How Mental Health Nurses Perceive Cultural Competence

**Abstract**

Israel’s diverse cultures presents challenges to the nation’s healthcare system; a lack of culturally appropriate care adversely affects the overall quality of care. Therefore, cultural competence needs strengthening, especially among mental health nurses, for whom communication is the essence of treatment. This study used a structured self-report questionnaire form to survey 107 Israeli mental health nurses about their perceptions of their own cultural competence. Most participants attributed great importance to sociocultural aspects of patient care (4/5 ±­ 0.628) and were knowledgeable, but a majority (3/5­ ±­ 0.830) reported having difficulty implementing their knowledge during treatment. Cultural knowledge and awareness correlated with personal characteristics, such as participants’ gender and country of origin. There were gaps between cultural knowledge and the ability to apply existing knowledge in practice. A need exists not only for ongoing training in and maintenance of cultural knowledge, but also for tools to implement culturally adapted care.

*Keywords:* cultural awareness, cultural competence, mental health nursing, minorities

**Introduction**

The State of Israel has a large population of immigrants from various countries. Thirty-five percent of Israel’s residents (nearly 3.3 million) are immigrants (Israeli Bureau of Statistics, 2020), making Israel a multicultural country and creating a growing need for multicultural awareness in general, and cultural competence in particular. Cultural competence in a health care context is defined as the capacity of a service provider to offer effective treatment to patients from every possible cultural background (Anderson et al., 2003; Saha et al., 2008),taking into account the patient’s beliefs, behaviors, and specific cultural needs. Cultural competence is a process as well as a product derived from the merging of knowledge and skills that people acquire throughout their personal and professional lives. In nursing, cultural competence refers to the nurse’s cultural knowledge, awareness, and skills, and includes the goal of providing culturally focused care to patients even if their culture differs from that of the nurse (Shepherd et al., 2019).

Immigrants have been shown to experience higher rates of illness and disability than the general population (Betancourt et al., 2016; Castañeda et al., 2015). Immigration is also known to be a risk factor for developing psychiatric disorders and psychological distress (Alegría et al., 2017) associated with challenges such as linguistic and cultural barriers, socioeconomic limitations, difficulty accessing health care, stress owing to adaptation and everyday living, and social integration issues (Szaflarski & Bauldry, 2019). However, immigrants tend to apply for mental health services less frequently than do individuals from the native population.

In the health sector, cultural diversity has been found to be reflected in patients’ beliefs regarding illness, expectations about the role of the therapist, treatment preferences, symptom expression, and acceptance of or lack of willingness to receive treatment (Babitsch et al., 2020). Similarly, in the field of mental health, culture affects the willingness of the patient to receive treatment and to cooperate with health promotion, prevention, and therapeutic intervention (Kirmayer, 2012). In parallel, caregivers are committed to treating every patient regardless of their cultural values, beliefs, and lifestyles, with no judgmental biases or prejudices towards the patient (Nobel, 2007). The issue of the need for culturally appropriate treatments has become more prominent recently, emphasizing the need for cultural competency among the multidisciplinary staff of caregivers.

A lack of cultural awareness and failure to provide culturally appropriate treatment might lead to misdiagnosis, inadequate treatment by health professionals, decline in treatment compliance, and exacerbation of patients’ physical and/or mental conditions (Hall et al., 2015; van Loon et al., 2011). A focus on culture, religion, and language in health care improves medication adherence and treatment outcomes (Mahabeer, 2009; Waite & Calamaro, 2010).

During the past 30 years, there has been a substantial increase in cultural skills training, especially as a way to reduce disparities in health and health services among diverse populations. In 2001, the American Nurses Association (ANA) identified the need to promote cultural and therapeutic competence. In 2015, an ANA workgroup produced *Nursing: Scope and Standards of Practice* during a time of social change and increasing cultural and ethnic diversity among consumers, declaring in the publication that nurses must practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person in all professional relationships (American Nurses Association, 2015). In the same period, New Zealand developed a framework for training in cultural competency in nursing (Ramsden, 2002) involving enhancing nurses’ knowledge about incorporating certain cultural protocols toward clients of different ethnic or religious backgrounds (Taylor & Guerin, 2019). In North America, training programs for cultural competence were implemented at the undergraduate nurse training level (Lipson & Desantis, 2007). Over time, many researchers have developed theoretical frameworks to manage the difficulties and challenges that health care providers often encounter during cross-cultural interactions (Campinha-Bacote, 2011; Shen, 2015). In Israel, a Ministry of Health circular published in 2011 and validated in 2013 introduced a landmark policy regarding health care in the country’s culturally diverse population. There is considerable activity in Israel on the subject of diversity in health care, mainly on the systemic level, and the field has grown and evolved in a relatively short period (Dayan and Biderman, 2014).

Research from Turkey, the United States, Taiwan, and other countries examining nurses’ perceptions of their sociocultural competence and the effect of those perceptions on their functioning with patients from other cultures has revealed that most nurses rate themselves as not culturally competent or as having low cultural competence (Chang et al., 2013; Lin et al., 2017; Seright, 2012; Yilmaz et al., 2017). Regarding nurses in the field of mental health, a U.S. study revealed that most nurses felt a lack of ability and confidence in coping with refugees’ and immigrants’ distress and mental disorders (Nardi et al., 2012).

There has been only limited assessment of nurses’ cultural competence in Israel. Studies conducted among nurses in the country have found that they face many obstacles and difficulties rooted mainly in cultural barriers (Regev, 2014). Experiences of cultural differences evoke feelings of inconvenience and insecurities (Tuononen. 2019), and nurses have rated their level of cultural competence as low (Noble et al., 2009). Even nurses who reported succeeding in developing awareness, openness, flexibility, and cultural creativity while working still felt that they faced many language and cultural barriers (Regev, 2014). In addition, one study revealed that nurses reported a lack of training in cultural competence and that they would be interested in receiving more knowledge about and training in multicultural nursing (Yellon, 2012).

Cultural competence is becoming recognized as a necessary skill among mental health caregivers (Griner, 2007; Sue et al., 2009). Israel is a small, westernized country with immense cultural diversity, as evidenced by its varied population groups, religions, religious identities, ethnicities, and languages (Israel Ministry of Foreign Affairs, 2018). Immigrants experience mental health problems such as depression, anxiety, and somatic disorders, and pathologies related to stress experienced during the immigration process (Bas-Sarmiento et al., 2017; Sangalang et al., 2019). Given that nurses compose the largest proportion of professionals among health care staff and have a significant impact on treatment outcomes (Randall et al., 2017) cultural competence among nurses is a highly important issue. Most studies in this area have assessed nurses’ educational needs (Khatib & Hadid, 2019; Noble et al., 2014; Segev et al., 2020), but few have examined attitudes among nurses in general hospitals (Noble et al., 2009; Regev, 2014; Tuononen, 2019), and, to our knowledge, no study has yet been conducted to examine cultural competence and attitudes about cultural competence among mental health nurses in Israel. Providing mental health care to patients is dependent on cultural influences and beliefs, and addressing diversity and equity issues is recognized as an essential component of effective mental health care (Bhui et al., 2007; Fung et al., 2012). To examine this issue, the current survey study was conducted in Israel among mental health nurses.

**Methods**

Data were collected using an online survey titled “Social and Cultural Aspects of Nursing.” This structured self-report questionnaire examines cultural knowledge, cultural awareness, and cultural competence and has been used in a number of studies performed in Israel (Sagiv-Schifter & Ehrenfeld, 2007). The survey includes 177 questions that examine social and cultural aspects of nursing. The questionnaire is divided into eight sections. The first (questions 1 to 24) examines to what degree the staff inquire about patients’ social background and characteristics. The second (questions 25 to 45) examines the level of importance that nurses believe should be attributed to information regarding sociocultural features. The third (questions 46 to 87) examines to what degree the staff inquire about and recognize the social and cultural characteristics of patients and to what degree they take this information into account when treating patients. The fourth section (questions 88 to 112) deals with language limitations in nursing care, and the fifth (questions 113 to 121) examines religious authority and its effect on nursing care. The sixth section (questions 122 to 129) examines the effect of patients’ religiosity on nursing care, and the seventh section (questions 147 to 177) examines the correlation between nurses’ education regarding various cultures as well as the cultural competence of the staff and how to collect information on social and cultural characteristics of patients who are very sensitive to those issues. Answers were given using a Likert scale ranging from 1 (*not at all*) to 5 (*a great deal*). Ten questions were open-ended. Based on several studies, the Cronbach alpha coefficient was 0.90 (Logbinski, 2011).

The questionnaire was distributed by email to 150 nurses, all registered members of the Psychiatric Nursing Association in Israel working in psychiatric hospitals, psychiatric wards in general hospitals, or mental health clinics. A total of 107 nurses (71.33%) completed the questionnaire. The study was approved by the Institutional Review Board of the XXX Mental Health Center. Data analysis was performed using IBM SPSS, version 23 (IBM Corp., 2015).

**Results**

A total of 107 mental health nurses from various mental health centers, psychiatric wards of general hospitals, and mental health clinics in Israel participated in the survey; 76 (71.0%) were women and 31 (29.0%) were men. The mean age of the participants was 44.8 ± 8.17 years, and the mean number of years of seniority they had at work was 19.45 ± 9.44. A total of 85 participants (79.4%) were married, 91 (85.0%) were Jewish, 62 (57.9%) were born in Israel, 93 (86.9%) had studied nursing in Israel, and 71 (66.3%) had academic degrees. The languages spoken by participants were Hebrew (99.1% of respondents), Russian (36.9%), and Arabic (27%) (Table 1).

**Table 1**

*Sociodemographic Characteristics of the 107 Survey Participants*

|  |  |  |
| --- | --- | --- |
| *n* (%) |  | Characteristic |
| 31 (29.0)  76 (71.0) |  | Gender  Male  Female |
| 9 (8.1)  85 (76.6)  14 (12.6)  3 (2.7) |  | Marital status  Single  Married  Divorced  Widowed |
| 68 (63.6)  26 (24.1)  13 (12.1)  1 (0.9) |  | Degree of religiosity  Secular  Traditional  Religious  Ultra-Orthodox |
| 91 (85.0)  13 (12.1)  3 (2.8) |  | Religion  Jewish  Muslim Arab  Christian Arab |
| 62 (58.5)  28 (26.4)  16 (15.1) |  | Country of birth  Israel  Russia  Other |
| 93 (85.3)  16 (14.7) |  | Country of nursing studies  Israel  Russia |
| 22 (53.7)  19 (46.3) |  | Year of immigration  1951–1990  1991–001 |

The mental health nurses who responded to the survey attributed great importance to social and cultural aspects of patients’ lives, questioned patients about these issues, and had a high level of knowledge regarding their patients’ cultures. However, the gap was very large regarding the actual implementation of changes to treatment owing to social and cultural attributes.

In evaluating the caregivers’ experiences, a *t*-test revealed significant differences between male and female nurses in the extent to which they considered patients’ social and cultural characterististics when determining the type of treatment to administer (*t*[105] = 2.91; *p* < .01). Male nurses considered the social and cultural characteristics of the patients significantly more frequently than did female nurses (men, M *=* 3.64 ± 0.75; women, M = 3.06 ± 1.00).

A *t*-test also found significant differences between male and female nurses in the extent to which they found it necessary to adapt nursing care to the level of religiosity of the patient (*t*[103] = –2.12; *p* < .05), with it being significantly higher among male nurses than among female nurses (men, M = 2.96 ± 1.30; women, M = 3.44 ± 0.93).



In the examination of differences in the reported level of knowledge about patients’ social and cultural attributes, a *t*-test revealed significant differences (*t*[106] = 2.22; *p* < .05) between those who had studied nursing in Israel and those who had studied nursing in Russia. Among nurses whohad studied in Israel, the reported degree of knowledge of patients’ social and cultural attributes was significantly higher than that of the nurses who had studied in Russia (Israel, M = 3.76 ± 0.64; Russia, M = 3.39 ± 0.51) (Table 2).

**Table 2**

*Independent Samples t-Test for Examination of Differences Between Measures According to Country of Nursing Studies*

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Israel  *(n* = 93) | Russia  *(n* = 16) | Difference |
| Mean (SD) | Mean (SD) | *t* |
| Degree of knowledge | 3.76 (0.64) | 3.39 (0.51) | \*2.22 |
| Frequency of impact of language difficulties | 2.59 (0.79) | 3.34 (0.98) | –3.39\*\* |

\**p* < .05; \*\**p* < .01; SD = standard deviation.

In the examination of differences in the frequency that language difficulties had an effect on treatment, significant differences were found (t[107] = –3.39; *p* < .01) between those who had studied nursing in Israel and those who had studied nursing in Russia. Among nurses who had studied in Russia, the reported effect of language difficulties on treatment was significantly higher (M = 3.34 ± 0.98) than among nurses who had studied in Israel (M = 2.59 ± 0.79).



A positive correlation was found between the number of languages the nurses understood and the extent of responsibility they felt to understand the spoken languages of the patients they were treating (*r* = 0.24; *p* < .05). The greater the number of languages that nurses understood, the greater the responsibility they reported they felt to know the spoken languages of the patients they were treating (Table 3).

**Table 3**

*Pearson Correlation for the Relationship Between the Number of Languages Spoken by the Nurse and the Extent of the Nurse’s Responsibility to Know Patients’ Spoken Language*

|  |  |  |
| --- | --- | --- |
| Variable |  | Mean (SD) |
| Number of languages nurse understood | 1 | 2.79 (0.76) |
| Extent of nurse’s responsibility to understand the spoken language of the patient | \*0.238 | 3.11 (1.00) |

\*p < .05; \*\**p* < .01.

The findings indicate that the mental health nurses who participated in this study attributed great importance to sociocultural aspects of care, asked patients about their cultural and social background, and had a high degree of cultural knowledge, but found it difficult to implement appropriate changes. The findings suggest that the nurses’ gender, the country in which they studied nursing, and their language proficiency influenced their cultural awareness.

**Discussion**

Cultural competence is a crucial component in the provision of health care services in general and in nursing care in particular. Culturally competent treatment requires the nurse to be accepting of those who are different and to be able to detect and treat patients even when there is a lack of cultural understanding (Lerner-Zechut, 2015). The aim of this survey study was to examine and evaluate the degree of cultural competence of mental health nurses in Israel.

We found that the mental health nurses who participated in this study perceived themselves as having a moderate level of cultural competence compared with midwife-nurses in Israel, among whom higher scores of cultural competence have been found (Noble et al., 2009), and with nurses in other countries who rate themselves as not culturally competent (a mean score of 68.1 out of 100 was found by Seright [2012]) or as having low cultural competence (a score of 2.23 out of 5 [SD = 0.82] was found by Hart & Mareno [2016]).

In this study, mental health nurses reported having high awareness regarding the issue of cultural competence; they understood the meaning of cultural differences among their patients and the effect of these differences on diagnoses, processes, and management in mental care. However, they reported that they are not always able to provide culturally appropriate care in practice. Male mental health nurses were found to have greater cultural awareness. Although men outnumber women in most health care professions, in nursing, male nurses are the minority (Ashkenazi et al., 2017). According to Meadus and Twomey (2011), male nurses’ social identity is malleable; they may perceive themselves as the minority gender, and they often feel that they are discriminated against by the staff. Consequently, male nurses may identify with patients from cultural minorities, which may lead to increased cultural sensitivity and awareness (Keshet & Popper-Giveon, 2016; Segev et al., 2020).

In this study, cultural gaps among nursing staff members were found between nurses who had studied in Israel compared with those who had studied in Russia. Itzhaki et al. (2013) noted in their work that those who were born in and studied in the former Soviet Union and who then immigrated to Israel continued to identify with the culture of their country of birth. This finding was supported in the present survey, which revealed that the degree of nurses’ knowledge regarding their patients’ social and cultural attributes was lower among nurses who had studied in Russia and immigrated to Israel compared with those who had studied in Israel. An additional difference between study participants who had studied in Israel and those who had studied in Russia was that latter had a higher awareness of the impact of language difficulties on patient care. Thus, nurses who had studied in Israel had greater cultural knowledge in comparison with those who studied in Russia but had less cultural awareness. This finding is consistent with literature that suggests that a high level of cultural knowledge does not necessarily imply high cultural awareness and vice versa (Mareno and Hart, 2014).

The study’s findings suggest that by virtue of being members of minority populations, male nurses and nurses who immigrated to Israel from Russia had greater cultural awareness compared with the rest of the staff. We also found greater cultural awareness among nurses who spoke or understood multiple languages. Multilingual nurses tended to perceive themselves as bearing more responsibility for learning other languages; that is, they were more likely to report feeling responsible for developing cultural competence compared with nurses who spoke only one language. A similar study reported significantly higher cultural competence scores among nurses who spoke a second language at home compared with nurses who spoke only English (De Beer & Chipps, 2014).

Verbal and nonverbal communication are critically important in the patient/caregiver interaction and are essential components of cross-cultural clinical competence and quality care (Lorié et al., 2017). In this survey study, we found that more than 50% of the nurses reported communication problems with patients, mainly during patient education. Regev (2014) also found that nurses reported obstacles owing to language difficulties. When there are language barriers (based on ethnicity), gaps are created in the medical treatment process and are reflected in its outcomes (van Rosse et al., 2016).

The present study found that ethnic differences existed even among staff members who shared a common country of birth. However, there are also differences in terms of social status, religious customs, cultural beliefs, and even attitudes toward illness and recovery (Sue, 2001). This indicates the importance of professional training and culturally focused work procedures, which will lead to comparable work standards among staff members from various ethnic groups (Bhui et al., 2007).

**Conclusion**

Cultural diversity in the State of Israel presents challenges to the health system in general and to mental health care in particular. In the field of mental health, cultural skills within the system and among its employees are of particular importance, because the effectiveness of mental health treatment depends on the quality of communication between the service provider and the service recipient. The cultural awareness of the service provider is a cardinal component in creating that optimal communication. Mental health nurses must recognize the need to respect the cultures, values, and preferred treatment methods of health care consumers. To do so, mental health nurses must abandon stereotypes associated with certain cultures and be sensitive to the cultural needs of their patients. The main skills mental health nurses need to practice include verbal communication and listening abilities.

***Implications for Practice***

This study, as well as other studies that have examined cultural competence of nurses, revealed a need among mental health nurses for professional multicultural education. We recommend that stakeholders in mental health policy prioritize cultural competence to increase its perceived importance among caregivers. Educating staff and encouraging the use of professional translators are necessary measures. Another important aspect is to recognize male nurses as a minority group among mental health nurses. Policy makers and supervisors should be more attentive to the needs of male nurses and nurture their cultural competence qualifications in day-to-day care, enabling them to become leaders in this endeavor within their own medical centers. Cultural competence should also be embedded and role modeled at the organizational level.

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Mona Shattell

Editor, *Journal of Psychosocial Nursing and Mental Health Services*

‏Dear Prof. Shattell:

Attached please find our original manuscript entitled “How Mental Health Nurses Perceive Cultural Competence.”

In this study, we surveyed Israeli mental health nurses to investigate their perceptions of their cultural competence. The nurses in the study attributed great importance to sociocultural aspects of patient care, but reported having difficulty implementing these aspects in their caregiving. We also found that cultural knowledge and awareness correlated with personal characteristics, such as the nurses’ gender and country of origin. We concluded that there is a need not only for ongoing training and maintenance of cultural knowledge but also to provide tools for implementing culturally adapted care.

We believe this article will be of interest to researchers, educators, and health care policy-makers in the clinical fields of mental health and welfare.

None of the data have previously been published, nor is the article under consideration for publication elsewhere. As the principal authors, we declare full responsibility for the data, the analyses and interpretation, and the conduct of the research, and we declare that we have the right to publish any and all of the data. This study was conducted with the approval of the Institutional Review Board of Lev-Hasharon Mental Health Center, as stated in the Methods.

We thank you for considering our manuscript as an original article for publication in the *Journal of Psychosocial Nursing and Mental Health Services.*

Sincerely,

Jenny Segalovich, Sagit Dahan, Galit Levi, and Dr. Ronen Segev