Nurses care for culturally diverse patients. Current challenges in care are related to: lack of awareness or knowledge of cultural differences, communication difficulties due to language differences, ethnocentrism and prejudice in caregivers, and lack of organizational support to meet the needs of diverse patients (Taylor & Alfred, 2010). The United States Census Bureau (2010) projects continued significant increases in racial and ethnic diversity over the next four decades, therefore the provision of culturally congruent care has become a priority (Taylor & Alfred, 2010). Because nurses provide most of the direct health care services in an organization, they are expected to be knowledgeable about the diverse health beliefs and practices of their patients in an effort to plan and implement culturally appropriate interventions.

Empowerment is often discussed in the literature in the context of factors that influence the nurse’s ability to make autonomous decisions based on professional judgment and expertise (Laschinger & Wong, 1999). A common theme found in several definitions of empowerment is that individuals require power in order to do their work in a meaningful way (Laschinger, Gilbert, Smith, & Leslie, 2010). It is assumed

---

**Abstract**

Increased cultural diversity of patients requires that nurses manage differences in health beliefs, practices, and expectations. It has been suggested that cultural competence is fundamentally nursing competence because it reflects the nurse’s ability to provide individualized patient care regardless of the patient’s social or cultural background. Psychological empowerment has been identified as an important contributor to professional nursing practice and may influence the provision of culturally competent care. The purpose of this study was to describe the relationship between cultural competence and psychological empowerment among acute care nurses in one urban hospital in Southern Connecticut. Schim and colleagues’ Cultural Competence Model was used as the theoretical framework.

Nurses care for culturally diverse patients. Current challenges in care are related to: lack of awareness or knowledge of cultural differences, communication difficulties due to language differences, ethnocentrism and prejudice in caregivers, and lack of organizational support to meet the needs of diverse patients (Taylor & Alfred, 2010). The United States Census Bureau (2010) projects continued significant increases in racial and ethnic diversity over the next four decades, therefore the provision of culturally congruent care has become a priority (Taylor & Alfred, 2010). Because nurses provide most of the direct health care services in an organization, they are expected to be knowledgeable about the diverse health beliefs and practices of their patients in an effort to plan and implement culturally appropriate interventions.

Empowerment is often discussed in the literature in the context of factors that influence the nurse’s ability to make autonomous decisions based on professional judgment and expertise (Laschinger & Wong, 1999). A common theme found in several definitions of empowerment is that individuals require power in order to do their work in a meaningful way (Laschinger, Gilbert, Smith, & Leslie, 2010). It is assumed

---

**Keywords**

cultural competence, cross cultural nursing, psychological empowerment, empowerment, nurses
that empowered nurses will provide better care, resulting in better patient outcomes (Laschinger et al., 2010). Psychological empowerment, as conceptualized by Spreitzer (1995), reflects an individual’s intrinsic task motivation to positively influence his job and workplace. There is empirical support for psychological empowerment as an essential component of positive patient outcomes (Laschinger, Finegan, Shamian, & Wilk, 2004; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

A literature review resulted in no published studies regarding the effect of psychological empowerment on cultural competence or cultural competence on psychological empowerment. The purpose of this study, therefore, was to describe the relationship between cultural competence and perceptions of psychological empowerment among acute care nurses.

**Theoretical Framework**

The theoretical rationale for this study is based on the Cultural Competence Model, developed by Schim and Miller (1999) and subsequently revised (Schim, Doorenboos, Benkert, & Miller, 2007), using the analogy of a three-dimensional (3-D) jigsaw puzzle (Figure 1) to represent the four pieces of provider level competence. The four constructs include: (a) cultural diversity, which varies in quantity and quality across place and time and includes not only differences in race and ethnicity but also differences in language, religion, gender, sexual orientation, and socioeconomic class; (b) cultural awareness, which includes knowledge and recognition of the various factors that contribute to differences in and between groups; (c) cultural sensitivity, or attitudes about oneself and willingness to become more culturally knowledgeable and skillful; and (d) cultural competence behaviors, which involves a set of behaviors demonstrated in response to cultural diversity, awareness, and sensitivity (Schim et al., 2007).

Schim and colleagues (2007) theorize that all four constructs are required, but are not individually sufficient to achieve culturally competent care. In addition, the development of cultural competence is an ongoing process that is informed by each cross-cultural encounter. The goal is not complete mastery of cultural competence, but rather matching provider competencies to meet the needs of specific populations and individuals who are the recipients of care (Schim et al., 2007).

**Literature Review**

Research regarding variables associated with cultural competence has demonstrated a positive correlation between level of educational attainment and cultural competence, and prior training and cultural competence (Schim, Doorenbos, & Borse, 2005; Schim, Doorenbos, & Borse, 2006). Nurses who have obtained a BSN or higher academic degrees are more likely to score higher on measures of cultural awareness.
and sensitivity (Schim et al., 2006). Greater experience with culturally diverse patient populations has not been linked with cultural competence among nurses (Schim et al., 2005), which may indicate that clinical encounters alone are insufficient to minimize cultural dissonance.

Taylor and Alfred’s (2010) study of nurses’ perceptions of organizational supports needed for culturally competent care identified several challenges, including: language barriers, lack of knowledge of cultural differences, minimal training programs, and the absence of explicit organizational expectations. Nurses’ communication difficulties and insufficient knowledge of cultural differences created misunderstandings with patients and their families that made care more challenging. However, the authors concluded that even with the availability of adequate interpreter services and educational programs, nurses may not incorporate training into patient care in the absence of explicit organizational expectations for cultural competence, accountability, and support for behavioral change.

While several researchers (Salman et al., 2007; Schim et al., 2005; Taylor & Alfred, 2010) suggest that training and education may enhance cultural competence, there is little empirical research that demonstrates the effectiveness of such training in improving clinical outcomes or identifies the requirements for sustainability. Furthermore, the nurse’s personal motivation to become culturally aware, knowledgeable, and skillful, may be a variable associated with cultural competence.

Empirical research has focused primarily on Kanter’s (1999) structural determinants of empowerment and less on the psychological experience of empowerment, conceptualized by Spreitzer (1995) as a set of cognitions that reflect an individual’s intrinsic task motivation to positively influence his job and workplace. Spreitzer (1995) theorizes that unless an individual is psychologically receptive, social and structural empowering conditions will not be fully realized.

Psychologically empowered individuals report high job satisfaction and less job strain, and demonstrate positive work performance (Spreitzer, 1995). Faulkner and Laschinger (2008) found psychological empowerment to be associated with nurses’ perceptions of respect, and Laschinger et al. (2004) reported psychological empowerment to be a significant predictor of job satisfaction, productivity, effectiveness, and decreased intent to leave the organization. Purdy et al. (2010) also found that nurses’ perceptions of psychological empowerment were significantly associated with empowered behaviors, job satisfaction, and nurse-assessed quality of care, which provides support for psychological empowerment as an essential component of positive patient outcomes.

Psychological empowerment has been identified as a predictor of innovative behavior (Knol & van Linge, 2009; Spreitzer, 1995), as well as a mediator between structural empowerment and innovative behavior (Knol & van Linge, 2009). Knol and van Linge (2009) suggest that psychologically empowered nurses believe they are autonomous and have an impact on their immediate work environment, and as a result may be more likely to be creative and engage in innovative behaviors. They further suggest that psychological empowerment may be important for stimulating and managing organizational change.

Leggat, Bartram, Casimir, and Stanton’s (2010) research indicated that psychological empowerment mediated the relationship between high-performance work systems and nurses’ perceptions of the quality of patient care. The mediating effect of psychological empowerment on other outcome variables important for nursing practice (e.g., burnout and organizational commitment) has been previously reported (Hochwalder, 2007; Avolio, Zhu, Koh, & Bhatia, 2004).

In summary, cultural competence of nurses is influenced by level of educational attainment and cultural diversity training, as well as explic-
it organizational expectations for cultural competence. In addition, psychological empowerment enhances nurses’ work effectiveness and job satisfaction, which lead to positive patient outcomes.

**Research Methods**

**Design**
A quantitative descriptive correlational design was used to examine the relationship between cultural competence and perceptions of psychological empowerment among acute care registered nurses. The setting for the study was a 425-bed licensed acute care urban hospital in Southern Connecticut. Data were collected over an eight-week period.

**Sample**
A non-probability convenience sampling strategy was used to obtain participants for this study. The accessible population (n = 593) consisted of acute care nurses working at the study facility. Inclusion criteria for the sample consisted of nurses working a minimum of 24 hours weekly and willingness to participate in the study.

Sample size was determined from power analysis, using a power level of 0.80. A small effect size of 0.20 to 0.30 (Burns & Grove, 2009) was assumed because this study represented a new area of research. With an alpha level of significance = 0.05, a minimum of 83 nurse participants were needed to detect statistically significant differences.

Following institutional review board approval from the study facility and the Human Rights Review Committee at Oak University in Rochester, Michigan, survey questionnaires were given to nurse managers, who informed nurses where the questionnaires were located on their units. Completed and returned questionnaires indicated nurses’ consent to participate in the study. The researcher collected completed questionnaires on a weekly basis over an eight-week period. A final sample of 120 nurses was obtained, indicating a 20% response rate.

**Instruments**
Cultural competence was measured using the Cultural Competence Assessment (CCA) questionnaire, a 26-item instrument designed to measure cultural diversity experience, awareness and sensitivity, and competence behaviors. The CCA can be applied to a wide range of health care disciplines, cultural groups, and education levels (Schim, Doorenboos, Miller, & Benkert, 2003). Cultural diversity experience is measured by respondents’ answer to a single question asking about specific racial or ethnic groups encountered in the workplace in the past 12 months. The item score is a count of the number of groups checked, with higher numbers indicating a greater diversity experience. The CCA has two subscales: the first subscale includes cultural awareness (knowledge) and cultural sensitivity (attitude) (CAS), and is measured with a 7-point Likert-scale with responses ranging from “strongly agree (7) to strongly disagree (1).” A “no opinion” response option is included but not scored. The second subscale for cultural competence behavior (CCB) is also measured with a 7-point Likert-like response set, with categories ranging from “always (7) to never (1).” A “not sure” response option is included but not scored. The items in each subscale are summed, with higher scores indicating higher levels of knowledge, more positive attitudes, and greater self-reported frequency of competence behaviors. In this study, the CAS and CCB subscale scores were added as an indicator of total cultural competence (S.M. Schim, personal communication, December 11, 2011). Demographic items on the CCA include questions about age, prior cultural diversity training, self-identified race or ethnicity, and level of education. The researcher added three additional demographic questions pertaining to gender, number of hours worked per week, and number of years worked in the nursing field.
The Cronbach alpha coefficient for the total CCA has been reported in previous studies at over 0.80 (Schim et al., 2006). In a study among acute care nurses, Cronbach alpha for the CCA was 0.89; 0.76 for the CAS subscale; and 0.93 for the CCB subscale (Schim et al., 2005). Content and face validity of the CCA were initially established by a panel of expert reviewers and also supported in contrasted groups validity tests (Schim et al., 2003). An examination of concurrent validity between Campinha-Bacote’s (1999) Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals (IAPCC) and the CCA revealed that scores from the CCA moderately correlated ($r = 0.66$) with those from the IAPCC (Schim et al., 2003).

Psychological empowerment was measured using the Psychological Empowerment Questionnaire (PEQ) (Spreitzer, 1995), a 12-item instrument that uses a 7-point Likert scale to measure the four subconstructs (meaning, competence, self-determination, impact) of psychological empowerment in the workplace. There are three items per dimension, and responses range from “very strongly agree (7) to very strongly disagree (1).” Items from each of the four subscales are added to measure total empowerment, with higher scores indicating higher degrees of psychological empowerment. Each subscale total is divided by three to indicate the average score of that subscale.

Cronbach alpha coefficients for the PEQ have ranged from 0.85 to 0.93 for the four subscales, and 0.85 for the total score (DeCicco, Laschinger, & Kerr, 2006). Faulkner and Laschinger (2008) reported Cronbach alphas ranging from 0.86 to 0.91 for the four subscales, and 0.89 for the total scale. Second-order confirmatory factor analysis to assess convergent and discriminant validity of the four subconstructs of psychological empowerment has indicated that each of the four dimensions represent different aspects of empowerment and contribute to the overall construct (Spreitzer, 1995). Spreitzer (1995) has reported that validity estimates for the dimensions are typically around 0.80 across a wide range of work environments, employees, and cultures.

**Data Analysis**

Data analysis was completed using the Statistical Program for Social Sciences software (Version 19.0). An apriori alpha level of significance was set at .05. Surveys with more than 10% missing data ($n = 9$) were excluded from analysis. The final sample size ($n = 120$) was sufficiently powered to detect a small effect ($r = .25$). Descriptive statistics were computed to characterize the study sample. A Pearson’s product-moment correlation coefficient was calculated to determine statistical significance between cultural competence and perception of psychological empowerment. Cronbach alpha reliability coefficients were computed for the major study variables.

**Research Results**

Demographic characteristics of the nurses in the study sample are described in Table 1. A majority of the participants were female (92.6%) with a mean age of 45.4 ($SD = 12.19$). Most of the nurses were White (81.8%), but the sample also included Black/African American, Hispanic/Latino, and Asian. Mean years working as an RN was 17.01 ($SD = 13.40$), and mean number of hours worked per week was 35.6 ($SD = 5.8$). Sixty percent held a bachelor’s or graduate level degree, and 91% had participated in cultural diversity training.

Descriptive statistics and Cronbach alpha reliability analyses related to the CCA and PEQ are presented in Table 2. Cronbach alpha for the total CCA in this study, as measured by the combined CCA and CCB subscales was .86, and the total PEQ alpha was .84. All of the subscale reliabilities were above 0.70 except for the CCA subscale, which was .61.

Nurses perceived themselves as having a moderate/high level of overall cultural competence ($M = 5.1$, $SD = 0.67$) and a high level of
Nurses reported experiencing a moderate/high level of total psychological empowerment ($M = 5.42$, $SD 0.7$). They reported a high sense of meaning ($M = 6.32$, $SD 0.06$) and competence ($M = 6.10$, $SD 0.7$) in their work, a moderate/high sense of self-determination ($M = 5.14$, $SD 1.2$), and a moderate ability to make an impact on organizational outcomes ($M = 4.13$, $SD 1.3$).

Pearson’s product-moment correlation analysis indicated that total cultural competence...
was not significantly related to total psychological empowerment ($p > .05$). Additional analysis of the CCA and PEQ subscale scores demonstrated that the PEQ meaning subscale was significantly correlated with self-reported cultural competence ($r = 0.24, p < 0.01$), cultural competence behaviors ($r = 0.22, p < 0.05$), and total cultural competence ($r = 0.23, p < 0.05$). The PEQ competence subscale was significantly associated with cultural competence behaviors ($r = 0.20, p < 0.05$). Correlations between cultural competence (CCA) and psychological empowerment (PEQ) are presented in Table 3.

Additional statistical analysis conducted for demographic effects on the major study variables used a lower alpha level of significance of $\alpha = 0.01$ due to the number of tests performed. There were no significant relationships between the demographic variables and total cultural competence or total psychological empowerment. There was a significant positive correlation between years working and competence score ($r = 0.34, p < .001$), where more years working was associated with higher competence scores.

In addition, there was a significant difference in cultural competence based on years of RN experience ($F(3, 116) = 6.23, p = .001$). The Bonferroni post-hoc tests showed nurses with less than one year of experience had lower scores than nurses with five to ten years of experience ($p < .001$), and also lower scores than nurses with more than 10 years experience ($p = .001$). The mean score for nurses with less than one year of experience was $3.6 (SD = 1.1)$, while the mean for nurses with five to ten years of experience was $5.0 (SD = 0)$, and for nurses with more than ten years of experience the mean was $4.5 (SD = 0.6)$.

### Discussion

Because each patient has a unique experience of health and illness, all encounters between nurses and patients can be viewed as cross-cultural encounters (Wepa, 2005). Culture, therefore, remains an important organizing construct in guiding nursing practice and in developing nursing knowledge (Dreher & MacNaughton, 2002). Findings from this study provide preliminary evidence of a relationship between cultural competence and dimensions of psychological empowerment. The results are noteworthy given the absence of research on psychological empowerment as a factor that affects the achievement of cultural competence.

In this study, the PEQ meaning subscale correlated significantly with total cultural competence. Meaning occurs when there is a fit between job requirements and an individual’s beliefs, values, and behaviors (Spreitzer, 1995); it is a reflection of the individual’s intrinsic caring preferences.

### Table 2: Descriptive Statistics for Major Study Variables

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Score range</th>
<th>Cronbach alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural awareness and sensitivity</td>
<td>6.05</td>
<td>.47</td>
<td>1-7</td>
<td>.61</td>
</tr>
<tr>
<td>Cultural competence behaviors</td>
<td>4.73</td>
<td>1.08</td>
<td>1-7</td>
<td>.89</td>
</tr>
<tr>
<td>Total cultural competence</td>
<td>5.13</td>
<td>.67</td>
<td>1-7</td>
<td>.86</td>
</tr>
<tr>
<td>PEQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meaning</td>
<td>6.32</td>
<td>.64</td>
<td>1-7</td>
<td>.86</td>
</tr>
<tr>
<td>Competence</td>
<td>6.10</td>
<td>.74</td>
<td>1-7</td>
<td>.72</td>
</tr>
<tr>
<td>Self-determination</td>
<td>5.15</td>
<td>1.16</td>
<td>1-7</td>
<td>.80</td>
</tr>
<tr>
<td>Impact</td>
<td>4.14</td>
<td>1.30</td>
<td>1-7</td>
<td>.87</td>
</tr>
<tr>
<td>Total empowerment</td>
<td>5.43</td>
<td>.71</td>
<td>1-7</td>
<td>.84</td>
</tr>
</tbody>
</table>

**Table 2:** Descriptive Statistics for Major Study Variables
about a task and its purpose (Thomas & Velt-house, 1990). The nurses in this study reported a high sense of meaning, which indicates that they highly value and care about the work they do. The correlation between meaning and total cultural competence suggests that cultural awareness and sensitivity and cultural competence behaviors are influenced by the nurse’s intrinsic caring about their work with patients. Nurses with high perceptions of meaning in their work may be more motivated to become culturally aware and sensitive and develop the knowledge and behaviors required to meet patients’ cultural-specific care needs. Having a passion for work that is personally meaningful may enhance the nurse’s capacity for what Doorenbos, Schim, Benkert, and Borse (2005) describe as culturally attuned nursing. They describe this as the “complex interplay of sensitivity, knowledge, behaviors, and awareness” (Doorenbos et al., 2005, p. 325) that results in culturally congruent care. A sense of meaning in their work may facilitate the nurse’s commitment to the ongoing process of becoming culturally competent.

The PEQ meaning subscale also correlated significantly with the cultural competence behaviors subscale (CCA). Cultural competence behaviors, which include conducting cultural assessments, respecting cultural customs, and seeking information and resources (Doorenbos et al., 2005), may be more frequently and consistently demonstrated in practice by nurses for whom work is personally meaningful and important. Similar to the relationship with total cultural competence, meaning may be a mechanism through which nurses develop the attitudes, knowledge, and skills that contribute to cultural competence behaviors. Meaning has been described as the driver of empowerment that energizes individuals about their work (Kizilos, Nason, & Spreitzer, 1997). Nurses who experience psychological empowerment through a high sense of meaning may be more motivated to minimize barriers to care, such as communication difficulties, and incorporate cultural preferences into care planning.

The third significant correlation with the PEQ meaning subscale was self-reported cultural competence, which reflects the nurse’s assessment of their competence working with people from different cultures. The nurses in this study described themselves as having a high level of cultural competence. Given that 91% of the nurses participated in prior diversity training and reported a moderate/high level of exposure to diversity, the favorable self-assessment of cultural competence is not surprising. The correlation between meaning and self-reported cultural competence, similar to total cultural competence and cultural competence behaviors, reinforces the role that caring deeply about work may have on nurses’ perceptions and behaviors. Although the use of self-evaluative

<table>
<thead>
<tr>
<th></th>
<th>CCA total</th>
<th>Cultural awareness and sensitivity</th>
<th>Cultural competence behaviors</th>
<th>Self-reported cultural competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEQ total</td>
<td>.12</td>
<td>-.09</td>
<td>.15</td>
<td>.16</td>
</tr>
<tr>
<td>Meaning</td>
<td>.23*</td>
<td>.08</td>
<td>.22*</td>
<td>.24**</td>
</tr>
<tr>
<td>Competence</td>
<td>.17</td>
<td>-.06</td>
<td>.20*</td>
<td>.15</td>
</tr>
<tr>
<td>Self-determination</td>
<td>-.04</td>
<td>-.14</td>
<td>-.01</td>
<td>.05</td>
</tr>
<tr>
<td>Impact</td>
<td>.09</td>
<td>-.08</td>
<td>.11</td>
<td>.10</td>
</tr>
</tbody>
</table>

*p < .05
**p < .01

Table 3: Correlations Between Cultural Competence (CCA) and Psychological Empowerment (PEQ)
tion measures is problematic in many ways (e.g., they do not include directly observable behavior and the patient does not participate in the evaluation process), it is a practical approach to obtaining information that can provide insight into behaviors. Thus, the nurse’s perception of her own cultural competence may be a credible indicator of cultural competence behaviors. Favorable self-assessment of cultural competence may possibly reflect a social desire for cultural expertise, although neither the overall CCA nor its subscales have shown correlation with social desirability as measured by the Marlow-Crowne Social Desirability Scale (S. M. Schim, personal communication, November 7, 2011).

In addition to experiencing psychological empowerment through a high sense of meaning, the nurses in this study also reported a high sense of competence. Competence, or self-efficacy, is related to the belief in one’s ability to perform work activities with skill (Spreitzer, 1995). The results of this study demonstrated a significant correlation between the PEQ competence subscale and cultural competence behaviors. Nurses who are self-assured about their professional skills may be more confident in their abilities to provide individualized care to all patients, regardless of cultural background. This sense of competence may result in the demonstration of culturally competent behaviors. This finding supports Dreher and MacNaughton’s (2002) contention that cultural competence is fundamentally the same as nursing competence, because it reflects the nurse’s ability to be equally therapeutic with all patients. Previous research (Kizilos et al., 1997) has identified a significant relationship between competence and work effectiveness, suggesting that nurses who experience psychological empowerment through a sense of competence may be more effective in meeting their patient’s cultural care needs. These nurses may demonstrate more innovative behaviors when implementing culturally appropriate interventions, consistent with Knol and van Linge’s (2009) finding that psychological empowerment is a predictor of innovative behavior.

A significant positive correlation between years of RN experience and PEQ competence scores was found in this study, as well as a significant difference between years of RN experience and self-reported cultural competence. Nurses with more years of experience had higher competence scores and higher self-reported cultural competence. Self-confidence and competence in professional nursing practice develop over time through experiential learning and skill acquisition (Benner, 2001). As a result, nurses with more years of experience may perceive themselves as more competent in their clinical practice. Similarly, competence in providing cultural-specific care develops over time, partly as a result of learning from previous cross-cultural encounters (Schim, 2005). Nurses with more years of experience perceive themselves as having greater mastery of the skills required to provide care to patients from a broad range of cultural backgrounds, and therefore assess themselves as having higher levels of cultural competence.

The results of this study did not support a significant correlation between total cultural competence and total psychological empowerment. While this finding was not significant with respect to the overall construct of psychological empowerment, empirical evidence suggests that each of its four dimensions contribute to different outcomes (Kizilos et al., 1997). Just as meaning and competence have been shown to demonstrate differential relationships with work effectiveness, work satisfaction, and job-strain (Kizilos et al., 1997), meaning and competence in this study demonstrated differential relationships with total cultural competence and its dimensions. The meaning and competence dimensions of psychological empowerment may be more important to the manifestation of cultural competence than the other dimensions of psychological empowerment (self-determination and impact).
Limitations

Several limitations were related to the study design and sampling methodology. The cross-sectional nature of the design, non-probability convenience sampling strategy, and small sample size (n = 120) limit generalizations to a greater population of nurses. Since participation in the study was voluntary, nurses who completed the questionnaires may not have been a representative sample. Furthermore, the majority of the study participants were white females with a mean age of 45.4. While this sample may have reflected the demographics of the nursing population in the United States, it would be important to know the relationship between the study variables in other ethnic and racial groups of nurses, and in nurses who may have been socialized in another culture (e.g., immigrant nurses).

Additional study limitations include self-reporting of cultural competence and psychological empowerment rather than direct observation of behaviors. The CAS subscale’s weak alpha reliability coefficient (0.61) may have also made it difficult to find significant relationships with the CAS. Finally, there may have been other variables influencing the findings that were not accounted for.

Conclusion and Implications for Future Research

This is the first study to examine the relationship between cultural competence and psychological empowerment among acute care nurses. Major findings suggest that the ability to provide culturally competent care may be related to the nurse’s experience of psychological empowerment through a sense of meaning and competence in work. These results contribute to a growing body of empirical knowledge regarding factors that influence culturally competent practice. Further research is required to determine if study findings are similar in hospitals in different regions of the United States and with different demographics in nurses and patient populations. While the sample size was adequate to detect statistically significant differences, increasing the sample size and including nurses from other specialties would enhance generalization. It would also be important for future research to investigate the effect of nurses’ socialization in another country on the relationship between cultural competence and psychological empowerment. Additional knowledge may be gained from conducting an intervention study that includes a continuing education session on cultural competence, and a pretest-posttest design to evaluate the effect on cultural competence.
References


Schim, S. M., & Miller, J. E. (1999). *Cultural competence program core components*. Detroit, MI: Henry Ford Health System/Oakland University Center for Academic Nursing. Available from s.schim@wayne.edu


The Authors

Karen Bauce, DNP, RN, NEA-BC
Dr. Bauce is an Adjunct Professor at Sacred Heart University, School of Nursing. Previously she was a health care consultant at Bridgeport Hospital, Bridgeport, Connecticut, where she designed and implemented the structures and processes for collaborative professional practice.

Suha Al-Oballi Kridli, PhD, RN
Dr. Kridli is an Associate professor at Oakland University, School of Nursing. She received her Bachelor degree from University of Jordan and her Master and doctoral degrees from University of Missouri-Columbia. Her research interest is in the areas of health beliefs and practices of Middle Eastern population and childhood obesity.

Joyce J. Fitzpatrick, PhD, RN, FAAN
Dr. Fitzpatrick is an Elizabeth Brooks Ford professor of nursing at the Frances Payne Bolton School of Nursing, Case Western Reserve University in Cleveland, Ohio.