

RESEARCH ARTICLE

The relationship between ethnocentrism and xenophobia level and predictors: A descriptive and correlational study of nurses working in two cities where refugees live intensively in Turkey

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Abstract

Determining the ethnocentrism and xenophobia levels of nurses contributes to nurses' awareness regarding their attitudes on the issue and providing quality care. This descriptive and correlational study aimed to determine the relationship between ethnocentrism and xenophobia levels of nurses working in hospitals located in two different border regions where refugees live intensively in Turkey. The study was conducted with 386 nurses who were working in two different hospitals located in two cities in the south of Turkey. Data were collected using the "Personal Information Form," "Ethnocentrism Scale," and "Xenophobia Scale." About half of the nurses did not want to care for foreign patients. There was a positive and statistically significant relationship between mean scores of the Ethnocentrism Scale and the Xenophobia Scale ($p < 0.05$). The regression analysis indicated that the level of ethnocentrism explains the level of xenophobia by 9%. Nurses had a high level of xenophobia and moderate ethnocentric attitudes. The level of xenophobia increased as the ethnocentrism level of nurses increased. It is recommended to conduct further studies to determine different predictors of xenophobia among nurses.

KEYWORDS

ethnocentrism, nursing, refugees, xenophobia

Key points

- About half of the nurses did not want to care for foreign patients.
- There was a positive relationship between nurses' ethnocentrism and xenophobia levels.
- Gender and educational level were statistically significant predictors of ethnocentrism scores.

1 | INTRODUCTION

Xenophobia is defined as "attitudes, prejudices, and behaviors that reject, exclude, and often disparage people who are alien to society or national identity or whom they perceive as foreign" (Bozdağ &

Kocatürk, 2017, p. 615–620). Xenophobia affects individuals' fundamental rights to food, shelter, and access to health care. Therefore, due to the effects of xenophobia on individual and public health, this issue requires more attention in terms of public health (Durat & Tarsuslu, 2022). The xenophobic attitude of the health personnel of

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the host country in accessing health services for foreigners causes communication problems and barriers to receiving health care (Alkan et al., 2016; Kahraman et al., 2021).

Ethnocentrism is defined as centering own culture and evaluating other cultures in terms of their culture (Kaya et al., 2021). Ethnocentrism is one of the factors that prevent communication between individuals with different cultural, ethnic, religious, and regional backgrounds. An individual who respects different cultures cannot be expected to be an excessive defender of his own culture. Therefore, those with high intercultural sensitivity are expected to have low levels of ethnocentrism (Beser et al., 2021).

Migration due to economic crises, ethnic conflicts, and wars has led to the emergence of cultural diversity all over the world (Almutairi et al., 2017; Delibaş et al., 2020). Today, there are an average of 1 billion immigrants, of whom 258 million are international migrants and 763 million are internal migrants, which corresponds to one seventh of the world's population (World Health Organization [WHO], 2019). Turkey, which is affected by population mobility due to its geopolitical position, hosts approximately 5.5 million refugees and international migrants. In addition, Turkey has been the third country receiving the highest number of immigrants in the world between 2010 and 2015 (International Organization for Migration, 2018; Şatır & Aydın Avcı, 2019; WHO, 2018). According to the February 2020 data of the United Nations High Commissioner for Refugees (UNHCR), Turkey hosts the largest refugee population in the world, with approximately 3.6 million Syrian refugees (UNHCR Turkey, 2020).

2 | BACKGROUND

Multicultural societies formed due to migration have affected the provision of health services as well as all services, and this has increased the importance of providing cultural services (Liu et al., 2018). While these social changes increase the necessity of providing health care to individuals with different cultural and ethnic origins in accordance with their cultures, they also cause various problems (Bilgiç & Şahin, 2019). Factors such as the high number of refugees in the border provinces and the lack of adequate health institutions and health manpower cause deterioration in public health and problems in the health sector (Akköz Çevik, 2016; Babacan et al., 2017; Çiçek Korkmaz, 2014). Syrian refugees, who have a large population, increase the burden on health institutions and therefore cause the institutions to provide services beyond their capacity. On the other hand, considering the physical facilities and the quantitative inadequacy of manpower in the field of health, the quality of health care may be negatively affected. Health services provided to Syrian refugees with insufficient resources cause burnout of health professionals (Al-Rousan et al., 2018; Ekmekci, 2017; Eriş et al., 2017). In addition to positive concepts, such as culturally sensitive care, negative concepts, such as xenophobia and ethnocentrism, have come to the fore.

Xenophobia and ethnocentric behaviors are among the factors that can hinder culturally sensitive care. As care and ethical principles are at the core of the nursing discipline (American Nurses Association

[ANA], 2015), nurses play a key role in reducing health inequalities (Purtzer & Thomas, 2019). At the same time, nurses are at the forefront of care services for refugees, who are considered one of the most vulnerable population groups in the world (Ogunsiji et al., 2018). In this context, nursing profession is most affected by the workload and bad conditions that arise during the care and treatment of refugee patients (Çiçek Korkmaz, 2014). In a qualitative study conducted in Lebanon, the effect of Syrian refugees on nurses and the health system was evaluated, and it was reported that the refugee patients increased the workload of nurses, affecting the physical and psychological health of nurses negatively, and causing the quality of care to decrease (Dumit & Honein-AbouHaidar, 2019). In another study, as the level of intercultural sensitivity of nursing students increased, the level of ethnocentrism decreased (Bilgiç & Şahin, 2019). Durat and Tarsuslu (2022) emphasize that as the level of xenophobia decreases, the level of empathy and cultural sensitivity increases.

Syrian refugees are treated in many hospitals in Turkey due to acute or chronic diseases (Sevinç et al., 2016). The fact that Turkey has a large international immigrant population makes it inevitable for Turkish nurses to encounter cultural factors during care. To provide quality health care, it is vital to evaluate individuals with a holistic perspective and to provide care in line with cultural needs. Ethnocentrism and xenophobia levels of nurses are among the factors affecting care planning in line with cultural needs (Baksi et al., 2019). As far as we know, there is no study that determines the relationship between ethnocentrism and xenophobia levels of Turkish nurses. The lack of studies on the relationship between ethnocentrism and xenophobia levels of Turkish nurses demonstrates a gap in the literature.

2.1 | Aim of the study

This study aims to determine the relationship between ethnocentrism and xenophobia levels of nurses working in hospitals located in two different border regions where refugees live intensively in Turkey.

This article will address the following questions:

1. What are the ethnocentrism and xenophobia levels of nurses?
2. What are the sociodemographic, occupational, and cultural care characteristics that affect the level of ethnocentrism and xenophobia?
3. Is there a relationship between the level of ethnocentrism and xenophobia?
4. Is the ethnocentric attitude of nurses a predictor of xenophobia?

3 | METHODS

3.1 | Study design

A descriptive and correlational design was used. Descriptive studies are used to describe the distribution of one or more variables. Correlational study design involves looking for associations between

exposure and an outcome across populations (Aggarwal & Ranganathan, 2019). In this study, the descriptive design was utilized to describe the general characteristics of the nurses in terms of the level of ethnocentrism and xenophobia. The result of the sociodemographic, occupational, and cultural care characteristics was also part of the descriptive design. Correlational design was used to determine whether there was a significant relationship between the level of ethnocentrism and xenophobia.

3.2 | Participants

The study population consisted of nurses working in two different hospitals in the provinces of Hatay and Kilis in the south of Turkey, where refugee and immigrant populations are common. Four hundred and thirty nurses work in the university hospital in Hatay and 336 nurses in the state hospital in Kilis. The study consisted of nurses who were citizens of the Republic of Turkey, who can speak Turkish, and agreed to participate in the study. Nurses who did not want to participate in the study were excluded from the study. The sample size of the study was calculated using the G*Power 3.1.9.7 software program. In the calculation, the correlation value was taken as 0.30 for a medium effect size, and a two-tailed hypothesis was established. The required sample size was calculated as 138 with a 5% margin of error and 95% power for the correlation analysis (Cohen, 1988; Faul et al., 2007). The research was completed with a total of 386 nurses, 265 nurses in Hatay and 121 in Kilis.

3.3 | Instruments

Data were collected via the “Personal Information Form,” the “Ethnocentrism Scale,” and the “Xenophobia Scale.”

The Personal Information Form: This was developed by the researchers in light of the literature (Baksi et al., 2019; Bozdağ & Kocatürk, 2017); the form contains 15 questions regarding sociodemographic and occupational characteristics, and characteristics associated with intercultural care that might affect the attitudes of nurses toward foreign patients.

The Ethnocentrism Scale: The scale was developed by Neuliep and McCroskey (1997). The Turkish reliability and validity of the scale were performed by Üstün (2011) and it was determined that the scale was a valid and reliable scale to be applied to Turkish society. It is a 22-item, 5-point Likert-type scale. Items 4, 7, 9, 12, 15, and 19 are reverse-scored. Scores to be obtained from the scale range between 20 and 100. High scores indicate a high level of ethnocentrism. The reliability study for the scale found that Cronbach's α coefficient was 0.82. In this study, Cronbach's α value was found to be 0.80.

The Xenophobia Scale: The scale was developed by Van der Veer et al. (2011) and adapted into Turkish by Özmete et al. (2018). The scale is a valid and reliable tool to measure the hostile attitudes, thoughts, and judgments of individuals in society based on fear of

strangers. The scale has 11 items with responses that use a six-point Likert scale with options ranging from “I totally disagree (1)” to “I totally agree (6).” While items 1–10 are scored normal, the 11th item is scored reversely. According to Özmete et al. (2018), the scores obtained from the Turkish Xenophobia Scale range between 11 and 66, with higher scores indicating higher xenophobia risk. For the participants, 11 points indicate no xenophobia, and 66 points indicate the highest level of xenophobia. An increase in the score explains the emergence of xenophobia based on fear. The Cronbach alpha value of the scale was 0.87 in the Turkish adaptation study. In this study, Cronbach's α value was found to be 0.86.

3.4 | Data collection

The study, which was designed as a self-administered online survey, was conducted between January and May 2022. After approvals from the ethics committee and hospital administration of the study, the online questionnaire was distributed through WhatsApp to all eligible participants. Nurses completed the survey via Google Forms. The online data collection form was first sent to the WhatsApp group of the supervisor nurses of each unit through the health care services directorate in the hospitals. Then the online data collection form was sent to the nurses via the supervisor nurses of each unit to their service nurses in the same way. The questionnaires were completed in approximately 15–20 min.

3.5 | Data analysis

The data were analyzed using SPSS 22.0 program (IBM, Armonk, NY, USA). Descriptive statistics were used to evaluate the data. Skewness and kurtosis values were used to determine whether the data were normally distributed (Tabachnick & Fidell, 2013). As the data were normally distributed, parametric tests were used. The independent variables were sociodemographic, occupational, and cultural care characteristics. The effects of the independent variables on the Ethnocentrism Scale and the Xenophobia Scale were analyzed by “Independent Samples *t*-test” for two groups, and a one-way analysis of variance test for three or more groups. Tukey's and Scheffe's tests were used for post hoc analysis and correlation coefficients were used to assess two continuous variables. Pearson correlation analyses were used to determine the relationship between the Ethnocentrism Scale and the Xenophobia Scale mean scores. Simple linear regression analysis was used to test the relationship between xenophobia and ethnocentrism. Also, we used multiple regression analysis to test the relationship between independent (sociodemographic characteristics; six variables) and dependent (xenophobia and ethnocentrism) variables. The multicollinearity between independent variables was evaluated, followed by regression analysis. The values of the variance inflation factor were <10 , indicating no multicollinearity. The statistical significance level was considered as $p < 0.05$.

TABLE 1 Distribution of the characteristics of nurses and the relationship between the Ethnocentrism Scale and the Xenophobia Scale scores ($N = 386$).

Characteristics	N	%	Ethnocentrism Scale $X \pm SS$	Xenophobia Scale $X \pm SS$
Provinces where the hospitals were located				
Hatay	265	68.7	56.84 ± 7.51	49.00 ± 10.53
Kilis	121	31.3	57.41 ± 7.59	48.13 ± 8.93
Test* and p			$t = -0.682$ $p = 0.496$	$t = 0.793$ $p = 0.428$
Age groups $X \pm SS$ (min–max) = 30.57 ± 6.54 (21–50)				
<35 years	308	79.8	56.62 ± 7.40	48.82 ± 9.91
≥ 35 years	78	20.2	58.58 ± 7.90	48.37 ± 10.65
Test* and p			$t = -2.060$ $p = 0.040$	$t = 0.355$ $p = 0.723$
Gender				
Female	248	64.2	56.35 ± 7.35	48.45 ± 9.81
Male	138	35.8	58.22 ± 7.72	49.22 ± 10.50
Test and p			$t = -2.345$ $p = 0.02$	$t = -0.716$ $p = 0.475$
Marital status				
Married	227	58.8	57.32 ± 7.56	48.21 ± 10.08
Single	159	41.2	56.60 ± 7.49	49.47 ± 10.00
Test and p			$t = 0.921$ $p = 0.358$	$t = -1.208$ $p = 0.228$
Educational level				
High school	30	7.8	59.43 ± 8.31	50.66 ± 11.04
Associate degree	48	12.4	57.35 ± 6.13	51.52 ± 8.23
Bachelor's degree and postgraduate	308	79.8	56.74 ± 7.63	48.11 ± 10.14
Test and p^{**}			$F = 1.805$ $p = 0.166$	$F = 3.019$ $p = 0.050$
Work experience				
<10	286	74.1	56.63 ± 7.40	48.74 ± 9.87
≥ 10	100	25.9	58.14 ± 7.82	48.71 ± 10.60
Test and p			$t = -1.722$ $p = 0.086$	$t = 0.027$ $p = 0.979$
Work experience in the unit worked				
<10	329	85.2	56.90 ± 7.49	48.50 ± 10.07
≥ 10	57	14.8	57.73 ± 7.81	50.03 ± 9.93
Test and p			$t = -0.771$ $p = 0.441$	$t = -1.059$ $p = 0.290$
Worked unit				
Surgical units ^a	106	27.5	58.72 ± 7.89	48.84 ± 9.52
Internal units ^b	90	23.3	55.62 ± 6.76	48.34 ± 9.61
Intensive care units ^c	159	41.2	57.05 ± 7.61	48.91 ± 10.53
Others ^{d ***}	31	8.0	55.16 ± 7.08	48.51 ± 11.03
Test and p			$F = 3.542$ $p = 0.015(a,b)$	$F = 0.072$ $p = 0.975$
Knowledge of languages other than mother tongue				
Yes	160	41.5	56.20 ± 7.34	48.45 ± 10.72
No	226	58.5	57.60 ± 7.63	48.92 ± 9.58
Test and p			$t = -1.803$	$t = -0.455$

TABLE 1 (Continued)

Characteristics	N	%	Ethnocentrism Scale X ± SS	Xenophobia Scale X ± SS
			$p = 0.072$	$p = 0.650$
Thinking that foreign national patients cause diseases				
Yes	313	81.1	57.21 ± 7.49	49.68 ± 9.58
No	73	18.9	56.20 ± 7.72	44.67 ± 11.07
Test and p			$t = 1.033$ $p = 0.302$	$t = 3.902$ $p = 0.000$
Abroad experience				
Yes	116	30.1	56.71 ± 7.12	47.55 ± 10.55
No	270	69.9	57.15 ± 7.71	49.24 ± 9.81
Test and p			$t = -0.530$ $p = 0.596$	$t = -1.515$ $p = 0.131$
Presence of foreign national relatives				
Yes	97	25.1	55.95 ± 7.14	48.34 ± 11.42
No	289	74.9	57.38 ± 7.63	48.86 ± 9.57
Test and p			$t = -1.615$ $p = 0.107$	$t = -0.444$ $p = 0.657$
Experience in caring for foreign national patients				
Yes	329	85.2	57.07 ± 7.48	48.84 ± 9.71
No	57	14.8	56.75 ± 7.85	48.08 ± 11.91
Test and p			$t = 0.294$ $p = 0.769$	$t = 0.524$ $p = 0.600$
Willingness to care for foreign patients				
Yes	188	48.7	55.93 ± 7.41	44.90 ± 9.78
No	198	51.3	58.06 ± 7.51	52.36 ± 8.92
Test and p			$t = -2.793$ $p = 0.005$	$t = -7.839$ $p = 0.000$
Sufficient knowledge about the cultures of the patients				
Yes	85	22.0	57.80 ± 8.10	47.72 ± 11.46
No	301	78.0	56.80 ± 7.36	49.01 ± 9.62
Test and p			$t = 1.073$ $p = 0.284$	$t = -1.042$ $p = 0.298$
Received education about intercultural care				
Yes	50	13.0	57.04 ± 7.52	47.08 ± 10.61
No	336	87.0	57.02 ± 7.54	48.97 ± 9.96
Test and p			$t = 0.014$ $p = 0.989$	$t = -1.247$ $p = 0.213$

Note: The significances are shown in bold values. (a,b): Groups that make a difference. The p -value of the Scheffe test for a and b is 0.039. $p < 0.05$ (* t = independent samples t -test, ** F = analysis of variance test). ***Others: Administrative units, polyclinics, infection control committee.

3.6 | Ethical considerations

The study was conducted in accordance with the Helsinki Declaration principles. Ethical approval from the ethics committee of the relevant university was obtained (Number: 2021/27). Likewise, institutional permission was obtained from both hospitals where the research was conducted. All nurses were digitally informed about the aim of the study, the voluntary nature of participation, and that they could withdraw from the study at any time, with the information text at the beginning of the online questionnaire. Descriptive information about

the nurses, such as name and surname, was not asked and all data were collected anonymously.

4 | RESULTS

The mean age of the nurses participating in the study was 30.57 ± 6.54 (min-max: 21–50), 64.2% of the nurses were women, 58.8% were married, and 79.8% were graduates with bachelor's degrees or postgraduates. The majority of the nurses (41.2%) worked in the

TABLE 2 The distribution of mean scores of the Ethnocentrism Scale and the Xenophobia Scale ($N = 386$).

Scales	Min–Max	Mean $\pm$ SD	Cronbach alpha
Ethnocentrism Scale	40–80	57.02 $\pm$ 7.53	0.80
Xenophobia Scale	13–66	48.73 $\pm$ 10.05	0.86

TABLE 3 Correlation between the Ethnocentrism Scale versus the Xenophobia Scale mean scores ($n = 386$).

Scales	Xenophobia Scale	
Ethnocentrism scale	$r = 0.300^a$	$p = 0.000$

Note: The significance of bold values was provided.

^aCorrelation is significant at the 0.01 level (two-tailed).

intensive care unit, and the professional experience of the majority (74.1%) and the working time in the units they worked (85.2%) were less than 10 years. 58.5% of the nurses did not speak a second language other than their mother tongue, 81.1% believed that foreign national patients cause diseases, 69.9% had abroad experience, 74.9% had a foreign national relative, 85.2% of the nurses had given care to foreign patients before, 51.3% did not want to care for foreign patients, and 87% had not received training on intercultural care before (Table 1).

Nurses' mean total scores of the Ethnocentrism Scale and the Xenophobia Scale were respectively 57.02 ± 7.53 and 48.73 ± 10.05 (Table 2).

There was a statistically significant difference between the total mean scores of the Ethnocentrism Scale and age, gender, and unit of work ($p < 0.05$). Nurses, who are aged 35 and over, compared with nurses under 35 years ($t = -2.060$, $p = 0.040$), males compared with females ($t = -2.345$, $p = 0.02$), and work in the surgical units, compared with nurses working in the internal units ($F = 3.542$, $p = 0.015$), had higher total mean scores of the Ethnocentrism Scale (Table 1).

There was a statistically significant difference between the Xenophobia Scale total mean score of the nurses and believing that foreign national patients cause disease and wanting to care for foreign patients ($p < 0.05$). These results indicate that the Xenophobia Scale mean scores of the nurses, who believed that foreign national patients brought diseases, were higher than those who did not ($t = 3.902$, $p = 0.000$), and those who did not want to care for foreign patients compared with those who wanted to ($t = -7.839$, $p = 0.000$) (Table 1).

There was a weak positive and statistically significant relationship between the total mean scores of Ethnocentrism Scale and the Xenophobia Scale. The mean scores of the Ethnocentrism level increased, as the mean scores of the Xenophobia level increased ($r = 0.300$, $p < 0.01$) (Table 3). Table 4 presents the results of the simple regression analysis. Ethnocentrism level was taken as the independent variable and xenophobia level as the dependent variable. There is a weak and significant relationship between ethnocentrism and the xenophobia level ($R = 0.300$, $R^2 = 0.090$, $p = 0.000$).

The level of ethnocentrism explains the level of xenophobia by 9% (Table 4).

The results of the multiple regression analysis conducted to investigate the effect of nurses' sociodemographic characteristics on xenophobia were not found statistically significant ($F = 1.503$, $p > 0.05$). On the other hand, the results of the multiple regression analysis conducted to investigate the effect of nurses' ethnocentrism levels on sociodemographic characteristics were found to be statistically significant ($F = 2.113$, $p < 0.05$). Gender and educational level were statistically significant predictors of ethnocentrism scores ($p < 0.05$). Male nurses displayed 0.127 times higher ethnocentrism levels than female nurses ($\beta = 0.127$, $p = 0.013$). High school graduates displayed 0.105 times higher ethnocentrism than nurses with bachelor's and postgraduate degrees ($\beta = 0.105$, $p = 0.041$). These variables contributed to the total ethnocentrism scores of nurses by 3.6% ($R^2 = 0.036$). However, the other factors, including age, marital status, educational level, work experience, and work experience in the unit worked and worked unit were not considered predictors of the ethnocentrism scores in nurses. These findings provide valuable insights into the complex interplay between demographic characteristics and ethnocentrism scores among nurses (Table 5).

5 | DISCUSSION

Xenophobia is a widespread phenomenon globally (Durat & Tarsuslu, 2022). In this study, the nurses' xenophobia scores were above the mean and the participating nurses had a high level of xenophobia. These results suggest that nurses have fears and concerns about immigration and foreigners. In a descriptive study conducted with 257 undergraduate nursing students and 341 vocational schools of health services students to identify the relationship between intercultural effectiveness and awareness of xenophobia, the students had a high level of xenophobia (Gungor et al., 2021). The studies showed high levels of xenophobia among nurses and nursing students (Çetin & Savaş, 2023; Karadas et al., 2023). Contrary to the findings of this study, in another study conducted in Turkey with 486 nursing and midwifery students to examine the cultural sensitivity of nursing and midwifery students and its relationship with xenophobia, the students had a low level of xenophobia (Durat & Tarsuslu, 2022). In the field report of the Association for Migration Research, the Syrian immigrants interviewed stated that those whose names are not Turkish and those who do not speak Turkish face discrimination and hostile attitudes in hospitals (Association for Migration Research Report, 2020). These results indicate that xenophobia is an important problem that exists among nurses all over the world and affects the

TABLE 4 The effect of ethnocentrism on xenophobia level.

Variable	B	Standard error	β	t	p
(Constant)	25.904	3.738	-	6.931	$p < 0.001$
Ethnocentrism level	0.400	0.065	0.300	6.161	$p < 0.001$
$R = 0.300$; $R^2 = 0.090$; $F = 37.956$; $p < 0.001$					

Note: Dependent variable: Xenophobia level.

TABLE 5 Factors influencing xenophobia and ethnocentrism as shown by regression analysis ($N = 386$).

Variables	Xenophobia Scale				Ethnocentrism Scale			
	B	SD	β	p	B	SD	β	p
Constant	47.103	0.961		0.000	55.587	0.716		0.000
Age								
≥ 35 years	-0.847	1.835	-0.034	0.645	1.517	1.367	0.081	0.268
Gender								
Male	0.900	1.071	0.043	0.401	1.992	0.798	0.127	0.013*
Marital status								
Single	1.315	1.112	0.064	0.238	-0.074	0.829	-0.005	0.929
Educational level ^a								
High school	2.687	1.923	0.072	1.397	2.944	1.433	0.105	0.041*
Associate degree	3.318	1.561	0.109	0.034	0.570	1.163	0.025	0.624
Work experience								
≥ 10	-0.431	1.848	-0.019	0.816	1.008	1.377	0.059	0.465
Work experience in the unit worked								
≥ 10	2.896	1.893	0.102	0.127	-0.744	1.410	-0.035	0.598
	$R = 0.165$ $R^2 = 0.027$ Adjusted $R^2 = 0.009$ $F = 1.503$, $p > 0.05$				$R = 0.194$ $R^2 = 0.038$ Adjusted $R^2 = 0.020$ $F = 2.113$, $p < 0.05$			

Note: B = unstandardized coefficients B; SD = standard deviation; β = standardized coefficients beta; F = analysis of variance value.

^aReference value = Bachelor's degree and postgraduate.

* $p < 0.05$.

quality of care negatively. The increase in the number of refugees throughout the country, the high number of refugees in the provinces where the research was carried out, and the idea that the economic and social problems experienced in the country are caused by refugees may have caused xenophobia among nurses, especially toward Syrian refugees fleeing the war (Tosun & Sinan, 2020).

It is important for nurses to be aware of their ethnocentrism attitudes and to determine the level of ethnocentrism of nurses to provide and maintain effective care (Bilgiç & Şahin, 2019; Karasu et al., 2022). In this study, the ethnocentric attitudes of the nurses were below the mean but close to the scale mean. In a study by Karasu et al. (2022), the ethnocentrism scores of nurses and nursing students were similar to the findings of this study. In Ahn's (2017) study, investigating the cultural competence of nurses who cared for foreign patients, the ethnocentrism scores of nurses were found to be low. It has been reported that the ethnocentrism scores of nursing students are close to the mean (Beser et al., 2021). A qualitative study conducted in Iran showed that nurses can behave in an ethnocentric manner toward patients from different cultures (Amiri & Heydari, 2017).

Turkey is a multicultural country and nurses often care for patients from different cultures and ethnicities. Due to the multicultural structure in the provinces, where the research was conducted, the fact that the nurses working here often gave care to individuals from different cultures may have enabled them to provide intercultural care that is sensitive to cultural differences and away from ethnocentrism. One of the most effective ways to reduce ethnocentrism between groups is cultural exposure (Bilgiç & Şahin, 2019).

In this study, older nurses had higher ethnocentrism levels. In a study conducted with 604 local people from Mardin aged between 16 and 85, the older adults exhibited more xenophobic attitudes toward Syrian refugees (Padir, 2019). Studies have shown that the age factor has a significant effect on the levels of intercultural self-efficacy (Tong et al., 2021), cultural intelligence, and intercultural communication anxiety (Coşkun Erçelik et al., 2022), which are known to be associated with ethnocentrism. Contrary to our study findings, intercultural sensitivity (Kaya et al., 2021) of nursing students increased with age. This difference between the study findings may be related to the difference between the region and the hospital

where the studies were conducted. This study was conducted in hospitals where there are many foreign national patients, mostly Syrians. In addition, the increase in the number of courses, including intercultural nursing and ethics within the scope of nursing education in Turkey, and the increase in the importance given to these concepts in recent years, can be related to the lower ethnocentrism attitudes of the younger age group nurses. It has been reported that cultural awareness training reduces the level of ethnocentrism (Topcu, 2019).

Studies suggest that male nurses have higher levels of ethnocentrism than female nurses. Studies were conducted with nursing students (Beser et al., 2021; Bilgiç & Şahin, 2019; Kaya et al., 2021), which conclude that male students have higher levels of ethnocentrism than female students. In a study conducted with 604 people aged between 16 and 85, to examine the relationships among perceived threats, contact quality and quantity, and xenophobia in the context of Syrian refugees, males exhibited more xenophobic attitudes toward Syrian refugees (Padir, 2019). The result of the present study is similar to previous studies. Gender had a predictive effect on the ethnocentrism level of nurses, and male nurses displayed higher ethnocentrism than female nurses. It is an expected finding that females' cultural perception and intercultural sensitivity are higher than males', due to the values that Turkish society imposes on women. The results suggest that male nurses should be supported more than female nurses in terms of intercultural sensitivity and competence that affect their ethnocentric attitudes.

The results demonstrated that the ethnocentrism level of nurses working in surgical units was higher than nurses working in internal units. This result may be related to the differences in characteristics such as age and gender between the groups.

All the problems related to language and cultural differences during nursing care result in the reluctance of nurses to accept refugee patients (Zengin et al., 2021). In this study, the xenophobia levels of the nurses, who believed that foreign nationals caused diseases and did not want to care for these patients, were higher. This result was expected but undesirable and contrary to the nature of the nursing profession. Because ethical obligations and care practices are inherent in nursing practice (ANA, 2015), nurses are expected to lead efforts to reduce health inequalities (Purtzer & Thomas, 2019).

For a culture to maintain its existence, members of that culture must have a somewhat ethnocentric attitude, while an increase in the level of ethnocentrism causes a decrease in cultural competence and sensitivity (Beser et al., 2021). In a study conducted with health education students, it was determined that intercultural sensitivity had a negative and significant effect on the level of xenophobia (Yildiz et al., 2023). In a study conducted with nursing students, ethnocentrism was determined to be a positive predictor of the level of xenophobia in students (Karadas et al., 2023). In this study, in parallel with the literature, there was a positive relationship between nurses' ethnocentrism and xenophobia levels, and ethnocentrism had a predictive effect on the xenophobia level of nurses. This result shows that ethnocentric attitudes cause negative effects on nurses caring for refugees, and nurses with ethnocentric attitudes may exhibit a xenophobic attitude toward refugees. These results indicate that

preventing ethnocentric attitudes of nurses by being aware of their ethnocentric attitudes and increasing their cultural competence and sensitivity will reduce xenophobia.

5.1 | Limitations and strengths

This study had some limitations. First, the results cannot be generalized to all nurses because the sample only includes nurses from two hospitals in Turkey. Second, collecting data online may affect the reliability of nurses' answers. As this study was an online survey, not including other possible factors affecting nurses' level of ethnocentrism and xenophobia reduces the scope of the results. Additional qualitative questions could have helped to investigate deeper into the topic. The low rate of variance explained by the model can also be considered a limitation of the study. On the other hand, it is important to guide future research as it reveals that different variables predict xenophobia. The contribution of this study to the literature and the use of validated scales for measurements can be considered as the strengths of the study.

6 | CONCLUSIONS

In this study, it was determined that the ethnocentrism levels of the nurses were below the mean, xenophobia levels were above the mean, and the level of xenophobia increased as the level of ethnocentrism increased. Ethnocentrism levels and xenophobia attitudes of nurses can affect the quality of nursing care. The findings highlight the need to develop effective strategies to counteract xenophobia. To reduce ethnocentric and xenophobic attitudes and improve the positive cultural experiences of nurses, it is recommended to provide in-service training and include course content in the nursing curriculum that will increase their awareness of this subject. Conducting further studies examining different predictive variables that the model cannot explain in this study may increase the percentage of variance explained. This will contribute to enriching functional information that can be used in applications to reduce xenophobia and planning strategies on the subject.

7 | RELEVANCE FOR CLINICAL PRACTICE

High cultural sensitivity and awareness of nurses are essential for high-quality care. As nurses are critical team members in the continuation of the health services of refugees and asylum seekers, it would be beneficial to provide in-service training, which will enable nurses to be aware of their attitudes on the subject, improve their cultural sensitivity, ethnocentrism knowledge, and reduce xenophobic attitudes. Nursing education and in-service training should adopt strategies to reduce xenophobia and prevent ethnocentric attitudes. Such education and training can equip nurses to provide higher quality care to foreign national patients. In addition, conducting this research with

other cultures will contribute to the determination of the differences and similarities.

AUTHOR CONTRIBUTIONS

İpek Köse Tosunöz: Conceptualization; methodology; data curation; formal analysis; writing – original draft; writing – review and editing.
Ebru Öztürk Çopur: Conceptualization; methodology; data curation; writing – original draft; writing – review and editing; formal analysis.

CONFLICT OF INTEREST STATEMENT

The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Approval from the Kilis 7 Aralık University Rectorate Ethics Committee was obtained (Date: November 11, 2021, Number: 2021/27). Participants were informed about the aim of the study, which was conducted with students who agreed to participate.

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