

# Transcultural health: attitudes, perceptions, knowledge of Italian nurses. An observational study

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**Abstract.** *Background and aim of the work.* The Italian health profile of foreigners depends from several factors and events, such as: environmental, microbiological, cultural and / or behavioral. Healthcare professionals might have greater and better basic and post-basic training in approaching foreign users. Listening and empathy, with complementary training can help to reduce distances and better understand the patient's socio-cultural background. The aim of the study is to explore the basic intercultural knowledge of the Italian nurses, the perception of the problems encountered during the interaction with foreign users and any solution strategies. *Methods.* From December 2020 to March 2021 a national observational study was conducted by involving 327 nurses. *Results.* 85.5% among participants were females and most of them aged between 20 and 30 years (20.20%) and were employed in medical wards (22.60%). Among the hindering barriers explored, linguistic ones are highlighted (41.30%), specifically for the description of hospital rules (34.90%) and of social and health regulations (34.90%). *Conclusions.* From the present findings, it emerges that the cultural competence of nurses could be developed by offering a multicultural education through basic and post-basic courses. ([www.actabiomedica.it](http://www.actabiomedica.it))

**Key words:** Attitude; Emotion; Improvement; Perception; Transcultural Nursing.

## Introduction

In recent years, the need for a healthcare approach, that takes into account all the possible cultural divergences in order to guarantee the patient's well-being, has emerged through a personalized and respectful approach to the culture of the patient (1). The relationship of care that might be established with patients belonging to different ethnic groups, complicated by various social and cultural factors, is

becoming a priority. The foreign person is not always able to follow, understand, share therapeutic paths and manifest pain and illness in different ways and with different meanings. The migratory phenomenon has determined new social dynamics to which one is often unprepared, inducing various types of reactions in the population; attitudes that are assumed because of the difficulties in communicating to be sought not only in linguistic differences, but also in cultural differences that arise from the psychological experiences of

individuals. These problems are expressed to a decisive extent in the health field where the figure of the foreign patient with his/her need for health is opposed to the figure of the health worker with his/her scientific and bureaucratic language. Therefore, a cultural gap emerges that leads to misunderstandings, as well as to an exasperation of the behavior of the operators, which can lead to an incorrect diagnosis (2,3). Today's society, which should guarantee access to healthcare for all, has a decisive role on the health system of its members and on the state of social and individual well-being. However, it is easy to be faced with discriminatory behaviors (4), since it makes us reflect in a society where services dedicated to migrant populations are absent and / or lacking, denying the possibility of being treated: this is probably the true face of discrimination (5). In fact, 12 out of 100 foreigners, over the age of 14, had difficulties in carrying out the procedures necessary to access medical services, and among foreigners over 14 years of age, 14% said they had difficulty explaining to the doctor the symptoms of one's malaise (6). The hospitalization of foreigners is one of the most important areas for the health care of the immigrant population, at the same time, it risks being underestimated due to the lack of attention on the part of operators (7). The other face of discrimination is reflected in the attitudes of practitioners: the stigma and discrimination suffered were examined in a review conducted in 2017 in which participants in various studies felt the burden of discrimination on them through the attitudes of health professionals in their comparisons, such as: wearing double personal protective equipment, stereotypes related to religion and clothing, less sensitive care, denied hospitalization or too long waiting times. All these perceptions are inserted in a scenario characterized by a lack of knowledge of access to basic health care services and language barriers (8). The intertwining of values, symbols, beliefs and behaviors, the presence of people from different countries, has outlined a multicultural society, which requires the health system the urgent need to reorganize itself. This is reflected in what was argued by the anthropologist and nurse Madeleine Leininger who, around the 1950s, made the migratory phenomenon the object of reflection of the nursing sciences by laying the foundations for transcultural nursing, such as: palliative, rehabilitative,

preventive assistance, addressed to the person with a different culture (9). Transculturalism has historically invested decisive health care areas: therapy and care of the migrant have proved to be fraught with difficulties, so much so as to give rise to the need for a new health perspective that represents the fil rouge between the interpretation of meaning oriented to the purpose - the cure- and the cultural dimensions of which each person is a bearer with his or her peculiarities. To be realistically implemented, transculturalism requires a particular ability to interact between scientific knowledge and the social dimension within which the perception of health and disease develops (3). In recent years, we have witnessed a transformation of society that implies the need for nurses to know the beliefs and values of their caregivers in order to ensure competent care. The greatest shortcomings are found in health workers who are not aware of the possibility of being able to make use of cultural mediators to facilitate the therapeutic-assistance path, and of a health service oriented too often to reduce the welfare costs borne by human ones. Often the limit of health workers does not consist in not being able to identify the disorder that the patient presents to him, but lies precisely in the partial socio-cultural conception / construction that every physician, nurse, therapist possesses regarding the concept of health and the type of interaction that he manages to establish with the person. In order to achieve the tangibility of cross-cultural health, it is necessary to understand the symptom, the real need, restoring a sense within the cultural dimension of the individual by contextualizing the discomfort (10). Therefore, the increase in foreign people has created new health needs in society and leads to the need for a new cultural awareness in the nursing profession which presupposes the overcoming of closed attitudes and openness to cultural differences. Differences represent a cornerstone of any society and can become the strength for a renewed welfare. Since very few literature that have explored these all abovementioned dimensions in transcultural nursing, the present study aimed to assess how the transcultural nursing perception level influenced difficulties in their nursing working activities.

## Materials and methods

### *Study design*

An observational, cross-sectional, multicenter study was carried out from December 2020 to March 2021.

### *Participants*

Participants were recruited online through six Italian Nursing Profession Orders, particularly: Arezzo, Campobasso and Molise, Lecce, Genoa, Udine, Varese. Only after obtaining access authorizations from the respective Presidents of each of the provincial Orders in the Nursing Professions abovementioned, an email containing a brief presentation of the survey and the link to access to the online questionnaire was sent for each nursing member. The study was carried out through the electronic dissemination of the survey tool (14), disseminated thanks a link to all the Presidents of the nursing professions' orders, disseminated in the national territory (n=102), also sending a letter of presentation of the study and formal request to participate in the survey. After obtaining the authorization from the abovementioned Presidents, an email with a brief presentation of the study and the link to access the online questionnaire was sent. The link to the study was then forwarded by the presidents, through a mailing list, to each belonging registered nurse for each participating nursing order. In total, nursing order belonging to 7 different Italian regions (Tuscany, Molise, Puglia, Liguria, Friuli -Venezia Giulia, Lombardy) agreed to participate.

### *The questionnaire*

The questionnaire contained two essential sections. Specifically, in the first part of the questionnaire, socio-demographic data were collected, including:

- gender: female and male;
- age, divided into five age groups, specifically: until 30 years, from 31 to 40 years, from 41 to 50 years from 51 to 60 years and over 61 years;
- nursing professional profile, as: registered nurse, nursing coordinator, nursing manager;

- years of work experience: nurses employed until 5 years and nurses employed over 6 years;
- nursing educational levels: unit 3 years, from 4 to 5 years and over 5 years in nursing education;
- work area: surgical, Covid-19, emergency, administrative, medicine, territorial departments;
- if participants considered the own preparation level as insufficient, sufficient or good.

The second part of the questionnaire investigated difficulties encountered in their transcultural nursing activities, classified as: not enough, enough and much. For each proposal item a 3-point Likert scale was associated which varied from 1, as "in no way" to 3, as "very".

Difficulties mentioned included: language – communication, prejudices of nurses towards foreign patients, difficulties in explaining hospital rules, in explaining the social and health legislation for immigrants, in defining care or therapeutic priorities, differences and / or conflicts on the respective reference values and violent patients.

### *Data analysis*

All answers received were collected in an Excel data sheet and processed thanks to the SPSS, version 20. All variables were categorical variables and presented as frequencies and percentages. *Chi square test* was performed between the perception level in transcultural nursing knowledge according to sampling characteristics, such as: gender, age, job role, years of work experience, educational level and work areas. Then, chi square test was also performed between the transcultural nursing perception level according to any difficulties occurred in their work experiences. All p- values <.05 were considered as statistical significant.

### *Ethical considerations*

The ethical characteristics of the study were stated within the presentation of the questionnaire. It was stated that the participation was free and the participant could be withdrawn in any moment.

At the beginning of the questionnaire, a clearly statement of agreement, since all ethical characteristics

were exposed according to Helsinki declaration. The questionnaire was anonymous and no form of return of the data provided has been envisaged.

## Results

At the beginning of the study we expected that almost 1,000 Italian nurses could be enrolled in our study, by also considering that in Italy nurses were almost 360,000. Meanwhile, only 327 Italian nurses agreed to participate in this study (response rate=32.7%). This might depend surely by the fact that only 7 nursing orders given their consents to participate and then, divulgate the questionnaire. By considering differences among nurses according to their sampling characteristics and knowledge on transcultural nursing, none significant differences ( $p>.05$ ) were recorded among participants. In fact, most females declared

to have a sufficient preparation level (55.00%) than males, although difference was not statistically significant ( $p=.657$ ). Additionally, most of nurses, in all the age groups considered reported sufficient perception level in the transcultural nursing, too ( $p=.317$ ). Also, by considering the profile job, 56.00% of the interviewed nurses recorded sufficient perception level and nurses who worked more than 6 years reported more sufficient (41.90%) and good (10.70%) level in transcultural nursing knowledge than their younger colleagues ( $p=.124$ ). By considering educational level, we expected that nurses who had more years in nursing studies could report a higher perception level in their transcultural knowledge. Although, this did not happen, since nurses who attended almost 3 years in nursing studies recorded sufficient (55.70%) and good level (13.80%) in transcultural nursing matters, too ( $p=.831$ ). Finally, work area did not influence the transcultural nursing perception level (Table 1).

**Table 1.** Sampling characteristics according to preparation's perception of each participant supposed to have in the transcultural nursing (n=327).

Sampling characteristics/ Preparation's perception levels	Insufficient n(%)	Enough n(%)	Good n(%)	p-value
<b>Gender</b>				
Female	57(17.40)	180(55.00)	43(13.10)	.657
Male	11(3.40)	27(8.30)	9(2.80)	
<b>Age</b>				
Until 30 years	14(4.30)	66(20.20)	5(4.60)	.317
31-40 years	12(3.70)	43(13.10)	9(2.80)	
41-50 years	24(7.30)	49(15.00)	13(4.00)	
51-60 years	17(5.20)	46(14.10)	12(3.70)	
Over 61 years	1(0.30)	3(0.90)	3(0.90)	
<b>Nursing professional profile:</b>				
Registered Nurse	60(18.30)	183(56.00)	47(14.40)	.124
Nursing Coordinator	8(2.40)	23(7.00)	3(0.90)	
Nursing Manager	0(0)	1(0.30)	2(0.60)	
<b>Years of work experience:</b>				
>5 years	16(4.90)	70(21.40)	17(5.20)	.279
<6 years	52(15.90)	137(41.90)	35(10.70)	
<b>Nursing educational level:</b>				
Until 3 years	61(18.70)	182(55.70)	45(13.80)	.831
4-5 years	7(2.10)	23(7.00)	7(2.10)	
Over 5 years	0(0)	2(0.60)	0(0)	

Sampling characteristics/ Preparation's perception levels	Insufficient n(%)	Enough n(%)	Good n(%)	p-value
<b>Employment Department:</b>				
Surgical	13(4.00)	34(10.40)	7(2.10)	.712
Covid-19	6(1.80)	26(8.00)	3(0.90)	
Emergency	17(5.20)	46(14.10)	11(3.40)	
Administration	2(0.60)	12(3.70)	5(1.50)	
Medicine	22(6.70)	74(22.60)	20(6.10)	
Territorial	8(2.40)	15(4.60)	6(1.80)	

By considering differences between preparation level and difficulties occurred in their work activities (Table 2), significant differences were reported between perception levels in transcultural knowledge and language/communication approach ( $p=.009$ ), since 41.30% of nurses who declared a sufficient perception level reported also high difficulties in language/communication. The same significant trend was reported by considering the explaining the social and health legislation for immigrants' relationship.

## Discussion

More often it happens to meet people belonging to different cultures from ours in several hospital wards. This involves various problems, from those related to misunderstanding and difficulties in communicating to more problematic conditions where our actions or our expectations collide with our patient's values, beliefs and lifestyles. Knowledge and understanding of user / patient cultures becomes important and fundamental where the concept of health and care varies from one culture to another. The aim of the study was to investigate problems encountered by the nursing staff during assistance with foreign users, highlighting the difficulties during assistance. By "foreign citizens" we mean, according to the common meaning of the term, people who have citizenship other than Italian or who are stateless, habitually or temporarily residing in Italy, in possession of a regular residence permit. Every person coming from another country brings with them a culture, traditions and, sometimes, another religion that imposes a lifestyle different from the Italian one. The comparison with

people of cultures, histories, expectations, expressions and perceptions of needs other than our own leads and will lead to continuous changes in our society, not only in behaviors, attitudes, language, but also in healthcare and nursing, too. The theory of transcultural nursing developed by Leininger and subsequently by other theorists such as Purnell, Giger-Davidhizar and Campinha-Bacote have contributed to enrich the knowledge of the nursing profession (11,12). For a coherent response to be realized, it is important to know the migratory phenomenon: its origin, its evolution, its causes, its characteristics, its specificity. This knowledge is important for professionals working in the healthcare sector who are asked to redefine their modus operandi within the operator / patient relationship who, in the case of a migrant person, acquires roles and meanings in a different way from the past or for those which are traditionally been trained, since health is good for all 327 Italian nurses participated in the study. Most females declared to have a sufficient preparation level (57.00%) than males, although difference was not statistically significant ( $p=.657$ ). Additionally, most of nurses, in all the age groups considered reported sufficient perception level in the transcultural nursing, too. Additionally, by considering their profile job, 18.30% of the interviewed nurses recorded insufficient perception level and the 10.70% of nurses who worked more than 6 years reported a good self-perception level in transcultural nursing knowledge than their younger colleagues. By considering educational level, we expected that nurses who registered more years in nursing studies will report higher perception level in their transcultural knowledge. Although, this did not happen, since nurses who attended almost 3 years in nursing studies recorded sufficient (55.70%) and good level

**Table 2.** Difficulties occurred with foreign patients according to preparation's perception of each participant (n=327).

Sampling characteristics/Preparation's perception levels	Insufficient n(%)	Enough n(%)	Good n(%)	p-value
<b>Language - communication</b>				
In no way	7(2.10)	14(4.30)	7(2.10)	.009*
Enough	9(2.80)	58(17.80)	20(6.10)	
Much	52(15.90)	135(41.30)	25(7.60)	
<b>Prejudices of nurses towards foreign patients</b>				
In no way	30(9.20)	109(33.30)	30(9.20)	.368
Enough	15(4.60)	50(15.30)	9(2.80)	
Much	23(7.00)	48(14.70)	13(4.00)	
<b>Difficulty in explaining hospital rules</b>				
In no way	10(3.10)	29(8.90)	12(3.70)	.028*
Enough	11(3.40)	64(19.60)	18(5.50)	
Much	47(14.40)	114(34.90)	22(6.70)	
<b>Difficulty in explaining the social and health legislation for immigrants</b>				
In no way	10(3.10)	26(8.00)	11(3.40)	.250
Enough	16(4.90)	67(20.50)	18(5.50)	
Much	42(12.80)	114(34.90)	23(7.00)	
<b>Difficulty in defining care or therapeutic priorities</b>				
In no way	19(5.80)	51(5.60)	17(5.20)	.230
Enough	17(5.20)	78(23.90)	19(5.80)	
Much	32(9.80)	78(23.90)	16(4.90)	
<b>Differences and / or conflicts on the respective reference values</b>				
In no way	34(10.40)	92(28.10)	23(7.00)	.337
Enough	13(4.00)	63(19.30)	18(5.50)	
Much	21(6.40)	52(15.90)	11(3.40)	
<b>Violent patients</b>				
In no way	46(14.10)	140(42.80)	30(9.20)	.098
Enough	6(1.80)	37(11.30)	13(4.00)	
Much	16(4.90)	30(9.20)	9(2.80)	

\*p<.05 is statistically significant.

(13.80%) in transcultural nursing matters, too. Finally, work area did not influence the transcultural nursing perception level. Dealing with the suffering of foreigners in a care relationship means being empathetic and knowing the characteristics of their culture of origin. Foreigners, by definition, find themselves in a first difficult, tiring situation, which is to have abandoned the known to go towards the unknown, to find themselves living with a culture, a society, completely different

from that of origin, with all that goes with it. To this are often added difficult economic conditions, more or less sensational episodes of discrimination, a sense of disorientation and loneliness. Therefore, it is evidently fundamental more than the relationship with the therapist becomes a welcoming and safe place, also with a view to avoid to these people what could be yet another episode of estrangement, distance, social exclusion (13). The greatest difficulties are concentrated



around the verbal communicative sphere in line with the results of one conducted by Manara et al. (14). From a qualitative study conducted among nurses, it emerged that communication was the most important aspect of the provision of care and an essential component of the professional role of a nurse regardless of clinical area. Language barriers have been identified as the major obstacles in providing adequate, appropriate, effective and timely care to patients with limited English proficiency (15). Our data revealed difficulties in communication skills in the sample with sufficiently sufficient levels of preparation (41.30%), with difficulty in describing hospital rules (34.90%) and social and health legislation (34.90%), while difficulties in defining nursing priorities are lower (23.90%), or to consider foreign patients as violent (42.80%). The nurse and the patient meet and discover each other different, belonging to different cultures. However, these differences should not be overestimated and above all they should not be used to justify a relational inability or, even worse, prejudices. Having prejudices is “normal”, the important thing is to understand how they compromise our way of relating to others. Cultural difference becomes a tool to give voice and body to a discomfort, hiding reasons of another type; sometimes under the often abused term of culture, there is a discriminating attitude: the term “culturally different” often means “inferior”. The prejudice that migrants find it hard to understand, diagnostic-therapeutic explanations is a widespread problem among healthcare workers. In fact, the nurse often shows impatience in providing information / instructions, and the silence or embarrassment that encountering with respect to normal things for him/her are a reason for misunderstanding, such as: doses of drugs are not respected, the frequency of administration is not respected, the therapy stops at the first sign of well-being / recovery and the disease has a relapse. From an Italian study, a focus groups, conducted among healthcare professionals, contradictory feelings emerged ranging from empathic understanding, to the difficulty of understanding, up to the rejection of certain cultures, feelings of exasperation and a decrease in availability due to the incorrect use of extra-hospital services, which irremediably becomes a drop in listening and a lack of acceptance, becoming a clear alarm bell that heavily undermines the

quality of care (16). We recall how important it is in the training of health professionals to acquire the ability and willingness to listen and observe others and their own diversity. Understanding the needs of those in front of us, welcoming, accepting and being authentic and knowing how to listen, understand and guide people who ask for help are skills and abilities that stand out in those who do counseling and have chosen to follow a difficult and demanding professional path. Therefore, correct communication is fundamental to any aid project, especially in some clinical settings, such as dialysis. The lack of understanding of meaning is a deafening noise in the communicative flow that is sharpened if this is generated within the space of the treatment. It is the silence that surrounds while everyone is talking, the not being able to understand what is being said, the inability to know and be able to listen: it is the feeling occluded by ineffective communication. This represents the first sign of isolation, of an individual's stigma. From an Italian study, it emerged the difficulty of the operators to not being able to manage any emotional involvements well. Nurses on hemodialysis are aware of this communication deficit and, together with the sick, they live together in the same place without empathically entering into a relationship (17). A further problematic factor is what can be defined as the “conflict of values” and which occurs in care cases in which, precisely because there is a different frame of reference, nurses-users clash over the moral meaning of a welfare act (18). In this regard, some examples are: the refusal of therapeutic practices such as transfusions, transplants or organ donations, such as the “Oneda case” or the request by patients for practices deemed unfair for us operators, such as infibulation (19); despite this, 28.10% of our sample does not in any way present conflicts or differences on the respective cultural values of reference. In the approach to intercultural assistance, as emerges from the literature, the difficulties that are mainly detectable with foreign patients in addition to communication and / or language problems (49%), there are also those inherent to religious (26%) and cultural differences (25%), (20). One of the potential solution strategies that can be implemented could be the introduction of a Cultural Mediation service. This possibility has already proved useful in improving awareness of health rights and

promoting access to health care services and providing knowledge on the possibilities of screening, preventive checks and facilities to receive care (21). The need for effective communication is an essential part of human nature which, if not satisfied, leads the person to exclusion, becoming a co-factor of an incorrect diagnosis, of an incomplete therapy, of a body that carries clinical signs. The cross-cultural mediator is a professional figure who was born in Italy in the late 1980s, with the aim of interposing, between person and operator, an expert able to act as a bridge between cultures. It is therefore necessary to include a theoretical-practical cultural training to have a better intercultural perspective because health is a right for everyone, in Europe and in the rest of the world, even if it still represents a right that too many are still deprived of, without forgetting that migration has a deleterious impact on health, especially in the case of cross-border displacement (22,23). Implementing intercultural nursing in basic courses with the introduction of the transcultural nursing model (11) would certainly have positive implications for the training of future professionals. As well as organizing specific Masters, refresher courses for ad hoc continuous training. A study was conducted in South Korea in 2017 that aimed to build and test a hypothetical model that included factors related to the cultural competence of nurses caring for foreign patients, providing encouraging results (24). In Turkey, an intercultural nursing course was recently introduced which improved their cultural sensitivity and self-confidence in intercultural communication and ensured the maintenance of their empathic abilities. The Intercultural Nursing course can therefore contribute invaluablely to understanding the cultural structure and values of society and to the development of techniques that can deliver nursing care accordingly (25). Intercultural sensitivity is therefore considered a very important aspect, however not easy to detect. As evidence of the transversal nature of this topic, subsequent adaptations and tests were also carried out in other fields, including health and nursing. In recent years the same type of study has been and is being conducted around the world and with encouraging results (26-28). Another in-depth aspect is related to mental health: many people have survived extreme trauma suffered in their countries of origin or along the

migratory route, particularly in Libya, as a result of torture, forced labor and abuse; the lack of individualization of persons with vulnerability and the predisposition of a rapid take-up can entail serious risks of re-traumatization as well as negative repercussions on collective health and on public health and social spending. However, it is necessary to ensure health and well-being for all and at all ages, as defined in the third of the Sustainable Development Goals launched by the United Nations for 2030 (29). maintenance of a good quality of life, through awareness raising, activation and promotion of initial resources, an essential prerequisite for maintaining the state of health, leading to fewer requests for care. It is necessary to ask oneself about one's role, the objectives pursued and the skills required and the possible need to introduce a third pole in the interaction with the patient (for example with the effective involvement of the territory) as an effective mediator. Although much effort and progress has been made, much remains to be done in the health of migrants. With respect to these dimensions, further observational studies must be carried out (15,30). since there are few studies in the literature. The massive introduction of nursing staff from other cultural contexts also implies a change on the part of hospitals and requires knowledge of what could be similarities but also differences in responding to the disease and the system of care within inevitably multicultural equips. Renewed policy strategies would reduce the difficulties inherent in accessing, guaranteeing treatment and assistance paths. Assistance which, we recall, has as its center the person with his experiences and his ethnocultural identity, an expression of transcultural health.

## Conclusion

The aim of the study was to explore the basic intercultural knowledge of the Italian nurses, the perception of the problems encountered during the interaction with foreign users and any solution strategies. Through the results of our study it was possible to highlight some fundamental aspects of the relationship with the foreign patient and of transcultural health, in a population of Italian nurses (registered nurse, nursing coordinator, nursing manager). The results of the



study show a predisposition to deepen skills in the socio-cultural field, understood as a set of individual attitudes and communication and practical skills that enable operators to effectively carry out care work and fully satisfy their needs. It is necessary to introduce the multi-ethnic topic right from the first level courses, starting from the comparison between the logics and care models present in our realities.

The limits of the study are certainly linked to the exclusion from the participation of all other healthcare professionals involved in the care project that revolves around the patient. The small size of the sample and the transversal study design, which on the one hand allow a general description of the problem, do not fully investigate any of the problems emerged. For these aspects it would be necessary to deepen the investigation with other qualitative tools and methodological approaches such as ethnographic studies or narrative investigations.

**Conflicts of interest:** Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article.

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