two measures of PsyCap. (Harms & Luthans, 2012b, p. 8)

Confirmatory Factor Analysis was .87 for the I-PCQ scale (Harms & Luthans, 2012b).

Data Analysis

Quantitative Phase

The IDI was administered to all faculty and staff of the college in 2010 and 2013. The researcher received approval from the IRB of the college of health sciences as well as University of Nebraska-Lincoln to conduct the study. Once approval was obtained, the faculty and staff were notified via email and asked to participate in the study. If they agreed to participate in the study, their IDI assessment from 2010 and 2013 were imported from IDI software program where the participants’ results are calculated using a proprietary formula (Hammer, 2011). Higher DO scores indicate higher levels of intercultural sensitivity. Prior to analysis, participant names were removed and participants were assigned code names using letters of the alphabet.

Participants were sent a link generated by Qualtrics and took the I-PCQ online. Prior to analysis, participant names were removed and code names assigned during IDI analysis and were combined with PsyCap results matching participants’ IDI results from 2010, 2013, and PsyCap results. The data was analyzed using SPSS software. Descriptive statistics were obtained. Repeated measures analysis of variance (ANOVA) was conducted for analysis of Hypothesis 1, and correlational analysis were conducted for analysis of Hypothesis 2.
Qualitative Phase

A case study provided the opportunity to gain an “in-depth understanding of the case” (Creswell, 2013, p. 98). In this situation the case study boundaries were: (a) the faculty and staff, (b) at a college of health sciences in the Midwest, and (c) process of intercultural sensitivity development. Most often, a case study is utilized when studying a current real-life situation (Yin, 2009). This particular case was bound by a group of people who have gone through workplace training and development efforts during a 3-year period (2010-2013).

For this phase of the study, participants were selected based on the results of the quantitative results. Because this was a sequential explanatory mixed methods research, the participants for the qualitative phase were selected to help explain the quantitative findings (Creswell & Plano-Clark, 2011). Using Maximum Variation Sampling (Creswell, 2013), the selection criteria was participants with different levels of change in their IDI developmental orientation scores and different levels of PsyCap. Since this study involved a bounded system, the case study method was used for the qualitative phase.

According to Hancock and Algozzine (2011), case study research that is used properly is a valuable method for health science research. Stake (1995) and Yin (2009) approach case study research on the constructivist paradigm; constructivists assert that truth is related to one’s perspective. Constructivism recognizes the significance human beings place on their approach to creating meaning and that the meaning is subjective (Hancock & Algozzine, 2011). The IDI is based on the dimensions of the DMIS which is rooted in constructivism and phenomenology.
Piaget’s work is the foundation of constructivism, which is centered on the principle of a social construct of reality. Piaget believed that cognitive development occurs when learners are engaged in learning and the objective is personally relevant and meaningful (as cited in Wood, Smith, & Grossniklaus, 2001). Another reason for utilizing case study is the collaboration between the researcher and the participants, which allows the participants to share their stories. Through their stories the participants are able to describe their experiences and views, leading the researcher to a better understanding of the participants’ actions and thought process (Creswell, 2013; Yin, 2009). Because of the previously established relationship between the participants and researcher, it was highly likely that the participants would be comfortable and open to sharing their experiences and development journey during the 3-year time frame.

With the central phenomenon of the study in mind (what happened that caused changes in their DO level), interview questions were created. Questions were reviewed by two individuals with Ph.D.s and expertise in qualitative interviewing. Some adjustments were made according to their feedback. The qualitative phase participants were contacted by email to explain that they had been selected to participate in Phase 2 of the interview. This phase of the study was explained along with what was expected of them and what they could expect from the researcher. The participants could have declined to participate in this phase of the study (17 individuals were asked to participate; 14 agreed). Interview questions (Appendix F) and consent agreement (Appendix C2) were also sent for their review at that time. Interviews were scheduled for a time that was convenient for the participant during the dates of the qualitative phase data collection (2-week time frame). Semistructured interviews were then conducted with 14 participants.
The time frame was short to ensure that participants had similar workplace experiences. All interviews were conducted at the college in a private meeting room or a space the participant felt comfortable. Interviews were recorded, and the researcher took notes during the interview. Informed consent was obtained prior to the interview, and no information that would identify the participant was collected after the recorder was turned on. The recordings were transcribed by a contract transcriptionist with expertise in transcribing qualitative interview data. Confidentiality agreement was obtained from the transcriptionist (Appendix E) prior to beginning work on the project. The recordings were uploaded to a secure server, and the transcriptionist loaded the transcription back onto the secure server once completed.

Member checking was accomplished by the researcher to establish credibility. This technique, according to Lincoln and Guba (1985), is the “most critical technique for establishing credibility” (p. 314). Upon transcription of the interviews and review by the researcher, summaries were sent to participants for member checking. Each participant gave approval of the summary shared with them.

Interview transcripts were coded using in vivo coding following Creswell’s (2013) process for coding qualitative data. The process began by reading each transcript in its entirety and recording notes and thoughts in the margins. The transcript was read again while highlighting significant statements as codes. These codes were categorized into subthemes which were then combined to create themes.

In order to ensure that researcher biases were not skewing the coding of data, three Ph.D.s with expertise in coding qualitative interviews participated as peer reviewers. Each reviewer received a transcript and was asked to highlight or circle
significant statements and identify potential themes in the margins. Almost 22% of the transcripts (3 of 14) were also coded by reviewers. The significant statements and themes identified by the reviewers were compared with the researcher’s. While recognizing that the identification of significant themes to the researcher was different than to the reviewers and that “validation serves as a guide to inform plausible interpretation” (Wolcott, 1990, p. 139), there was a high degree of interrater reliability between the reviewers and the researcher. For case study, it is important to have more than one form of data. There were two other forms of data collected for this case study.

Open-ended questions from IDI assessments of participants in 2010 and 2013 were also analyzed as part of the data, along with a descriptive document supplied by the college regarding activities that occurred during the 3-year time frame. This additional information provided further verification and triangulation (Lincoln & Guba, 1985) of the qualitative data.

Mixed Methods

As stated by Teddlie and Tashakkori (2009), interpretations in MMR are conclusions drawn from each phase (quantitative and qualitative) of a study as well as across the two phases together. Sequential explanatory assumes that there is a sequence where one phase explains the other (Creswell & Plano-Clark, 2011). Therefore, the data analysis is connected and sequential.

Connected data analysis is the process where the mixed method questions were considered at each phase of the study. The data was analyzed during the quantitative phase “using analytical approaches that best suited the quantitative research questions” (Creswell & Plano-Clark, 2011, p. 217). The participants selected for the qualitative
phase were based on which results needed further explanation (the MMR question). Through this process, the themes and subthemes explained the quantitative results in a manner than could not have been accomplished using either quantitative or qualitative alone. This study used the Onwuegbuzie and Teddlie (2003) seven-step process for analyzing the data together. First, quantitative and qualitative data was reduced to key elements. Next a table was created with the reduced elements of PsyCap, IDI from quantitative, and themes and subthemes from the qualitative data were all displayed together. The third step was the transferring of data into the table, and fourth was looking for correlations. Next steps were data consolidation, comparison, and integration, respectively, to create a complete picture of the research.

**Research Permission and Ethical Considerations**

In each phase of the study, ethical issues were considered and addressed. The researcher and faculty advisor met with the college IRB to obtain approval for conducting the research. During that meeting, information regarding the research design and goals was shared. Once approval was obtained, a request for approval was filed with the University of Nebraska IRB. Request for Review Form was filed, providing information about the principal investigators, the project title and type, source of funding, type of review requested, number and type of subjects. Application for research permission contained the description of the project and its significance, methods and procedures, participants, and research status. Survey instruments were submitted for review for Phase 1 of the research. The permission for conducting the research was obtained in August, 2013. Due to the nature of the research design (mixed methods sequential explanatory design), a request for a change in the IRB protocol was submitted after obtaining the
results in Phase 1 and developing the interview protocol for Phase 2 of the study. The permission for conducting the qualitative phase of the study was obtained in December, 2013. Two distinct informed consent forms were created for Phase 1 and Phase 2 of the study. The forms included statements about the participants’ rights, agreement to be involved in the study, and acknowledged their rights were protected. The informed consent form for Phase 1 was included in the Qualtrics survey emailed to faculty and staff of the college. They could choose to delete the email or read the request for participation email and click on the link to learn more about the study. Once they reached the survey site (by clicking the link in the email), the entire study was described to them (including descriptions of Phase 1 and Phase 2). At that time they chose “Agree” or “Decline.” If they agreed to participate, they were directed to the survey. If they declined, they were directed to a page that thanked them and were put on the do-not-contact list.

Once participants were selected for the qualitative case study, they were notified to request their participation in Phase 2. If they chose to participate, they responded to the email to schedule the interview. Prior to the interview, a copy of the interview questions and the informed consent form were emailed to the participants; they could decline to participate any time prior to the interview. At the time of the interview, the participants were asked to read the consent form and sign the form stating that they were agreeing to participate in the study. The participants kept a copy of the agreement and questions for future references.

The anonymity of the participants in Phase 1 was protected by assigning a unique alphabet code name to each participant. While conducting the case studies with the selected participants in Phase 2, the code names were also used in their description and
reporting the results, thus keeping the responses confidential. In addition, all the names and gender-related pronouns were removed from the quotations used as illustrations in the second qualitative phase of the study. All study data—including the survey electronic files, interview tapes, and transcripts—was secured. Participants were informed the summary data would be shared in professional communities, but it would not be possible to trace responses to individuals.

**Role of the Researcher**

The role of the researcher in a mixed methods study differs depending on the design of the study. Creswell and Plano Clark (2011) explain the mixed methods design encourages researchers to collaborate between quantitative and qualitative methods. In particular, a researcher collects data using a quantitative survey and in qualitative interviews. Typically in quantitative, the researcher role is not as involved; however, in the qualitative portion of the study, the researcher is heavily involved in data collection through a variety of interactions with the participants.

Because of previous relationship with the health system, the researcher’s role in this study was unique. The researcher was a full-time employee with the health system in a leadership position for a period of 8 years. From 2007-2010, the researcher taught as an adjunct at the college of this health system. Later the college utilized the researcher from time to time for her expertise in the area of cultural competence and diversity. Therefore, the researcher knew many of the participants in the study. All of these experiences introduced a possibility for subjective interpretations of the phenomenon being studied and created a potential for bias (Locke, Spirduso, & Silverman, 2000). At the same time, it bears noting the researcher was not engaged in the day-to-day activities of the college
since 2010 (and the health system since 2007). This argument, although not strong enough to eliminate the possibility for bias, provides some reasons why the researcher decided to neglect the warning not to conduct a qualitative research “in one’s own backyard” (Creswell, 2013; Merriam, 2009). Verification procedures were comprehensive to control for some of the “backyard” research issues. These included member checking, triangulation of data sources, and thick and rich descriptions of the cases.

Both deductive and inductive strategies are present in the mixed methods approach (Creswell & Plano-Clark, 2011). Data analysis within mixed methods research occurs both with the quantitative (descriptive and statistical analysis) and qualitative (description and thematic analysis) approach and often between the two approaches (Creswell, 2009). Since several methods are used to analyze data, both deductive and inductive strategies were used in this study.

In summary, this chapter began with a discussion of MMR followed by an overview of the setting, participants, and selection process of participants. Next a discussion of the research design, measures used in the quantitative phase, and the approach to the qualitative phase was presented. The chapter ended with data analysis and the process used at each phase of the research. In the next chapter, results for each phase will be discussed.
CHAPTER IV
RESULTS

The purpose of this explanatory sequential mixed methods study was to examine the intercultural sensitivity development process of faculty and staff at a health sciences college; specifically, to examine the link between PsyCap and understand what contributed to the changes in their developmental level as measured by the IDI. In this chapter the results from the quantitative phase (Phase 1) will be presented followed by the qualitative case study (Phase 2). Table 4.1 represents Bryman’s (2008) explanation of the differences between quantitative and qualitative research. This comparison is important in setting the stage for the approach to analysis.

Table 4.1. Comparing Quantitative and Qualitative Research

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Qualitative</th>
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<tbody>
<tr>
<td>Number</td>
<td>Words</td>
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<td>Point of View of Participants</td>
</tr>
<tr>
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<td>Researcher Close</td>
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<tr>
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<td>Theory Emergent</td>
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<td>Static</td>
<td>Process</td>
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<td>Unstructured</td>
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<td>Context Understanding</td>
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<td>Hard Reliable Data</td>
<td>Rich in Depth</td>
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<tr>
<td>Macro</td>
<td>Micro</td>
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<tr>
<td>Behavior</td>
<td>Meaning</td>
</tr>
<tr>
<td>Artificial Setting</td>
<td>Natural Setting</td>
</tr>
</tbody>
</table>


Phase 1: Quantitative

The objective of this phase of the study was to examine the relationship between change in developmental level of intercultural sensitivity (Developmental Orientation score [DO] in IDI) and PsyCap. In this study, the change in the IDI DO was the
dependent variable, and the PsyCap was the independent variable. The hypotheses driving this phase were:

*Hypothesis 1:* There will be a significant increase in developmental level of intercultural sensitivity of faculty and staff from 2010 to 2013.

*Hypothesis 2:* There will be a positive relationship between PsyCap score and change in IDI DO.

**Reliability**

For testing the reliability of the measures used in this study, Cronbach's alpha was used. According to Tavakol & Dennick (2011), Cronbach’s alpha generally increases as the intercorrelations among items in a measure increases. Scale reliabilities are considered good for anything above .70 and less than .90; reliabilities above .90 are considered excellent (Tavakol & Dennick, 2011). The Cronbach’s alpha for I-PCQ was $\alpha = .89$ and, the IDI DO Cronbach’s alpha was $\alpha = .83$.

**Descriptive Statistics**

Table 4.2 presents the descriptive statistics for both measures. The sample included 33 participants who took the IDI in 2010 and 2013. The Mean from 2010 to 2013 increased by 7.12 points ($SD = 16.08$), indicating a general upward trend in DO level of intercultural sensitivity. There was a cumulative PsyCap Mean of 5.58 ($SD = 1.00$) on a 7-point scale.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std.</th>
<th>N</th>
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<tr>
<td>DO2010</td>
<td>99.58</td>
<td>18.21</td>
<td>33</td>
</tr>
<tr>
<td>DO2013</td>
<td>106.70</td>
<td>16.94</td>
<td>33</td>
</tr>
<tr>
<td>DO Change</td>
<td>7.12</td>
<td>16.08</td>
<td>33</td>
</tr>
<tr>
<td>Cumulative PsyCap</td>
<td>5.58</td>
<td>1.00</td>
<td>33</td>
</tr>
</tbody>
</table>
Hypothesis Testing

In order to test the hypotheses, repeated measure ANOVA was conducted to test Hypothesis 1 and Pearson’s correlational was performed to test Hypothesis 2.

To test the significance of the change in DO level of participants, repeated measures ANOVA was used. Repeated measures ANOVA is used when measurements are repeated over time; in this case the measure is the dependent variable and time is the independent variable (Keppel & Wickens, 2004). This was the measure used to test Hypothesis 1: There will be a significant increase in developmental level of intercultural sensitivity of faculty and staff from 2010 to 2013.

Table 4.3 shows the results of the repeated measure ANOVA. As hypothesized, there was a linear trend in the data, $F(1,32) = 6.483, p .05, MSE = 838.31$. This indicates that the DO of the faculty and staff increased from the first time they took the IDI in 2010 to the second time they took the IDI in 2013 (also represented in Figure 4.1). Therefore, Hypothesis 1 was supported.

Table 4.3. Repeated Measures ANOVA ($n = 33$)

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
<th>Noncent. Parameter</th>
<th>Observed Power*</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO Change</td>
<td>Sphericity Assumed Greenhouse-Geisser</td>
<td>838.31</td>
<td>1</td>
<td>838.31</td>
<td>6.483*</td>
<td>.016</td>
<td>.168</td>
<td>6.483</td>
</tr>
<tr>
<td></td>
<td>Huynh-Feldt Lower-bound</td>
<td>838.31</td>
<td>1.00</td>
<td>838.31</td>
<td>6.483*</td>
<td>.016</td>
<td>.168</td>
<td>6.483</td>
</tr>
<tr>
<td>Error (DO Change)</td>
<td>Sphericity Assumed Greenhouse-Geisser</td>
<td>4137.71</td>
<td>32</td>
<td>129.30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Huynh-Feldt Lower-bound</td>
<td>4137.71</td>
<td>32.00</td>
<td>129.30</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Computed using alpha = .05* is significant.
A correlation analysis is used to assess whether two variables of interest covary or are related, and ultimately draw conclusions about the relationship that exists between sets of data. A common measure of correlation in research is the Pearson’s product-moment correlation coefficient ($r$) which answers the question of whether there is a relationship between Change in DO and PsyCap.

Pearson’s correlation was used to test Hypothesis 2: There will be a positive relationship between PsyCap score and change in IDI DO. Table 4.4 shows results of the correlation analysis indicating that the relationship between the DO change and PsyCap was not significant.
Table 4.4. Means, Standard Deviations and Correlations
(p Values in Parentheses) Among Variables (n = 33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std</th>
<th>DO 2010</th>
<th>DO 2013</th>
<th>DO Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DO 2010</td>
<td>99.58</td>
<td>18.21</td>
<td>.583**</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>2 DO 2013</td>
<td>106.70</td>
<td>16.94</td>
<td>.518**</td>
<td>.002</td>
<td>.392* (.024)</td>
</tr>
<tr>
<td>3 DO Change</td>
<td>7.13</td>
<td>16.08</td>
<td>.145</td>
<td>.422</td>
<td>.160 (.375)</td>
</tr>
<tr>
<td>4 Cumul. PsyCap</td>
<td>5.58</td>
<td>1.00</td>
<td></td>
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</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

As Figure 4.2 shows, there was not a relationship between the variables, therefore Hypothesis 2 was not supported. Despite the fact that no significant relationship was found, there were some interesting anomalies in the data. These results presented additional questions and confirmed the need for conducting in-depth exploration of the quantitative data utilizing a MMR approach (Creswell & Plano-Clark 2011).
A distribution chart of participants’ IDI (DO scores) in 2010 and 2013 is provided in Figure 4.3.

Figure 4.3. Distribution of Participant IDI (DO Scores)
Connecting Quantitative and Qualitative Data in Mixed Methods Design

The second, qualitative, phase in the study goal was to understand what happened that led to changes in developmental level of intercultural sensitivity for each participant. It is hoped that this examination would help in explanation of the results from the quantitative analysis (Phase 1). In mixed methods sequential explanatory design, two sets of data are mixed between the two phases. Selection of the participants for the qualitative follow-up analysis was based on the quantitative results of the first phase. To obtain the greatest explanation and understanding of the quantitative results, Maximum Variation Sampling was the process utilized for selection of the participants in the qualitative phase (Creswell & Plano-Clark, 2011).

In this study, the quantitative and qualitative methods were connected first while selecting the participants for multiple case study analysis. They were connected again while developing the interview questions for qualitative phase (see Appendix C). These questions were based on the results of the statistical tests from the quantitative phase. The results of the two phases were also integrated during the interpretation of the outcomes of the whole study.

Phase 2: Qualitative

Participant/Case Selection

Participant selection was the first connecting point between the quantitative and the qualitative phases of the study in the mixed methods sequential explanatory design (Teddlie & Tashakkori, 2009). In this study, maximum variation sampling was utilized for selection of the qualitative phase participants (cases). The researcher and the faculty advisor selected the participants that would enable the understanding of the quantitative
results (using Figure 4.4). The goal was to interview outliers and unusual cases as well as “likely” cases. Of the 33 participants from the quantitative phase, 17 were identified for the qualitative phase. Of the 17 participants identified, 14 agreed to participate (82.4% participation rate). Those who agreed to participate are represented by circles and those who declined/did not respond are represented by triangles in Figure 4.4.

![Figure 4.4. Participants Selected for Qualitative Phase](image)

Of the 14 participants in the qualitative phase, serendipitously, seven were faculty and seven were staff (five of whom are in leadership positions in the college). During the maximum variation sampling done by the researcher and advising professor, looking for an equal distribution between faculty and staff was not an intent (selection was done by looking at Figure 4.4 which had no identifying information about the participants; only
codes). Table 4.5 is the breakout of the IDI DO (Developmental Orientation) scores from 2010, 2013, change, and their respective PsyCap score for participants selected for the qualitative phase of the study. The participants are presented in order from the greatest positive change in developmental level to greatest negative change in developmental level.
Table 4.5. Participant IDI Scores from 2010, 2013, Change, and PsyCap Score

<table>
<thead>
<tr>
<th></th>
<th>YR</th>
<th>Code</th>
<th>Name</th>
<th>Position</th>
<th>IDI</th>
<th>DO</th>
<th>PsyCap Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2010</td>
<td>X</td>
<td>Staff</td>
<td>87.34</td>
<td>128.91</td>
<td>41.57</td>
<td>6.25</td>
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<tr>
<td></td>
<td>2013</td>
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<td></td>
<td></td>
<td>Change</td>
<td>41.57</td>
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<tr>
<td>2</td>
<td>2010</td>
<td>R</td>
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<td>30.39</td>
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<td></td>
<td>Change</td>
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<tr>
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<td>2010</td>
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<td>91.4</td>
<td>121.28</td>
<td>29.88</td>
<td>3.50</td>
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<td>Change</td>
<td>-16.1</td>
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Interview Protocol and Data Collection

The interview protocol (Appendix F) was created with the goal of further exploration of the quantitative results. The mixed methods sequential explanatory design (Creswell & Plano-Clark, 2011) necessitates that the content of the interview be grounded in the results of the statistical test conducted in Phase 1: The relationships between the change in developmental level of intercultural sensitivity and the participant’s PsyCap scores.

The interview protocol consisted of three sections with open-ended questions within each section. To explore the participants’ (cases) PsyCap, questions were asked that would give further insight into their resilience, optimism, hopefulness, and efficacy (Luthans, Youssef, et al., 2007). The first set of questions asked the participant to describe any changes and challenges faced during the 3-year time frame of the study (2010-2013). The purpose of this question was two-fold: to serve as an ice-breaker (Yin, 2009) and to explore how participants described their approach to development.

The second set of questions was specifically related to participants’ approaches to development of intercultural sensitivity. The purpose of this was to understand if their approach to development mattered in the changes in their developmental level. This was based on the developmental process created by Hammer (2011), Bennett and Bennett (2004), and Paige et al. (2003).

The final set of questions was related to the diversity and cultural competence initiative of the college. The purpose was to go further into participants’ commitment to and engagement with the process at the college. A number of probing questions were added to each open-ended question to make sure all parts of this multifaceted case were
discussed during the interview. The interview closed with a question about any additional information participants believed might be important that had not been discussed during the interview.

Three sources of data were collected and analyzed. In addition to interviewing the participants, open-end responses (questions asked in the IDI assessments taken in 2010 and 2013), and a comprehensive schedule of the diversity and cultural competence events organized by the college were collected and included in the analysis.

**Data Analysis**

This study used a multiple case study design. In such designs, the analysis is performed at two levels: within each case and across the cases (Stake, 1995; Yin, 2009). After each individual case was analyzed for themes and subthemes, the cross-case comparison of the themes and subthemes was performed. The data analysis will be presented in two ways: first individual case analysis of the 14 cases, followed by a cross-case analysis.

Since the central theme of the qualitative phase was to understand the experiences that led to changes in the developmental level of intercultural sensitivity, during the data analysis two broad categories were explored: (a) what happened during the 3-year time frame, and (b) how did the participant make sense of what happened. These categories are presented by themes and subthemes (Table 4.6). Categorical examination of the themes and subthemes will be presented in this section. To maintain authenticity of the experiences of the participants, the words of the participants were used whenever possible.
Table 4.6. Categories, Themes, and Subthemes

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Subtheme</th>
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</table>
| What Happened In Participant’s Life | Personal Life | - Loss of loved ones  
                                         - Changes and challenges with children’s needs  
                                         - Advancing education |
|                              | Professional Life | - Promotion  
                                         - Job change  
                                         - Expansion of duties  
                                         - Increased needs of students |
|                              | Development Activities | - Reading/Discussion groups  
                                         - Traveling  
                                         - Movies  
                                         - Speakers  
                                         - Incorporating into course  
                                         - Diversity bursts at meetings  
                                         - Engaging with diverse communities/ populations  
                                         - Language learning |
| How Participants Made Sense of It | Identify Support/Help | - Family/Friends  
                                         - Colleagues  
                                         - Supervisor  
                                         - Professional help  
                                         - Faith/Church |
|                              | Approach to Development | - Intentional (need to)  
                                         - Enjoyment (want to)  
                                         - Meet requirements (have to) |
|                              | Introspection About Experiences | - Changing perspectives  
                                         - Actions  
                                         - Beliefs about self  
                                         - Beliefs about others  
                                         - Perception of others  
                                         - Values  
                                         - Challenging own beliefs  
                                         - Self-awareness |

**Individual Case Analysis**

During this analysis, each case was positioned within the perspective of the participant. This type of analysis is rich in the words and context in which the case presents itself (Merriam, 2009). Based on this process of analysis, a narration of the case is provided using descriptions to present and situate the case. The thematic analysis of the
initial codes and illustrative quotes is provided to supplement the discussion and provide the participants’ perspectives. This information about the participants (cases) will be shared by clusters (Table 4.7): (a) participants (cases) that had statistically significant positive change in their developmental level (greater than +7 points); (b) participants (cases) that had no statistical change in their developmental level (between -7 and +7 points); and (c) Participants (cases) that had statistically significant negative change in their developmental level (greater than -7 points).

Table 4.7. Participant Clusters

<table>
<thead>
<tr>
<th>Change</th>
<th>Participants/Cases</th>
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<tbody>
<tr>
<td>Statistically significant <strong>positive</strong> change (greater than +7 points)</td>
<td>X, R, P, N, S, D</td>
</tr>
<tr>
<td><strong>No</strong> statistical change (between -7 and +7 points)</td>
<td>E, L, F, J, C</td>
</tr>
<tr>
<td>Statistically significant <strong>negative</strong> change in their developmental level (greater than -7 points)</td>
<td>K, G, Q</td>
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Individual analysis of each participant (case) will be presented in the following format: what happened and how they made sense of it from a personal and professional perspective, followed by the support they received during this season, and closing with their approach and commitment to their developmental growth during this season. See Table 4.5 for IDI DO changes and PsyCap scores of each participant.
Participants Who Had Statistically Significant Positive Change (Greater Than +7 Points) on Their IDI DO Level from 2010 to 2013

Case Study 1: X. “I’ve learned to be open to changes, to learning, that everybody has their right to an opinion or thoughts and to be accepting of them...to just be open-minded and to accept differences.”

X is a staff member at the college who has experienced an expansion of duties because of the diversity and cultural competence initiative of the college. Of all the participants in this study, X experienced the largest growth in DO from 2010 to 2013. Having grown through the ranks in the years with the health system and now the college, X has had a shift in perspective. The biggest challenge X has experienced in the time frame has been at work. X said:

Making accommodations for students has really opened my eyes to the needs and diversity of our students. I was probably a little more close minded to begin with in thinking that everybody takes the same test, same amount of time. These are the rules. And to realize that not everybody can fall in those parameters, and so you do have to make some exceptions or changes to the way you’re doing things to help them. And then the Diversity Council has really exploded. I mean the work and my role, and the activities that we’re doing here at the college.

When asked what impact these challenges have on her, she indicated:

I just think that I have grown a little bit. Due to my upbringing, I grew up more like, this is the rule, this is what you have to do and don’t ask for anything else. Now, I see things differently. So I think I’ve just changed. I’ve changed my mind set, now it’s there’s always room to ask. And if it’s feasible, then it will be accommodated. If it’s too much to ask, then they’ll let you know what they can do or cannot do.

While X said there really weren’t any challenges in her personal life, she was “just busy with kids and they are getting older.” She does believe that the developmental growth has impacted how she is raising her children. X stated, “Being in this role has
changed how I’m raising my children. I think I’m raising them differently. I’m raising them to just be open-minded and to accept differences.” She gave the example about a field trip she went on with her son.

I went on a field trip with my son, and there’s a little boy in his class. I’m not sure what his race is, but he had some orange staining on his hand. And when we went on the field trip, the field trip leader who didn’t know the kids at all, said, “Oh, you need to wash your hands.” And all the kids in the class said, “Oh, no, that’s part of his culture.” Like they knew. And I didn’t know, you know, and I didn’t say anything. I just thought it looked like orange marker; he colored his hand with orange marker. It was so neat to see the kids just jump in and defend his culture. I think before kids wouldn’t know or even made fun of that. But the kids were all, “Oh, that’s part of his culture,” you know. It was just interesting to watch these kids…my son. Seeing these kids that knowing about the culture is just part of their life.

X believes the biggest support for her has been her direct supervisor:

I’d have to credit to my boss, a lot of credit. When things come up, she’s the person who comes and talks things through, and she’s always been, I think, a good role model as far as, “knowing the way and showing the way,” which is one of our values.

When it comes to commitment and approach to development, X has participated in everything the college has had. She stated it was mainly because of her role. She believes that it is important to be a good role model.

I’ve pretty much done everything we’ve had here. I’ve gone to all the guest speakers coming in from the community. I’ve participated in all the book studies. I really felt I needed to because of my position, you know, “to show that, we live it, own it”—one of our other core values—But also, why not? Why not do those things when they’re here and you can grow from it?

When asked about which activity had the most impact on her, she indicated it was the book studies:

...because you do have to read the book. Then you have to reflect on it yourself. And then you go to a book study and discuss it with other people,
so I really think it opens your eyes to, to listen to what other people got out of that book that maybe oh, I didn’t feel that way, and discussing that. I think that that’s a great way to grow. And to know other people here at the college and what they’re thinking too.

The books that had the greatest impact on X were *The Other Wes Moore* and *My Two Moms*.

I learned you don’t judge a book by its cover, you know, as far as a person goes. When I was reading about Wes Moore, and how his family moved around to try to get him a better life but it didn’t work. And it’s not that people don’t try to, to get outta bad situations or to not get in them. And with *My Two Moms*, sometimes things just happen you can’t control.

X said she was very hopeful that she would grow. She exclaimed:

I had lots of room to grow. I didn’t like being in the lower end of the category I was in, so I was disappointed. But I felt I was more culturally competent than what the test revealed. But when you stop and look at it, you’re probably not. You know, I think you said it too. When you came and spoke, I think you said, you thought you would be one thing but you weren’t. And you know what, I think most of us may not say things out loud, but in the back of our mind somewhere I’m thinking a different way.

In terms of what impact she believed the initiative has had on the college, she stated:

It’s made us more knowledgeable. People were worried, but realized, you don’t need to change your values, but you do have to be accepting because you are going to be caring for patients and their families...and you need to be able to make accommodations. Even just working here, you have students you have to take care of and so you can’t say, “I’ll help you, but not you,” or “I can’t help you because of this and this.”

The essence of introspection about X’s experiences in this season can be summed up with her phrase: “I’ve learned to be open to changes, to learning, that everybody has their right to an opinion or thoughts and to be accepting of them...to just be open-minded and to accept differences.”
Case Study 2: R.

I’ve had tons of insights about myself. That really gave me the best insight for what it’s like to really not understand and experience how others feel; especially the problems some of our students face...I’ve tried to take advantage of all the opportunities I can.

R is in a key leadership position at the college (since 2010). She has been with the college for over three decades. She indicated that she had multiple personal and professional challenges between 2010 and 2013. When asked about her challenges she responded with:

...oh, I have had tons of things. Let’s see from professional perspective: a new position, filling an interim key leadership position for a year, redesigning a division, started a new program. From a personal aspect, my only sibling passed away totally unexpectedly, our daughter lived abroad for a year, and then returned and got married. I’ve had to be the only child caring for an aging parent who had a health episode and was in the hospital for some time. So, lots of things.

She talked about the many things that she accomplished even with all these changes and challenges. She believes that she has learned a lot about herself. She stated the main thing she learned is about:

...resiliency; I realized that if you take things a day at a time, you can work through ‘em. When I took the interim leadership position, when I was asked to do it, it was would I do it for a month. And I said, “Yeah! For a month I can do that.” Well, the month became a year.

R believed that support was absolutely essential to her ability to be successful during the 3-year period.

I’ve had lots of insights about myself. I learned who my supports are. I learned what I needed to do to take care of myself. And I found that I was doing a lot of juggling of multiple roles. But yet, this environment here, I had tremendous support from faculty and staff...that was, a real plus. We sailed along very well during that time period and implemented things that we wanted to do. We never went “on hold” with anything. We just continued and very well.
R stated that the critical supports for her were her colleagues, the senior leadership of the health system, her spouse, her adult child (only child), and her faith.

My supports have definitely been my husband, my daughter, and my faith. I also had very strong support from senior administration, they all made themselves available if I had questions or needs or anything. But our leadership team here at the college is pretty amazing too. My colleagues, you know I’ve got a few colleagues here that we can talk over just about anything really. We have been through so many transitions together that I believe is a special thing that makes this college so strong—the relationships between the leaders, you know.

R talked about being adaptable as being an important factor in being successful.

She also believes that communication and collaboration is the key to all the changes and challenges they have gone through as a college.

I realized all of us in leadership were getting sucked into way too many meetings. So we created a once-a-month leadership council, where we brought everyone together for a 3-hour time block and hit all the major divisions/departments. It was a big help, so we have continued it. It helps us to communicate and collaborate together.

R also explained that her church community was a big support to her personally.

...you know a church community and stuff that is outside of my work community has been a big support. My faith, the belief in God and knowing that death is not the end. You know, I’ve reflected a lot on that with my sister’s loss! I don’t take anything for granted. And I just don’t know not having that belief system, how that would have affected me.

R’s commitment to growth and development is seen in the ways she has taken advantage of personal and professional opportunities to raise her developmental level.

She talked at length about the multiple trips she and her spouse have been on during this season.

You know, when our daughter was gone for a year, we learned a lot through her eyes. And we traveled. I mean after my sibling died, it was like we’ve got stuff on the bucket list we’d better get to doing ‘em. So we
took advantage of our daughter being there and we joined her a couple times. And we went to a few places just to go. We did a lot of travel and saw countries not as a tourist but as locals...it was wonderful and so very educational for me.

R continued with:

I haven’t taken formal classes, but I’ve helped my daughter in her ELL class. We are very close, her and I. And I have learned a lot from her as she’s worked with the families and children that have just come over here. She works with a lot of diversity, like last year she had a little girl come in from China (straight from China). Dad was going to the university so he had some sense of English. She had no English whatsoever. So I mean, I’ve learned just a lot with her and working with the kids and getting them comfortable with the culture and starting to learn the language, and I think that makes a big difference. My husband has employees that work for him from everywhere. My daughter has students in her class from everywhere. I realized humans are very adaptable really.

R reflected a great deal on what her daughter told her about being in a country where you can’t read the street signs or understand anything anyone said. She said, “That really gave me the best insight for what it’s like to really not understand and experience how others feel; especially the problems some of our students face.”

R has also been a big supporter and participant in the college activities.

I’ve tried to take advantage of all the opportunities I could that have come up here that would fit in. You know, the book studies, the speakers we’ve brought in. And the activities we’ve had our students do, those are really cool, just this week we saw the, six-word identity project, they put them up and we get to walk around and see them. They were so well done. You could see life experience and maturity. I mean everything in those different statements. But, I mean, I think by participating in those different things have given me a lot more insight about our students and myself.

R wrapped up our conversation by saying, “I am doing this for my own growth. But this is hard stuff.” R also recognized that this initiative has been difficult for her colleagues, especially her colleague who is spearheading this project.
She took a lot of flack at different times. You have to have someone that will lead the initiative. You know this, you lived it. It can’t be something that’s a rotating thing, you really have to have a leader that lives it, demonstrates it and is part of it. And I think she was disappointed because I think her IDI score went down over time. But I think some of that probably is because of the flack she got from different people. You know, some people didn’t like the requirements that we have to do so many hours of activities toward improving our understanding of diversity. Some people didn’t like the incorporating of like the One Book-One College. So I don’t know if some of those excuses (the negative feedback she got) influenced how she did the second time.

The essence of introspection about R’s experiences in this season can be summed up with her phrases: “I’ve had tons of insights about myself....That experience gave me the best insight for what it’s like to really not understand and experience how others feel; especially the problems some of our students face...I’ve tried to take advantage of all the opportunities I can.”

**Case Study 3: P.** “I realized I don’t always feel as competent as I really am...This whole development process is complex. It takes time. It’s a process. If I’m not mindful, it would be missed.”

P is a seasoned faculty member who was promoted into a key leadership position. Her faculty career was nearly three decades long. She hadn’t ever thought of herself as a leader, at least not until someone told her she was. Going into a leadership position was the biggest challenge she faced during this 3-year period.

I knew the BSN program really well. I never had administrative responsibility. Building a whole new program, learning all about accreditation and top it off with how to be a supervisor, that was all new to me. My first instinct was I felt inadequate. But my colleague, she was just very confident that I could do it or that I was doing it already. I was very concerned that I was going to get blindsided by what I didn’t know I needed to know.
When I asked P what she learned about herself during this season she said, “I realized I
don’t always feel as competent as I really am.” She also realized that there are many
people willing to help her.

A lot of people accompanied me on the journey. It was different people for different things. I have many friends here and one of them made me realize that I can be highly critical of myself. I asked them questions and they were open to me seeking their help. Collaboration is our norm.

P stated that from a personal standpoint:

...there really weren’t many changes or challenges. Just my mother (in her late 80s), we moved her from small town, sold her house. She is very independent, so I haven’t had to do much for her other than that. Thinking about this now makes me realize that, I am a lot like my mother.

When we began discussing her approach to development P stated that:

I was looking at the questions before I came to this interview today, I realized that there’s been a lot of the things, and partly because of the college’s initiative. And also because I am competitive, I knew that I could be better than what my results showed. Before the diversity initiative people didn’t go around talking about their identity. I was surprised that I hadn’t looked at that as part of diversity. You might be thinking, really? I know, and so I think I was so very naive. I needed to become better at it after the things, you and I had talked about when you gave us our results. That conversation just gave me a different perspective. I started to recognize things (mostly by teaching a course that began the diversity initiative for our students). Then there was the film—the rabbit proof fence. Something about it surprised me and made me see things differently. I don’t even remember, but it surprised me that it made me think about my own culture. I have done a lot of the readings and attended a lot of the programs and the speakers.

P said the biggest lesson through the development work she has done has been “this whole development process is complex. It takes time. It’s a process. If I’m not mindful, it would be missed.” Her main reason for attending the events she attended was

“convenience. The things that were on site here are the things I participated in.” The essence of introspection about P’s experiences in this season can be summed up with her
phrase: “...this whole development process is complex, takes time, it’s a process and if I’m not mindful, it would be missed.”

**Case Study 4: N.** “I’ve learned that I’m more adaptable than I thought. I can’t control certain parts of life and I’m OK with that; that surprised me.”

N is a seasoned faculty member in the college. She has been teaching the whole time during the extensive career at the college that spans over three decades. She experienced some personal and professional challenges during 2010-2013 (the 3-year time frame of interest in this study). From a professional standpoint, the major challenge was the increase in the number of students and her role with getting prepared for two different accreditation visits.

Professionally, I think one of our biggest challenges recently has been the accreditation, our accreditation, preparing for that. And then we have HLC accreditation coming up, so that’s a challenge; making sure that we’re very well prepared. Of getting all the data together that you know exists, and you know that the college does a, a good job with it, but just making sure that the surveyors understand what we’re doing. And the increase in the students, it’s just that it creates more work. There is just more work really.

N believed that this has helped her learn how to prioritize better and focus on what’s important. She said:

I have learned I need to prioritize what’s important and what’s not. There are other things in my life that are important. You know what I mean? Just to try to do the best you can at what you’re doing and not to live and die by the outcome.

From a personal standpoint, the two major challenges were working on her doctorate degree and having two of her children and their families so far away from her.

Let’s see, the last three years I’ve had two of my grown children move—so that distance from them and from grandchildren is tough. But the
upside of that has been that I’ve gotten to visit both place. Oh, and I’m working on my doctorate.

When I asked N about her support network, she identified God, family, friends, and colleagues.

My faith is important to me. So, I would say that God has been a present force in my life. And then people who have insights, spiritual insights, have been valuable to me, so friends in that way; and family members. And I feel like I’ve gotten good support at the college.

This opened her eyes to new insights about herself. “I’ve learned that I’m more adaptable than I thought. I can’t control certain parts of life and I’m OK with that; that surprised me.”

N shared about her approach to her developmental journey and her commitment to it. She had been involved with diversity and cultural competence longer than anyone else at the college. She served on the health system diversity council almost from its inception in 2001. She was the person who wrote several proposals to support the expansion of the educational requirements for faculty, staff, and students.

I proposed the One Book-One College that we do now. I wrote that proposal, and we’ve implemented it. That’s been fun to see. So reading and I continue to learn. Be open to things falling into your life...like while helping at an elementary school with the ELL class, I met a woman who had cancer and wanted to get back to her country before it got too bad. It took lots of work since she didn’t have money. Many people got involved in it.

When I asked N about her involvement with the diversity and cultural competence initiative at the college she said:

Served on the Diversity Council, serve on the Diversity Advisory Committee (to report some of the issues we’ve had at the college, to listen, take back some ideas). I have just been assisting in things like the Diversity Day, Week, participating in activities that are offered. Making
sure activities are offered; just opportunity to engage with different
cultures.

N also shared her frustration with her IDI results from 2010 to 2013; she really
wanted to experience growth and didn’t.

I’ve read a lot of the books that we’ve had on the list before I was part of
those things. I got to hear the speakers. The speakers have been interesting
and helpful. I haven’t done that because I’ve been part of the committee,
but because I’ve seen it as helpful, especially in working with our
students. So I don’t know what piece I’m missing. There’s like a blind
spot for me that I don’t understand how I’m missing how differences
matter, because I’ve stayed in Minimization although I’ve moved a little
bit further along.

N has also incorporated the lessons learned from multiple sources in the courses that she
teaches. She said:

I’ve incorporated the One Book in my course. Our students get extra
credit points for reading the book. It’s a course requirement that they
participate in the book discussion, and we host one, our course does. So,
we invite staff and faculty to come to our book discussion. And from the
Diversity Advisory Committee, I got the idea of splitting our first test in
half which has been beneficial for everybody.

The essence of introspection about N’s experiences can be summed up with her
phrase: “Can’t control certain parts of life and I’m OK with that; that surprised me.”

Case Study 5: S. “You know, it’s been a very internal process...I’ve discovered
the more I learn, the more I need to learn. It’s like thinking you’re working on a 500-
piece puzzle and realize that it’s really a 2,000-piece puzzle.”

S is a long-term staff member, who has been with the organization for over a
decade. She has been doing the same for much of that time with the exception of the
rapid expansion during the time of the study. The challenges S described were from both
a personal and professional standpoint. We spent the majority of the time talking about
personal challenges because “they brought the greatest opportunity for personal growth and development.” Both of her adult children are married, one of them recently.

One of her adult children revealed some deep personal issues with sexual orientation. According to S:

This was by far the biggest challenge, because no one knows and it is hard to not be able to talk to anyone about this. I knew my husband would not accept that at all. And so, one of the challenges I faced was what I do to help my husband ease into understanding our daughter. It’s been a process, and I’ve been able to introduce articles, movies, and other media to help him understand and not totally have that blow up. But I still don’t know that he would understand. I mean...she isn’t practicing or acting on her desires...but the connections are still there...they are what they are! He doesn’t know. He may never know.

S also expressed that her own health issues caused her to quit a dream.

I had to quit going on with my doctorate, and that was hard because my parents are very education driven. I mean, that was always an expectation that I would always pursue my education. I was the first person ever to graduate from college. And the expectation was that I would continue.

She expressed that she learned:

I have limitations. That was partly what finally spurred me to be able to let the Ph.D. go and feel comfortable doing that. I realized I had more pride than I realized, than I thought I had had. I mean to let go of that pride is harder than I realized.

When I asked her who helped her with the challenges, she talked about it being an internal process and that she hadn’t talked to anyone much.

I do talk to my husband about my letting go of the Ph.D. but he often can’t relate because we grew up very differently. He’s very supportive, you know. And, I read a lot. I read some books during that time about other women going through other crises and stories that were just regular people with regular life things. Because I read a lot I always could relate to their stories and that helps.
Reading has also been the major way S has embarked on increasing her developmental level.

I have read several books. They helped me see things from perspectives that I had not considered before. Some of them were things that were really eye opening. Some of them I took to the college and they adopted them.

S also talked about films that she and her husband have watched. In fact, she said, “My husband and I really enjoy movies, and we like watching international channels like BBC and the China perspective. We don’t watch regular TV. We are really academic in our entertainment.” S talked at length about a variety of movies they had watched: “You know, like Grand Torino. That’s probably the most profound one I watched, and I’ve tried to get other people to watch it.” But when family and friends “didn’t get it,” they told S “your view is twisted.” She said, “I don’t know, maybe we are, but I think we’re more open-minded in that we think there’s always two sides to a story.”

S indicated that she has participated in a lot of the things the college has offered.

She said:

I try very hard, so if I could work it in my schedule, of course. I do it because of the research that you shared that said we can’t pull students’ cultural competence up if we don’t pull ourselves up. That’s why I get involved and bring ideas, you know. Even though I don’t directly teach students, I do work with faculty. So I have to be culturally competent too.

S believes that the initiative has had “very positive impact” on the college. She stated that it has opened faculty’s eyes to:

First and foremost, they could reflect back on things that we had been doing and talking about and began to recognize students’ issues and needs as legitimate issues instead of just writing them off as “a student trying to be noncompliant,” you know.
The essence of introspection about S’s experiences during this season can be summed up with her phrase: “Discovered the more I learn, the more I need to learn. It’s like thinking you’re working on a 500-piece puzzle and realize that it’s really a 2,000-piece puzzle.”

**Case Study 6: D.** “Daily personal interactions and being intentional about observing; trying to figure out why people do what they do, more like being in their shoes.”

D is a seasoned nurse with many years of bedside nursing, management, and teaching experience. She has held multiple positions in her career with the health system. She has been teaching at the college for over 5 years. She experienced some personal and professional challenges during 2010-2013 (the 3-year time frame of interest in this study). From a professional standpoint, the major challenge was getting other faculty to include content in their courses that she believed was important and necessary for future nurses to learn. D stated:

A student might, may be a novice but they wanna know more why we’re doing what we’re doing. What am I not thinking about that I need to think about? It could be cultural too...it could be trying to understand a population.

D believed that her persevering through this professional challenge has made her more patient and creative. She said:

I have learned patience...because that can’t happen overnight. And it takes certain steps. It takes time. It will get there, though it’s hard to be patient. It takes creativity too...it’s been planning and being able to be patient and being creative with that planning...continue doing these steps and be patient about it.
From a personal standpoint, the two major challenges were finishing her doctorate degree and having to take care of a sick parent. She talked about the challenge of trying to manage life and teaching and school all together. She felt the challenge helped her learn to be more adaptable and give up the need to be in control. D said:

I’ve learned about myself is, I can be controlling. But the biggest thing is that I am adaptable. I wouldn’t say that I’m necessarily a rigid person, but you know, the routine that you live and are used to, that definitely had to change...have to learn to rely on other people. And the one thing that was so helpful to me in that too was learning to trust other people. I had not done this before. I had people around me that I knew I just had to trust.

D also talked about the impact taking care of a sick parent had on her. She shared:

When it first happened, I thought, “Why did God do this? Why did this happen? My kids are so young and they need their grandparent!” Well, now I realize that my kids know how to relate to somebody that’s disabled because of it. They go towards people that are disabled. It doesn’t bother them at all. And so that’s why I know my parent had this stroke, and they were the oldest grandkids too so they were able to role model that for their younger cousins, that you know, it’s OK to hug ‘em.

When I asked D about her support network, she identified three specific sources: her husband, her colleagues, and her program chair for her doctoral degree. She shared that at a specifically difficult time:

My husband was truly there for me. And I also talked to my colleague. We went to coffee one morning and I told her about this problem...I am also really blessed to end up with the chair that I did. She was a big help.

D was intentional in her approach to growing in developmental level of intercultural sensitivity. She said:

Daily personal interactions and being intentional about observation. Trying to figure out why people do what they do, more like being in their shoes. And I guess the other thing would be reading. Being open to reading different types of topic...from books I would’ve never chosen in the past or articles to read in the paper.
D shared her approach and her commitment to her developmental journey. This was evidenced in her frustrations with others’ commitment versus her own.

I want people to understand at my level. I mean it really bothers me when derogatory names are used toward a culture that’s not the same as whoever that person is that’s speaking. And I cannot stand it when people say, “Live here in the United States so learn to speak English.” I mean, yeah, should they know English? Yeah. But where are they at in that process? They might be a refuge that’s just come over. Well, people still say that... So those are the emotions that I have when people haven’t taken the time now to understand. And speaking up is difficult. And what I have to say is, well not nice…but I answer that kinda thing by having a dialogue with ‘em. I wanna challenge ‘em.

She also talked about the frustration she experiences with people who complained about having to do the activities the college required of them. When I asked her which activities she participated in, she responded with,

I’ve participated in a lot of them that we have had. Presentations, speakers, book club. I’ve also participated in the debates we’ve had…where, in fact, some people are sayin’, “I don’t wanna do this stuff. Or we already are required to do so much,” that’s been kind of a fun challenge to engage in. I mean it’s been good debates. Actually, I had a little debate with someone about the One Book-One College book and speaker, you know, My Two Moms book, and after doing the activity, the person thought it was really worthwhile. And I thought, well OK.

The essence of introspection about D’s experiences in this season can be summed up with her phrase: “Daily personal interactions and being intentional about observing; trying to figure out why people do what they do, more like being in their shoes.”
Participants Who Had No Statistical Change (Between -7 and +7 Points) on Their IDI DO Level from 2010 to 2013

Case Study 7: E. “I fully knew I could. I assumed by being involved I would learn something…it wasn’t planned or anything.”

E is the youngest leader in the group. She has quickly moved through the ranks at the college and it has been “hard work. I have worked very hard.” E has been at the health system well over a decade and has been with the college for much of that time. She finished her master’s degree and Ph.D. (in 3 years) while teaching at the college. Her move into a leadership position came on the heels of her being selected for a national nursing leadership program. As she stated, “Thousands of nurses apply and only a few get selected for this. I applied, but honestly I was surprised that I was selected.” For E, the major challenges during this season have come from a professional standpoint. She said, “Life at home had been pretty normal stuff with kids getting older, one starting high school, you know.”

The national program, according to E:

…changed things for me because it opened my eyes to the many opportunities that I was now going to have because of having been selected for this. And meeting all these different people and being able to experience what nursing is like across the entire United States. That changed my perspective a lot.

Since her promotion into leadership came on the heels of this program, she used her knowledge from that program and her dissertation to help her enhance things that she was now responsible for.

I met with every single one of the employees that reported to me, one on one, and asked them what their expectations were. And, so then I compiled all of that feedback and summarized it and presented it at a
meeting and told them what I was going to do to meet their needs and expectation. I have been doing everything I can to make things better. I have been doing it since then. And my engagement scores (on the employee engagement survey) have gone up. I think I made some huge improvements there. It was a challenge, and it continues to be a challenge. Yes, I am young but I definitely know my stuff and am serious about being a leader they can rely on. I know that I need to make sure and communicate in an effective way, in multiple manners, so that everybody knows exactly what they need to do and they know that I’m working on things. It’s a continual learning process.

E’s sources of support are her husband and her faith. She talked at length about her husband.

I have wonderful support from him. I mean I cannot even begin to express what he is for us and our family. I don’t want it to sound cocky. But we have a very open communication in our marriage, and he equally supports me and I support him. And actually he was the one that encouraged me to go back and get my doctorate. And I did my doctoral program, in three years because he was so very supportive.

She talked about how her commitment outside of the college with family and church has helped her. E shared, “I could not have gotten through the last few years without my faith. Being involved with our church, it’s something outside of work, it’s challenging and rewarding. I love those kids.”

E has attended several of the events at the college. She stated that even though she doesn’t know how hopeful she was about raising her developmental level, she did it because she wanted to learn more, and “I fully knew I could. I assumed by being involved I would learn something.” But E’s biggest approach to development has come from activities she has engaged in outside of the college. And as she says, “It wasn’t planned or anything.” She shared that though she had done “study abroad to Europe while in college as part of my undergrad,” she hadn’t really engaged with people from other cultures until an event that occurred on a flight which led to a lot of self-reflection.
On a stormy flight home, returning from speaking at a conference, I noticed this group. I didn’t know where they were from; I just knew that they were from some place in the Middle East. I could tell they hardly understood English. They knew just a few words. And when they got onto the plane, they ended up sitting right next to me. Because of the storms they ended up diverting the plane around all of the thunderstorms. Since none of them could speak English, I could tell they didn’t understand and they were scared. I was trying to make some conversation but it wasn’t working. I drew a bunch of storm clouds and bolts of lightning, and pointing outside, and I drew that we were going around the storm to go to Lincoln. Then they started to get it. They were like “Oh.” And I could tell they understood me. And the one young girl knew a little bit, few words of English. So we were able to connect a little. When we landed, there were all these people there to greet them. And they erupted in applause. It gives me goose bumps even now. And some of the women there had their head veiled and some didn’t and there were children and just lots of people. So when we got down to the baggage claim, I saw a man talking then to this one girl. I went up to him, and I said, “Where are they from?” He said, “They’re from Iraq. She’s my sister and I’m bringing her over here to be with the rest of our family.” And I explained to him who I was and explained why we were so late. He thanked me, and I gave them my card. I said, “You contact me. Let me know if you need anything.” He spoke very good English. He has been in the States for a while. He sponsored her through Catholic Social Services and several other agencies that work with stuff like that. Anyway I’ve been over to their home and had lunch with them. I’ve eaten a traditional Iraqi meal on the floor with foods I have no idea what they were. But it was wonderful, even sitting on the floor. I brought them a gift, a welcome gift, and they even had something for me. We had them over to our house last Christmas. I knew they didn’t celebrate Christmas; I was trying to be really sensitive to the fact that we’re Christian. Our kids were there and so we were all trying to learn about them and develop really. We’re hoping to get together again soon! Every time I tell the story, I get goose bumps. But I can’t imagine what they went through to try and come here. And I think about my own ancestors. My great-grandma was put on a boat by her parents with her sister to come to the United States of America, by themselves, and she was sixteen. And her sister died on the way. So she ended up coming to the United States and being here all by herself and was told to go to Nebraska. How she ever figured out how to get here on her own, I will never know. So I think about that and I think about their journey now and how similar it must be. So those are the emotions I think about.

The essence of introspection about E’s experiences in this season can be summed up with her phrase: “I assumed by being involved I would learn something.”
Case Study 8: L. “I just shared openly with my students…that I am learning this stuff too…and there is this internal struggle I feel with what I believe and what I am learning.”

L is a faculty member at the college for well over a decade. She has taught clinical and nonclinical classes. While professionally her workload has increased due to the growth in the student population, things haven’t been very different for her in the professional environment. L stated, “The numbers of students have grown, so that has added responsibility; just getting the same amount of work done with more students. More diverse students, means more work.” From a personal life standpoint, L endured a significant challenge.

The biggest challenge is that 3 years ago I lost my sibling. I was enrolled in a doctoral study at the time and, and during the illness, when my sibling passed away it was very hard. I am looking to return now, but definitely that was the biggest challenge in the past 3 years.

L realized that she is “more human than I thought I was. Or thought I was so that, you know, things affect me more emotionally than maybe I realize.” She talked about the fact that while she likes to think the loss didn’t impact her professional life, it really did. She stated, “Looking back, I realize that maybe I didn't have the same passion or commitment as I have now.”

In reflecting on the support in her life, L stated that, “I believe definitely my faith and my family. You know, personally, the closeness of our family has been the biggest thing beside my faith; and very good co-workers, as well too.” She connected the role her faith and her family played in her life, especially during the past 3 years, as being crucial supports for her. This led to her sharing about the challenge that was created for her when
the developmental work she was involved in at the college created the internal struggle for her; an internal struggle between her faith, the beliefs and values she was raised with.

L said:

I grew up very Christian, very strict. My family, growing up, believed that, it’s a man and a woman that would be a couple; very against same-sex marriage or same-sex unions. And as a nurse, and even as a faculty, I see that and I have to be open to that. I guess I always thought I was accepting of that, but encountering same-sex couples, realized that there are some feelings that come up, and you know this is still very much part of me. I mean I’ve just had to work with that and deal with that and think about it.

L realized that this came up for her with the implementation of the One Book-One College program where everyone has to read the same book in the college and engage in a college-wide dialogue about it.

Reading the book *My Two Moms* by Zach Wahls (2012) and then listening to him speak about it at the event at the college, followed by class discussion with students, caused some of this internal struggle. L shared:

Well, and it’s been really interesting. This is the first semester that we’ve done the One Book-One College, and the book was *My Two Moms*. And so, I guess I just shared openly with my students in the dialogue after the book and the speaker. That I am learning this stuff too...and there is this internal struggle I feel with what I believe and what I am learning. I go home and this is what my faith and my family says too. And so, I just felt like it was a good way for the students to feel comfortable to also share about what they felt. And then we kinda just talked about how we would handle that as nurses and professionals. We decided, in our class discussions, that if we felt like we really couldn’t be nice or couldn’t professionally take care of that patient that we could ask for an assignment change, if we needed to. But in most of our discussions we all felt that everyone deserves care and professionalism and that it is our job to do that.

L talked about the awareness the development created for her. She shared:
There’s always something new to learn, to just be open, and to talk about it before making judgments. I don’t know if it’s a Midwest thing or a Nebraska thing that we don’t talk about things. Sometimes it gets brushed aside. I was taught to do the job and not think about my own ideas.

When we talked about approach to development, L reflected on the challenge with creating time for including it in her busy life and how that connected with her beliefs.

It is hard to find the time to go to another educational session or time to read a book. Logistically the hardest part is fitting it in with everything else. But I guess the other part is, with certain things, you know like the same-sex couples, how does it, how does it mirror or go against, you know, all those things that you, I grew up with and was taught for, you know, 40 years that shouldn’t be right. And so, I guess, a challenge as well too. And at first I went in thinking that I wasn’t close-minded or that I was doing fine and everybody is the same and I treat everybody nice, but my views on that have been challenged.

Since time is a critical factor for L, she talked about the fact that the reason she engaged with the development was because of convenience. L said:

Probably mostly because convenience, to be honest with you, that they were offered here. And so I could come to those as well. And I enjoy reading, so the books seemed like a great fit to me. Oh, the one outside one at the other college, I chose that because it was about nursing and my scheduled allowed it.

The essence of introspection about L’s experiences in this season can be summed up with her phrase: “I just shared openly with my students…that I am learning this stuff too…and there is this internal struggle I feel with what I believe and what I am learning.”

**Case Study 9: F.** “It is uncomfortable but I don’t know! I’m not sure this is something that can be overcome, so much as being aware of it, being open to it, kind of watching for cues and proceeding accordingly.”
F is a faculty member who has been at the college over a decade. She has taught classes and served on various curriculum and faculty committees. The dialogue with F began with an emotionally charged personal issue related to her young child. The conversation then led to some things that she changed in her course that challenged her own beliefs and biases.

Regarding the challenge with her child, F stated, “A real big personal challenge…it challenged us emotionally to a point where we had to search community resources to help us troubleshoot the situation. When I say we, I guess I mean me.” When I asked her about the support she received, she replied with,

I prayed a lot. I’m a problem solver. That is what I do. If I have a problem, my coping is try to tackle it head-on, try and figure out the source of the problem, where, what is the nature of the problem impacting me. I was able to talk to some colleagues who have connections in the community, and, our family doctor, I’ve gone to her too. I faced many roadblocks and learned we didn’t qualify for any of the services in the community.

What she learned about herself is that:

My first response to challenge is emotional. Then I gain control better. I also learned that I am more resilient than I give myself credit. The situation with my son has redefined what hardy and resilient mean to me and the emotional piece too. And you can still be hardy and resilient...and emotional...and that all of it is part of your coping or grieving.

In regards to professional challenges she’d faced during this time frame, she said:

We wanted to give our students some diversity experiences, whether it was ethnic or another part of diversity. So, 2 years ago, we developed a 2-day case simulation scenario. There is a patient who is dying who is gay or lesbian. The reason was really the diversity stuff. Simulation is just a prime opportunity to create whatever you want to create that is either frequent or critical. Since the diversity of our patients isn’t something we can control in a live clinical setting. We could get diversity of any kind, we don’t plan encounters, as nurses we encounter what we encounter. Every student, at some point in their career, will face diversity.
This simulation created some personal reflection for F:

That made me reflect more on who do I know in my life who is gay or lesbian? It made me think of times in my life when I wish I would have been there for my cousin who is transgender. I have not, I didn’t, wasn’t close to before. What could I have done, gone out of my way to say to her at a family gathering, what could I do to make her feel more welcome? Could I be the cousin who responds with acceptance? This simulation really drove my personal reflections. I would add that the One Book-One College that we just did, I think that is also influencing some of my personal beliefs.

F talked about the fact that while the simulation is something they want to do, it isn’t always possible. This is because “the emotional maturity of the students drives how far we could push them in terms of own beliefs. And of course my comfort level with portraying it (because I act as the same-sex partner) is the other part of how far we push.”

In reflecting on this simulation experience, F talked about her own discomfort with being in bed with a colleague (same-sex faculty member) who is acting in the simulation as the partner that is dying:

When my colleague in the simulation, who is laying in the bed as this dying patient, and I have to cozy up in bed next to her and I am feeling really uncomfortable, I think, “Oh, can I do this? Am I uncomfortable with it because I am playing a same-sex partner? Or am I uncomfortable because I wouldn’t be able to watch this with my patients?”

When I asked her what conclusions she had come to, she responded with, “It is uncomfortable but I don’t know! I’m not sure this is something that can be overcome, so much as being aware of it, being open to it, kind of watching for cues and proceeding accordingly.” I probed about what she does with that discomfort in the moment. F replied:

I just focus on the fact that what I’m doing is designed to facilitate learning. That’s the whole focus. And that’s something I’m good at; to cry
on command when my partner dies. I think about that emotion, and that is
how I am able to do it.

F also shared that they are very careful to stop the simulation if they believe the students
aren’t mature enough or don’t have the skill level to proceed to more complex levels of
the simulation.

F believes the debriefing in such a simulation is critical:

We always spend an equal amount of time talking about the simulation as
we do having them experience the simulation. And you know what? For
majority of them, this topic is a nonissue. Most of them have friends who
are homosexual. I’ve been surprised at the degree of acceptance by the
students. It is much different than I expected. They almost seemed
surprised that we would even consider it an issue and that the care would
be any different. So, I ask the question, “Does it matter? Do we need to
know, as the nurse, what the nature of their relationship is?” Usually
they’ll say, “No, it doesn’t matter at all.” And that is wrong. It absolutely
matters. We do need to know as nurses. If the nature of their relationship
is friends, we aren’t going to explain things the way we do to a partner or
a spouse. Our nursing care needs to be modified. It is really getting them
to think about why and how. It should be different because if we know
that she has a partner, we need to teach them both about intimacy
precautions to take and so on.

F also shared how she uses the simulation as a way to teach her students how to handle a
situation even if their beliefs differ from their patients. “I tell them that I think every
individual deserves to be treated with dignity and respect. You want it to be the same if
you were in that type of situation, would you?”

When we discussed the approach and commitment to development, F shared that:

Role requires me to evaluate the diversity content within each course, to
make sure faculty are including it. Looking at every single course at the
college and how the faculty are helping students grow in cultural
competence. I have also participated in the diversity activities the college
offers, like reading the books and attending events, and volunteering with
the students at Clinic with a Heart and Matt Talbot. I’ve also gone to the
Samples of the World and attended the sessions with the guest speakers.
Oh, and I’m in a really good book club and so, many of our readings, I
think I zero in on things that maybe other people in the book club don’t necessarily zero in on. Things like health, diversity, and ethics. And so I try to bring those things up during our discussions. 

F shared that the reason she has participated in the activities she’s selected has been convenience. “A big reason for me is convenience. I would say that is the biggest reason. They are offered here. Also, I enjoy reading and that’s why I do the book club.” F ended our conversation with:

I feel like I’ve grown. I know some faculty take their IDI results personally; they feel like it doesn’t reflect what they want it to reflect. They feel that it is so different than how they see themselves. And, you know, that too, to some extent is eye opening.

The essence of introspection about F’s experiences in this season can be summed up with her phrase: “It is uncomfortable but I don’t know! I’m not sure this is something that can be overcome, so much as being aware of it, being open to it, kind of watching for cues and proceeding accordingly.”

**Case Study 10: J.**

Program’s grown. Many things have been mandated and with also the challenge of learning how to do class dynamics with growth in the program…I started a doctoral program trying to balance that with work…family…husband’s work situation…finding balance…it’s been hard and tiring with all the mandated things.

J has been busy. Her life has been full, personally and professionally. J talked about her professional challenges less than her personal challenges. But overall, J talked less about challenges than about what she had been doing. “You don’t think at the time with everything going on that it’s hard to go through it, but really, it’s all for the best, all the challenges.” Through the increase in the size of the program, her husband’s job changes, her own advanced education, their young child and pregnancy, J said she’s realized that:
I have a lot of resilience. At least I hear that from other people too. From friends and family, they’re like, “How, how do you do it? You’re, you’re working full time plus you’re pregnant, and doing a doctoral program, where do you find the time?” I think I just stay organized. But the thing is, I am a very optimistic person too. I don’t give up when I put my mind to something. I’ve had a lot of challenges along the way. With the pregnancy I was never so sick, and I was trying to take classes, and there were times I wanted to give up. But I would talk to myself and I still stuck with it and it worked out.

J talked about her sources of support during the stuff she’s been doing.

My husband has been a great source of help. If I didn’t have him, I wouldn’t be able to maneuver a professional life as well as a home life and a school life. But my husband’s probably the biggest. I do also have a good support system professionally. I have a great mentor who I know if I run into anything that if I came to that particular person, if that person doesn’t know, my supervisor will help me find it. Just having someone have your back, I know I have that at home and at work. And I have colleagues too that are willing to help me.

J has engaged in multiple activities with the goal of becoming more culturally competent. She talked about a variety of activities at the college that she has engaged in and a large number of activities she and her family have engaged in.

As a college, we’re required, for cultural competence, to participate in at least three activities a year. I engaged in a variety of like presentations. I’ve gone to Morrill Hall and bringing my family along too. I went to, there’s a Native American presentation. We’ve gone to dances, the art, coursework, I read a lot of journal articles specifically on different ethnic groups and interactions from, I love to interact with my classmates at school who are from China, because the culture is so different than what I have experienced. It’s neat to talk to them and tap into them, the differences and just the conversations are just so rich. And I’ve enrolled oldest child in a Spanish immersion course. So, that helps me to remember my years of learning Spanish and speaking Spanish, and so helping me to remember that. So we speak Spanish at home as much as we can which helps our eldest. And we’re hoping to do Mandarin Chinese too. I’m glad we started with Spanish first, but hopefully some other languages too. But I love learning languages too so we integrate sign language too at home.

J talked at length about the enjoyment of doing all these things with her family.
In fact, she enjoys this so much that it has created a sense of frustration for her to have to be mandated to do the cultural competence work. She stated that she really didn’t think about growing in cultural competence when she was doing these activities; she did them for enjoyment.

It never occurred to me whether I would grow. I do it more for enjoyment. I wasn’t looking at it as the outcome that I would grow. It’s just along the process; I do feel like I have grown. And when you engage in different experiences, your prior experiences, you draw on those. They, in some way, they may not help you directly at that moment, but they may help you indirectly later on.

J said that she realizes that finding the time to add additional stuff is hard. “Well, if you’re mandated to do at least three a year, you do that. And actually, it disturbs me that it’s mandated. I can see why that might be.” J stated that the activities she has attended at the college were varied and she liked that there was lots of variety. She stated:

I think convenience and time are the biggest factors in what I’ve chosen to participate in. There have been quite a few different presentations. And we’re highly recommended to attend some of them. But for me the main thing is if it fits into my schedule. But the other piece is that it is something that interests me. Because we do have more variety of activities (at first, we were very limited) so I can be a little bit more choosy, go to the things that interest me. But mostly if it works into my schedule with everything else going on.

J believes the impact on the students has been similar to the faculty. Mostly:

From what I hear from the students, they already have a lot going, learning the basics. And this is kinda adding one more thing. Kinda puts ‘em over the top at times. Specifically, I have one more book to read, like the One Book-One College. They’ll go ahead and do it, and they understand, I feel, that, you know, this is good information but it’s one more mandated thing put on them. As a faculty, I can relate to that. But if we didn’t have this initiative they wouldn’t have had the exposure, if it wasn’t mandated. For me personally, it’s exposed me to things I wouldn’t have probably been exposed to otherwise.
The essence of introspection about J’s experiences in this season can be summed up with her phrase: “Many things have been mandated and with also the challenge of learning…finding balance…it’s been hard and tiring with all the mandated things.”

**Case Study 11: C.**

I’ve realized in nursing, we train people to think and make decisions. We don’t train them to explore the possibilities but rather to think and make decisions based on set things. Also, we have tried to make some suggestions but the faculty resisted when we try to help them. I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to, I mean, are really resistant to change.

C is in a leadership position at the college. She has been with the college over three decades, so she has a unique perspective. She has been involved with the initiative and has experienced a great deal of challenges with the initiative. As the college has grown, so has her workload. During the conversation, she focused mostly on the challenges in her professional life. She briefly touched on personal life by saying, “I am getting older and my adult child lives in another state which makes it hard and helping care for my older parent and that means more attention and assistance.”

From a professional standpoint, C talked about the many things the college has done with this initiative and the many ways she has been challenged. She began by talking about the IDI and how it opened their eyes: “When we took the IDI the first time, we realized that there were things we needed to be doing.” She then talked about things they did so they could hear from people outside of the college and people inside of the college.

We established the Diversity Advisory Committee, selected 11 people from the community, who were either culturally diverse or leaders of organizations that worked with culturally diverse individuals, to participate. And that has been extremely interesting, at times challenging.
and a real learning experience. I think they have been able to really share a lot of interesting challenges for individuals who are culturally diverse that we weren’t aware of. And they have really challenged us to look at that issue to help our diverse student population. We’ve developed a lot of initiatives as a result of the diversity advisory committee recommendations. One specific one is the continuing education requirement. All faculty and staff have to regularly participate in educational activities that will enhance their intercultural sensitivity. While working on that requirement, there were some interesting questions and concerns that people had in regards to this new requirement. We also created a Diversity Council made up of faculty and staff. And from there we have had bursts of knowledge that are related to diversity and cultural sensitivity. That is something that all of our staff took turns facilitating at our monthly staff meetings and program meetings. The other thing we did then was the One Book. We started reading books about different cultures, different individuals’ experiences, individuals with disabilities, cultures.

C talked about the lessons that she learned in the challenges they experienced with faculty and staff. She reflected on the differences and similarities between herself and other faculty and staff. This reflection led to a realization for C:

One of the first things that has stood out is that because of my background in psych nursing and counseling, it seems like most people in healthcare who have been taught in clinical practice like nursing schools or just healthcare in general, people see things as black or white. This is the way we do it for everyone, kind of thinking. And I feel very fortunate in the fact that maybe I’ve had a little bit broader, more liberal arts kind of education and looking at things differently. I feel like I’ve learned that how I’m different from other faculty and staff is mostly because I don’t see things as being black or white the way some of the people I work with do. And so when a student has a difficulty, you know, I don’t feel like right away I know the answer or I know why they did this. Some faculty and staff seem to jump to conclusions and I don’t wanna say are judgmental, but make a judgment on something without pausing to think why.

She believes how nurses are trained is a critical reason why they see things the way they do. She stated:

I think I have come to realize we train them to think and make decisions; we don’t train them to explore the possibilities but rather to think and make decisions based on set things. So our nursing and other healthcare
faculty has been trained to think and make decisions. It’s either right or it’s wrong. And that training is not helping us in the things we want to make happen here. There’s a lot of very gray when you are dealing with changing things related to how we treat people. This has made me realize that maybe there isn’t a right way until we’ve really tried to understand. I think that’s been something that I have learned about myself.

C believes that the majority of the faculty and staff isn’t trying to be close minded and that this initiative is having an impact. “I believe most are starting to explore. You have helped me understand how to do that and that this exploration is important for nurses who are going to be caring for individuals who are different than them.”

C talked about the “resistance” that she has experienced from some of the faculty regarding some of the suggestions and ideas. One specific one that stood out was related to test bias.

We thought it would be good to learn about testing bias. So we brought in a well-known faculty member from another college with expertise in testing bias. He gave some great examples on testing and testing bias. I thought his session was very helpful to faculty, and he did it in such a way, you know, when people question some things, he would tell you a story to help you understand. Like who wouldn’t want to do this then? I mean, he was just excellent in what he shared. It was so great that we brought him back again. And, so I was very, very hopeful that, we’re learning new things because as our culturally diverse individuals have a hard time passing exams, but really kind of trying to hone in on what is it about our exams. And he gave us feedback. One of the faculty members was willing to share her exams with him and he gave some great insights and she let him use those as examples. I think it gave, you know, real-life examples to people who would include similar types of things in their exams. And that was extremely eye opening. So I have asked faculty have you gone back, you know, after we brought in this faculty expert to train you, have you gone back and looked at your exams? And to find out that not everybody did. In fact, I offered once or twice to review some tests for them and help reduce their workload. And, you know, not necessarily for the content, but just to look to and see if there’s anything in there like what he talked about. I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to, I mean, are really resistant to change.
Another example that C gave is related to a course that they know is especially hard for the students whose native language isn’t English.

There are some courses that are difficult for students. One particular course is hard for all students and especially our non-native English students. I wanted to offer a summer prep course to help people succeed in that particular course. It would be open to anyone. But I really wanted to invite specific students who would be taking the class in the fall and who we thought could use the additional help. I wanted the summer program where we would read the books, answer just questions randomly out of the back of the book, out of other, you know, like any text book not the specific one they would use in the class. I thought we could meet once a week to just get them familiar with the content to just do a pilot run and see if this would help them be successful. And the faculty, they did not want us doing that. We don’t need to be involved. They resisted and said, “No, you can't do that.” I tried explaining to them that I’m not sharing any of their course content or objectives. You know, we’re just gonna read a book! I don’t even care if it’s your book, you know, your textbook. I mean, I was surprised at, you know, like what would be the problem with this, if students wanted to come, jumpstart, because we know they’re taking two nursing courses. Students are at risk, and they need the help with some courses.

C believes that this resistance has been:

…really frustrating and required patience on my part. It really just surprised me. They didn’t even want me to help or for me to even come up with other approaches. It wasn’t even necessarily that I have to be involved, but that a group of other faculty could help.

C explained that another time:

A group of faculty identified at-risk courses and some additional things that they wanted the faculty in those courses to do. And the faculty in those courses, they’re like, “Nope, we’re not gonna do that.” So, I mean, it’s like, I just don’t wanna try new things, new approaches. That is really tough when you get that kind of resistance; because faculty sees these suggestions as providing unfair advantage. I know developmentally we are growing, but for some faculty who aren’t budging in their approach to teaching or testing, and while I don’t know where they are on the IDI, my guess is they are the ones who aren’t growing developmentally. The real frustration is that there are individuals who wanna help students but then there are those who just wanna do things the way they have always done it.
When I asked C about the support she has to help her with this level of push-back, she said:

Talk to peers. You know, we’ve talked a lot about this within our Success Center. So, we will keep coming up with ideas to approach it differently. I think just knowing maybe it just isn’t the right approach that I’ve taken and try to do things differently. There will always be some resistance to changing things. I think the resistance isn’t that the faculty member wants to be difficult. I personally think it’s their way of seeing that everybody has to be treated the same and that it’s not fair that we’re doing this for these people. That’s the paradigm we’re battling against. I laugh all the time because it is so hard. I also try to remind myself: Every person is looking at this through their own lens—all the things that have happened to them. I have learned that communication is important. Usually I try to remind myself to find out what are the facts? You know then that can help us maybe come up with some things to agree which is really hard, especially because it takes so much time.

Because of C’s unique role, she has been involved in all the things the college has offered. She has read all the books and attended all the discussions and the activities at the college. She has also led the academic abroad group from the college on a couple of trips.

We visit clinical spaces in the other countries. It’s been interesting to go to the hospitals and to see how different they really are. You know, the healthcare systems there are way different from here, so that’s been a very interesting aspect. And we also get to see a lot of the historical/sightseeing kinds of things. It is all so very interesting and exciting. I think it is very fun for me to go to different parts of the world and experience new things.

The essence of introspection about C’s experiences during this season can be summed up with her phrase: “I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to, I mean, are really resistant to change.”
Participants Who Had Statistically Significant Negative Change (Greater Than -7 Points) on Their IDI DO Level From 2010 to 2013

Case Study 12: K.

I have learned the hard way sometimes. I found that I don’t communicate well because there are things that happen that I don’t see as important to communicate but staff sees this as withholding information. The perception that I have versus what they have can create problems along the way.

K is a staff member in a leadership position. She was promoted into leadership during the 2010-2013 time frame. She has had equal amounts of personal and professional challenges. From a personal standpoint, she experienced something that is really embarrassing to talk about, she said. “I learned to recognize that as a behavior that needs changed. What I was doing was about the process and looking for a perfect thing…and you know it is really uncomfortable to talk about even now.” From a professional perspective, the challenge was the promotion. It created some new opportunities for K to learn things about herself. Mostly the lessons came around the topic of communication.

I have learned that I need to communicate to better. I have learned the hard way. I found that I really don’t communicate well because there are things that happen that I don’t see as important to communicate, but staff sees this as withholding information. The perception that I have versus what they have can create problems along the way. I learned that staff thought I was being secretive when that was not my intention. Communicating regularly is what they wanted. So I realized it’s my issue.

When the conversation led to support she received to help with the challenges she’d experienced, she indicated:

Definitely my boss when it comes to the work challenge. I have been able to be very open with about frustrations that I have, getting guidance, asking for help and advice of what I do about certain situations. So that’s
definitely the person I go to for guidance. I sometimes vent to family and friends, even though they can’t do anything. I just talk about things that have happened at work and ask what they would do and things like that.

In regards to her personal challenge, she felt it best to get professional help.

I realized that I probably needed to talk to a professional about it because it was somebody who could be completely removed from the situation and offer really sound advice and tools to help me. I didn’t really talk to my family because I’m uncomfortable talking about it with them.

Regarding K’s approach to development, she stated that she had stuck with the things the college offers and she also likes watching documentaries.

I have been participating in the activities that they’ve sponsored here at the college. If my schedule allows and I’m able to participate, I do it. I haven’t really been proactive about going to any events outside of the college. I am proud that I am doing my part to try to become more cognitively, you know, culturally competent, becoming more aware of biases. I was always very hopeful that I would grow. I also watch a lot of PBS too and they show a ton of documentaries and just different shows. I love documentaries and watching them gives you such a different understanding of everything that we are doing here. So, I would say things along that line are why I was hopeful. Though, I feel good that I’m making progress, I’m also very conscious that I still have a lot of growth that needs to happen.

The reason K has selected the activities at the college to attend has been:

…convenience really. It’s right here. It’s easy to go to. It’s interesting to me. So I think mainly does it fit into my schedule. Obviously, if it interests me, like the book discussions. I like a good book discussion. And I thought the webinar on the cultural initiatives in the Brooklyn hospital was very good.

K talked about her frustration with others at the college and she realized that this meant:

I still have biases that aren’t accurate. I mean when people were complaining about the One Book-One College that was selected, you know the *My Two Moms* book, I was thinking to myself, “What’s wrong with these people? I mean, I understand that they have a different
viewpoint,” but really, you know what I mean? I would say that kind of attitude is one thing that has been challenging to me. The essence of introspection about K’s experiences during this season can be summed up with her phrase: “The perception that I have versus what they have can create problems along the way.”

**Case Study 13: G.**

I have realized that I don’t have to live in a totally different culture to learn and grow...And I don’t intentionally go out and say, “Oh, this is going to be my cultural time.” I really just go casually and just try to absorb what’s going on.

G is a seasoned nurse who is a faculty member at the college. She has the least amount of time with the college of all the participants in this study. She has experienced mostly personal challenges during the 2010 to 2013 time frame. She stated, “Probably my greatest challenge would be more of a personal nature, parental losses, dealing with elderly parents, living a distance from them.” During this time, G learned that she needed to rely on others to assist her.

I realized that family and friends want to and can assist us while going through these things. Husband has been a huge support. Support from friends that have gone through similar situations, caring for dying parents and in-laws, their end-of-life issues has been wonderful. My faith has also strengthened through this season. Our church family has been a big help. We look to God for to help us out with this and see what we can learn through the experience. We just rely a lot on God. Also, I’ve realized that I’m more resilient that I thought. I didn’t think I had it in me to deal with these kinds of issues; making funeral plans or taking care of an estate, dealing with and getting rid of a house and household goods and just caring for all those kind of arrangements. I also realized that while dealing with these issues, I need to make sure I still have adequate focus for the work that I do here. I don’t want to not be not taking care of my job responsibility or my own kids.

When asked about developmental activities G had engaged in, she responded with:
I read that question before I came here today and to be honest I was stuck in coming up with an answer. I don’t intentionally go out and say, “Oh, this is going to be my cultural time.” I really just go casually and just try to absorb what’s going on. As far as being intentional about them, those opportunities that the college offers for us as far as at faculty meetings, the diversity bursts, I have done that and attended some of the speakers. Of course with students, the book initiatives, you know the One College-One Book like the one we just did, *My Two Moms*, that helped the students focus in on a particular topic or story so that we are all on the same page for anyway, at this point, leads into discussions so that’s been my main emphasis.

G’s reasons for the activities that she has been involved in has been:

It was available that I could attend schedule-wise. So the availability and to learn more about what’s being shared; I wanna learn more about that particular culture that are available and we’re around right here that’s close so we don’t have to travel far.

She believes that the initiative has made her more open and helped her to realize that “more attention to the needs that these students will have in the future working as a nursing professional. It’s important part of their future. We need to help the student be successful.”

The essence of introspection about G’s experiences during this season can be summed up with her phrase: “I don’t intentionally go out and say, ‘Oh, this is going to be my cultural time.’ I really just go casually and just try to absorb what’s going on.”

**Case Study 14: Q.** “I always feel like I put myself out there but maybe I am still focusing on commonalities; I don’t know, it’s just that I’m putting in adequate effort but not seeing results.”

Q is a faculty member in the health professions area. As a minority (male faculty member), he is also one of the newer faculty members. He has been with the college just a little longer than G. The biggest challenge Q has faced has been workload expansion.
He talked about personal challenges as being really just about juggling work with the busy pace of family life with the number of children they have. Q tried to focus the conversation on the changes in the IDI scores from 2010 to 2013.

It was strange because, I’ve always felt like I’ve been somebody that reaches out and is willing to just participate, put myself out there. I’ve always been interested in diversity. My undergraduate was psychology; a majority of my coursework in sociology was on delinquency and anything that was related to that since I was an education major at first. So the fact that my results went down so much is unbelievable really. Because, I mean, I am very open to learning about others.

Q talked at length about the variety of activities he had engaged in with people who are very different than him and why that should mean his IDI should have gone up but it didn’t.

When I was at training, I met a Hispanic male. I was just out one night eating dinner and then he was there as well, and we were just sittin’ at the bar eating and we just started talking. And about a half hour goes by and he was wearing I guess maybe what you can consider maybe just stereotypical shirt (wife-beater) just carryin’ on a conversation. And out of nowhere, he said, “Did you know that I’m in the Army and here on leave?” I go, “Oh, that’s cool. Appreciate your service.” And he goes, “You know, I really wanted to let you know that I appreciate you, actually even talking to me ‘cause most people would be is this guy here and he’s got his wife-beater on and would ignore me.” He basically said, “Thank you for just talkin’ to me.” And I was like, “Yeah, no problem.” I mean, we were just sittin’ there. So we ended up actually hanging out for the next several hours. And it was, it was just a good time. We didn’t exchange any information or anything. So I always feel like I put myself out there but maybe I am still focusing on the commonalities; I don’t know, it’s just that I’m putting in adequate effort but not seeing results.

Because of the additional duties assigned, Q felt that the job grew to:

…more than what two people are doing in two full-time jobs, I was doing with just myself. I was feeling frustrated at that point. It was nerve-wracking. So I requested for changes to be made and I actually am going to be doing something different but still teaching at the college part time.
The changes are creating more opportunities to focus on things Q enjoys doing like technology. Q said:

I will get to work one on one, and a lot of times it’s just me and the machine and when I’m finished I’ve accomplished something. I’ve troubleshoot the machine or the technology without all of the intricacies and challenges that people can bring to a particular situation, which is kinda nice sometimes...work with others, yet a lot of the job will be autonomous. I actually have to force myself to go and eat with other people. And it’s not necessarily that I don’t want to, I’d rather just work and when I’m done with work, I wanna leave.

Q talked about controversial topics with family that create opportunities to engage in development work outside of the stuff the college is doing.

My son (he is in 8th grade) and I have some pretty deep conversations. He’s into Discovery Channel and the History Channel. He wants to get into the military. So I’d say I’ve found that sometimes having good conversations can be great and very deep. But when you’re on a schedule you’re limited as to what you can actually do.

In regards to involvement with the college activities, Q stated:

I’ve enjoyed the books, even though I haven’t sat down and honestly read them the way I would like to, but at least being told you have to do it, you’re still getting something out of the books. And at least, you know, once you get into some good parts of a book, it still kinda takes you away a little bit. You get to think about things. It forces you to learn more about it. But yet, if I wasn’t told to do that, I wouldn’t think that I had time to do it, so time is probably my biggest obstacle. Maybe it’s me maybe not making the time, but it definitely is the biggest obstacle for me.

The essence of introspection about Q’s experiences during this season can be summed up with his phrase: “I always feel like I put myself out there but maybe I am still focusing on commonalities; I don’t know, it’s just that I’m putting in adequate effort but not seeing results.”
Cross-Case Analysis

For the cross-case analysis, categorical examination of the themes and subthemes was conducted. To maintain authenticity to the experiences of the participants, the words of the participants were used whenever possible.

What Happened in Participant’s Life is the category that includes thematic analysis of changes and challenges that took place during the 3-year time frame in the personal and professional life of the participants.
**Personal Life**

Twelve of the 14 participants had faced personal challenges during the 3-year time frame that was of concern to this case study. This theme is made up of four subthemes: Loss of loved ones, Changes and challenges with children’s needs, and advancing education. A summary of the statements that generated the subthemes is found in Table 4.8.

**Table 4.8. Participant’s Words about Challenges in Personal Life**

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Statements</th>
</tr>
</thead>
</table>
| C         | • Just getting older.  
|           | • Don’t see my child as much; in another state. That is hard. |
| D         | • Finished my Ph.D. That was good and hard. Caused an anxiety attack.  
|           | • Parent’s health issue was hard. |
| E         | • Kids are growing. One in high school. That’s been an adjustment. |
| F         | • Young child had a serious issue. It was a long ordeal. Major challenge. Doctors and counseling and lots of work. |
| G         | • Family loss. Dealing with funerals, an estate, and household stuff and getting rid of them and selling a house. |
| J         | • Started a Ph.D. program. Spouse job issues.  
|           | • Family expanding, being tired, and not feeling well. |
| K         | • Personal challenge is embarrassing to talk about. |
| L         | • Sibling died. I had to quit my Ph.D. for a while. Thinking about going back. |
| N         | • Kids moved out of state, in opposite directions.  
|           | • Started a Ph.D. program. |
| P         | • There really weren’t many changes or challenges.  
|           | • My mother is in her late 80s, so we moved her from small town, sold her house. |
| Q         | • Very busy with kids growing and their activities. |
| R         | • My only sibling died suddenly and unexpectedly. I had to step in as grandparent to my sibling’s grandkids.  
|           | • Child moved to another country for school. Then came back and got married. |
| S         | • Child went off to college, met someone, and got married. It was a good thing, but was hard.  
|           | • Other child told me about sexual orientation matters. Can’t tell my
spouse. That has been hard.

- My own health issues, had to quit Ph.D. That was a big dream, hard to let go of.

- Nothing really.
- Kids keep growing.
Professional Life

Because of major changes and growth at the college, the participants dealt with quite a bit in their professional lives. Subthemes are Promotion, Job change, Expansion of duties, and Increased needs of students. The key statements that generated these subthemes are summarized below (Table 4.9).

Table 4.9. Participant’s Words about Challenges in Professional Life

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>• Job expanded with the addition of the Diversity Advisory Board and the creation of the Diversity Council. Lots of work related to that.</td>
</tr>
<tr>
<td>D</td>
<td>• My focus area changed as a faculty. I am now teaching something very different from before. And now teaching in the MSN program too.</td>
</tr>
<tr>
<td>E</td>
<td>• Promoted to a new position. Direct reports are peers. • Created changes in how things are being done. • Selected for a national program.</td>
</tr>
<tr>
<td>F</td>
<td>• Curriculum changes. • Expanded work responsibilities.</td>
</tr>
<tr>
<td>G</td>
<td>• Just keep teaching classes; more students.</td>
</tr>
<tr>
<td>J</td>
<td>• Big increase in number of students in our program. • Made for lots of extra duties.</td>
</tr>
<tr>
<td>K</td>
<td>• Promotion, addition of staff.</td>
</tr>
<tr>
<td>L</td>
<td>• The numbers of students have grown, so that has added responsibility. Just getting the same amount of work done with more students. • More diverse students, means more work.</td>
</tr>
<tr>
<td>N</td>
<td>• More students. Increase in workload. • Trying to get to know their needs. Not always easy. • Changes in my teaching.</td>
</tr>
<tr>
<td>P</td>
<td>• Got a promotion; went from teaching to having to create a new program. • It was challenging to figure out what I didn’t know.</td>
</tr>
<tr>
<td>Q</td>
<td>• Expanded role. • Took on coordination role and teaching. That made it harder. • Meeting with students has added additional work.</td>
</tr>
<tr>
<td>R</td>
<td>• A new position, plus filling an interim leadership position (started with just one month; actually ended up being one year). • Redesigning a division, creating/starting new programs.</td>
</tr>
<tr>
<td>S</td>
<td>• My workload has grown exponentially. From 3 classes to 50 classes that need my help.</td>
</tr>
</tbody>
</table>
- We started the testing center and making accommodations for students.
- Diversity role with Diversity Council.
- Addition of all the diversity activities.
Development Activities

These were the activities that the participants embarked on during the 3-year time frame (Table 4.10). Five participants engaged in things that were not organized by the college. These five participants are identified with an * next to their code name. The item mentioned by the participant that was not organized by the college is also designated with an *.

Table 4.10. Participants’ Words about Development Activities

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Statements</th>
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</table>
| C         | - Diversity Advisory Committee opened my eyes.  
- Reading. Each semester, reading a book related to individuals who are different.  
- Academic travel abroad trips to European countries included clinic visits and sightseeing to historical places.  
- Conversations with students, different experiences, where they’re from.  
- I attend as many of the stuff we do as I can. |
| D         | - Daily personal interaction...and better eye on observation.  
- Trying to put myself in their shoes.  
- Engaging with people I would have stayed away from before.  
- Reading—have become really open to different types of topic. From books I would’ve never chosen in the past or articles to read in the paper.  
- Diversity Bursts in meetings.  
- Attending the diversity events the college puts on.  
- Mayor’s Prayer Breakfast. |
| *E        | - Engaging with people I would have not engaged with in the past. Inviting them into my home. Going to their home. Scary but exciting.*  
- Trying to learn things in another language.*  
- Reading.  
- Attending the speakers.  
- Diversity Bursts in meetings.  
- Making sure there is diversity included in the nursing courses. |
| F         | - Developed a 2-day case simulation scenario. There is a patient who is dying who is a lesbian.  
- Ensuring, evaluating diversity content within each nursing course.  
- Diversity activities the college offers: reading the books and attending events, and volunteering with the students at Clinic with a Heart, and Matt Talbot, Samples of the World, guest speakers. |
• Great book club—many of the books, I zero in on things health, diversity, and ethics. I try to bring those things up.

• I read that question before I came here today and to be honest I was stuck in coming up with an answer. I mean, I don’t think I purposely go out and say, “Oh, I’m going to, this is going to be my cultural time.” I just casually go and absorb it.

• I guess the opportunities the college offers for us as far as at faculty meetings, diversity bursts, the book initiatives, One College-One Book, like the one we just did, My Two Moms.

• I engaged in a variety of like presentations.
• Gone to Morrill Hall and bringing my family along too, a Native American presentation and exhibit.*
• Gone to watch the dances, the art and coursework.*
• Read a lot of journal articles specifically on different ethnic groups and interactions.
• Love to interact with my fellow peers at UNL who are from China, because the culture is so different than what I have experienced. So it’s so neat to talk to them and tap into them, the differences and, and it’s just the conversations that they come up with in the classroom there, they’re just so rich.*
• Enrolled my son in a Spanish immersion course. So, and with that, that helps me to remember my years of learning Spanish and speaking Spanish, and so helping me to remember that. So we talk, we say that at home. I mean, we speak Spanish at home as much as we can which helps him.*
• We also use sign language at home.*
• The One Book-One College.
• The speakers.

• One Book-One College.
• Participating in the activities that they’ve sponsored.
• Watch a lot of PBS too, a ton of variety of documentaries and just different shows. I love documentaries.*

• Book study.
• Attended a presentation at another college by a nurse about her research on racial bias in nurses.
• I didn’t get a chance to read all the books. But I attended the book discussions and at least listened to understand other people’s views.

• One thing that I’ve is you know how they say you have to make a connection with your own culture. I joined group that’s connected to my ancestors. It is more for fun than cultural I think.
• Continuing to read the books. I like to read a lot. And I know that to read intentionally to see how things affect people. I try to do that.
• I proposed the One Book-One College that we do now. I wrote that
<table>
<thead>
<tr>
<th>Proposal</th>
<th>And, and we’ve implemented that. And that’s been fun to see.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Helped a woman to get back home to Argentina before her cancer got bad.</td>
</tr>
<tr>
<td>P</td>
<td>• A lot of the programs that were presented here I’ve attended.</td>
</tr>
<tr>
<td></td>
<td>• Taste of the World.</td>
</tr>
<tr>
<td></td>
<td>• Speakers.</td>
</tr>
<tr>
<td>Q</td>
<td>• Talk to people I don’t know.</td>
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<tr>
<td></td>
<td>• Deep conversations with family.</td>
</tr>
<tr>
<td></td>
<td>• Reading books; not the way I want, but reading.</td>
</tr>
<tr>
<td>R</td>
<td>• Travel’s been a big one. But we saw it not as a tourist would see it but as how you actually lived there. We shopped at all the little bitty markets and the chino stores and stuff. We really took in the local culture. We went to the, the local places whether that was the little local bars, the little local type of food so that it wasn’t like when you’re on a tour group and you’re still totally Americanized on the tour group. We, you know, and we saw a lot of Spain. We spent time in Italy. And I think hearing our daughter’s experiences and kinda processing what she was going through was very educational for me.</td>
</tr>
<tr>
<td></td>
<td>• Not taken formal classes or anything.</td>
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<tr>
<td></td>
<td>• I have gone and helped in my daughter’s ELL class sometimes with activities with the kids and have done field trips with them.</td>
</tr>
<tr>
<td></td>
<td>• I’ve tried to take advantage of all the opportunities I could that have come up here that would fit in.</td>
</tr>
<tr>
<td></td>
<td>• The book studies.</td>
</tr>
<tr>
<td></td>
<td>• The speakers we’ve brought in, the activities we’ve had our students do.</td>
</tr>
<tr>
<td>S</td>
<td>• Read several books for entertainment purposes. Some of them I took to the college and they adopted them.</td>
</tr>
<tr>
<td></td>
<td>• Introduce articles, movies, and other media.</td>
</tr>
<tr>
<td></td>
<td>• Attend the speakers and the book discussions.</td>
</tr>
<tr>
<td></td>
<td>• Films that are educational and make us think.</td>
</tr>
<tr>
<td></td>
<td>• Meeting people and helping students.</td>
</tr>
<tr>
<td>X</td>
<td>• I have done everything we’ve done.</td>
</tr>
<tr>
<td></td>
<td>• Attended all the guest speakers coming in from the community.</td>
</tr>
<tr>
<td></td>
<td>• Participated in all the book studies. I really felt I needed to, to show that, we live it, own it—one of our other core values—but also, why not? Why not do those things when they’re here and you can grow from it?</td>
</tr>
</tbody>
</table>
How Participants Made Sense of Experiences is the category that is about how participants made sense of the changes and challenges. The way they made sense of the things that occurred (during the 3-year period) is divided into three themes: Who Provided Support/Help, Commitment/Approach to Development, and Depth of Introspection.

Support People

One of the ways the participants made meaning of their experiences was by identifying at least one source of support. These were narrowed to four subthemes: Family/friends, Colleagues/Direct supervisor, Professional help, and Faith/church activities/church family. Below (Table 4.11) is a list of their statements that generated the subthemes.

Table 4.11. Participant’s Words about Support

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Colleagues. Diversity Advisory group</td>
<td>was a huge sounding board too.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J</td>
</tr>
<tr>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Approach and Commitment to Development

The participants’ descriptions of their approach and commitment to growth and development is another theme in the sense-making category. The subthemes for this theme were Intentional (I need to do this for myself), Enjoyment (I engaged in things I enjoyed), and Meet requirements (I have to do it because it is required). The key statements that generated these subthemes are summarized below (Table 4.12).

Table 4.12: Participants’ Words about Approach and Commitment to Development

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td></td>
<td>I was really excited. I wanted to do everything I could to help students and the faculty and staff.</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>I thought I would learn. I served because I could learn and it very much interests me. I really wanted to do it.</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td>I’ve attended as much as I can fit into my schedule.</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>Convenience is the reason; actually it is a big reason.</td>
</tr>
<tr>
<td>G</td>
<td></td>
<td>Availability and my time.</td>
</tr>
<tr>
<td>J</td>
<td></td>
<td>If time allows and it interests me. Mandated to do things.</td>
</tr>
<tr>
<td>L</td>
<td></td>
<td>It’s really about the time. One more thing that takes time. Convenience really. Activities offered at the college because it is convenient.</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>I am very interested in learning and I wanted to do it.</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>Convenience. I participated in the activities that were offered here.</td>
</tr>
<tr>
<td>Q</td>
<td></td>
<td>I put myself out there.</td>
</tr>
<tr>
<td>R</td>
<td></td>
<td>I did it because I want to grow.</td>
</tr>
<tr>
<td>S</td>
<td></td>
<td>I am committed to learning and I enjoy making others think.</td>
</tr>
<tr>
<td>X</td>
<td></td>
<td>I really felt I needed to because of my position. But also, why not! I mean, it’s here; why not go to learn and grow?</td>
</tr>
</tbody>
</table>
**Introspection About Experiences**

Another way participants made meaning of the experiences they had during the time frame of this case study was through introspection about their experiences. These are statements that sum up the essence of their introspection about experiences. The subthemes were: Changing perspectives, Actions, Beliefs about self, Beliefs about others, Perception of others, Values, Challenging own beliefs, and Self-awareness. The key statements that made up these subthemes are presented below (Table 4.13).

Table 4.13. Participant’s Words about Introspection About Experiences

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to. I mean, are really resistant to change.</td>
</tr>
<tr>
<td>D</td>
<td>Daily personal interactions and being intentional about observing; trying to figure out why people do what they do, more like being in their shoes.</td>
</tr>
<tr>
<td>E</td>
<td>I assumed by being involved I would learn something.</td>
</tr>
<tr>
<td>F</td>
<td>It is uncomfortable but I don’t know! I’m not sure this is something that can be overcome, so much as being aware of it, being open to it, kind of watching for cues and proceeding accordingly.</td>
</tr>
<tr>
<td>G</td>
<td>I don’t intentionally go out and say, “Oh, this is going to be my cultural time.” I really just go casually and just try to absorb what’s going on.</td>
</tr>
<tr>
<td>J</td>
<td>Many things have been mandated and with also the challenge of learning…finding balance…it’s been hard and tiring with all the mandated things.</td>
</tr>
<tr>
<td>K</td>
<td>The perception that I have versus what they have can create problems along the way.</td>
</tr>
<tr>
<td>L</td>
<td>I just shared openly with my students…that I am learning this stuff too…and there is this internal struggle I feel with what I believe and what I am learning.</td>
</tr>
<tr>
<td>N</td>
<td>Can’t control certain parts of life and I’m OK with that; that surprised me.</td>
</tr>
<tr>
<td>P</td>
<td>This whole development process is complex, takes time, it’s a process and if I’m not mindful, it would be missed.</td>
</tr>
<tr>
<td>Q</td>
<td>I always feel like I put myself out there but maybe I am still focusing on commonalities; I don’t know, it’s just that I’m putting in adequate effort but not seeing results.</td>
</tr>
</tbody>
</table>
I’ve had tons of insights about myself….That experience gave me the best insight for what it’s like to really not understand and experience how others feel; especially the problems some of our students face… I’ve tried to take advantage of all the opportunities I can.

Discovered the more I learn, the more I need to learn. It’s like thinking you’re working on a 500-piece puzzle and realize that it’s really a 2,000-piece puzzle.

I’ve learned to be open to changes, to learning, that everybody has their right to an opinion or thoughts and to be accepting of them…to just be open-minded and to accept differences.

**Essence of Introspection**

To fully understand what happened across the cases, the participants’ essence of introspection statements is presented in Table 4.14 based on level of change in DO.

Further discussion of this information will be offered in Chapter V.
<table>
<thead>
<tr>
<th>Case/Participant</th>
<th>Essence of Introspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>I’ve learned to be open to changes, to learning, that everybody has their right to an opinion or thoughts and to be accepting of them... to just be open-minded and to accept differences.</td>
</tr>
<tr>
<td>R</td>
<td>I’ve had tons of insights about myself... That experience gave me the best insight for what it’s like to really not understand and experience how others feel; especially the problems some of our students face... I’ve tried to take advantage of all the opportunities I can.</td>
</tr>
<tr>
<td>P</td>
<td>This whole development process is complex, takes time, it’s a process and if I’m not mindful, it would be missed.</td>
</tr>
<tr>
<td>N</td>
<td>Can’t control certain parts of life and I’m OK with that; that surprised me.</td>
</tr>
<tr>
<td>S</td>
<td>Discovered the more I learn, the more I need to learn. It’s like thinking you’re working on a 500-piece puzzle and realize that it’s really a 2,000-piece puzzle.</td>
</tr>
<tr>
<td>D</td>
<td>Daily personal interactions and being intentional about observing; trying to figure out why people do what they do, more like being in their shoes.</td>
</tr>
<tr>
<td>E</td>
<td>I assumed by being involved I would learn something.</td>
</tr>
<tr>
<td>L</td>
<td>I just shared openly with my students... that I am learning this stuff too... and there is this internal struggle I feel with what I believe and what I am learning.</td>
</tr>
<tr>
<td>F</td>
<td>It is uncomfortable but I don’t know! I’m not sure this is something that can be overcome, so much as being aware of it, being open to it, kind of watching for cues and proceeding accordingly.</td>
</tr>
<tr>
<td>J</td>
<td>Many things have been mandated and with also the challenge of learning... finding balance... it’s been hard and tiring with all the mandated things.</td>
</tr>
<tr>
<td>C</td>
<td>I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to. I mean, are really resistant to change.</td>
</tr>
<tr>
<td>K</td>
<td>The perception that I have versus what they have can create problems along the way.</td>
</tr>
<tr>
<td>G</td>
<td>I don’t intentionally go out and say, “Oh, this is going to be my cultural time.” I really just go casually and just try to absorb what’s going on.</td>
</tr>
<tr>
<td>Q</td>
<td>I always feel like I put myself out there but maybe I am still focusing on commonalities; I don’t know, it’s just that I’m putting in adequate effort but not seeing results.</td>
</tr>
</tbody>
</table>

Table 4.14. Essence of Introspection Organized by Level of Change in DO
In Summary, this chapter began with presentation of the results from the quantitative phase. Then the findings from the qualitative phase were presented by participant and across the case. Chapter V will be dedicated to integrating the results from both the quantitative and qualitative phases with the purpose of understanding how the qualitative content informs the quantitative findings to answer the mixed methods questions.
CHAPTER V  
DISCUSSION

The purpose of this sequential explanatory mixed methods study was to examine the intercultural sensitivity development process of faculty and staff at a health sciences college in the Midwest. Specifically, this study investigated the relationship between developmental level of intercultural sensitivity to PsyCap, while understanding the approach to development.

Chapter V will begin with a discussion of the quantitative results followed by a discussion of the qualitative results. Then the results from both the quantitative and qualitative phases were combined to examine the mixed methods research questions:

1. How does the qualitative case study create a more complete explanation of the changes in IDI developmental scores and the relationship to PsyCap?
2. How does the qualitative case study explain the changes in organizational structures that support developmental growth in faculty and staff?

Chapter V will close with recommendations for future research, a review of implications, and researcher reflections.

**Discussion of Quantitative Phase**

The goal of the quantitative phase of the study was to examine the relationship between change in developmental level of intercultural sensitivity (DO in IDI) and PsyCap. The hypotheses that were tested in the quantitative phase were:

*Hypothesis 1:* There will be a significant increase in developmental level of intercultural sensitivity of faculty and staff from 2010 to 2013.

*Hypothesis 2:* There will be a positive relationship between PsyCap score and change in IDI DO.
While Hypothesis 1 was supported, Hypothesis 2 was not supported. There are two possible reasons which will be explored in this section. The first possible reason could be the lack of adequate \( n \). There were 52 faculty and staff who took the IDI and PsyCap; the priory power analysis indicated that an \( n \) of 40 would provide enough participants to avoid a Type 1 error. However, once the data was cleaned to meet the criteria of this study (taken the IDI in 2010 AND 2013, along with PsyCap), only 33 participants met the criteria. Therefore, a reason for a lack of finding for Hypothesis 2 could be small \( n \). The second possible reason could be while there is no relationship between PsyCap and change in IDI DO, had the data been controlled to only include participants at the Minimization DO level (at the time of the first IDI assessment in 2010), there may have been different findings. This will be discussed further in the mixed methods analysis section.

**Discussion of Qualitative Case Study**

The goal of the qualitative case study was to understand what happened that led to changes in developmental level of intercultural sensitivity for each participant. The case study analysis revealed three key findings across the cases: (a) level of desire by the participant to engage in developmental activities, (b) level and type of support the participant received, and (c) depth of introspection by the participant. Each finding will be explored in detail in the following paragraphs.

The participants in this case study all engaged in a tremendous amount of developmental activities. Most of the activities were organized and offered onsite at the college and are required for all regular faculty and staff. The policy, implemented in 2011, states:
All regular employees (0.6 FTE or greater) are required to participate in a minimum of three approved diversity-related activities per year. These activities will be reviewed by the employee’s manager at the employee’s annual review. The activities must be approved by the Diversity Council, and two of them must be designated by the Council as educational in nature. Consequences for a failure to meet the requirement will be determined by the manager conducting the annual review. (Bryan College of Health Sciences, 2011, p. 1)

**Level of Desire to Engage in Developmental Activities**

One of the findings from the case study revealed that while everyone participated in diversity activities, not everyone participated in these activities with the same level of desire. The majority (5 out of 6) of participants who experienced positive changes in their DO level expressed a strong desire to participate in activities. The participants’ statements ranged from “I wanted to learn” to “I am very interested in learning” to “I am committed to learning and I enjoy making others think.” Whereas the majority (4 out of 5) of those who stayed the same and those who had negative changes in their DO level (3 out of 3) expressed the reason for participation was because it was convenient or required. Typical statements from this group were: “If time allows and it interests me because mandated to do it” to “Convenience really, it is right here” to “It’s really about the time. One more thing that takes time, so activities offered at the college during work because it is convenient.”

This finding supports the argument that “the key to cultural competency is cultural desire, wanting to, rather than having to, learn and interact with other cultures” (Kardong-Edgren & Campinha-Bacote, 2008, p. 38).
Level and Type of Support the Participant Received

Another finding from the cross-case analysis was that, while all participants had faced challenges in their personal and/or professional life, those who had positive gains in their DO level were the participants who had strong support at home and at work. The support led to a depth of introspection that was not evidenced in the participants whose DO level remained the same or declined. Some participants identified their supervisor as the reason for their ability to effectively deal with the challenges. X experienced the most growth in DO (+41.57). The greatest challenges for X were professional, mostly due to a tremendous increase in her duties. X stated:

I’d have to credit my boss, a lot of credit. When things come up, she’s the person who comes and talks things through, and she’s always been, I think, a good role model as far as, “knowing the way and showing the way,” which is one of our values.

Similar to X, Q experienced mainly professional challenges due to a tremendous increase in workload.

Q experienced the highest level of decline in DO level (-16.10). Q stated, “I was doing more than what two people are doing in two full-time jobs; I was doing with just myself. I was feeling frustrated at that point. It was nerve-wracking.” Q stated that the subject had to be approached with care with the supervisor. “I requested for changes to be made, and I actually am going to be doing something different.” K also experienced decline in DO level (-7.93), though not quite as much as Q.

K talked about both personal and professional challenges. K stated, “Definitely my boss when it comes to the work challenge. I have been able to be very open with about frustrations…asking for help and advice of what I do about certain situations.” So
while K received a tremendous amount of support from the boss for work challenges, there was a specific and difficult personal challenge that K believed could not be discussed with anyone. K stated, “I realized that I probably needed to talk to a professional…I didn’t really talk to my family because I’m uncomfortable talking about it with them.” C had no significant changes in IDI developmental level (-4.61).

C had tremendous growth in job requirements which were similar to X and Q. While C had many colleagues who supported her efforts at work, “I talked to peers…we’ve talked a lot about this within our Success Center.” C experienced a great deal of resistance from other colleagues for wanting to make educational activities a requirement to help faculty, staff, and students grow in their developmental level. She also experienced strong resistance for wanting to create processes/courses to help at-risk students (specifically nontraditional/minority students) succeed. “I was shocked when people said NO. I was really surprised by how people sometimes just don’t want to. I mean, are really are resistant to change.” This resistance from colleagues (some colleagues C has been working with for nearly three decades) is the reason indicated by her long-time friend and colleague as a potential reason C’s developmental level didn’t increase:

She took a lot of flak at different times…And I think she was disappointed because she said her IDI score went down...But I think some of that probably is because of the flack she got from different people. You know, some people didn’t like the requirements that we have to do so many hours of activities toward improving our understanding of diversity. Some people didn’t like the incorporating of like the One Book-One College. So I don’t know if some of the negative feedback she got influenced how she did the second time.
These are a few of the examples. All of the 14 participants talked about the variety of levels of support which led to the discovery that, while all participants faced challenges in their personal and/or professional life, those who had positive gains in their developmental level were the participants who had strong support at home and at work. This discovery is supported in other organizational change studies. Dr. Heifetz (as cited in Parks, 2005) explains it as:

If people are going to move from one way of seeing and behaving to another, they need to be in a social culture that will hold them in a trustworthy way and keep them focused and working on the issues, even and especially when it gets uncomfortable. (p. 57)

**Depth of Introspection by the Participant**

The next discovery from the cross-case analysis indicates that the depth of reflection was a critical factor in changes in developmental level. The literature in intercultural development (Bennett, 1986, 1993; Bennett & Bennett, 2004; Hammer et al., 2003) discusses the process for development involving intentional self-reflection. This body of research indicates that in order for a person to grow in intercultural sensitivity, it is not simply participating in activities or attending events that is important; however, intentionally reflecting on the similarities and differences between oneself and others (in one’s beliefs, values, biases, assumptions, stereotypes) that will contribute to an increase in developmental level.

The participants who experienced statistically significant increases had deeper level of reflection identified with phrases like: “open to changes, learning, being open-minded”; “it’s a process, mindful or it will be missed”; “personal interaction with an eye on being intentional about observing, trying to figure out why people do what they do”;
and “can’t control it…and I’m OK with that.” Statements from those who had no significant changes were identified with phrases like: “I assumed by being involved I would learn something”; “it is hard and tiring to do this stuff”; and “it is uncomfortable, but I don’t know.” And the participants who experienced a statistically significant decreased level of reflection were identified with phrases like, “I don’t intentionally go out and say, ‘Oh this is my cultural time.’ I just go casually and just try to absorb what’s going on”; and “I always feel like I put myself out there.”

The depth of intentionality in self-reflection is the factor which has the most impact on the changes in developmental level (Hammer, 2011). In the book *Deep Change*, Robert Quinn (1996) talks about the essential path to internal development as the ability to “reinvent ourselves by changing our perspectives” (p. 66) and to see that “our lives are full of significant things about which we are unaware. Gaining an appreciation of these things can radically alter how we see the world and how we behave” (p. 70).

**Discussion of Mixed Methods Analysis**

In this part of Chapter V the results from both the quantitative and qualitative phases are combined to examine the mixed methods research questions:

1. How does the qualitative case study create a more complete explanation of the changes in IDI developmental scores and the relationship to PsyCap?

2. How does the qualitative case study explain the changes in organizational structures that support developmental growth in faculty and staff?

The data was mixed at multiple stages of the research. The findings in the quantitative phase drove the interview protocol and the selection of the participants in the
qualitative phase. In that process, the quantitative results informed the qualitative findings (Creswell & Plano-Clark, 2011). This study also used Onwuegbuzie and Teddlie’s (2003) seven-step process for analyzing the data together. First, quantitative and qualitative data were reduced to key elements. Next a table was created with the reduced elements of PsyCap, DO change from quantitative, and significant themes (utilizing participants’ statements as much as possible) from the qualitative data are all displayed together. The third step was the transferring of data into the table, and fourth was looking for correlations. Final steps are data consolidation, comparison, and integration, respectively, to create a complete picture of the research. That information is presented for a side-by-side analysis in Table 5.1.
<table>
<thead>
<tr>
<th>Code</th>
<th>PsyCap Score</th>
<th>DO in 2010</th>
<th>DO Change</th>
<th>Position</th>
<th>Major Challenge</th>
<th>Support System</th>
<th>Introspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>6.92</td>
<td>118.26</td>
<td>-4.61</td>
<td>Staff Leadership</td>
<td>Faced multiple challenges to recommending and implementing changes</td>
<td>Some colleagues, internal drive, personal beliefs</td>
<td>Shocked by resistance. I need to be patient. I don’t think people mean to be difficult. I think it’s the way we train them to think.</td>
</tr>
<tr>
<td>S</td>
<td>6.42</td>
<td>99.23</td>
<td>19.25</td>
<td>Staff</td>
<td>Difficult family issue, Significant growth at work</td>
<td>Mostly internal, spouse at times, church, sometimes colleagues</td>
<td>The more I learn, the more I need to learn. Challenge others to learn.</td>
</tr>
<tr>
<td>R</td>
<td>6.33</td>
<td>85.02</td>
<td>30.39</td>
<td>Staff Leadership</td>
<td>Multiple tough family issues, Work demands increased exponentially</td>
<td>Spouse, adult child, faith, church, family, multiple colleagues and leaders</td>
<td>I am resilient; take it one day at a time. Taking advantage of opportunities; helps me understand how others feel.</td>
</tr>
<tr>
<td>X</td>
<td>6.25</td>
<td>87.34</td>
<td>41.57</td>
<td>Staff</td>
<td>Multiple new workplace changes and challenges</td>
<td>Supervisor, gave support and modeled the behavior</td>
<td>Open to changes, to learning; I am just way more open-minded.</td>
</tr>
<tr>
<td>N</td>
<td>5.92</td>
<td>87.61</td>
<td>21.19</td>
<td>Faculty</td>
<td>Adult children moving away, Increase in students/work</td>
<td>Faith, family, colleagues, supervisor</td>
<td>Can’t control certain parts of life, and I’m ok with that; that surprised me.</td>
</tr>
<tr>
<td>E</td>
<td>5.92</td>
<td>111.56</td>
<td>3.84</td>
<td>Staff Leadership</td>
<td>Big promotion and recognition</td>
<td>Spouse, faith, colleagues, supervisor</td>
<td>Being involved means growth will happen.</td>
</tr>
<tr>
<td>D</td>
<td>5.83</td>
<td>120.06</td>
<td>10.25</td>
<td>Faculty</td>
<td>Getting other faculty to implement the changes needed</td>
<td>Spouse, colleagues</td>
<td>Stay the course; challenge others.</td>
</tr>
<tr>
<td>Q</td>
<td>5.58</td>
<td>99.67</td>
<td>-16.1</td>
<td>Faculty</td>
<td>Overwhelmed by work and family demands</td>
<td>Spouse, belief in myself, colleagues at times</td>
<td>I believe I am doing all the right things.</td>
</tr>
<tr>
<td>F</td>
<td>5.50</td>
<td>94.33</td>
<td>2.28</td>
<td>Faculty</td>
<td>Difficult family issue</td>
<td>Colleagues, doctor, self, colleagues, students, self</td>
<td>Emotions first, then take action. Willing to put myself in difficult situation for sake of students’ growth.</td>
</tr>
<tr>
<td>L</td>
<td>4.25</td>
<td>85.27</td>
<td>2.7</td>
<td>Faculty</td>
<td>Loss of an important family member, New content is personally challenging me</td>
<td>Faith, family, colleagues, students</td>
<td>I openly shared with my students the internal struggle for me; I don’t have answers.</td>
</tr>
<tr>
<td>K</td>
<td>4.25</td>
<td>116.73</td>
<td>-7.93</td>
<td>Staff Leadership</td>
<td>Embarrassing personal challenge, Work growth/promotion</td>
<td>Professional help, supervisor, family, friends</td>
<td>The perception I have versus what others have has created problems along the way.</td>
</tr>
<tr>
<td>J</td>
<td>3.92</td>
<td>91.19</td>
<td>-1.33</td>
<td>Faculty</td>
<td>Lots of changes in personal/family life, Growth in students made classroom dynamics challenging</td>
<td>Spouse, family, friends, colleagues, mentor, supervisor</td>
<td>Hard to find balance to manage and learn with all that is changing and being mandated. Why does it have to be mandated? Annoying really.</td>
</tr>
<tr>
<td>G</td>
<td>3.75</td>
<td>122.24</td>
<td>-13.23</td>
<td>Faculty</td>
<td>Significant losses and changes in family</td>
<td>Family, friends, faith, spouse</td>
<td>I casually try to absorb what’s going on.</td>
</tr>
<tr>
<td>P</td>
<td>3.50</td>
<td>91.40</td>
<td>29.88</td>
<td>Staff Leadership</td>
<td>Big job change and promotion</td>
<td>Lots of people at different stages for different things</td>
<td>I didn’t believe I could do it. Others did and supported me.</td>
</tr>
</tbody>
</table>

Table 5.1. Mixing of Quantitative and Qualitative Findings
The findings from the qualitative phase of this study enhanced the understanding of the quantitative results by revealing that in this study high PsyCap supported growth in developmental level in several ways:

1. Key leaders with high PsyCap and relatively high developmental level created environments and initiatives that encouraged the development and growth of others in the organization.

2. Leaders with high PsyCap and relatively high developmental levels who directly supervised individuals with high PsyCap, were described as having a positive impact on direct reports’ developmental levels.

3. Individuals with low PsyCap experienced developmental gains if they were in close working relationship with others with high PsyCap.

These findings will be discussed in detail in the following paragraphs.

1) Key Leaders with High PsyCap and Relatively High Developmental Level

Create Environments and Initiatives that Encouraged the Development and Growth of Others in the Organization.

C is the participant who had the highest PsyCap score, yet her developmental level did not have statistically significant change from Time 1 to Time 2 (DO Change = -4.16; statistical significance is > +/- 7 points). C is one of the key leaders in initiating the changes during the cultural competence and diversity initiative. In fact, she is the person who has fought hardest for accommodations to support nontraditional/minority students. This has created the biggest challenge for C. Several participants named C as the reason for the initiative’s success. The fact that C has the highest PsyCap and had a relatively
high starting DO level of Acceptance is a potential reason why others recognized her as the reason for the initiative’s success. During the qualitative phase several participants mentioned her support. In this study it could be surmised that her high PsyCap combined with her relative high IDI DO level helped create an environment that led to growth and forward momentum for the initiative as well as raising the developmental levels of those in direct relationship with C.

C shared about the enthusiasm in engaging in multiple activities with a strong desire to learn and grow. The fact that C engaged in multiple learning opportunities, combined with C’s high PsyCap level, is a potential reason C’s developmental level did not decline further. The lack of change C experienced in developmental level could be a potential mechanism of coping with the pushback and resistance C experienced (specifically the resistance and pushback from faculty about changing processes to support nontraditional/minority students) along with the immersion in a minimization culture. This finding is supported in research on social exchange theory (SET) (Blau, 1964; Emerson, 1976; Erdogan & Liden, 2002). SET suggests individuals characterize themselves in terms of who they interact with and how they interact with them. C’s experiences and challenges with colleagues could be understood through further exploration using SET.

2) Leaders with high PsyCap and relatively high developmental levels who directly supervised individuals with high PsyCap, were described as having a positive impact on direct reports’ developmental levels.

Another interesting way the qualitative data informs the quantitative findings was the relationship between C and X, and the reasons cited by X as the explanations for the
large developmental gains X experienced. X had the largest increase in developmental level (+41.57 points). X had a PsyCap score of 6.25, which puts X as the fourth highest PsyCap score in the qualitative participants. X stated that while there was a marked increase in work responsibilities, due to the initiative, X didn’t feel overwhelmed. The biggest support came from C (direct supervisor). In fact, the data revealed that C created an environment of trust, authenticity, and openness. X said:

I’d have to credit to my boss, a lot of credit. When things come up, she’s the person who comes and talks things through, and she’s always been, I think, a good role model as far as, “knowing the way and showing the way,” which is one of our values.

The relationship between X and C is supported by recent research in authentic leadership and PsyCap (Rego, Sousa, Marques, & Pina e Cunha, 2012; Wang, Sui, Luthans, Wang, & Wu, 2014). Authentic leadership is considered a positive, genuine, transparent, ethical form of leadership (Luthans & Avolio, 2003; Walumbwa, Luthans, Avey, & Oke, 2011). Wang et al. (2014) found that authentic leaders with high PsyCap created environments of trust which improved the performance of followers. While the present study did not delve into leaders’ impact or authentic leadership, the behaviors and attributes of C (as described by X) are consistent with previous research in authentic leadership (Reichard & Avolio, 2005). Furthermore, the growth in developmental level experienced by X, in spite of the tremendous amount of increase in the duties at work, suggests that X’s high PsyCap and relationship with direct supervisor (C) could be an indication that since both of them had high PsyCap it helped to propel X into being the highest person with developmental gains.
3) **Individuals with low PsyCap experienced developmental gains if they were in close working relationship with others with high PsyCap.**

P experienced the third highest growth in developmental level (DO change = 29.88); however, had the lowest PsyCap score (3.50) amongst the participants. During the qualitative interview, the data indicated that P was promoted into a leadership position and charged with the responsibility to create and grow a new program. P had strong doubts regarding the ability to make that happen:

My first instinct was I felt inadequate. But one of my colleagues, she was just very confident that I could do it…that I was doing it already. I was very concerned that I was going to get blindsided by what I didn’t know I needed to know.

P had strong support from leaders with high PsyCap (C, R, E, and several who were not selected for the qualitative case study but had taken the PsyCap as part of Phase 1 of the study) who encouraged and came alongside her:

A lot of people accompanied me on the journey. It was different people for different things. I have many friends here and one of them made me realize that I can be highly critical of myself. I asked them questions and they were open to me seeking their help. Collaboration is our norm.

Even though P had the lowest PsyCap, the level of support from supervisors and other colleagues in leadership with high PsyCap encouraged and empowered P to accept the challenges at work; by doing so, she was able to experience developmental growth.

Similar findings were identified in the Wang et al. (2014) research related to performance of those with low PsyCap.

The qualitative and quantitative data were also analyzed in order to answer the second mixed methods question: How does the qualitative case study explain the changes in organizational structures that support developmental growth in faculty and staff? The
college’s process was extensive and comprehensive. They began with the involvement of the college president and all the deans. They included this initiative in their strategic initiatives.

A leader in the organization was charged with operationalizing this initiative. Giberson, Resick, and Dickson (2005) believed organizations take on the personality of their leaders. The person selected to lead the college’s initiative was described by the provost as a person who “believes it and lives it authentically.” The leader selected to move this initiative created an internal Diversity Council made up of faculty and staff, along with an external Diversity Advisory Board made up of community experts in areas of diversity and cultural competence.

These were two ways the leadership of the college was able to gain input from both internal and external stakeholders, which created additional momentum to create sustainable changes in the organization’s policies and practices. The most talked about policy changes by the participants in the study were:

1. Requirement for all employees to engage in ongoing cultural competence activities/educational opportunities as an essential step in ensuring faculty and staff are learning and growing in new knowledge.
2. One Book-One College program whereby all faculty and staff, along with all students, are required to read/discuss the same book each semester as a way to create a community dialogue that challenges everyone’s developmental level.
3. A variety of onsite and ongoing activities at times that the majority of faculty and staff can participate.
These are the changes in organizational structures that this college engaged in. These were obtained through the qualitative case study which enriched the study. This information connects with current research in diversity and cultural competence in healthcare.

Richard (2000) stated that increasing diversity programming will improve organizational performance. Dreachslin (2007) observed that those leading organizational diversity and cultural competence initiatives must work to create environments in which diversity and cultural competence is fostered, encouraged, and reinforced. Wilson-Stronks and Mutha (2010) interviewed 59 hospital CEOs and discovered that diversity and cultural competence initiatives succeed when directive and support for the initiative comes from the top leadership—specifically the CEO—and that the support encourages changes to current and future policies and procedures.

In conclusion, the quantitative results indicated that the faculty and staff of the college experienced significant growth in DO and that there was not a significant relationship between PsyCap and the changes in DO. However, the findings from the qualitative phase of this study enhanced the understanding of the quantitative results in that high PsyCap supported growth in developmental level in several ways:

4. Key leaders with high PsyCap and relatively high developmental level created environments and initiatives that encouraged the development and growth of others in the organization.

5. When the leaders with high PsyCap and relatively high developmental level directly supervised individuals with high PsyCap, it led to gains in the direct report’s developmental level.
6. Individuals with low PsyCap experienced developmental gains if they were in close working relationship with others with high PsyCap. Further, the qualitative results indicated that the changes in the organizational structures created the right mix for significant growth in developmental level.
Implications

The mixed methods findings from this study offer implications related to cultural competence in healthcare. The implications will be explored from both research and practical lenses.

From a practical lens, this study revealed that individuals charged with implementing a diversity and cultural competence initiative must be developmentally ready (at Acceptance or Adaptation) to envision and create policies and practices that enhance the developmental level of others in the organization. That developmental readiness, along with high PsyCap, enabled the leaders to tackle the challenges that came with implementing changes in organizations. Since PsyCap is a state-like higher order construct (Luthans et al., 2007), the data revealed that health sciences colleges could greatly benefit from PsyCap intervention before embarking on a long-term organizational change initiative.

Campinha-Bacote’s (2002) work focused on cultural desire as the first step necessary to move into cultural competence. This study adds to that body of knowledge in providing an important first step—developmental readiness. In order for healthcare educators to be able to effectively meet the needs of their students, they must be developmentally at the level of acceptance and adaptation (Hammer, 2009, 2011). This developmental level generates a cultural desire that has been long missed as an antecedent to effective operationalization of diversity and cultural competence initiatives in healthcare, from a clinical and nonclinical standpoint.

Using the standard bell curve, we know that approximately 65% of the population falls into Minimization (Hammer et al., 2003). In 1946, Albert Einstein gave a speech on
why education is the key to ceasing the proliferation of nuclear weapons. Similar to Einstein’s belief that “…a new type of thinking is essential if mankind is to survive and move toward higher levels” (“Atomic Education,” 1946, p. 13) is the core belief of this researcher that new developmental levels of the masses are necessary to innovatively transform healthcare. Those in education and leadership of healthcare systems must be working toward higher developmental levels in order to engage in problem solving at a new level. This study indicated that individuals who are willing to embark on this challenging work are those with high levels of hope, efficacy, resilience, and optimism (PsyCap).

Additionally, the data revealed that requiring employees to engage in ongoing cultural competence activities/educational opportunities is an essential step in ensuring faculty and staff are learning and growing in new knowledge. These activities are best when offered onsite and at times that the majority of faculty and staff can participate. The qualitative phase also indicated that the One Book-One College program, whereby all faculty and staff along with all students are required to read/discuss the same book each semester, is an effective way to create a community dialogue that challenges individuals’ developmental level. Last, having an internal Diversity Council made up of faculty and staff, along with an external Diversity Advisory Board made up of community experts in areas of diversity and cultural competence, are two ways the leadership of the college gain input from both internal and external stakeholders and created the momentum necessary to create sustainable changes in the organization’s policies and practices.

From a research lens, the process of changing how healthcare workers are prepared for current and future challenges begins with healthcare educators and leaders.
In order for future healthcare workers to be ready to face the changing environment, they must be developmentally ready to face the challenges that come with caring for diverse populations. This developmental readiness, as identified by research (Hammer 2009, 2011), has been set at the Acceptance and Adaptation levels. At the developmental level of Denial is an attitude to proclaim one’s own culture is real or legitimate and the other cultures are irrelevant in some sense. A person may recognize observable cultural differences like food but denies deeper ones such as communication styles. Polarization is the developmental level that polarizes differences into either defense or reversal. In defense the individual believes his or her culture is better than the others, while those in reversal believe other cultures are better than their own. Minimization tends to highlight cultural commonality and mask cultural difference. Individuals in Minimization believe humans are “basically the same” and, as such, treat others the way they would want to be treated. However, an interculturally competent individual is believed to be able to “accept” both cultural commonality and difference in one’s own and other cultures, and better to “adapt” by shifting cultural perspective and changing behavior in culturally appropriate and authentic ways (Bennett, 2004; Hammer, 2011).

The data collected in healthcare had revealed that the culture of healthcare is in Minimization (Altshuler et al., 2003; Huckabee & Matkin, 2012; Li, 2010). In healthcare patients are diagnosed using “the same” processes and treated using scientifically proven methods that are standard practice. When individuals are taught to think and make decisions based on these standard procedures, they are being socialized into a culture of similarity and fairness is equal treatment. However, recent research (Altshuler et al., 2003; Hammer, 2009, 2011; Huckabee & Matkin, 2012; Li, 2010)—the present study
included—indicates that when teaching, leading, working with or caring for individuals who have been socialized differently—whose beliefs, values, norms, and traditions differ from the teacher, leader, or healthcare provider—highlighting commonality while masking difference results in disconnection. Intercultural competence has been proposed as one way to reduce health disparities in racial and ethnic minority populations (IOM, 2003).

In an increasingly global economy, intercultural competence may be the single most important quality required to lead and inspire others toward innovation. To achieve that level of competence requires that educators and leaders evaluate and change the ways they think and interact with others. In order to do that, educators and leaders must be willing to explore how their own background, beliefs, biases, and assumptions shape the way they think and interact with others. This depth of exploration is neither easy nor does it occur only through experiences with diverse populations. This development work requires intentional self-reflection during challenging and new experiences with diverse populations. The antecedent to embarking in this level of development work is having high levels of hope, efficacy, resilience, and optimism (PsyCap) or a strong support system that possesses high PsyCap.

**Future Research**

The body of research in intercultural competence in healthcare focuses on those currently providing care, and some body of research exists that focuses on healthcare educators. This is the first research to look at developmental levels of health sciences faculty and staff using the IDI and PsyCap. This study is also the first MMR to combine PsyCap with IDI developmental levels. However, the results of this study indicate that
additional MMR research using PsyCap would enhance the PsyCap research. Another study with a larger number of participants in a health sciences college could provide further insights that may have been missed in the present study.

A significant finding from this study is that the participants described how leaders with high PsyCap and even relatively high DO helped them increase their developmental level of intercultural sensitivity. Future research may want to expand on this to further explore how leaders with high PsyCap and high or relatively high DO impact the development of intercultural sensitivity in healthcare organizations. This work could explore whether there is and “augmentation effect” that PsyCap provides to help leaders develop and encourage higher levels of intercultural sensitivity in their followers and in their organizations. This line of research could also bring new insights in education and business environments.

Furthermore, this research focused on the changes in developmental level not necessarily where a participant began. There may be a relationship between starting DO level and PsyCap instead of a relationship between changes in DO level and PsyCap. Combined with that, the group/organization’s DO level may have an impact on a participant’s ability to increase their DO level. For example, in 2010, C’s DO level was in Acceptance. While her DO level did not have a significant change over the course of the three years, she was higher than the group DO level by almost 20 points. Whereas, X, R, P, N & S were all in minimization in 2010 and all increased their DO level from 19 to 42 points. Additional study of this phenomenon could further expand the body of knowledge.
Additional research in healthcare using the IDI and Campinha-Bacote’s model (2002) could provide further insight into the link between cultural desire and developmental levels as measured by the IDI. Dr. Campinha-Bacote believes that cultural desire is underlying piece for individuals in healthcare to engage in learning about the populations they serve. Future researchers may want to explore the relationship between developmental level (readiness) and cultural desire. This knowledge could expand the present body of knowledge of cultural competence and process for effective implementation of diversity and cultural competence initiatives in healthcare education.

Future researchers may want to extend the body of research offered in this study to include authentic leadership development. An antecedent of authentic leadership development is said to be self-knowledge (Peus, Wesche, Streicher, Braun, & Frey, 2012; Reichard & Avolio, 2005) and “trigger moments” (Luthans & Avolio, 2003). Engaging in activities that involve self-reflection (i.e., when interacting with others, do I know why I behave the way I do?) to gain greater clarity about oneself is an essential means of increasing developmental level of intercultural sensitivity. Another method is contemplating on key moments of discovery regarding cultural differences (Bennett, 2004; Hammer, 2011). The present study suggests that those who were able to identify specific events and specific ways those events challenged the participants to change the way they see themselves, as well as others, leads to increases in developmental levels of intercultural sensitivity.

Additionally, researchers may want to further study the relationship between leader’s level of PsyCap and its impact on follower PsyCap and IDI development controlling for where the follower begins on the IDI DO level using a larger sample size.
This would be similar to the Matkin and Barbuto (2012) research that used IDI and Leader-Member Exchange (LMX).

As indicated in the limitations sections, the current study was conducted in one small college with a limited number of participants and a lack of racial/ethnic diversity in the participants. While this is an important first step in studying the relationship between PsyCap and changes in developmental levels, future researchers may find it beneficial to replicate the research protocols in this study with larger participant numbers, with a racially/ethnically diverse population. There may be a significant relationship that was missed due to a small \( n \) at the quantitative phase. Another limitation of this study was that the participants had only taken the I-PCQ one time. Future researchers should consider administering the PsyCap and IDI equal number of times considering PsyCap is a state-like condition that can change over time. This researcher hopes to be able to continue this study by administering the PsyCap and IDI in 2016 for additional research.

**Summary**

In summary, the purpose of this sequential explanatory mixed methods study was to examine the intercultural sensitivity development process of faculty and staff at a health sciences college in the Midwest. Specifically, this study investigated the relationship between developmental level of intercultural sensitivity to PsyCap, while understanding the approach to development. The findings from the qualitative phase of this study enhanced the understanding of the quantitative results by revealing high PsyCap supports growth in developmental level in several ways:
1. Key leaders with high PsyCap and relatively high developmental level created environments and initiatives that encouraged the development and growth of others in the organization.

2. Leaders with high PsyCap and relatively high developmental levels who directly supervised individuals with high PsyCap, were described as having a positive impact on direct reports’ developmental levels.

3. Individuals with low PsyCap experienced developmental gains if they were in close working relationship with others with high PsyCap.

**Researcher Reflections**

One of the main reasons I chose to pursue a Ph.D. was to be able to get answers to questions I was asking as a practitioner and believed weren’t being researched. As a leader, I saw issues I believed needed to be addressed, but not the evidence base to support the change. I conducted qualitative research before knowing what those words meant. After presenting the results to a group of about 150 leaders, one of them suggested I consider presenting the results at a conference because this was the type of information people needed to know. That initial research was titled, *Understanding the Healthcare Challenges and Needs of Immigrant and Refugee Women in Nebraska*. The results of that research impacted the design, layout, structure, and process of healthcare delivery at The Women’s & Children’s Health Services at the health system. Even the head of that division was specifically hired with the identified needs in mind (Dr. Albert Ansah, Neonatologist, is from Ghana). I continued to provide insight to leaders in that division
even after having been gone from the organization for over 5 years. That is considered to
be one of the most rewarding things in my career.

While teaching at the college of health sciences, I began using the IDI with
students as a way to help understand how developmental level could impact the way they
approach their patients’ differences. Prior to entering my Ph.D. program, in 2008, with
the support of the college president, we implemented the use of the IDI with all incoming
and graduating students with specific and targeted interventions during their degree
program. In 2010, I recommended and facilitated the use of the IDI as a developmental
tool for faculty and staff being implemented. While I intuitively believed, and had seen
evidence of this belief, that those who are higher in developmental level would be better
able to handle the complexity of healthcare in this season, I had no idea what the research
would show regarding PsyCap and IDI developmental levels. As I poured over the data
and later conducted interviews with the participants, I discerned the dilemma, changes,
challenges, relief, and even anguish the participants experienced during the past 3 years.

I had no idea how the participants would feel about sharing personal and
workplace challenges with me (a person most of them have known for over a decade). I
was pleasantly surprised by the authenticity in what I heard. Their willingness to be real,
and share the good and the bad with genuineness, is what I believe gave this study the
richness it contains. While I believe I have obtained answers to the questions this study
asks, I fully recognize (and am excited) that there are many more questions that need to
be answered. I am not the same person who began this research a year ago. I have gained
a depth of knowledge and a stronger desire to continue to conduct research as a
practitioner—pragmatic researcher. Research that changes the way we educate present
and future healthcare providers; that opens the door to growth and learning in others. I fully believe human beings are made for connection. What’s more, I believes the healthcare delivery system is where those who desire to heal connect with those who need healing. My purpose—as a practitioner, educator, and researcher—is to do all that I can to enhance the skills of those who teach the healers and those who do the work of healing. I desire to do this so that the teacher and the healer would connect more authentically with themselves; as a way to create a path to connecting with others from all walks of life. I trust this study has brought me a little closer to that purpose.
REFERENCES


Appendices A: Internal Review Board Approval

1 – Bryan College of Health Sciences
2 – University of Nebraska-Lincoln IRB Approval
July 1, 2013

Helen Fagan
5310 Drew Place
Lincoln, NE 68516

Dear Helen,

The BryanLGH College of Health Sciences’ Internal Review Board (IRB) has unanimously approved your study, “Understanding Intercultural Sensitivity Development of Nurses using IDI and PsyCap: A Mixed Methods Study,” for implementation at the Bryan College of Health Sciences. The committee members are satisfied that your research methodology is sound and the privacy of your survey subjects will be adequately protected.

Please inform the IRB if you make changes to your research design or if any circumstances related to your study negatively impact one or more of your research subjects.

The Bryan IRB wishes you much success with this study and looks forward to hearing the results of your work.

Sincerely,

Jane Smith
June E. Smith, PhD, RN
Chair, BryanLGH College of Health Sciences IRB
Your project has been approved by the IRB.

Project Title: Developmental Level of Intercultural Sensitivity of Faculty and Staff at a Health Sciences College: A Mixed Methods Approach to Exploring the Relationship with Psychological Capital

Approvers Comments:

Dear Ms. Fagan and Dr. Matkin,

Project #13694 titled Developmental Level of Intercultural Sensitivity of Faculty and Staff at a Health Sciences College: A Mixed Methods Approach to Exploring the Relationship with Psychological Capital has been approved. You are authorized to begin your research.

Your stamped and approved informed consent form has been uploaded to NUgrant. Please use this form to make copies to distribute to participants. If changes need to be made, please submit the revised informed consent form to the IRB for approval prior to using it.

Your project was approved as an Expedited protocol, category 6 & 7. Please allow sufficient time for the official IRB approval letter to be available within NUgrant.

Cordially,

Rachel Wenzl
Research Compliance Services Specialist
Human Research Protection Program
Appendices B: Quantitative Measures

1 – Implicit PsyCap
2 – IDI Sample Questions
B1 – Implicit PsyCap

12 Item PsyCap Questionnaire (PCQ 12)

Below are statements that describe how you may think about yourself RIGHT NOW. Use the following scales to indicate your level of agreement or disagreement with each statement.

(1 = Strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, 6 = strongly agree)

1. I feel confident in representing my work area in meetings with management.
2. I feel confident contributing to discussions about the company's strategy.
3. I feel confident presenting information to a group of colleagues.
4. If I should find myself in a jam at work, I could think of many ways to get out of it.
5. Right now I see myself as being pretty successful at work.
6. I can think of many ways to reach my current work goals.
7. At this time, I am meeting the work goals that I have set for myself.
8. I can be “on my own” so to speak at work if I have to.
9. I usually take stressful things at work in stride.
10. I can get through difficult times at work because I've experienced difficulty before.
11. I always look on the bright side of things regarding my job.
12. I’m optimistic about what will happen to me in the future as it pertains to work.


Items adapted from: Parker, 1998; Snyder et al., 1996; Wagnild & Young, 1993; Scheier & Carver, 1985.

**Efficacy: Items 1-3**
**Hope: Items 4-7**
**Resilience: 8-10**
**Optimism: 11-12**
B2 – IDI Sample Questions

Intercultural Development Inventory

For each statement, please fill in the number that most accurately indicates your agreement or disagreement with the item. When a statement presents an opinion or viewpoint, respond to that item as if you overheard someone making the statement. Also, be sure to respond to each item in terms of the specific culture(s) with which you have had the most contact.

Responses: 1=disagree 2=disagree somewhat more than agree 3=disagree some and agree some 4=agree somewhat more than disagree 5=agree

1. It is appropriate that people do not care what happens outside their country.  
   1 2 3 4 5

7. People are the same; we have the same needs, interests, and goals in life.  
   1 2 3 4 5

22. If only other cultures were more like ours, the world would be a better place.  
   1 2 3 4 5

37. Family values are stronger in other cultures than in our culture.  
   1 2 3 4 5

47. I have frequently observed cultural differences in how problems are defined and solved.  
   1 2 3 4 5

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Appendices C: Informed Consent

1 – Quantitative Phase

2 – Qualitative Phase
C1 – Quantitative Phase

Dear Bryan College of Health Sciences Faculty and Staff,

Research indicates that Psychological Capital (Hope, Optimism, Resiliency and Efficacy) may be linked cultural intelligence, openness to experience, ethnocentrism, and cross-cultural adjustment (Dollwet M. 2010; Dollwet, M. & Reichard, R. J. 2013). For my Dissertation, I am conducting a study, to understand how your intercultural sensitivity development [changes in IDI] is linked to Psychological Capital. This is an important study that could potentially impact how we develop faculty and staff at healthcare colleges around the country.

Would you please consider being a participant in this study? If you choose to participate you are agreeing to:

1. **Taking an on-line assessment** (PsyCap) which will take **no more than 15 minutes of your time**. Since this is an online assessment, you may complete it at any time before [Insert Date] at a computer of your choice.
2. **Allowing me to use the results of your IDI assessments taken in 2010 & 2013 for data analysis** with the PsyCap assessment you will take.
3. You **may also be asked** to participate in the **second phase of the study** which entails being interviewed by the researcher (Helen Fagan). The interview will last approximately 30-45 minutes. During the interview, you will be asked to describe your intercultural development process between the time you took the IDI assessment the first time (2010) and the second time (2013).

**Phase 1** - All participants, who complete the online PsyCap survey, will be entered in a drawing for **Four $50 amazon gift cards**. Odds of winning are 1 in 15 (60 participants divided by 4 gift cards). Winners will be notified at the end of Phase 1 on or about September 15th.

**Phase 2** - All participants, who complete the semi-structured interview, will be entered in a drawing for **Two additional $50 amazon gift cards**. Odds of winning are 1 in 10 (20 participants divided by 2 gift cards). Participants will be notified at the end of phase 2 on or about January 15th.

There are no anticipated risks to your participation. Your confidentiality will be maintained at all times. Participants will not be identified by name or any unique information. A pseudonym will be chosen in place of name. If you are selected for the second phase any information obtained in the interview (through recording) will be transcribed and shared with you for accuracy of interpretation prior to being used in the analysis. No one other than the researcher will have access to your assessment results and/or your interview.

You are free to decide not to participate in this study. Your relationship with Bryan College or Bryan Health System will not be affected in any way if you choose to not participate. Further, you can also withdraw at any time without harming your relationship with me, the researcher, Bryan College of Health Sciences, Bryan Health System or University of Nebraska.

If you have any questions about this study or if you want to voice any concerns, please feel free to contact Helen Fagan, Doctoral Candidate and researcher, at (402) 770-4664 or helen.fagan@um.edu or Dr. Gina Matkin (402) 472-4454 or gmatkin1@um.edu. Also, you may contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965 if you wish to talk to someone other than the research staff to obtain answers to questions about your rights as a research participant; to voice concerns or complaints about the research or to provide input concerning the research process.

You are voluntarily making a decision whether or not to participate in this research study. Clicking ‘accept’ below certifies that you have decided to participate having read and understood the information presented. Please print a copy of this informed consent page for your records.

- Accept
- Decline
Dear Bryan College of Health Sciences Faculty and Staff,

Thank you for agreeing to participate in this Phase of the study. Research indicates that Psychological Capital (Hope, Optimism, Resiliency and Efficacy) may be linked cultural intelligence, openness to experience, ethnocentrism, and cross-cultural adjustment (Dollwet M. 2010; Dollwet, M. & Reichard, R. J, 2013). For my Dissertation, I am conducting a study, to understand how your intercultural sensitivity development (changes in IDI) is linked to Psychological Capital. This is an important study that could potentially impact how we develop faculty and staff at healthcare colleges around the country.

You have been selected to participate in this phase of the study. If you choose to participate you are:

1. Agreeing to participate in an interview conducted by the researcher (Helen Fagan). The interview will last approximately 30-45 minutes. During the interview, you will be asked to describe your intercultural development process between the time you took the IDI assessment the first time (2010) and the second time (2013).

2. All Phase 2 participants who complete the interview with the researcher, will be entered into a drawing for two additional $50 Amazon gift cards. Odds of winning are 1 in 10. Participants will be notified of winners at the end of the Phase 2 interviews on or about January 15th. Drawing will be conducted by a neutral party.

There are no anticipated risks to your participation. Your confidentiality will be maintained at all times. Participants will not be identified by name or any unique information. A pseudonym will be chosen in place of name. If you are selected for the second phase any information obtained in the interview (through recording) will be transcribed and shared with you for accuracy of interpretation prior to being used in the analysis. No one other than the researcher will have access to your assessment results and/or your interview.

You are free to decide not to participate in this study. Your relationship with Bryan College or Bryan Health System will not be affected in any way if you choose to not participate. Further, you can also withdraw at any time without harming your relationship with me, the researcher, Bryan College of Health Sciences, Bryan Health System or University of Nebraska.

If you have any questions about this study or if you want to voice any concerns, please feel free to contact, Helen Fagan, Doctoral Candidate and researcher, at (402) 770-4664 or helen.fagan@unl.edu or Dr. Gina Matkin (402) 472-4454 or gmatkin1@unl.edu. Also, you may contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965 if you wish to talk to someone other than the research staff to obtain answers to questions about your rights as a research participant: to voice concerns or complaints about the research or to provide input concerning the research process.
You are voluntarily making a decision whether or not to participate in this research study. 
Your signature below verifies that you have decided to participate having read and 
understood the information presented. A copy of this informed consent will be provided to 
you for your records.

Participant Signature: ___________________________ Date/Time: ______________

Witnessed by: ___________________________ Date/Time: ______________
APPENDIX D

Participant Recruitment Letter
Dear Bryan Faculty and Staff,

By now you have received a letter from the Diversity Council, that I am conducting my dissertation research about the process of development of intercultural sensitivity. Since you took the IDI in 2010 and 2013, I would like to ask you to consider participating in my research. My goal is to look at the development process to see what can be learned that can help other healthcare faculty and staff in other colleges. My study is a Mixed Methods study; therefore it will include a quantitative phase and a qualitative phase.

If you choose to participate, you would be asked to:
1) Phase 1 - complete the PsyCap Survey (15 minutes) by August 25th.
2) Your IDI assessment from 2010 and 2013 will be used in the study along with the PsyCap assessment.
3) If selected for phase 2 - you would be asked to participate in brief interview with me (30 minutes) by October 19th.

Compensation:
1) Everyone who participates in Phase 1 will be entered in a drawing for 4 (four) $50 Amazon Gift Cards.
2) If selected to participate in phase 2, you would be entered in another drawing for 2 (two) other $50 Amazon Gift Cards.

What are the risks of participation?
1) There are no known risks to participation.
2) All information will be kept confidential and no one but the researcher will see the results of the PsyCap survey and the interview contents.
3) All information that would identify a participant will be removed to keep the identity of the participant confidential.

How will the study benefit me?
1) The study would give you the opportunity to understand the link between your developmental level of intercultural sensitivity and Psychological Capital (Hope, Efficacy, Resiliency and Optimism) and to gain a more in-depth understanding of how to develop both.
2) Advance the field of cultural competence in healthcare.

If you are interested in participating in this study, please email me at helen.fagan@uni.edu and I will send you a confidential link to take the PsyCap Survey online.

Sincerely,
Helen A Fagan
Doctoral Candidate
University of Nebraska-Lincoln
Leadership Education
APPENDIX E

Transcriptionist Confidentiality Agreement Form
Confidentiality Agreement
Transcription Services

1. Glenda Hinz, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes, digital recordings and documentation received from Helen Fagan related to her doctoral study at the University of Nebraska-Lincoln exploring the developmental growth of faculty and staff. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews or in any associated documents.

2. To not make copies of any audiotapes, digital recordings or computerized files of the transcribed interview texts, unless specifically requested to do so by Helen Fagan.

3. To store all study-related audiotapes, digital recordings and materials in a safe, secure location as long as they are in my possession.

4. To return study-related documents to Helen Fagan in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes, digital recordings and/or digital files to which I will have access.

Transcriber’s name (printed)  Glenda Hinz______________________________

Transcriber’s signature  __________________________________

Date: __Nov. 18, 2013__________
APPENDIX F

Interview Protocol
Date and Time: __________________________________________________________

Location: ________________________________________________________________________________________

Interviewer: _______________________________________________________________________________________

Interviewee: _______________________________________________________________________________________

Time of Interview: Start: ___________ End: ___________

Thank you for agreeing to meet with me today for this interview. Qualitative researchers often view the interview process as a focused conversation about the central phenomenon of interest they are studying. I intend for this interview to be a conversation and want you to feel comfortable throughout our time together to ask questions. Before we get started with a few basic demographic questions, we need to go over the informed consent form and have you sign it. As you are aware, this form provides some basic information as to how we will proceed, what the study is about, your role and my role.

Review Informed Consent

Do you have any questions before we move forward with this conversation?

What is your position? ________________________________________________________________________________

Turn on tape recorder

To start with, would you please answer a few questions about your time here?

How long have you been in this position? _______________________________________________________________________

How long have you been with the organization? _______________________________________________________________________

I. Could you name and describe any changes/challenges (job, family, and personal) you have experienced in the last three years (Between 2010 and 2013 when you took the IDI)?
   a. What did you learn about yourself through these challenges/changes?
   b. Who guided you through the process (changes/challenges)?

II. Can you describe to me any experiences (coursework, travel, personal interactions, journaling, etc.) that you have embarked on specifically with the goal of becoming more culturally competent?
   a. What were your thoughts/emotions as you went through these experiences?
   b. How hopeful were you that you would succeed in your journey?
   c. What challenges did you face during the experiences?
   d. How did you overcome the challenges?
   e. What were the lessons learned from the experiences?

III. I know the college has had a Diversity and Cultural Competence initiative:
   a. What has been your role in this initiative?
   b. Which activities have you participated in?
   c. Why did these particular activities?
d. In your opinion, what has been the impact of this initiative so far?

IV. Is there anything else that you feel is important for me to know that I haven’t asked?