Original Article

Determination of Intercultural Sensitivity Levels of Nurses and the Factors Affecting their Intercultural Sensitivity

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Abstract

Aim: This study was conducted to find out intercultural sensitivity levels of nurses and the factors influencing these levels.
Method: This descriptive study was conducted between September 1 and November 15, 2019 with 156 nurses who were not in their leave period and who agreed to participate in the study from nurses working in all units of the health practice and research centre of a university in Black Sea region. The data in the study were collected with face-to-face interview technique by using descriptive information form which included 23 items developed by the researchers in line with the literature and Intercultural Sensitivity Scale (ISS). SPSS package program (version 24.0) was used in the assessment of data. For data analysis, Independent t test, ANOVA, Tukey test, Mann-Whitney U test and Kruskal Wallis test were used in addition to descriptive statistics. $p<0.05$ level was considered as statistically significant in all statistical analyses. Ethical board approval and permission from the related institution were taken.
Results: Average age of the nurses who participated in the study was 30,28±8,74 years and 80,8% were female. Statistically significant difference was found between nurses' ages, marital status and total years of working and ISS scores. In addition, it was found that the employees' states of knowing a foreign language and whether they could get preliminary information about the patient statistically significantly affected intercultural sensitivity.
Conclusion: Nurses have moderate level of intercultural sensitivity. Age, marital status and total years of working are the factors influencing intercultural sensitivity. Nurses have problems in communication most when providing care to individuals from different cultures. The results of the study show the importance of providing training to increase cultural sensitivity to nurses working in university hospital especially because there are too many patients from different cultures recently in Turkey.

Key Words: Patient, Nurse, Cultural Sensitivity

Introduction

Culture is the values, beliefs, attitudes and behaviours, traditions and customs learned and shared by a group of people and transferred from generation to generation. Culture is a permanent part of life and every person has a culture. In multicultural societies, complex and different cultural understandings are common due to cultural diversity. These cultural understandings are shaped by concepts such as gender, age, race, socioeconomic level, ethnic characteristics, religious identity, sexual behaviours, education and history (Bolsoy & Sevil , 2006, Bayik, 2008). The multiculturalism situation existing in Turkish society has become more important with the increase in immigration from neighbouring countries. In general, immigrants' specific beliefs about family, child raising practices, health and disease roles are among issues that should be emphasized. Before providing a culturally correct care, the Professional should have information about individual differences and similarities (Bulduk, Usta, Dincer, 2017). Individuals with different cultural characteristics also have different health needs. When individuals are ill, they should be given a chance to express their cultural assets, their values should be respected and care should be provided accordingly (Tortumluoglu, 2004, Murray & Mckinney, 2010). Cultural values, beliefs and practices of the patient are the most important steps in an integrative approach to the patient

(Aktas, Gok Ugur, Orak, 2016). Today, communication and dialogue with different cultures have increased due to reasons such as rapid growth of the country population, mobility in tourism, students' changing countries for education, increase in international trade and working areas, political and economical reasons and technological increase in communication (Bekiroglu & Balci, 2014). Intercultural sensitivity can be defined as an individual's ability to develop positive attitudes by understanding cultural differences and showing an effective behaviour in intercultural communication. Intercultural sensitivity is a dynamic concept and this shows that individuals with intercultural sensitivity are individuals who have the desire to motivate themselves to understand, appreciate and accept intercultural differences and to produce positive results from intercultural interactions (Chen, 1997). Individuals with intercultural sensitivity should have some characteristics to develop positive feelings to understand and appreciate cultural differences and to promote intercultural competence. These are self-esteem, self-regulation, open mindedness, empathy and not having prejudice (Ulrey & Amason, 2001, Rengi & Polat, 2014). Employees who provide primary care about health should be sensitive to cultural differences of individuals within the society and consider intercultural differences so that they can provide effective care and increase the quality of care (Ozturk & Oztas, 2012, Cetisli et al., 2016). Health personnel should develop their intercultural sensitivity to do this. Ulrey and Amason (2001) emphasized that the following questions should be answered to develop cultural sensitivity:

– What do I know about the patient's culture?
– Do I consider the patient's culture while applying treatment to the patient?
– Do I consider the patient's culture while giving advice?
– Do I change my language while communicating with the patient?
– Do I understand the patient's values?

Nurses develop their intercultural sensitivity when they accept that the people they are providing care are different from them culturally and when they respect and appreciate their cultural values (Chen, 2010). When health professionals have cultural competence, their personalities and cultural experiences will interact and they will be able to evaluate the patient culturally and provide personalized care (Serrant Green, 2001, Domenig, 2004). Positive effects are observed in culturally evaluated individual, family or society. This way, the benefit and quality of care increases in patients. The communication between the patient and the care giver becomes stronger. Satisfaction increases for both parties. The individual providing care to the patient acquires sufficient information and equipment. Health outcomes and recovery increase. Hospital costs decrease in individuals who have positive recovery and decreases occur in mortality rates. Improvements occur in caregivers' approach to individuals from different cultures and most importantly their prejudices disappear (Goode, Dunne, Bronheim, 2006). However, a great number of problems occur while providing care to individuals from different cultures. Problems also occur in collecting data from individuals with different cultures, providing them treatment, giving them physical examination, communicating with them, providing them care and training individuals (Polat & Akcan, 2016, Kara et al., 2017). Communication becomes more difficulty when the care giving staff do not know a foreign language, when foreign individuals cannot speak Turkish, when there are no interpreters or there are insufficient number of interpreters in the hospital and when health professionals do not have training on the care of patients with different cultures (Polat & Akcan, 2016). There should be sufficient number of interpreters in hospitals where there are individuals from different cultures in order to minimize the problems experienced when providing care to individuals from different cultures. Foreigners accepted in the country should be taught Turkish, the forms in hospitals, especially informed consents should be prepared in different languages. Another solution can be taking the views of refugees from different cultures while developing policies for them (Jirwe, Gerrish, Emami, 2010, Uzun & Sevinc, 2015, Aktas, Gok Ugur, Orak, 2016, Polat & Akcan, 2016, Danc & Guney, 2017). Based on these points, the aim of this study is to find out intercultural sensitivity levels of nurses working in the health application and research centre of a university in Black Sea region and the factors influencing these levels.

Material and Method

Type and place of research: This descriptive study was conducted between September 1 and November 15, 2019 with nurses working in the

health application and research centre of a university in Black Sea region.

Population-Sample: No sampling method was used in the study, the whole population was taken as the sample and the study was conducted with 156 nurses who were not on their leave and who agreed to participate in the study during the date the study was conducted.

Data Collection Tools: The data in the study were collected with face-to-face interview technique by using descriptive information form which included 23 items developed by the researchers in line with the literature and Intercultural Sensitivity Scale (ISS) to find out the cultural sensitivity of nurses.

Demographic Information Form: It a 23-item form including sociodemographic characteristics (age, gender, nationality, level of education, marital status) and descriptive information about the working area (total years of working, weekly working hours, way of working, daily number of patients cared for) developed by the researchers in line with the literature.

Intercultural Sensitivity Scale (ISS): Intercultural Sensitivity Scale (ISS), which was developed by Chen and Starosta in 2000 and adapted into Turkish and tested for validity and reliability by Bulduk, Tosun & Ardic in 2011, is a 5-Likert type scale which includes 24 items and five sub-scales. Interaction engagement sub-scale includes items 1, 11, 13, 21, 22, 23 and 24, respect for cultural differences sub-scale includes items 2, 7, 8, 16, 18 and 20, interaction confidence sub-scale includes items 3, 4, 5, 6 and 10, interaction enjoyment sub-scale includes items 9, 12 and 15 and interaction attentiveness includes items 14, 17 and 19. The score one can get from the scale is between 24 and 120 and higher scores show higher intercultural sensitivity. Cronbach Alpha coefficient of the scale was found as 0.72 (Bulduk at al., 2011). Cronbach Alpha was found as 0.831 for the present study.

Statistical Analysis: Statistical analyses were conducted by using IBM SPSS Statistics 24 version. Frequency tables and descriptive statistics were used in the interpretation of the results. Parametric methods were used for normally distributed measurement values. In accordance with parametric methods, "Independent Sample-t" test (t-table value) was used for the comparison of two independent groups, while "ANOVA" test (F-table value) was used for the comparison of independent three or more groups. For the paired comparison of the variables which were found to be different for three or more groups, Tukey test was used by taking the homogeneous variances into consideration. Non-parametric methods were used for measurement values which were not normally distributed. In accordance with non-parametric methods, "Mann-Whitney U" test (Z-table value) was used for the comparison of two independent groups with measurement values, while "Kruskal-Wallis H" test (χ2- table value) was used for the comparison of independent three or more groups with measurement values. For the paired comparison of the variables which were found to be different for three or more groups, Bonferroni correction was applied. Spearman correlation coefficient was used for the analysis of the measurement values which were not normally distributed with one another.

Ethical Principles: The study was conducted in line with the Declaration of Helsinki human rights, written permission was taken from the rectorate of the university the study was conducted in with the 27/06/2019 dated B.30.2ODM.0.20.08/552 numbered ethical board permission of the related Clinical researches ethical board and written consent was taken from the participants.

Results

Of the Turkish group, 126 (80.8%) were female, 46 (29.5%) were 35 years old and older and the participants average age was 30.28±8.74 (years). It was found that 80 (51.3%) of the study group were undergraduates, 68 (43.6%) had been working for 5 years or less and 65 (41.7%) had been working in their present service for 2-5 years. 75 (48.1%) had a weekly working hour of 40 hours, 125 (80.1%) worked in shifts and 73 (46.8%) cared for 10 or less patients in a day (Table 1). A 48(30.8%) of the participants did not have preliminary information about patients coming from different cultures, while 24 (61.5%) of those stated that they had information received from the patient's family/circle, there were interpreters in the institutions 54 (34.6%) of the participants and 37 (46.2%) of these interpreters used Arabic language. It was found that there was foreign patient admission procedure in the hospitals of 58 (37.2%) of the participants, 103 (66.0%) experienced problems in serving them and 120 (76.9%) stated that providing care to foreigners did not decrease their motivation/efficiency. 35 (86.5%) of the participants did not could speak a second language, 150 (96.2%) did not receive training

on intercultural care, 5 (83.3%) of those who received intercultural care training this training was during their undergraduate education and 112 (71.8%) of the participants thought that different cultures contributed to their profession (Table 2).

Table 1. Distribution of demographic characteristics and working conditions of the study group

Variable (N=156)	n	%
Gender		
Female	126	80.8
Male	30	19.2
Age groups ($\bar{X} \pm$ S.D.→30.28±8.74 (years))		
22 and younger	31	19.9
23-28	51	32.7
29-35	28	17.9
35 and older	46	29.5
Level of education		
High school	46	29.5
Associate degree	23	14.7
Undergraduate	80	51.3
Graduate	7	4.5
Marital status		
Married	81	51.9
Single	75	48.1
Total years of working ($\bar{X} \pm$ S.D.→9.20±8.19 (years))		
5 years and less	68	43.6
6-10 years	36	23.1
11-15 years	19	12.1
16-20 years	11	7.1
20 years and more	22	14.1
Years of working in the service ($\bar{X} \pm$ S.D.→4.84±4.62 (years))	44	28.2
1 year	65	41.7
2-5 years	20	12.8
6-9 years	27	17.3
10 years and more		
Weekly working hours		
40 hours	75	48.1
42-50 hours	53	34.0
>50	28	17.9
Way of working		
During day	31	19.9
In shifts	125	80.1
Daily number of patients cared for		
10 or less	73	46.8
11-20	62	39.8
>20	21	13.4

Table 2. Distribution of data of the study group and the hospital related with foreign patients

Variable (N=156)	n	%
Having preliminary information about patients from different cultures		
No	48	30.8
Yes	25	16.0
Sometimes	83	53.2
Where the information comes from		
The patient's family/circle	24	61.5
Internet	12	30.8
Individual research	1	2.6
Interpreter	2	5.1
Presence of interpreter in the institution		
No	102	65.4
Yes	54	34.6
Languages used by the interpreter		
Arabic	37	46.2
English	28	35.0
German	13	16.2
French	1	1.3
Sign language	1	1.3
Presence of foreign patient admission procedure in the hospital		
No	98	62.8
Yes	58	37.2
Problems in serving foreigners		
No	53	34.0
Yes	103	66.0
Problems experienced with foreigners		
Communication problems	60	58.3
Problems with faith	6	5.8
Differences in different culture practices	11	10.7
Lack of trust in healthcare professionals	14	13.6
Having prejudices	5	4.9
Some practices not being suitable for their culture	7	6.7
Does caring for foreigners decrease motivation/efficiency		
No	120	76.9
Yes	36	23.1
Second language		
No	135	86.5
Yes	21	13.5
Having been trained in intercultural care		
No	150	96.2
Yes	6	3.8
Place of training		
Undergraduate education	5	83.3
In-service training	1	16.7
Contribution of different cultures to the profession		
No	44	28.2
Yes	112	71.8

Table 3. Comparison of demographic data and Intercultural Sensitivity Scale scores of the study group

Variable (N=156)	n	Interaction engagement		Respect for cultural differences		Interaction confidence		Interaction enjoyment		Interaction attentiveness		ISS-Total	
		$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)
Gender													
Female	126	24.68±3.34	25.0 (5.0)	21.91±3.48	22.0 (6.0)	16.27±2.52	16.0 (3.0)	10.59±2.11	11.0 (3.0)	10.72±1.70	11.0 (3.0)	84.17±9.67	84.0 (15.0)
Male	30	25.30±4.01	25.0 (4.5)	21.26±2.41	21.0 (2.0)	16.63±3.68	17.0 (4.0)	10.37±1.83	10.0 (3.0)	10.23±2.22	10.5 (3.0)	83.80±10.29	85.5 (15.0)
Analysis*		Z=-0.509		Z=-1.231		Z=-1.061		Z=-0.766		Z=-1.109		t=0.184	
Probability		p=0.611		p=0.218		p=0.289		p=0.444		p=0.267		p=0.854	
Age													
22 and ↓ (1)	31	25.93±3.93	25.0 (5.0)	23.61±3.51	24.0 (5.0)	16.65±2.74	16.0 (3.0)	10.84±1.86	11.0 (2.0)	10.97±1.25	11.0 (2.0)	88.00±10.98	89.0 (14.0)
23-28 (2)	51	25.06±3.77	26.0 (7.0)	22.20±3.23	22.0 (5.0)	16.73±2.95	17.0 (4.0)	10.69±2.16	11.0 (3.0)	10.57±2.04	11.0 (3.0)	85.24±10.07	88.0 (13.0)
29-35 (3)	28	23.93±2.81	24.0 (5.0)	20.54±2.99	21.0 (4.8)	16.71±2.43	17.0 (2.8)	9.93±2.31	10.0 (3.0)	10.71±1.63	11.0 (3.0)	81.82±9.22	83.0 (16.8)
35 and ↑ (4)	46	24.26±3.01	24.5 (4.0)	20.87±2.85	21.0 (4.0)	15.48±2.69	15.5 (3.3)	10.57±1.89	11.0 (3.0)	1.41±1.97	11.0 (3.0)	81.59±7.93	81.5 (11.8)
Analysis		F=2.202		F=6.579		χ^2=7.247		χ^2=2.588		χ^2=1.410		χ^2=9.250	
Probability		p=0.090		**p=0.000**		p=0.064		p=0.460		p=0.703		**p=0.026**	
Difference				**(1-3.4)**								**(1-4)**	
Education													
High school	46	25.63±3.98	25.0 (4.3)	22.41±3.64	22.0 (6.3)	17.00±2.74	17.0 (4.0)	10.30±2.10	10.5 (3.0)	10.98±1.36	11.0 (2.0)	86.33±10.65	87.0 (15.5)
Associate	23	24.30±3.08	25.0 (6.0)	22.30±3.09	23.0 (3.0)	16.17±2.42	16.0 (3.0)	10.39±1.75	10.0 (3.0)	10.52±1.78	11.0 (3.0)	83.69±8.46	85.0 (10.0)
Undergraduate	80	24.46±3.26	25.0 (5.0)	21.36±3.05	21.0 (4.8)	15.96±2.88	16.0 (3.8)	10.81±1.98	11.0 (3.0)	10.48±1.98	11.0 (3.0)	83.08±9.31	82.5 (15.0)

Graduate	7	24.71±3.30	24.0 (7.0)	20.86±4.22	21.0 (7.0)	16.86±2.41	17.0 (2.0)	9.57±3.26	11.0 (7.0)	10.43±2.51	11.0 (4.0)	82.43±12.45	89.0 (21.0)
Analysis		χ^2=1.465		χ^2=3.087		χ^2=3.572		χ^2=2.207		χ^2=1.523		F=1.176	
Probability		p=0.690		p=0.378		p=0.312		p=0.531		p=0.677		p=0.321	
Marital													
Married	81	24.27±3.06	25.0 (4.0)	20.86±2.98	21.0 (4.0)	16.23±2.85	16.0 (4.0)	10.27±2.07	11.0 (3.0)	10.73±1.79	11.0 (2.5)	82.37±8.71	82.0 (14.0)
Single	75	25.36±3.82	25.0 (6.0)	22.79±3.36	22.0 (5.0)	16.45±2.71	17.0 (3.0)	10.84±2.02	11.0 (3.0)	10.52±1.84	11.0 (3.0)	85.96±10.53	88.0 (16.0)
Analysis		Z=-1.427		Z=-3.382		Z=-1.074		Z=-1.502		Z=-0.435		t=-2.326	
Probability		p=0.154		**p=0.001**		p=0.283		p=0.133		p=0.664		**p=0.021**	
Working													
years	68	25.65±3.80	25.5 (5.0)	23.00±3.52	23.0 (5.0)	16.65±2.80	17.0 (3.0)	10.97±1.96	11.0 (3.0)	10.74±1.76	11.0 (2.0)	87.00±10.39	89.0 (13.8)
5 years and ↓	36	23.97±3.33	24.0 (5.0)	20.94±2.81	21.0 (4.8)	16.83±2.71	16.0 (4.0)	9.78±2.06	9.5 (9.0)	10.64±1.71	11.0 (3.0)	82.17±9.17	81.5 (16.8)
6-10 years	19	24.26±3.01	25.0 (3.0)	20.58±2.73	21.0 (4.0)	15.68±3.28	16.0 (4.0)	10.814±2.29	11.0 (2.0)	10.36±2.24	11.0 (3.0)	81.74±9.71	80.0 (11.0)
11-15 years	11	23.55±3.70	24.0 (5.0)	21.09±2.34	22.0 (5.0)	15.91±2.88	16.0 (3.0)	10.09±2.12	10.0 (3.0)	10.18±1.78	10.0 (3.0)	80.82±8.81	79.0 (18.0)
16-20 years	22	24.59±2.39	24.5 (4.3)	20.82±3.22	20.0 (4.0)	15.36±2.04	15.5 (3.0)	10.45±1.87	11.0 (3.0)	10.73±1.86	11.0 (2.0)	81.95±7.24	82.0 (10.3)
20 and ↑													
Analysis		χ^2=5.553		χ^2=15.038		χ^2=7.562		χ^2=8.177		χ^2=2.149		F=2.125	
Probability		p=0.235		**p=0.005**		p=0.109		p=0.085		p=0.708		p=0.099	
Difference				**(1-2.3.5)**									

* In normally distributed data, “Independent Sample-t” test (t-table value) was used for the comparison of two independent groups, while “ANOVA” test (F-table value) was used for the comparison of independent three or more groups. In data which were not normally distributed, “Mann-Whitney U” test (Z-table value) was used for the comparison of two independent groups with measurement values, while “Kruskal-Wallis H” test (χ2- table value) was used for the comparison of independent three or more groups.

Table 4. Comparison of study group and hospital's data about foreign patients and Intercultural Sensitivity Scale scores

Variable (N=156)	n	Interaction engagement		Respect for cultural differences		Interaction confidence		Interaction enjoyment		Interaction attentiveness		ISS-Total	
		$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)	$\bar{X} \pm S.D.$	Median (IQR)
Preliminary information													
No	48	24.56±3.47	25.0 (6.0)	21.90±3.26	22.0 (4.0)	16.04±2.56	16.0 (2.0)	10.77±2.13	11.0 (3.0)	10.40±1.89	11.0 (3.0)	83.67±9.61	82.5 (15.0)
Yes	25	25.96±3.42	26.0 (4.0)	21.28±3.74	21.0 (3.5)	17.36±2.81	18.0 (3.0)	10.12±2.74	11.0 (4.0)	11.56±1.26	12.0 (1.0)	86.28±9.11	88.0 (11.0)
Sometimes	83	24.58±3.47	25.0 (5.0)	21.88±3.21	22.0 (5.0)	16.20±2.84	16.0 (3.0)	10.54±1.77	11.0 (3.0)	10.48±1.84	11.0 (3.0)	83.69±9.77	84.0 (15.0)
Analysis*		χ^2=2.212		χ^2=0.429		χ^2=3.803		χ^2=0.169		χ^2=8.577		χ^2=0.892	
Probability		p=0.137		p=0.513		p=0.051		p=0.681		**p=0.003**		p=0.345	
Difference										**(2-1.3)**			
Foreign admission procedure													
No	98	24.40±3.52	24.0 (5.3)	21.63±3.27	22.0 (5.0)	15.99±2.75	16.0 (4.0)	10.45±2.07	11.0 (3.0)	10.57±1.90	11.0 (3.0)	83.04±9.94	82.5 (15.0)

Yes	58	25.47±3.32	26.0 (5.0)	22.05±3.37	22.0 (6.0)	16.93±2.74	17.0 (4.0)	10.71±2.05	11.0 (3.0)	10.72±1.65	11.0 (2.0)	85.88±9.27	87.5 (12.0)
Analysis		Z=-1.886		t=-0.765		Z=-2.316		Z=-0.542		Z=-0.582		t=-1.766	
Probability		p=0.059		p=0.446		**p=0.021**		p=0.588		p=0.560		p=0.079	
Second language													
No	135	24.51±3.31	25.0 (4.0)	21.72±3.35	22.0 (5.0)	16.07±2.68	16.0 (3.0)	10.49±2.05	11.0 (3.0)	10.55±1.84	11.0 (3.0)	83.33±9.53	83.0 (15.0)
Yes	21	26.62±4.04	26.0 (3.5)	22.24±3.02	22.0 (3.5)	18.10±2.79	18.0 (4.0)	10.90±2.14	11.0 (3.5)	11.14±1.53	11.0 (1.0)	89.00±9.99	89.0 (8.5)
Analysis		Z=-2.422		t=-0.669		Z=-2.889		Z=-0.623		Z=-1.520		t=-2.516	
Probability		**p=0.015**		p=0.504		**p=0.004**		p=0.533		p=0.129		**p=0.013**	
Intercultural care training													
No	150	24.79±3.51	25.0 (5.0)	21.74±3.32	22.0 (5.0)	16.29±2.79	16.0 (3.0)	10.53±2.07	11.0 (3.0)	10.64±1.83	11.0 (3.0)	83.98±9.81	84.0 (14.0)
Yes	6	24.83±2.71	25.0 (4.3)	23.00±2.76	24.0 (4.0)	17.67±2.50	17.5 (5.3)	11.00±1.90	11.0 (4.0)	10.50±1.22	11.0 (2.3)	87.00±8.79	89.0 (12.5)
Analysis		Z=-0.065		Z=-1.116		Z=-1.203		Z=-0.632		Z=-0.480		t=-0.742	
Probability		p=0.948		p=0.265		p=0.229		p=0.527		p=0.631		p=0.459	

* In normally distributed data, “Independent Sample-t” test (t-table value) was used for the comparison of two independent groups, while “ANOVA” test (F-table value) was used for the comparison of independent three or more groups. In data which were not normally distributed, “Mann-Whitney U” test (Z-table value) was used for the comparison of two independent groups with measurement values, while “Kruskal-Wallis H” test (χ2- table value) was used for the comparison of independent three or more groups.

Table 5. Analysis of the correlation of ISS scale scores with each other

Correlation* (N=156)		Average	Standard deviation	Interaction engagement	Respect for cultural differences	Interaction confidence	Interaction enjoyment	Interaction attentiveness	ISS-total
	r			1	0.583	0.522	0.368	0.446	0.862
Interaction			3.48		**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
engagement	p	24.79							
	r			0.583	1	0.258	0.507	0.270	0.776
Respect for		21.79	3.30	0.000		**0.001**	**0.000**	**0.001**	**0.000**
cultural									
differences	p								
Interaction	r			0.522	0.258	1	0.285	0.386	0.689
confidence	p	16.34	2.77	0.000	0.001		**0.000**	**0.000**	**0.000**
Interaction	r			0.368	0.507	0.285	1	0.112	0.615
enjoyment	p	10.54	2.06	0.000	0.000	0.000		0.165	**0.000**
Interaction	r			0.446	0.270	0.386	0.112	1	0.569
attentiveness	p	10.63	1.81	0.000	0.001	0.000	0.165		**0.000**
	r			0.862	0.776	0.689	0.615	0.569	1
			9.77	0.000	0.000	0.000	0.000	0.000	
ISS-total	p	84.10							

***When at least one of the two quantitative variables did not have normal distribution, "Spearman" correlation coefficient was used.**

Statistically significant difference was found in terms of ISS-total scores according to the age groups of the participants (χ^2=9.250; p=0.026). ISS-total scores of the participants aged 22 years and younger were found to be statistically significantly higher when compared with those of the participants aged 35 and older. Statistically significant difference was found in terms of ISS-total scores according to the marital status of the participants (t=-2.326; p=0.021). ISS-total scores of the single participants were found to be statistically significantly higher than those of the married participants. Statistically significant difference was found in terms of ISS-respect for cultural differences subscale according to total working years of the participants (χ^2=15.038; p=0.005). Respect for cultural differences subscale scores of the participants who had been working for 5 years and less were found to be statistically significantly higher when compared with those of the participants who had been working for 6-10, 11-15 and more than 20 years (Table 3).

Statistically significant difference was found in terms of ISS-interaction attentiveness subscale according to the state of having preliminary information for patients from different cultures (χ^2=8.577; p=0.003). Statistically significant

difference was found between the participants who had preliminary information, those who did not and those who sometimes did in interaction attentiveness subscale scores. Interaction confidence subscale scores of the participants who had foreign patient admission procedure in their hospital were found to be statistically significantly higher when compared with those who did not (Z=-2.316; p=0.021). ISS-total scores of the participants who could speak a second language were statistically significantly higher when compared with those who could not (t=-2.516; p=0.013).

Discussion

In this study, which was conducted to find out the cultural sensitivity of nurses and the factors affecting their cultural sensitivity, average total intercultural sensitivity score was found as 84.10 (min:63.0- max:115.0). In studies conducted about cultural sensitivity in Turkey, average cultural sensitivity score was found as 84.32±11.40 (Min:24-Max:120) in a study conducted by Uzun & Sevinc (2015) with 120 nurses working with international patients; as 84.01± 9.1 (Min:24-Max:120) in a study conducted by Yilmaz et al. (2017) on 516 clinic nurses; as 85.28±10.01 (Min:24-Max:120) in a study conducted by Karadag Arli & Bakan (2018) on 134 nurses. In studies conducted in the world, average cultural sensitivity score was found as 32.8±5.3 (Min:8-Max:40) in a study conducted on 89 postgraduates in nursing faculty (Marzilli, 2016) and as 22.39±5.01 (Min:0, Max:32) in a study conducted by Lin et al. (2015) on 221 Taiwanese nurses. While the results of our study are in parallel with the results of the studies conducted in Turkey, it can be said that nurses in Turkey have higher cultural sensitivity. It can be said that the reason for this result can be the fact that Turkish culture already has different cultures and languages and that nurses frequently provide care for people from different cultures (Table 5).

Statistically significant difference was found in ISS total scores, ISS-interaction engagement sub-scale scores and interaction confidence subscale scores in terms of the presence of a second language spoken (t=-2.516; p=0.013). This is an expected result. Being able to speak different languages is a factor that eases communication. Similarly, in studies conducted, it was found that speaking two languages was effective in high intercultural sensitivity (Meydanlioglu, Arikan, Gozum, 2015, Simsek, Erkin, Bayık Temel, 2017). However, in some studies, it was also reported that speaking a foreign language did not create a difference in intercultural sensitivity (Kilic Parlar & Sevinc, 2018, Gol and Erkin, 2018) (Table 4).

In our study, while it was found that nurses got the information they needed mostly from the patients' family and circle, a small group of 5.1% was found to need an interpreter. Although the study was conducted in the same institution, the number of nurses knowing about the presence of interpreter was 54 (34.6%). When studies conducted in literature were reviewed, it was found that a lot of problems were experienced resulting from the absence of interpreters in hospitals in communicating with foreigners and that body language was used or support was taken from people who spoke foreign language in order to overcome these problems (Yildirim, 2019, Yalili & Danc, 2017). Although it is easier to communicate directly with the nurse, communicating in a language one does not have a command on is difficult both for health professionals and patients. For this reason, at least having interpreters who speak the language of the cultures that come most to hospitals and informing health professionals on this will ease communication and enable health professionals to feel safer and decrease misinformation that can result from communication (Table 2).

Since a great majority of the nurses in the study had high school or associate degree, it is an expected result that they do not have information about the concept of intercultural nursing. In the study, the number of nurses who received intercultural care course was very low (3.8%). In studies conducted with nurses and nursing students, it was found that nurses did not know about the concept of intercultural care, they did not receive enough information about intercultural care and competence, while nurses wanted to receive training to know and understand better the culture of the society they were in (Chuang, 2009, Ayaz, Bilgili, Akın, 2010, Karakus, 2013, Chang et al., 2013, Chen &Huang, 2018, Karadag Arli & Bakan, 2018, Yilmaz et al., 2019) (Table 2).

In the study, it was found that 44 (28%) participants thought providing care for individuals from different cultures did not contribute to the profession. Studies conducted have reported different results. In a study by

Ceylantekin and Ocalan (2016), it was stated that the students who received intercultural nursing course took into account the culture of patients and provided care accordingly, while Gol and Erkin (2018) found that speaking a foreign language and receiving a training for intercultural nursing did not create a difference in intercultural sensitivity (Gol and Erkin,2018). These different results may be due to the features of the groups in which the studies were conducted (Table 2).

Health professionals experience a great number of problems while providing care to individuals from different cultures. In the study, it was found that nurses experienced communication problems the most (58.3%). They were also found to experience problems about the beliefs of individuals from different cultures and different cultural practices. Similar to the result of our study, it was reported in a great number of studies conducted that while providing care to individuals from different cultures, the most frequently experienced problems were communication problems, problems about religious belief, problems resulting from intercultural differences and problems about traditional practices (Karakus et al., 2013, Tuzcu, 2014, Ceylantekin & Ocalan, 2016, Karadag Arli 2018).

In our study, respect for cultural differences subscale scores were statistically significantly higher in nurses aged 22 and younger when compared with those aged 29-35 and 35 and older. This result can mean that young people are more respectful for different cultures. The reason for this may be the fact that this issue is emphasized more in nursing education in recent years. However, there are also different results found in different groups. In a study examining the intercultural sensitivity levels of teachers working in public education centres, 30-40 age group was reported to have high intercultural sensitivity (Guner & Levent, 2018), while a study conducted on students by Bulduk et al. concluded that there was no significant association between students' ages and their intercultural sensitivity scores. This result may be due to the fact that the ages of students were very close to each other. However, age difference is more obvious in professionals (Bulduk, Usta, Dincer, 2017).

In our study, it was found that gender did not differ in terms of ISS. The fact that there were few males in the study group can have been effective on this result. However, a great number of missions have been attributed to women by the society. The leading role attributed to women is the role of caregiver. In this context, women's sensitivity to different situations is expected. It has also been researched in studies frequently whether individuals' intercultural sensitivity differs in terms of gender. A great number of studies report female students to have higher intercultural sensitivity (Holm et al., 2009, Nieto & Booth, 2010, Choi &Kim 2018, Kilic & Sevinc, 2018). Similar to our study, in a study conducted by Yilmaz & Gocen (2013) on intercultural sensitivity of prospective primary school teachers, no difference was found between gender and intercultural sensitivity. When literature is reviewed, it can be seen that there are also studies which have found that men have high intercultural sensitivity (Cetisli et al., 2016, Yilmaz et al., 2017, Durgun et al., 2019).

In working areas, personal communication and sensitivity mostly improve as clinical experience increases.

In their study they examined the cultural competence of newly graduated nursing students in Southern Finland, Repo et al. (2017) stated that students' cultural competence increased as their interactions with other cultures, language skills increased, while in Guner and Levent's (2018) study on teachers, it was found that individuals with a working period of 11 years and longer had high sensitivity. In the present study, it was found that the participants with a total working years of 5 and shorter had higher respect for cultural differences subscale scores when compared with participants who worked for a longer period of time ($\chi 2=15.038$; $p=0.005$). It can be thought that the reason for this result is the fact that the issue was examined more in nursing education in recent years. When it is considered that the professionals who worked for five years or less are recently graduated, this is an expected result. When the marital status of the nurses was examined, it was found that respect for cultural differences subscale scores and ISS-total scores of single participants were statistically significantly higher than those of married participants. Similarly, in a study conducted by Biyan et al. on 112 medical health workers, single participants were found to have higher average respect for cultural differences scores than married participants (Biyan, Aybaraz, Koc, 2018). In another study, no significant

difference was found between marital status and intercultural sensitivity scores of the teachers who constituted the sample group (Guner & Levent, 2018).

Conclusion: As a conclusion, intercultural sensitivity scores of the nurses were higher than moderate. However, most of them stated that they experienced problems while providing care to individuals from different cultures. Age, marital status, working years, having preliminary information about the patients, second language, presence of foreign patient protocol can be listed as effective factors. In line with these results, it can be said that providing training to health professionals for intercultural care and taking precautions to ease communication with these patients can increase quality of care and decrease the problems experienced. These trainings can be added in school curriculums or also can be continued as in-service training for continuity. Another way can be introducing the cultures with high patient admission to health professionals. In addition, it can be recommended to support and encourage health professionals about learning different languages. With these approaches, the quality of care given to individuals from different cultures will increase.

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References

Aktas Y. Gok Ugur H. Orak O. S. (2016). Examining nurses' views on intercultural nursing care. International Refereed Journal of Nursing Research, 8, 120-135.

Ayaz S. Bilgili N. Akin B. (2010). The transcultural nursing concept: A study of nursing students in Turkey. International Nursing Review, 5: 449-453.

Bayik A. (2008). Intercultural (multicultural) nursing education. Ataturk University School of Nursing Journal, 11(2):92- 101.

Bekiroglu O. Balci S. (2014). Searching for the traces of intercultural communication sensitivity: a study on the case of communication faculty students, Journal of Turkic Studies, 35, 429-459.

Biyan N. A. Aybaraz E. Koc E. (2018). Emotional intelligence and cultural sensitivity in medical tourism. Usak University Journal of Social Sciences, 11(C-IASOS Special Issue), 52-70.

Bolsoy N. Sevil U. (2006). Health-disease and culture interaction. Atatürk University School of Nursing Journal, 9(3):78-87.

Bulduk S. Usta U. Dincer Y. (2017). Cross-cultural sensitivity and determination of influencing factors: an example of a health services vocational school. Dü Sağlık Bil Enst Derg Journal Of Duzce Unversity Health Sciences Institute. 7(2): 73-77.

Bulduk S. Tosun H. Ardic E. (2011). Measurative characteristics of the Turkish cross-cultural sensitivity scale in nursing students. Turkey Clinics Journal of Medical Ethics-Law and History. 19(1): 25-31.

Ceylantekin Y. Ocalan D. (2016). Nursing students' cultural awareness and thoughts on intercultural nursing lesson. Gumushane University Journal of Health Sciences, 5(4): 45-53.

Chang HY. Yang YM. Kuo YL. (2013). Cultural sensitivity and related factors among community health nurses. J Nurs Res, 21(1): 67-73.

Chen GM. (1997). A Review of the Concept of Intercultural Sensitivity, Paper Presented at the Biennial Convention of Pacific and Asian Communication Association, January, Honolulu, Hawaii.

Chen GM. (2010). The impact of intercultural sensitivity on ethnocentrism and intercultural communication apprehension. Intercultural Communication Studies. 19 (1): 1-9.

Chen CI. Huang MC. (2018). Exploring the growth trajectory of cultural competence in Taiwanese paediatric nurses. Journal of Clinical Nursing, 27(23-24), 4331-4339.

Chuang WC. (2009). Cross-cultural communication between nurses and foreign health caretakers (dissertion). Tzu Chi University. Hualien County. Taiwan. ROC.

Cetisli NE. Isık G. Ozguven BO. (2016). Intercultural sensitivity of nursing students according to their empathy level. Izmir Kâtip Çelebi University Health Sciences Faculty Journal, 1 (1), 27-33.

Danc E. Guney R. (2017). Healthcare of refugees relies on google translate. I. International IV. National Intercultural Nursing Congress, 21-24 October 2017, Sanliurfa, (pp.83-84).

Domenig D. (2004). Transcultural change: a challenge for the public healthsystem. Applied Nursing Research. 17(3):213-216.

Durgun H. Uzunsoy E . Tumer A. Huysuz K . (2019). Intercultural sensitivity of nursing students and their perception of character and values for world citizenship. Ordu University Journal of Nursing Studies, 2 (2) , 87-95.

Goode TD. Dunne MC. Bronheim SM. (2006). The evidence base for cultural and linguistic competency in health care. New York, NY: Commonwealth Fund.

Gol I. Erkin O. (2018). Association between cultural intelligence and cultural sensitivity in nursing students: A cross-sectional descriptive study. Collegian. 26(4), 485-491.

Guner A. Levent A. (2018). The relationship between teachers' ıntercultural sensitivity levels and their empathic tendencies: Public Education Center

example. International Journal of Scientific Research (IBAD), 3 (2), 968-984.

Holm K. Nokelainen P. Tirri K. (2009). Relationship of gender and academic achievement to Finnish students' intercultural sensitivity. High Ability Studies. 20(2): 187-200.

Jirwe M. Gerrish K. Emami K. (2010). Student Nurses' Experiences Of Communication İn Cross - Cultural Care Encounters. Scand J Caring Sci. 24: 436-444.

Kara C. Aydin Cakirlar A. Ipek Y. Sahbaz E. (2017). Transcultural nursing care. 1st International 4th National Intercultural Nursing Congress, 21-24 October 2017, Sanliurfa, p.386.

Karadag Arli S. & Bakan AB. (2018). An investigation of the relationship between intercultural sensitivity and compassion in nurses. International Journal of Intercultural Relations, 63, 38-42.

Karadag Arli S. (2018). Factors affecting compassion and ıntercultural sensitivity in surgical nurses. STED / Journal of Continuing Medical Education, 27 (4), 277-283.

Karakus Z. Babadag B. Abay H. Akyar I. Celik S. (2013). Nurses' views related to transcultural nursing in Turkey. International Journal of Caring Sciences ;6(2): 201-207.

Kilic SP. Sevinc S. (2018). The relationship between cultural sensitivity and assertiveness in nursing students from Turkey. Journal of Transcultural Nursing, 29(4), 379-386.

Lin CN. Mastel-Smith B. Alfred D. & Lin YH. (2015). Cultural competence and related factors among Taiwanese nurses. Journal of Nursing Research, 23(4), 252-261.

Marzilli C. (2016). Assessment of cultural competence in Texas nursing faculty. Nurse Education Today, 45, 225-229.

Meydanlioglu A. Arikan F. & Gozum S. (2015). Cultural sensitivity levels of university students receiving education in health disciplines. Adv Health Sci Educ Theory Pract. 20(5), 1195-204.

Murray SS. Mckinney ES. (2010). Foundations Of Maternal - Newborn And Women's Health Nursing. (5 rd edition,12-13). Saunders Elsevier.

Nieto C. Zoller Booth M. (2010). Cultural competence: Its influence on the teaching and learning of international students. Journal of Studies in International Education. 14(4): 406-425.

Ozturk E, Oztas D (2012). Transcultural nursing. Batman University Journal of Life Sciences.,1(1):293-300.

Polat DC. Akcan E. (2016). Difficulties Experienced by Nursing Students in Caring for Foreign Patients. Anatolian Journal of Nursing and Health Sciences. 19: Special Issue: 9-13.

Repo H. Vahlberg T. Salminen L. Papadopoulos I. LeinoKilpi H. (2017). The cultural competence of graduating nursing students. Journal of Transcultural Nursing. 28(1): 98107.

Serrant Green L. (2001).Transcultural Nursing Education: A View From Within. Nurse Education Today. 21(8): 670-678.

Simsek H. Erkin O. & Bayık Temel A. (2017). Cultural sensitivity and related factors among nurse educators in Turkey. International Journal of Caring Sciences, 10(3), 1374-1381.

Tortumluoglu G. (2004). Transcultural Nursing and Cultural Care Model Examples. C.U. Journal of Nursing School. 8(2) 47-56.

Tuzcu A. (2014). Problems faced by nursing students personally and in the practice area while providing care to migrants in the immigrant city of Antalya International Journal of Human Sciences. 11: 1-10.

Ulrey KL. Amason P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. Health Communication, 13(4), 449-463.

Uzun O. Sevinc S. (2015). The relationship between cultural sensitivity and perceived stress among nurses working with foreign patients. Journal of Clinical Nursing, 24(2324), 3400-3408.

Rengi O. Polat S. (2014). Classroom teachers' perceptions of cultural differences and intercultural sensitivity. Journal of World of Turks, 6(3), 135-156

Yalili E. Danc E. (2017). Cultural competence of nurses caring for refugees. In: Tanrıverdi G. 1st International 4th National Intercultural Nursing Congress Proceedings. Journal of Human Sciences. 14(4):368- 369.

Yilmaz F, Gocen S. (2013). Examination of elementary teacher candidates' views on intercultural sensitivity according to different variables. Adıyaman University Institute of Social Sciences Journal. 6(15): 373-92.

Yildirim J. (2019). The experiences of nurse students caring for Syrian Refugees: A Phenomenological Study. STED / Journal of Continuing Medical Education, 28 (4) , 263-271.

Yilmaz M. Toksoy S. Direk ZD. Bezirgan S. & Boylu M. (2017). Cultural sensitivity among clinical nurses: A descriptive study. Journal of Nursing Scholarship, 49(2), 153-161.

Yilmaz M. Yeni C. Avcı E. Uluk N. (2019). Examination of cultural sensitivity and cultural skill levels of nurses/ midwives working in family health centers. DEUHFED, 12 (3), 170-178.