BACKGROUND

As the world becomes increasingly heterogeneous (Wilhelm&Zlotnick 2013) often as a consequence of mass-migration, cultural exchanges increase. In countries such as Turkey, which currently host millions of refugees, this aspect of globalisation highlights differences within cultures, such as social and community life, attitudes, expectations and the utilisation of health services (Duffy, 2001). In order to respond, health care systems need to ensure practitioners are culturally competent and responsive to the needs of people from different cultures to their own.

Culture, which manifests through the behavioural patterns that guide the lifestyle of a society, plays a vital role in health perceptions, behaviours and response (Gözüm et al. 2016). Cultural differences can affect the health care system and lead to health inequalities and disparities (Clark 2013). Potentially, within health care systems, cultural competence facilitates person-centred and integrated care (Douglas et al. 2014) and as such stems from the attitudes, and behaviours of practitioners and organisational policy or a combination of both (Halabi&Beer, 2018). Hence, the nursing workforce, the largest element of most health care systems, is in a unique position to reduce cultural disparities that arise when different cultures meet (Douglas et al. 2014).

The assumption in this paper is that cultural competence is a capability that can be nurtured and developed, which results in holistic care, increases the service user's quality of life, health care satisfaction and the perception of quality care (Leininger 2002, Yeager&Bauer-Wu, 2013). Effective cultural communication demonstrates respect, dignity and the preservation of human rights (Miller et al. 2008) and provides fair and equal opportunities thus reducing disparities (Dougles et al. 2014). In contrast, cultural insensitivity and incompetence in the health care system can generate barriers to health-seeking behaviour and create uncomfortable experiences for service users (Rew et al. 2003).

In mental health care, a person's cultural expression can have profound implications for their diagnosis and subequent care and treatment (Flanagan et al. 2016). Culture is a critical factor that can shape the expression of clinical symptoms, influence models of mental health and illness and treatment-seeking behaviours (Lewis-Fernandez et al., 2014). Nurses, therefore, need to be aware of the impact of culture on the trajectory of mental health issues and the subsequent recovery process (Sousa&Rojjanasrirat, 2011). Culturally-sensitive approaches may lead to a better understanding of a person's needs and health care outcomes.

One of the primary aims of pre-registration nursing education is to support students in developing cultural sensitivity and understanding the influences of culture on health, but also how their own cultural background affects others (Von Ah&Cassara, 2013). This has even more resonance in Turkey which seeks to provide care to large numbers of refugees who have experienced loss and trauma due to conflict. Cross cultural nursing education, it is argued, must be experiential to help build internalised knowledge through experience (Wilhelm&Zlotnick, 2012). However, despite the increased emphasis on cultural education in nursing curricula worldwide, culturally based problems in healthcare persist.

In culturally diverse countries, such as Turkey, where nurse education only includes around 300 hours of theory and practice specific to mental health, there is a need to explore the level of cultural awareness achieved by final year nursing students and to identify strategies for improving competency development, throughout the curricula. This is vital for those entering nurse education as they will become the nurse leaders of the future and will have a key role in shaping the practice culture and expectations within an increasingly heterogeneous society. Therefore, understanding the cultural expressions of mental health service users while providing culturally sensitive mental health care, should be an essential component of nurse education. However, the challenge is to maximise the opportunities for learning within the limited time available.

This study examines data drawn from final (4th) year nursing students from seven nursing schools across Turkey, to identify current levels of understanding and to make recommendations for curriculum design and delivery. We believe that the insights derived from this study will have wider relevance and appeal to countries facing similar challenges in meeting the growing population diversity within their own countries. Throughout this paper we have adopted the term ‘service user’ rather than ‘patient’, to refer to those receiving mental health care, acknowledging the dehumanising effect of medical labels. However, the term patient is used by some of the interview respondents and is included in their direct quotes.

METHOD

Aim of the study

This project aimed to identify the level of cross cultural competency of Turkish final year student nurses, and the challenges arising from mental health and students' internalised cultural perceptions. The study sought to address the following questions;

- What are student nurses’ perceptions of cross cultural nursing care in Turkey?

- What is the level of cross cultural competency amongst student nurses in Turkey?
- What are the implications arising from students' internalised cultural perceptions for the delivery of cross-cultural mental health care?
- What are the implications for the delivery of nurse education in Turkey?

Study Design

A mixed-methods study comprising two phases:

Quantitative Phase: Data were collected using the Nurse Cultural Competence Scale (NCCS), which includes questions about cross-cultural competency and some sociodemographics details of students.

Qualitative Phase: Data were collected through interviews with 25 undergraduate nursing students. The qualitative phase of the study was conducted by adopting a descriptive phenomenological approach, the purpose of which is to describe, interpret and understand the phenomena of cross-cultural mental health care. The approach was adopted because it provides rich data and enables the researchers to gain deep insights into the views of the participants (Hsieh and Shannon, 2005). The audio-taped interviews lasted 45 min on average. The first author performed all interviews, using the semi-structured questionnaire. The interviewer was aware of possible unequal power dynamics between the interviewer and the interviewee during the conversation and focused on respectful and empathic behaviour (Malterud, 2001). Interviews were finished once data saturation had been achieved.

The Study

The Turkish 4-year pre-registration nursing programme involves students undertaking compulsory and elective courses in order to be graduated as a general nurse by completing at least 240 ECTS. One of the compulsory courses is *"Mental Health Nursing"* which is a final year element consisting 308 hours learning activity. The theoretical and clinical placement components are focused on mental health and mental ill-health, which is typically the first time students have the opportunity to explore these subjects in depth. The assumption was that students in their fourth year would have a good appreciation of cross cultural care principles and would be able to apply these to the mental health context.

Setting and Participants

Between October 2017 and May 2018, all final year nursing students from seven Turkish nursing school were invited to participate in the study; 505 nursing students signed informed consent and participated. The participants of this study were selected through convenience sampling from nursing students attending seven universities in Turkey. All nursing schools

had very similar characteristics regarding their education system and courses. The study inclusion criteria were (1) being final year nursing students, (2) being able to communicate in Turkish, (3) completed mental health course, (4) voluntary participation in the study.

Data Collection

Data were collected using the NCCS and Qualitative Question Form. Information about data collection tools were as follows:

1. Student Nurse Data Sheet was developed to define sociodemographic characteristics and cross-cultural perspectives based on previous literature (Almutairi et al. 2015, Halabi&Beer 2018, Perng&Watson 2012). The questionnaire included questions regarding the socio demographic characteristics of the participants, such as age, gender, educational background and also, approaches of cross cultural nursing care.

2. Nurse Cultural Competence Scale (NCCS Perng and Watson, 2012) is a commonly used tool to assess cultural competency in nursing students and nurses. The Turkish version of the NCCS has been validated and assessed for reliability (internal consistency coefficient of 0.98) by Gözüm et al. (2016). The tool includes 20 closed-ended items that are rated using a five-point likert type scale. The range of scale score is 20-100. The higher scores indicate a higher level of cultural competency. The scale includes three subscales, namely, "cultural skills," "cultural knowledge," and "cultural sensitivity". There are twelve statements (1,2,4,5,6,7,8,10,14,16,18,19) related to cultural skills, six statements (3,9,11,12,13,15) related to cultural knowledge, and two statements (17,20) related to cultural sensitivity. The Cronbach's α values were between 0.66 and 0.81 in Turkish validity-reliability study of NCCS, and those in this study were between 0.82 and 0.93.

3. Qualitative Question Form is based on literature and includes questions related to cross cultural understanding and competency and perceptions of mental health nursing students (See Fig 1).

Ethical Considerations

The study adhered to the principles of the Declaration of Helsinki. The study procedures were approved by Hacettepe University Ethics Commission (protocol no. 431-1319) before it was initiated and the necessary permissions from the nursing faculties were approved. All the participants were informed of the voluntary nature of the participation. Verbal and written informed consent was obtained from each participant. The participants could withdraw from the study at any time without stating a reason, and they were not expected to pay for participation. All paticipants were informed that the findings obtained were being used for

scientific purposes only and that students' names should not be written on the forms to maintain confidentiality.

Data Analyses

Quantitative Data: Data were coded and analyzed using the SPSS 23 statistical software (IBM SPSS Statistics v23). Descriptive statistics and percentages on sociodemographic data, were used to present the findings. The data met the parametric test assumptions so, *t-test* was used to analyze the findings. A p value of <.05 was the significance level for statistical tests.

Qualitative Data: The content analysis method, which includes coding the data, determining the themes, and organizing and redefining the themes, was used for data analysis (Hsieh and Shannon, 2005). Transcripts were initially read through and reviewed again and again by authors to gain familiarity. Then, to ensure credibility and trustworthiness, each transcript was initially analysed independently by authors.

RESULTS

Demographic and cross-cultural care related results were presented in table 1 and table 2.

Quantitative Data - Main Findings

According to the results of the t-test, significant differences were obtained between cultural competency scores and some socio demographics ($p < 0.05$). For detailed information, please see table 3.

Qualitative Data - Main Findings

The opinions and experiences of nursing students of cross cultural mental health were obtained after the quantitative phase of the study. Key themes and sub-themes began to emerge by combining the codes. The quotes of student gathered under four main themes (see Table 4).

1. Conceptualizing Cross-Cultural Care

Cultural care involves expressions, meanings, patterns, and practices. Students noted that the curriculum did not always sufficiently help them to obtain culture-specific knowledge and awareness.

a) The meaning of cross-cultural care

Although, many students have an idea about cross-cultural care, some of them reported that they heard the cultural care in the first time with current study questions and attributed a negative meaning cross-cultural care as an impossible process. Many students described cross-cultural care as being aware of cultural differences in order to act and feel more confident. However, others appeared uncertain in defining cross-cultural care. One student

defined cross-cultural care as: *"Having knowledge about the culture of patient and transfer this knowledge into practice. I guess, act by knowing the effects of culture on individuals."*

b) Cultural competency

Students often describe cultural competency as being aware of the cultural needs of service users. But many students reported lower levels of cultural competency in providing mental health care and were uncertain whether some behaviors of service users were caused by their mental illness or their culture. One student reported: *"Cultural competency is being familiar to culture of individuals. It includes not being racist or humiliating toward people from different culture. To be honest I do not feel very competent where mental illness is concerned*"

2. Barriers in providing cross-cultural care

Although, Turkey has a multicultural background, the analysis showed that participants equated 'culture' with country of origin rather than taking a broader definition, so they often described language differences as a barrier. Therefore, students' self-perceived beliefs, and poorer cultural knowledge made them feel inadequate as professionals, and some felt that they just needed to provide medical care for service users rather than focusing on cultural needs.

a) Non-functional beliefs

Culture includes learned, shared and transmitted belief systems which guide decisions and actions. Unconsciously, such beliefs could impede the ability to penetrate more than superficial levels of student attitudes, leading to external conformity to perceived norms rather than genuine respect and understanding of difference. Students focused on their ignorance of cultural differences in order to act and feel more confident.

One student stated her ignorance to cultural behaviours of an individual, and she said: *"I was caring for an individual who was drinking alcohol. This does not suit my culture and moral, but it was normal for his culture. However, it was not normal while I was caring and it was expected from me to tolerate this behaviour and give care to this individual. I could not do that, I preferred not to contact him unless it is necessary for example giving medicine, measuring the vital signs etc."*

b) Lack of knowledge

Many students appeared to hold fairly negative views about their cultural competence training. Students reported limited knowledge in understanding and accepting differences and felt that they needed to be better informed in order to care for culturally different service users with a nonjudgmental attitude. Moreover, some worried that their lack of specific cultural knowledge may appear discriminatory or racist, creating further uncertainty about how to act.

One student reported that, *"I know I should be sensitive to different cultures of individuals. I cared, but I don't really know what they are... and how I can notice."*

There was also uncertainty as to how to engage with service users about their cultural values, perspectives, or practices for fear of ''getting it wrong.''

c) Language

Students noted that the influx of Syrian refugees has posed a particular problem in that there are language differences which also affect care provision. Students stated their own communication ability limits their ability to connecting with the service users, so they preferred not to communicate directly or alternatively use translators. Although communication was seen as an essential element, students often felt that language barriers made it difficult and they expressed unwillingness to communicate with service users who used a different language.

When students faced language differences, they often chose to provide only medical care instead of understanding deeper, psychological needs. One student defined language differences as a big wall between him and the service user. He said*: "I could not understand any of her words, even from her body language. Like a stone wall was there. I never want to remember this memory, I felt very useless."*

3. Benefits of cross-cultural care

The students were aware of the impact that one's cultural status has impacts on individual's health status, expressions and meaning of the care system. However, only some indicated the probable positive effects of culture.

a) Understanding of deeper needs

Cross-cultural sensitivity can explicate complex, covert, and largely unknown views of service users about care, health, and wellbeing. Cultural beliefs regarding health and disease can influence accessing and using effectively health care systems. Thus, implementing satisfying, meaningful, and beneficial care provides optimal health. Most students felt that they were in the process of learning to care for service users without being biased. One student stated: *"Culture helps us collaborate to individuals. Especially in mental health cultural communication is has greater importance to be able to prevent bias."*

b) Accessing qualified care

Culturally sensitive care requires a multidirectional approach and flexibility. However, students reported that service users could fear to share their needs as a result of insensitivity. Hence, students stated considering the cultural needs of service users had a beneficial effect

and led to better care. One student reported: *"When I am more open toward cultural differences, patients could feel more comfortable and focus on their treatment apart from the difficulties in expressing themselves in a sufficient way."*

4. Strategies for providing cross-cultural care

Although, many students are unsure how to provide cross cultural care, they were aware of the potential positive impacts of being culturally competent.

a) Improving self awareness and motivations

Most respondents saw a need to learn about their attitudes toward different cultures, by understanding these aspects, students can gain the ability to think and act flexibly or creatively. Students who reported a high degree of personal commitment to providing culturally sensitive care, could see beyond their own worlds and continued to feel well-equipped to respond to service users' needs.

The students learned to modify their practice to meet the needs of service users, and believed that they were subsequently able to build trusting relationships leading to improved outcomes for service users. These students were most effectively able to accommodate the cultural needs of service users. In this regard, improved self-awareness was considered an essential element in providing effective cross-cultural care. One student stated her perceived viewpoint that: *"When I realized my viewpoint, I begin to stop my negative thoughts and just concentrate on human to human communication, I could have noticed the cultural need and the patient beginning to open their worlds. In the first time it was really hard but, in time it becomes a routine, and makes me feel competent"*

b) Well-structured education

As indicated in the sub-theme of "*lack of knowledge*", many students expressed that they lack the education necessary to effectively care for people from other cultures, and indicated a desire to gain knowledge and expand their horizons in cultural differences. Nearly all students referred to education as a major factor in providing cross-cultural care. Many stated a strong interest in learning about other cultures. Students stated that additional methods were needed to increase cultural competency, and to take time to learn from the service users themselves and the value of being exposed to service users from different cultures. One student stated: *"If I had enough knowledge, I can specify the needs correctly and understand the meanings behind the behaviors. If we cannot provide culturally sensitive care, the quality of care can be poor and we cannot access the patient's world. Thus, our educational program can be revised, maybe a special lesson can be added to program"*

DISCUSSION

By identifying the four themes of *conceptualizing cross-cultural care*, *barriers in providing cross-cultural care*, *beneficences of cross-cultural care* and, s*trategies for providing cross-cultural care*, this study delineated deeper understanding of the competency and perspectives of nursing students in cross-cultural mental health care. This is crucial at a time when Turkey is offering support to large numbers of refugees with different language and cultural norms, an experience common to many countries around the world. Cultural competence combines behaviours, attitudes and knowledge of an individual in various cultural contexts outside their own culture. Although, it is expected that health care providers have the ability and availability to work effectively within the cultural context of service users (Campinha-Bacote, 2007), the findings suggest many students lack the skills and confidence in cross-cultural care which can limit or impare the crucial therapeutic relationship between the nurse and service users, a finding similar to Jerve et al. (2010).

The common experience of uncertainty can have a disempowering effect on the care given to individuals from different cultures. A symptom of this was students' admission that they preferred not to communicate with service users, or sometimes just rely on a translator. This decision is often for pragmatic reasons but it can decrease the quality of care, due to students' lack of confidence in the communication process. Students' uncertainty about how to negotiate encounters involving people with perceived cultural differences can potentially lead to inadequate or ill-judged approaches creating clinical risk. The barriers in providing cross-cultural care, including non-functional beliefs, language and lack of knowledge, therefore need to be overcome if nurses are to deliver effective mental health care within a culturally diverse context. On the positive side, those students who were aware that service users from different cultures were stigmatised, also had higher total competency and cultural skills scores suggesting that where students are aware and sensitive to stigma, they are more likely to be sensitive to cultural differences.

Even though educational attainment is an important predictor of cultural awareness, cultural sensitivity, and cultural competency of nurses (Mahabeer 2009, contrary to the previous literature (Halabi and De Beer, 2018; Sil Choi and Soo Kim, 2018), this study found that students with no previous study of cultural issues had more total competency, cultural skills and cultural knowledge than those who had previous training. However, other literature strongly suggests that education has a significant effect on cultural competence (Brathwaite & Majumdar, 2006; Majumdar et al., 2004) in particular the value of developing curricula with

humanism, cultural awareness and competency as central themes. This may prove challenging in an already busy curriculum where the ECTS education system limits the theoretical and practical hours available.

The challenge is identifying specifically what works and can be delivered in a timely and efficient manner. In a meta-analysis study, Gallgher and Polanin (2015) found that cultural competence training can lead to greater cultural awareness with potential benefit to the people receiving services. By providing cultural care awareness in the nursing curriculum via lectures, cultural engagement sessions and appropriate clinical placements, students can begin to understand and internalize the cultural frame of reference of individuals suffering from mental health problems.

Campinha-Bacote (2008) refers to cultural competence as a process of becoming competent, rather than achieving competence, with education being a critical element in achieving culturally congruent care (Diaz et al. 2015). Cultural competence encompasses more than being aware of a patient's cultural background when providing nursing care (Morton-Miller, 2013) it also includes awareness of one’s own self-efficacy through exposure to other cultures, values and beliefs (Halabi and De Beer, 2018; Marzilli, 2016).

The extensive literature around service user engagement in nurse education and the delivery of person-centred care (Tee SR 2016, O’Dowd Lernihan et al 2018, Heaslip et al 2018, Tee & Üzar Özçetin 2016, Tee 2012, Lathlean et al 2006), provide important indicators of the value of constructive engagement between the people that use mental health services and those being prepared to deliver services. It is known that where service user involvement occurs in meaningful ways throughout the student journey through training, this can break down barriers, promote positive perceptions, increase awareness of diversity in all its forms and enhance the student learning experience and their level of competency.

Implications for Education Practice

This study reveals important insights for those delivering mental health nursing training in diverse countries such as Turkey, experiencing an influx of refugees. Perhaps it is time to have a rethink as to how, when and where students achieve cultural competence, and ensure cultural diversity and competency is at the heart of the students learning journey.

Involving people from different cultures in recruitment, would help to ensure that those recruited into nurse training displayed appropriate values and behaviours from the outset. In addition, contact theory (Allport 1954), suggests that ‘contact’ in the form of contstructive engagement can overcome prejudice and bias in relationships and promote

cultural awareness. Therefore, enursing regular and meaningful contact with people from different cultures, either through placements or teaching and learning experiences, may address some of the confidence issues revealed in the data. This could be supported action-learning oriented, cross-cultural education, including sharing group-specific knowledge related to different cultures delivered by people from that cultural group who perhaps themselves have had experience of mental health problems. This would be a useful and relevant way in improving sensitivity and cultural knowledge. Where more specific assistance in learning how to deal with practical situations is needed, this could be addressed through role play and skills development jointly prepared and delivered by service users. Whatever the pedagogic solutions, setting the curriculum within a strong humanistic framework which puts cross-cultural care at the heart of mental health education would go some way to overcome the experience of cultural insensitivity and discrimination that characterizes some aspects of mental health services.

Strengths and Limitations

There are several limitations to this study. Firstly, the study was conducted nursing schools in one country, which limits the generalizability of the findings. Secondly, data was collected from undergraduate students thus, long-term competency levels after graduation could not be determined. However, the study assessed the cross-cultural competency levels of nursing students among people suffering from mental health problems using the Leininger's Transcultural theory. By doing so, it applied a methodological rigor. Moreover, the study was conducted using mixed method which helps to support quantitative data with qualitative ones and developed deeper understanding.

CONCLUSION

Cultural competence entails gaining knowledge of cultural differences, for example in health beliefs and practices, religion, and communication styles, but also developing awareness of personal biases, values, and assumptions. This study revealed that large numbers of students had only moderate levels of cultural competency, cultural sensitivity, cultural knowledge and cultural skill scores and highlights the importance of providing students with service user oriented and concrete, skill-based training to promote understanding of cultural difference and confront bias and prejudice.

Cross-cultural care education can help students engage in more meaningful contact with people, and overcome some of the dehumanizing effects of healthcare delivery. It is recommended that undergraduate nursing education in Turkey should be re-structured to

strengthen cultural competency levels of students, at an earlier stage of training, and revised at key stages in their learning journey, in order to improve their confidence and understanding. It is further recommened that regular auditing is conducted to monitor cultural competence of all nursing staff after graduation to ensure such competence is maintained. The worldwide refugee crisis, resulting in significant levels of mental distress and trauma, highlights a critical need for practitioners who are not only culturally competent but are able to deliver high quality mental health care to all members of a society.

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Table 1. Demographic and Cross Cultural Care Related Characteristics

	n	%
Age		
18-24	441	87.3
25>	63	12.5
Sex		
Female	434	85.9
Male	71	14.1
Marital Status		
Married	16	3.2
Single	489	96.8
Training in Cross Cultural Care		
Yes	118	23.4
No	387	76.6
Cared for Service Users From Different Cultures		
Yes	470	93.1
No	35	6.9
Experience Difficulties While Caring Service Users From Different Cultures		
Yes	290	57.4
No	215	42.6
Nurses Need to Be Trained to Care For Service Users From Different Cultures		
Yes	420	83.2
No	85	16.8
Heard About Cross-Cultural Nursing Before		
Yes	320	63.4
No	185	36.6
Easier To Care For Service Users From Her/ His Own Culture		
Yes	394	78.0
No	111	22.0
Difficult to Provide Care for Service Users From Different Cultures		
Yes	247	48.9
No	258	51.1
Feel Competent to Care for Service Users From Different Cultures		
Yes	243	48.1
No	262	51.9
Service Users From Different Cultures are Stigmatised		
Yes	290	57.4
No	215	42.6

Table 2. Cross Cultural Competency of Nursing Students

Questions of NCCS	n	%
I can teach and guide other nursing colleagues about the differences and similarities of diverse cultures		
Strongly agree	42	8.3
Agree	222	44.0
Undecided	161	31.9
Disagree	80	15.8
I can teach and guide other nursing colleagues about planning nursing interventions for clients from diverse cultural backgrounds		
Strongly agree	47	9.3
Agree	200	39.6
Undecided	216	42.8
Disagree	42	8.3
I can use examples to illustrate communication skills with clients of diverse cultural backgrounds		
Strongly agree	84	16.6
Agree	335	66.3
Undecided	78	15.4
Disagree	8	1.6
I can teach and guide other nursing colleagues about the communication skills for clients from diverse cultural backgrounds		
Strongly agree	23	4.6
Agree	215	42.6
Undecided	193	38.2
Disagree	74	14.7
I can explain the influences of cultural factors on one's beliefs/behaviour towards health/illness to clients from diverse ethnic groups		
Strongly agree	31	6.1
Agree	265	52.5
Undecided	143	28.3
Disagree	66	13.1
To me, collecting information on each client's beliefs/behaviour about health/illness is very easy		
Strongly agree	47	9.3
Agree	200	39.6
Undecided	216	42.8
Disagree	42	8.3
I can teach and guide other nursing colleagues about cultural knowledge of health and illness		
Strongly agree	51	10.1
Agree	168	33.3
Undecided	195	38.6
Disagree	91	18.0
I can teach and guide other nursing colleagues to display appropriate behaviour, when they implement nursing care for clients from diverse cultural groups		
Strongly agree	32	6.3
Agree	121	24.0
Undecided	237	46.9
Disagree	115	22.8
I am familiar with health- or illness-related cultural knowledge or theory		
Strongly agree	9	1.8
Agree	151	29.9
Undecided	200	39.6
Disagree	124	24.6
Strongly disagree	21	4.2
I can list the methods or ways of collecting health-, illness-, and cultural-related information		
Strongly agree	44	8.7
Agree	175	34.7
Undecided	176	34.9
Disagree	110	21.8
I can compare the health or illness beliefs among clients with diverse cultural background		

Strongly agree	27	5.3
Agree	189	37.4
Undecided	169	33.5
Disagree	120	23.8
I can explain the influence of culture on a client’s beliefs/behaviour about health/illness		
Strongly agree	15	3.0
Agree	236	46.7
Undecided	209	41.4
Disagree	45	8.9
I can easily identify the care needs of clients with diverse cultural backgrounds		
Strongly agree	14	2.8
Agree	139	27.5
Undecided	255	50.5
Disagree	71	14.1
Strongly disagree	26	5.1
When implementing nursing activities, I can fulfil the needs of clients from diverse cultural backgrounds		
Strongly agree	27	5.3
Agree	196	38.8
Undecided	225	44.6
Disagree	46	9.1
Strongly disagree	11	2.2
I can explain the possible relationships between the health/illness beliefs and culture of the clients		
Strongly agree	10	2.0
Agree	227	45.0
Undecided	212	42.0
Disagree	54	10.7
Strongly disagree	2	0.4
I can establish nursing goals according each client’s cultural background		
Strongly agree	35	6.9
Agree	238	47.1
Undecided	145	28.7
Disagree	77	15.2
Strongly disagree	10	2.0
I can explain the possible relationships between the health/illness beliefs and culture of the clients		
Strongly agree	10	2.0
Agree	227	45.0
Undecided	212	42.0
Disagree	54	10.7
Strongly disagree	2	0.4
I can establish nursing goals according each client’s cultural background		
Strongly agree	35	6.9
Agree	238	47.1
Undecided	145	28.7
Disagree	77	15.2
Strongly disagree	10	2.0
I usually actively strive to understand the beliefs of different cultural groups		
Strongly agree	26	5.1
Agree	170	33.7
Undecided	238	47.1
Disagree	58	11.5
Strongly disagree	13	2.6
When caring for clients from different cultural backgrounds, my behavioural response usually will not differ much from the client’s cultural norms		
Strongly agree	52	10.3
Agree	228	45.1
Undecided	176	34.9
Disagree	45	8.9
Strongly disagree	4	0.8
I can use communication skills with clients of different cultural backgrounds		
Strongly agree	48	9.5
Agree	266	52.7
Undecided	116	23.0
Disagree	61	12.1
Strongly disagree	14	2.8
I usually discuss differences between the client’s health beliefs/behaviour and nursing knowledge with each client		
Strongly agree	28	5.5

Agree	158	31.3
Undecided	190	37.6
Disagree	118	23.4
Strongly disagree	11	2.2

Table 3. Cross Cultural Competency in Mental Health Care of Nursing Students

Sociodemographics	NCCS							
	Total Competency		**Cultural Skill**		**Cultural Knowledge**		**Cultural Sensitivity**	
	Mean±Sd	**t-test**	**Mean±Sd**	**t-test**	**Mean±Sd**	**t-test**	**Mean±Sd**	**t-test**
Sex								
Female	52.94±8.23	**t=3.51**	31.28±6.13	**t=2.42**	15.66±6.13	**t=4.48**	5.54±1.25	t=1.51
Male	56.14±7.21	**p=0.000**	33.19±6.30	**p=0.16**	17.15±6.30	**p=0.000**	5.78±1.22	p=0.130
Marital Status								
Single	52.00±2.55	**t=1.39**	30.31±2.18	**t=2.08**	16.12±0.50	**t=1.50**	5.56±0.62	**t=1.09**
Married	53.03±8.31	**p=0.000**	31.59±6.27	**p=0.006**	15.86±2.69	**p=0.000**	5.58±1.26	**p=0.001**
Training in Cross Cultural Care								
Yes	50.71±8.49	**t=3.46**	30.35±6.13	**t=2.40**	14.64±2.26	**t=5.74**	5.70±1.28	t=1.20
No	53.71±8.02	**p=0.001**	31.94±6.18	**p=0.017**	16.23±2.66	**p=0.000**	5.54±1.24	p=0.236
Cared for Service Users From Different Cultures								
Yes	52.83±8.10	t=1.68	31.38±6.10	**t=2.23**	15.87±2.71	t=0.03	5.58±125	t=0.04
No	55.25±9.16	p=0.092	33.80±6.92	**p=0.026**	15.88±1.64	p=0.960	5.57±1.21	p=0.966
Experience Difficulties While Caring Service Users From Different Cultures								
Yes	52.68±8.03	t=1.02	31.45±5.70	t=0.42	15.78±2.50	t=0.80	5.44±1.27	**t=2.91**
No	53.43±6.40	p=0.307	31.68±6.79	p=0.679	15.98±2.84	p=0.431	5.76±1.20	**p=0.004**
Nurses Need to Be Trained to Care For Service Users From Different Cultures								
Yes	52.60±8.31	**t=2.63**	31.33±6.39	**t=2.08**	15.77±2.71	**t=2.03**	5.49±1.23	**t=3.32**
No	54.95±7.28	**p=0.009**	32.62±4.90	**p=0.039**	16.34±2.25	**p=0.044**	5.98±1.26	**p=0.001**
Heard About Cross-Cultural Nursing Before								
Yes	51.36±7.51	**t=5.89**	29.93±5.15	**t=7.66**	15.97±2.76	t=1.15	5.46±1.18	**t=2.62**
No	55.83±8.56	**p=0.000**	34.35±6.80	**p=0.000**	15.69±2.45	p=0.248	5.77±1.34	**p=0.009**
Easier To Care For Service Users From Her/ His Own Culture								
Yes	53.82±8.33	**t=4.32**	32.13±6.30	**t=4.47**	16.00±2.76	**t=2.41**	5.68±1.15	**t=3.20**
No	50.08±6.93	**p=0.000**	29.47±5.28	**p=0.000**	15.40±2.15	**p=0.017**	5.19±1.48	**p=0.002**
Difficult to Provide Care for Service Users From Different Cultures								
Yes	52.59±8.06	t=1.08	31.55±5.69	t=0.02	15.57±2.23	**t=2.51**	5.46±1.19	t=1.94
No	53.39±8.30	p=0.278	31.54±6.63	p=0.982	16.15±2.97	**p=0.012**	5.68±1.29	p=0.052
Feel Competent To Care For Service Users From Different Cultures								
Yes	53.44±9.11	t=1.15	31.90±7.10	t=1.23	16.01±3.04	t=1.15	5.52±1.19	t=0.99
No	52.59±7.22	p=0.249	31.22±5.18	p=0.217	15.74±2.23	p=0.256	5.63±1.30	p=0.319
Service Users From Different Cultures are Stigmatised								
Yes	53.72±7.50	**t=2.31**	32.12±5.36	**t=2.40**	16.03±3.08	t=1.60	5.57±1.05	t=0.16
No	52.02±8.36	**p=0.021**	30.78±7.08	**p=0.016**	15.65±1.91	p=0.108	5.59±1.47	p=0.877

Abbreviation: NCCS, Nurse Cultural Competence Scale. Effects of sociodemographics on Cultural Competency levels of students were assessed using independent sample t-test

Table 4: Quotes of Students

1. Conceptualizing Cross-Cultural Care	
a) The meaning of cross-cultural care	A student indicated her confusion about culture specific care as: *"I cannot be aware of cultural effects on mental health in clinics. All the symptoms look like a part of their illness, not a part of their culture. But, as I thought maybe some symptoms are caused by culture."* Another reported: *"I am not sure how to define it. Came to my mind that care for individuals from the same culture with own..."* One student stated: *"I've never heard about cross-cultural care and I do not have any idea of it. We cannot know each culture. If its mean is to be able to understand the culture of individuals, I think it is impossible to provide cross-cultural care."*
b) Cultural competency	A student indicated: *"Care to individuals by being aware of their ethnicity, values, beliefs and respect to their culture and cultural attitudes. Competency involves learning the cultural differences, because culture can affect every health related choices."* Another students stated her feelings more negatively. She said: "*I do not have cultural competency. I think, I cannot care effectively to people from different culture. It is hard to understand their cultural needs and also, I need to care many patients, so it is not realistic to give so much time for understanding the culture."*
2. Barriers in providing cross-cultural care	
a) Non-functional beliefs	A student said: *"Culturally specific care can affect routine care negatively and cannot be controlled if it is effective or not. The best way I guess, implementing standard care for individuals"* Another student said: *"Individuals with mental illnesses cannot open his/her thoughts/feelings, also if we are very different cultural background. It takes much more time... According to me, it is unnecessarily time west in mental health care."* One student reported: *"Mental health care is already difficult, so cross-cultural nursing provides extra difficulties."*
b) Lack of knowledge	A student said: *"Cross-cultural care is not an easy issue. Especially, if you do not know what is the real mean of it. I tried to understand my patient's culture who was from Syria, but I disappointed when I realised I am not sure how to ask his culture. I worried a lot to ask a wrong question. Culture includes every perspective and I am not competent to be able to even ask it. Hence, I do not see my ability enough to handle patient's cultural needs. It is easier to make routines. Now, I am doing this."* One student stated her experience as a disappointment while trying to care culturally competent. She said: *"I know very little about other cultures and do not believe I could be much help to anyone outside my culture."*
c) Language	A student said: *"Language barriers are very difficult and make me feel inadequate. I cared for a Syrian woman. I could not understand her and asked my mentor to change my patient."* Another student indicated that: *"One of my patients was from Russia and I tried to communicate with her by help of translator. She wanted to be taught how to prepare for discharged, but I could not understand her and she was very angry about that."*
3. Benefits of cross-cultural care	
a) Understanding of deeper needs	A student indicated: *"Maybe we can understand the causes of behaviours. Some behaviours can be originated by culture rather than mental health"*
b) Accessing qualified care	A student focused on the experiences of patients, and said; *"Individuals would leave the clinics with positive experiences which help them to return their daily life, and also we can provide individual-specific care."* Another student said: *"people with mental illness has called 'crazy' and occasionally their culture has been ignored just by this perspective of society. If we want to provide quality of our care, we need to have the flexibility to their cultural values."* One student reported: *"If we do not care by being sensitive to cultural differences, our care would be left half one. This means we split the patients according to their culture that leads to and stigma."*
4. Strategies for providing cross-cultural care	
a) Improving self-awareness and motivations	A student indicated: *"At the beginnings I always be a closed person and pushed myself in communicating patients from different culture. Yes, it was very very difficult and needed much affords to be able to understand cultures, but I succeed. When I was aware of my misbelieve, I could contact patients."* Another reported: *"I usually think about my approaches toward patients from different culture, I should not have many questions such as Did I provide effective care or Did I act professionally? These questions are my motivators... I am trying to do my best to be able to communicate and understand patients' cultural needs."* One student stated that: *"I think being sensitive to others includes subjective willingness. If I had motivation, I can be willing to learn much about patient, and learn more in cultural values, beliefs, expectations, needs, etc."*
b) Well-structured education	A student offered: *"Simulations can be a good option in learning cultures rather than theoretical lectures. It can give us change to assess ourselves in providing culture specific care. I am sure many of my friends would be agree with this idea"* Another student said: *"I began to rethink how I relate to other and how much sensitive I am toward other cultures by living in another country. I think exchange programs can be expanded. By this way more students can have chance to live in another culture"*

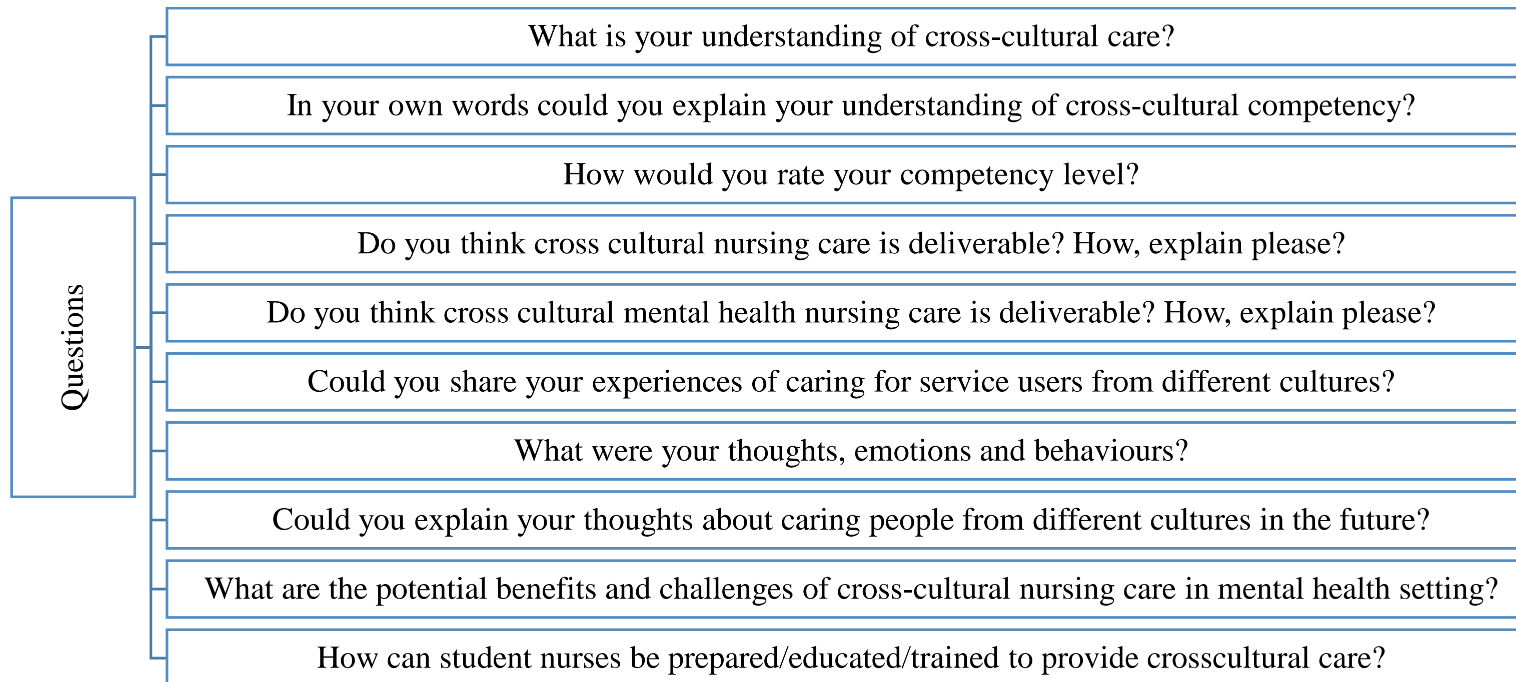

Fig 1: The semi-structured questions