

## RESEARCH ARTICLE

# Development and Validation of Culture Competence Tool for Filipino Nurses

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## ABSTRACT

**Background:** There are several metrics for determining cultural competency in nurses, but none of them apply to Filipino nurses caring for patients with mental health issues in the Philippines setting.

**Purpose:** The goal of this study was to create a cultural competency tool for Filipino nurses (CCTFN) caring for patients with mental health issues in hospitals, communities, or schools.

**Methodology:** A sequential exploratory design was used. The qualitative phase utilized a scoping review and guided interviews, followed by the quantitative phase involving the validity test by five experts and the reliability tests participated by 140 nurses in Zamboanga City. IBM SPSS Statistics 22.0 was used to examine the data.

**Results:** The scoping review utilized PRISMA to search for eligible articles and the interviews resulted in an initial 51-item pool. The tool's content validity (S-CVI=0.992) was confirmed by a panel of experts. The inter-rater (ICC=0.773), inter-item ( $\alpha$ =0.838) reliability, and exploratory factor analysis revealed four factors that accounted for 68.38 percent variance, resulting in 25 valid items. The four factors were "awareness on the Filipino concept of mental illness," "attitudes towards fostering an efficient relationship between patient with mental health problems and self," "skills in addressing cultural needs and issues of patients with mental health problems," and "knowledge on socio-political factors affecting patients with mental health problems."

**Conclusion/Implications for Practice:** Overall, the CCTFN was found to be valid and reliable. This tool can improve nursing care and inform training programs in the Philippines to improve mental health service provision and reduce stigma.

**Keywords:** *cultural competence, mental health nursing, Filipino culture, exploratory sequential design, tool development, Philippines*

## Introduction

The increasing diversity of populations and its subsequent problematic issues have challenged cultural experts to develop protocols for implementing culturally competent nursing care [1] because cultural competency is one of the most important factors in bridging healthcare gaps [2]. Leininger's culture care theory [3] brought forth various models [4-7], definitions [8-10], subconstructs, and instruments of cultural competence [11,12] that exist in the literature. The concept of cultural competency has been examined and explored by nurse experts in culture care for more than three decades in Western and European countries, but it is relatively new in the Philippines in terms of studies conducted, particularly with nursing [13] and mental health services [14].

According to the World Health Organization (WHO), 154 million people in the Philippines suffer from depression, 1 million

from schizophrenia, and 15.3 million from substance abuse problems, with 877,000 people dying each year from suicide [15]. At least 3.6 million Filipinos suffer from at least one type of mental, neurological, or substance use disease, according to the Philippine WHO Special Initiative for Mental Health in 2020 [16], making mental illness the country's third most common disability [17]. Contributing factors to the mental illnesses of Filipinos are social and economic [14], cultural [18], and other environmental conditions such as natural calamities [19] and armed conflicts [20,21]. Presently, the numbers are most likely much higher since many who suffer from some form of mental disorder, and those who attempt suicide hesitate to seek help due to shame [14] and the stigma [22,23] that surrounds it.

The Philippine Mental Health Law, Republic Act No. 11036 of 2018 stipulates in Section 2 that the State commits to ensuring

timely, affordable, high quality, and culturally appropriate mental health care for all [24]. Likewise, the National Mental Health Policy, DOH Administrative Order No. 8 series of 2001 articulates that in line with human resource development, the training for mental health care providers is responsive to the national and local culture [25]. Given that nurses are the most numerous among health care providers and are the first point of contact for many patients, the question, "How culture competent are the Filipino nurses in providing mental health services to the Filipino population?" comes to mind.

Providing competent care to patients is a challenge for Filipino nurses, the task becomes doubly challenging if the patients belong to different cultures with health conditions, such as those with mental illnesses [13]. Filipino nurses need to understand how Filipinos conceptualized mental illness to be able to understand their own culture to prevent negative attitudes and subsequently enhance their competence towards people with mental illness. Although there are articles that portray Filipino nurses as having positive attitudes towards patients in general, the information is scarce and mostly comes from the grey literature [26-28] and there were no patients with mental health conditions mentioned in the reviewed articles.

A vast number of reviews and studies on the cultural competence of nurses and the instruments used exist in the literature [11,12,29], including those from Asian countries [30-33]. The literature explains that the concept of cultural competence, in the point of view of a nurse, is generally understood as a capacity to promote the health and wellness of clients whose cultural backgrounds are different from that of a nurse. Also, the domains of awareness, knowledge, skills, and attitude are subconstructs common among the instruments. The reviewed instruments provided information on the related items used to develop the proposed CCTFN and on the process of tool development.

However, the studies were done in different countries and may not reflect the cultural competency of Filipino nurses living and caring for patients with mental illnesses in the Philippines. Although there is evidence that suggests Filipino nurses are culturally competent in caring for patients abroad [34-36] and in the Philippines [37,38], to what type of patients, is not stated in the studies. Hence, the development and validation of the Cultural Competence Tool for Filipino Nurses Caring for Patients with Mental Health Problems (CCTFN) was deemed necessary to improve the quality of nursing care and inform training programs aimed at improving mental health and reducing stigma in the Philippines.

## Methodology

In this study, the exploratory sequential design was selected to develop and validate a culture-sensitive tool to determine the cultural competency of Filipino nurses in caring for patients with mental health problems in the Philippine setting. This design is frequently discussed as a method of choice when a researcher needs to develop an instrument because existing instruments are insufficient or not available [39]. It typically starts with the qualitative phase and is followed by a quantitative phase [40]. Moreover, the five processes outlined by Kyriazos and Stalikas [41] in their integrative study on the scale development processes guided the development and validation of the CCTFN (Fig. 1).

### *Qualitative Phase*

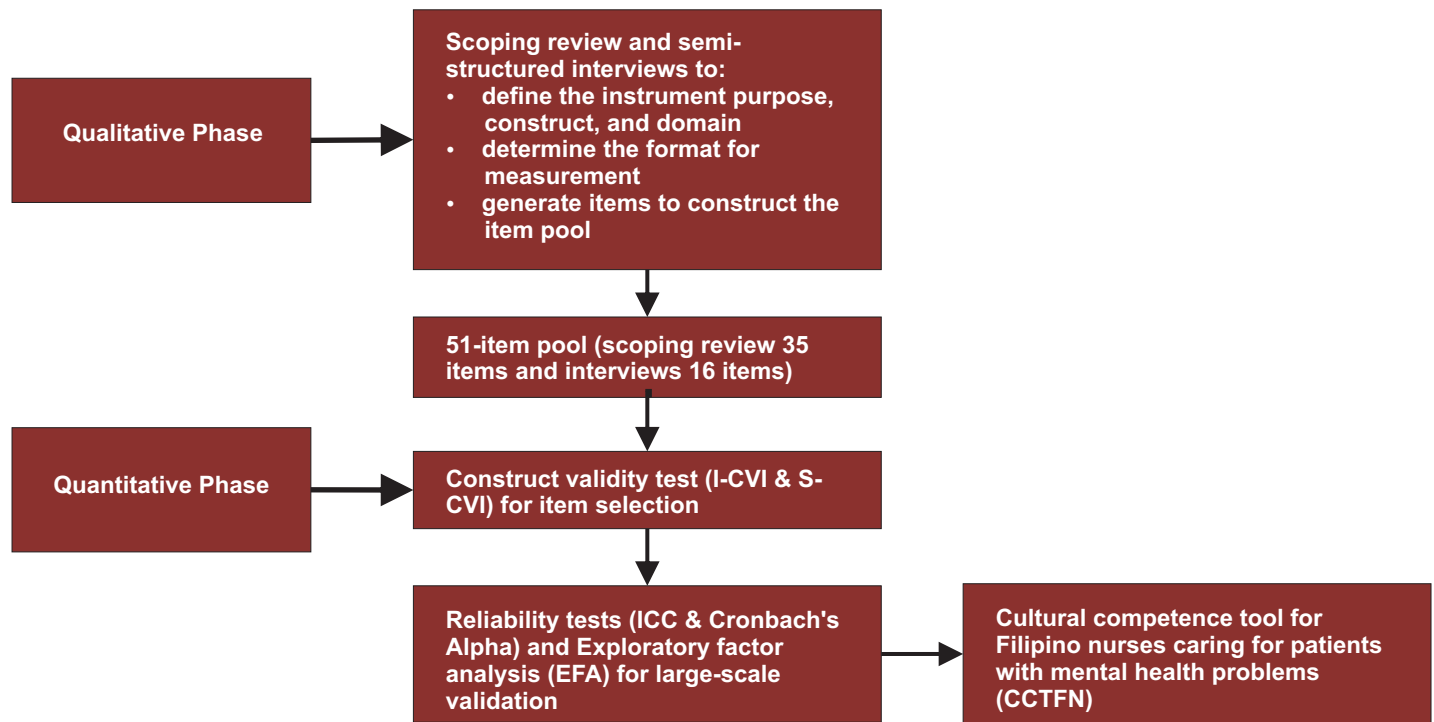
The qualitative phase of this study involves the use of scoping review framework [42] in identifying and selecting relevant articles and studies for defining the instrument purpose, construct, and domain [41]. This kind of review was used because the concept of cultural competence of Filipino nurses being studied has not yet been comprehensively reviewed and exhibits a large, complex, or heterogeneous nature not amenable to a more precise systematic review [43]. In the selection of eligible articles for Scoping review, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) was employed [44].

The next process in this phase was to determine the format for measurement [41]. The response format was decided early on for compatibility with the items generated [45]. A 4-point Likert scale was used to develop the response scale.

The process of generating items to construct an item pool [41] included eligible articles and studies from the scoping review and responses from the interviews participated by six nurses (4 males and 2 females), ages 30 to 63 with seven to 35 years of working experience in the psychiatric unit of a hospital. A semi-structured interview guide was used (Table 1) and the responses of the nurse participants were analyzed using thematic analysis.

### *Quantitative Phase*

The quantitative phase of this study involved the process of item selection [41] based on the item and scale content validity index (I-CVI and S-CVI). If the I-CVI value is greater than 0.79, the item is relevant; if the value is between 0.70 and 0.79, the item requires adjustment; and if the value is less



**Figure 1.** Exploratory Sequential Design of the study

**Table 1.** Interview Guide

<b>Interviewee Demographics</b>	Age, gender, ethnicity, highest educational attainment, place of practice, total years in service, mental health and/or cultural competency training in the past 12 months.
<b>Guide Questions</b>	<b>Knowledge:</b> <ul style="list-style-type: none"> <li>• What does cultural competence mean to you?</li> <li>• Can you distinguish your patients in terms of their cultural background? How? (Optional probe: What were your patients' cultural background?)</li> </ul>
	<b>Skills:</b> <ul style="list-style-type: none"> <li>• Can you describe your experience in caring for a patient with mental illness whose cultural background is different from yours?</li> <li>• What are/were your challenges in caring for them?</li> <li>• How do/did you address the challenges?</li> </ul>
	<b>Attitude:</b> <ul style="list-style-type: none"> <li>• Do you think cultural competence is important when caring for patients with mental illness? If yes, how so? If no, why not?</li> <li>• What do you believe could improve your cultural competence in caring for patients with mental illness?</li> </ul>
	<b>Opinion on the components or domains to be included in the tool:</b> <ul style="list-style-type: none"> <li>• What are components of cultural competence do you think should be included in the CCTFN?</li> </ul>

than 0.70, the item is removed [46]. The I-CVI should be 1.00 with five experts. The S-CVI of a tool should be greater than or equal to 0.90 for it to have good content validity [47].

The experts were composed of three nurse educators with doctorate degrees in nursing and in public administration, two of them teaching psychiatric nursing for more than 30 years. One expert was the ethics coordinator of their university for more

than three years with a master's in social psychology and was the only male in the group. The other expert was the guidance and counseling director of a university with a Ph.D. in Guidance and Counselling. The experts evaluated the appropriateness of the format, response scale, readability, clarity, and redundancy of the tool's items, and graded the relevance of the items to the concept of cultural competence and mental health nursing practice using a scale from 1 to 4 (not relevant to highly relevant).

The process of doing a large-scale validation [41] necessitated the participation of 140 nurses who were purposely chosen and consented to be part of the study. The nurses had previous experience caring for people with mental illnesses in psychiatric hospitals (27.1%), in communities as public health nurses (17.1%), and as school nurses (24.3%) (see Table 2). School nurses were included in the study because of their unique position to help manage the ongoing treatment of mental health issues in the school setting as the most recent survey by the World Health Organization shows that 16.8 percent of 8,761 student-participants aged 13 to 17 attempted suicide one or more times a year [48]. The figures may still be underreported because of the stigma and taboo which affect the help-seeking and reporting of mental health problems by the students.

The large-scale validation utilized intraclass correlation coefficient (ICC), Cronbach's Alpha, and the exploratory factor analysis (EFA). The ICC and Cronbach's alpha were used to calculate the inter-rater and inter-item reliability tests, respectively. Poor, moderate, good, and exceptional reliability are indicated by ICC values of less than 0.50, between 0.50 and 0.75, between 0.75 and 0.90, and better than 0.90, respectively [49]. The interpretation of Cronbach's dependability coefficient is as follows: .90 = Excellent, .80 = Good, .70 = Acceptable, .60 = Questionable, .50 = Poor, and .50 = Unacceptable [50].

The exploratory factor analysis (EFA) was utilized to investigate the tool's dimensions. To check the appropriateness of items for EFA, the Kaiser–Meyer–Olkin (KMO) test and Bartlett's test of sphericity were performed, and the principal axis factoring was done using Varimax rotation, which allows for correlations across factors. A KMO of 0.60 is deemed adequate, indicating that each factor has enough items. If  $p < 0.05$ , Bartlett's Test of Sphericity is significant, implying that the variables are sufficiently correlated for factor analysis [51].

### Data Analysis

IBM SPSS Statistics 22.0 was used to evaluate the gathered data. Descriptive statistics were used to examine the participants' general characteristics.

### Ethical Considerations

The Ethics and Review Committee of St. Paul University Philippines granted the study ethical permission (Protocol Code 2019-01-DNS-18). All the participants gave their informed consent after the researcher described the study's goal.

## Results

### Qualitative Phase

The identification and selection of relevant articles and studies for defining the instrument purpose, construct, and domain [41] using PRISMA resulted in articles and studies on several models [4-7], definitions [8-10], and instruments [11,12,29-38] on cultural competence which helped in the construction of the term "cultural competence" and its domains: awareness, knowledge, skills, and attitude. Moreover, the review on the most frequently used cultural competence instruments showed that they are not completely relevant to assessing Filipino nurses' cultural competency in caring for patients with mental health problems. Hence, the purpose of creating the CCTFN.

**Table 2.** Summary of the Demographic Profile of the 140 Nurse Participants

Gender		Frequency	Percentage
Gender	Male	47	33.6
	Female	93	66.4
Religion	Roman Catholic	87	62.1
	Islam	36	25.7
	Protestant	7	5.0
	Others	10	7.1
Ethnicity*	Zamboangueño	47	33.6
	Tausug	35	25.0
	Visayan	19	13.6
	Others	16	11.4
Highest Educational Attainment*	BSN degree	70	50.0
	MN/MAN degree	31	22.1
	Ph.D./Doctorate	11	7.9
	With units in MN/MAN	9	6.4
	With Ph.D./Doc units	17	12.1
Place of Practice	Psych hospital/unit	38	27.1
	Rehabilitation Center	3	2.1
	Public Health Unit	24	17.1
	School Clinic	34	24.3
	Academe (teaching Psych)	22	15.7
	Others	19	13.6
Years of Service	2 – 5 years	66	47.1
	6 – 10 years	16	11.4
	More than 10 years	58	41.4

Note: \*with missing data

The format for measurement or response scale of 1 "strongly disagree," 2 "disagree," 3 "agree," and 4 "very agree" was evaluated by the five experts and was deemed adequate.

The process of generating items for the item pool resulted in 35 items being adapted from the reviewed instruments. While the six interviews were able to generate 16 items with three themes. Theme 1 was named "Addressing customary needs, religious beliefs and practices of a patient with mental health problem", theme 2 "Fostering an effective nurse-patient relationship for better care of a patient with mental health problem", and theme 3 "Recognizing socio-political factors affecting patient with mental health problem". Each theme has 4, 7, and 5 items, respectively.

In all, the tool had an initial 51 items with 17 items for the domain of Knowledge, 19 for the Skills domain, and 15 for the Attitude domain.

#### Quantitative Phase

Out of the initial 51-item pool, 18 items were deleted mostly for redundancy or similarity in meaning as evaluated by the experts while 33 items were retained for content validation. As a result, 26 items were considered relevant (25 had an I-CVI of 1.00 and one item had 0.80). Overall, the S-CVI was 0.992, indicating excellent content validity [47].

For the ICC test, the average value of the tool was 0.773 which indicates that there was good inter-rater reliability [49]. The tool's overall inter-item dependability was also good, with Cronbach's  $\alpha = 0.838$ . Even if one of the items is deleted, the tool's internal consistency ( $\alpha = 0.827$ ) remains good [50].

The exploratory factor analysis (EFA) was utilized to investigate the tool's dimensions. To check for the adequacy of the items, the Kaiser–Meyer–Olkin (KMO) test value was 0.761 indicating that the 26 items met the minimum criteria of 0.6 and were appropriate for EFA. Moreover, the instrument's result for Bartlett's Test of Sphericity had a p-value of 0.000 (sig. <0.05), indicating that the items were correlated and suitable for factor analysis [51].

Furthermore, to assist in the decision concerning the number of factors to retain, the Kaiser's test was used and revealed eight (8) components (factors) that have eigenvalues greater than or equal to 1.0. The eight factors revealed can account for 68.38% of the tool's overall variance (Table 3). However, the eight factors were reduced to four by using the Scree plot (Figure 2) as a smaller number of factors is easier for naming. Deciding on the correct number of factors has been the subject of many studies but, it is better to think in terms of most appropriate than a correct number of factors [52].

**Table 3.** The Eigenvalue Result of the 26 Items

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	6.638	25.531	25.531	6.638	25.531	25.531	3.247	12.489	12.489
2	2.990	11.501	37.033	2.990	11.501	37.033	3.074	11.824	24.313
3	1.910	7.348	44.380	1.910	7.348	44.380	2.840	10.924	35.237
4	1.606	6.177	50.557	1.606	6.177	50.557	2.308	8.878	44.116
5	1.400	5.386	55.943	1.400	5.386	55.943	2.158	8.298	52.414
6	1.155	4.442	60.385	1.155	4.442	60.385	1.794	6.901	59.315
7	1.081	4.158	64.543	1.081	4.158	64.543	1.359	5.229	64.543
8	.998	3.839	68.383						

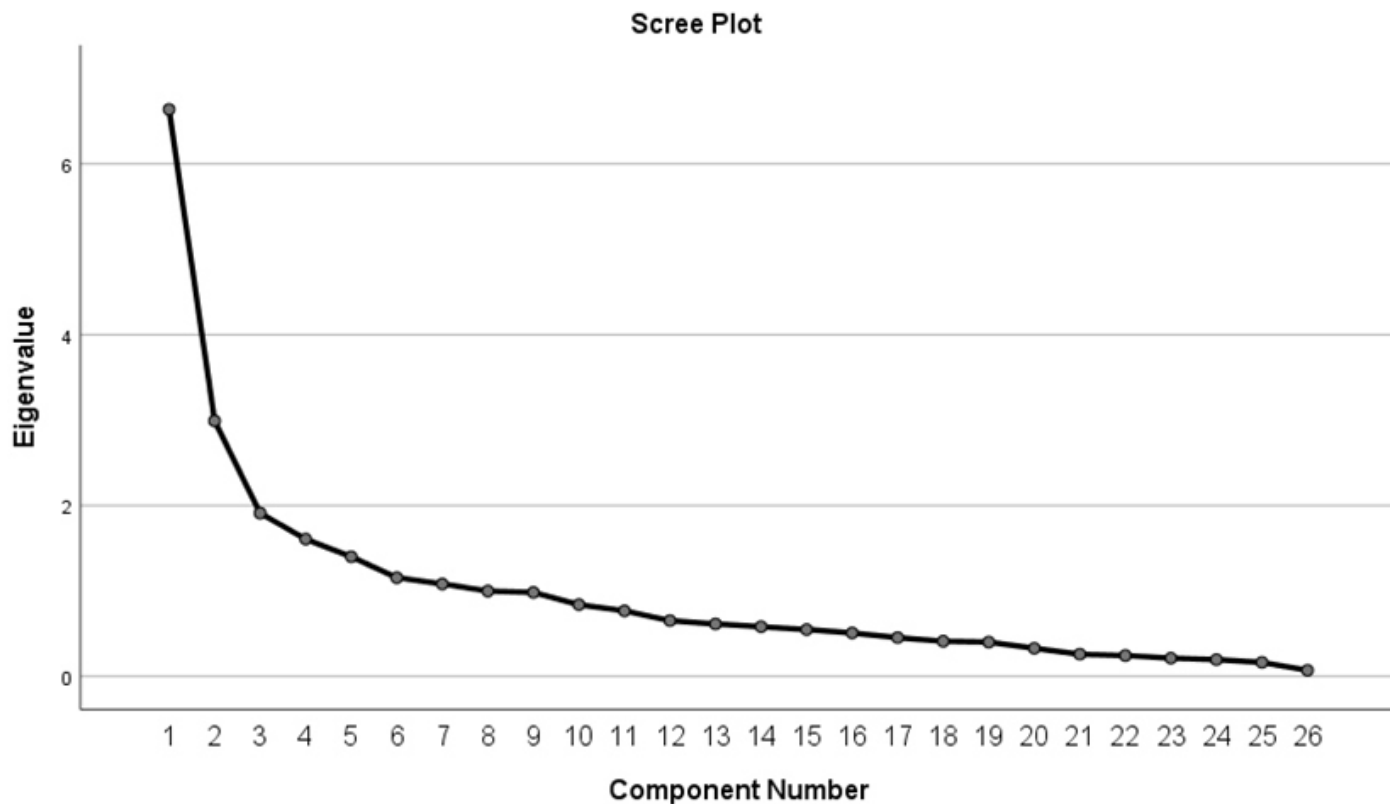


Figure 2. Scree Plot for Factor Extraction

Lastly, to determine which item goes to which factor, the Varimax technique was used resulting in 25 variables or items loaded to the four factors extracted at coefficient 0.40. One item (item no. 21) did not load in any of the factors (Table 4).

## Discussion

The concept of cultural competence in this study was based upon several models and definitions that are posited in Madeleine Leininger's culture care theory [3] who believes that care and culture are inextricably linked together. Her theory embodies the basis of much of the application of cultural competence in healthcare [53], and among the models, the Campinha-Bacote's Model of Cultural Competence in Healthcare Delivery [4] is most widely used and considered as ideal when educating providers on cultural competence. Many of the tools to measure cultural competence of nurses and other health professionals were patterned from her model.

Tools to measure the cultural competence of nurses designed explicitly for nurse practitioners working in the hospitals and the community in Asian countries like China [30], Korea [32], and Thailand [33] have been adapted to

develop the CCTFN. However, these tools were ineffective because they were designed for patients in general and not for patients with mental illnesses. Also, the tools were formulated in a different environmental setting which may not reflect the cultural competence of Filipino nurses living and working in the Philippines and caring for Filipino patients with mental health problems.

Moreover, with the differences in the demographic characteristics and experiences of the Filipino nurses and the patients, their conceptualization and understanding of mental illness or psychological distress may also differ. Hence, this is one area in the tool that needs to be considered. Nevertheless, not only did the reviewed instruments provided information on the related items that can be used to develop the CCTFN, but they also provided information on the process of tool development.

The scoping review has found that competence is often associated with the domains of knowledge, skills, or attitudes (KSA) [54] that enable a nurse to perform his or her work effectively. Together with the data from the interviews, the 51-item tool was generated based on the KSA domains.

**Table 4.** Results of Factor Rotation using Varimax

Items	F1	F2	F3	F4
1				.623
2	.584			
3	.740			
4	.792			
5				.662
6				.700
7	.401			.633
8	.629			
9	.492			
10		.645		
11		.405		
12	.485			
13			.592	
14			.626	
15			.737	
16			.818	
17			.455	
18			.676	
19				-.441
20	.463			
21				
22				-.570
23		.675		
24		.791		
25		.756		
26		.685		

Note: F1=Factor 1, F2=Factor 2, F3=Factor 3, F4=Factor 4, items are extracted at coefficient 0.40

The content validity test (S-CVI 0.992) revealed that 26 items from the 51-item tool should be retained and were then subjected to inter-rater (ICC) and inter-item (Cronbach's  $\alpha$ ) reliability tests. The result of the ICC (0.773) implies that the 140 nurse participants were generally in agreement as to the level of scores for the items in the 26-item tool, while the result of the Cronbach's  $\alpha$  (0.838) suggests that all items in the tool were internally consistent and reliable to assess the cultural competence of Filipino nurses caring for mentally ill patients.

The KMO test (0.761) and Bartlett's Test of Sphericity (p-value 0.000) scores in the EFA revealed that the 26 items were

sufficiently correlated for factor analysis. The Varimax method then identified four factors with 25 items retained. Item 21 was eliminated since it did not load in any of the four factors (see Table 4). Looking at each of the items, item 7 cross-loaded to factor 1 and factor 4. However, item 7 was closely correlated to factor 4 (.633) than factor 1 (.401); hence, the item was loaded to factor 4. Item 19 (-.441) and item 22 (-.570) had negative loadings in factor 4. Half of the participants interpreted the items in the opposite direction. In the case of item 19, the participants interpreted it as them not giving any preferential care to any patient. While item 22 was interpreted by the participants as them not using the terms *baliw* and *abnoy* to describe people with mental illnesses. Table 5 shows the names of the factors and the corresponding items of each.

Factor 1 was named "Awareness on the Filipino concept of mental illness" because the items in this factor pertain to how Filipinos conceptualized mental illness. Some studies link mental illnesses to Filipino beliefs in supernatural beings with supernatural powers [18,55,56]. Tan [55] documented some Filipino beliefs suggesting that physical and mental illnesses are caused by *sumpa* (curse) inflicted by a human being, *gaba* (retribution from God), inflicted on a person because he/she committed a social sin, and *pasma* (an "exposure illness") brought about by an imbalance between the hot and cold elements. These beliefs that God or the spirits punish the family for bad behavior in the past could bring shame to the family [57,58,23]. Also, the Filipino attitude of *bahala na* can influence treatment decisions or be a barrier to accessing assistance for mental health problems [59]. The concept of *bahala na* (Leave it to God or Come what may) refers to "passive acceptance of one's fate, or to determine in the face of uncertainty" [60]. The *bahala na* attitude is quite like the Filipino belief of *kaloob sa Diyos*. This attitude recognizes the limitations of the human being such that the intercession of a higher being is sought when humanly skills are not enough to overcome a problem [18].

Factor 2 was named "Attitudes towards fostering an efficient relationship between patient with mental health problems and self" because the items connote positive thinking or plan, whether on the part of the patient or on the part of the nurse to promote an efficient nurse-patient relationship to better patient care in the context of mental health. One plan in promoting an efficient nurse-patient relationship is using therapeutic communication techniques. Therapeutic communication is the interpersonal communication between the patient and the nurse and is intended to help the patient [61]. In addition, nurses should communicate in a language familiar to the patients or ask the assistance of an interpreter to avoid misdiagnosis and unnecessary treatments.

Factor 3 was named “Skills in addressing cultural needs and issues of patients with mental health problems” because the items suggest activities that can address the cultural needs and issues of the patient with mental health problems. Issues on establishing trust can be addressed by making sure resources and treatment are available to the patient, by considering the patient’s diet preferences or food restrictions because of religious beliefs, and by being careful on culture insensitive behaviors, whether done by self or by other colleagues, that could prejudice mentally ill patients.

While Factor 4 is titled "Knowledge of socio-political aspects impacting patients with mental health problems"

because the items are related to understanding the elements that have influenced or can affect patients who have mental health issues, whether social, political, or cultural. This factor included the nurses' understanding of the importance of cultural competence to the care of patients with mental health issues and that the cultural rights of the patients are human rights as expressed in Articles 4 and 5 of the 2001 UNESCO Declaration on Cultural Diversity [62]. Hence, patients with mental illness and their families have the right to be informed about their treatments and medications and nurses should secure their consent for such. Securing the approval of the patient and the family implies that the nurse recognizes the right of the patient to information and make decisions.

**Table 5.** Names of the Factors and the Items of the CCTFN

Factor/Name	Items
1. Awareness of the Filipino concept of mental illness	2. I think in the Filipino culture, mental illness is a family's illness. 3. I think sumpa, gaba, and pasma are perceived to cause mental illness in the Philippines. 4. I am aware that supernatural beings (e.g., kapre) are perceived to cause mental disorders in the Philippines. 8. I think Filipinos somatize mental distress/illness because physical manifestations (e.g., body aches and pain) are more socially acceptable. 9. I believe the Filipino attitude of bahala na influences treatment decisions made by patients with mental illness and their families. 12. I can distinguish the cultural background of patients with mental illness through their dialect. 20. I believe that Filipino cultural beliefs affect how mental health care is delivered
2. Attitudes towards fostering an efficient relationship between patients with mental health problems and self	10. I believe a culturally competent Filipino nurse uses therapeutic communication techniques in dealing with patients with mental illness. 11. I seek help from co-workers who speak the dialect of the patients with mental illness or the family to communicate with them during treatment or care. 23. I believe that a culturally competent nurse understands the patients with mental illness as a person and not as a disease. 24. I believe a Filipino nurse is sensitive to a mentally ill patient's personal experiences and needs. 25. I believe that knowing oneself is very important to be efficient in caring for patients with mental illness. 26. I am willing to enhance my cultural competence to keep abreast with the changing times.
3. Skills in addressing cultural needs and issues of patients with mental health problems	13. I make sure that resources for treatment or care are available to the patients with mental illness and their families to establish trust. 14. I consider the religious beliefs (e.g., food restrictions) of patients with mental illness if it does not contradict treatment or care. 15. I can explain the influence of culture on the beliefs of a patient with mental illness. 16. I can teach other co-workers appropriate behaviors when dealing with patients with mental illness from diverse cultures. 17. I intervene appropriately when I observe other co-workers engaging in behaviors that appear culturally insensitive or reflect prejudice to patients with mental illness. 18. I am aware of my own cultural biases and limitations.
4. Knowledge of socio-political factors affecting patients with mental health problems	1. I know that gender, age, social status, and generation are as important as ethnicity in forming the identity of patients with mental illness. 5. I know that socioeconomic (e.g., poverty) and environmental (e.g., typhoons, armed conflict) risk factors can contribute to mental health disparities in the Philippines. 6. I believe that patients with mental illness should be informed before giving medications. 7. I know that cultural competence is important in order not to violate the ways and beliefs of patients with mental illness. 19. I prefer to give care to a patient with mental illness whose socio-cultural background is similar to my own. 22. I sometimes would use the terms baliw, abnoy, etc., to describe people with mental illness to my co-workers.

Note: sumpa (curse), gaba (retribution from God), pasma (exposure illness), kapre (mythical tree giant), bahala na (leave it to God or come what may), baliw (crazy), abnoy (abnormal, crazy)



The researcher used the findings of this study to define "culture competency" as "the Filipino nurse's awareness, knowledge, skills, and attitude that are required to operate efficiently within the cultural context of the Filipino patient with mental health problems and their family." Instead of the original three dimensions of knowledge, skills, and attitudes, the created CCTFN contains four dimensions (factors) with 25 items or statements (see Table 5) that may be confirmed for dimensionality and structure using confirmatory factor analysis on a new sample. As part of its improvement, a scoring key to standardize the tool is proposed.

Overall, the CCTFN is valid and reliable. Because the tool is still deemed new, it requires additional research to establish the validity of the instrument among the nurses, and its use is encouraged for this reason. After all, cultural competence is a process in which nurses "constantly try to develop the ability to operate effectively within the cultural context of a client, person, family, or community" [4].

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## References

- Douglas MK, Rosenkoetter M, Pacquiao DF, *et al.* (2014) Guidelines for Implementing Culturally Competent Nursing Care. *Journal of Transcultural Nursing*, 25(2): 109–121. <https://doi.org/10.1177/1043659614520998>
- Office of Minority Health, U.S. Department of Health and Human Services. (2013) Cultural competency: What is cultural competency?
- Leininger M. (2002) Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing* 13(3): 189–192. doi: 10.1177/10459602013003005
- Campinha-Bacote J. (2003) Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing* 8:1.
- Giger J, Davidhizar R. (2008) *Transcultural nursing: Assessment and intervention* (5th ed.). Mosby, St. Louis, MO.
- Narayanasamy A. (1999) Transcultural mental health nursing. 1: Benefits and limitations. *British Journal of Nursing*, 8(10): 664–8. <https://doi.org/10.12968/bjon.1999.8.10.6605>
- Purnell L. (2002) The Purnell model for cultural competence. *Journal of Transcultural Nursing* 13: 193–196. doi: 10.1177/10459602013003006
- Alpers L-M, Hanssen I. (2013) Caring for ethnic minority patients: A mixed method study of nurses' self-assessment of cultural competency. *Nurse Education Today*, 34: 999–1004. <https://doi.org/10.1016/j.nedt.2013.12.004>
- Truong M, Paradies Y, Priest N. (2014) Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, 14(1):1–31. <https://doi.org/10.1186/1472-6963-14-99>
- UPenn Collaborative on Community Integration, National Institute on Disability and Rehabilitation Research (n.d.). Cultural competence in mental health.
- Loftin C, Hartin V, Branson M, Reyes H. (2013) Measures of cultural competence in nurses: An integrative review. *The Scientific World Journal*. <https://doi.org/10.1155/2013/289101>
- Lin CJ, Lee CK, Huang MC. (2016) Cultural competence of healthcare providers: A systematic review of assessment instruments. *The Journal of Nursing Research*, 00(0):00–00. doi:10.1097/jnr.000000000000153
- Rubio RRMA. (2019) Filipino Nurses' Attitudes and Cultural Competency in Caring for Mentally-Ill Patients: A Scoping Review. *International Journal of Caring Sciences* 12(2):798–809.
- Maravilla NMAT, Tan MJT. (2021) Philippine Mental Health Act: Just an Act? A Call to Look Into the Bi-directionality of Mental Health and Economy. *Frontiers in Psychology*, 12: 706483. <https://doi.org/10.3389/fpsyg.2021.706483>
- Department of Health. (2018) Mental Health Program.
- Department of Health. (2020) Your Mind Matters: DOH Calls for Unified Response to Mental Health.
- Martinez A, Co M, Lau J, Brown J. (2020) Filipino help-seeking for mental health problems and associated barriers and facilitators: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 55: 1397–1413. doi: 10.1007/s00127-020-01937-2
- Abad PJB, Tan ML, Baluyot MMP, *et al.* (2014) Cultural beliefs on disease causation in the Philippines: Challenge and implications in genetic counseling. *Journal of Community Genetics*, 5(4):399–407. <https://doi.org/10.1007/s12687-014-0193-1>
- Labarda CE, Chan CS. (2018) Sleep disturbances, posttraumatic stress, and psychological distress among survivors of the 2013 Super Typhoon

- Haiyan. *Psychiatry Research* 266:284-290.
20. Mueller Y, Cristofani S, Rodriguez C, *et al.* (2011) Integrating mental health into primary care for displaced populations: the experience of Mindanao, Philippines. *Conflict and Health* 5:3. doi:10.1186/1752-1505-5-3
  21. Pangandaman HK, Mala ND, Raki-in RM. (2019) Perceived psychophysiological effects of Marawi siege among internally displaced persons (IDPs) in the evacuation centers. *International Journal of Advanced Research* 7(1):573-578. <http://dx.doi.org/10.21474/IJAR01/8364>
  22. Rivera AKB, Antonio CAT. (2017) Mental health stigma among Filipinos: Time for a paradigm shift. *Philippine Journal of Health Research and Development* 21(2):20-24.
  23. Tanaka C, Tuliao MTR, Tanaka E, *et al.* (2018) A qualitative study on the stigma experienced by people with mental health problems and epilepsy in the Philippines. *BMC Psychiatry* 18:325. <https://doi.org/10.1186/s12888-018-1902-9>
  24. Official Gazette. (2018) Mental Health Act, R.A. 11036 § 2.
  25. Department of Health. (2016) Revised Operational Framework for A Comprehensive National Mental Health Program, Administrative Order No. 2016-0039.
  26. Cal B. (2018) US-based Pinoy cites Filipino nurses' contribution to global health. *Philippine News Agency*.
  27. Nursing Review. (2017) Filipino nurses: our fastest-growing nursing workforce.
  28. Pollack S. (2017, July 29) Ireland's Filipinos: caring for our young, old and sick. *The Irish Times*.
  29. de Almeida Vieira Monteiro APT, Fernandes AB. (2016) Cultural competence in mental health nursing: validity and internal consistency of the Portuguese version of the multicultural mental health awareness scale—MMHAS. *BMC Psychiatry* 16:149. doi: 10.1186/s12888-016-0848-z
  30. Cai D, Kunaviktikul W, Klunklin A, *et al.* (2017). Developing a cultural competence inventory for nurses in China. *International Nursing Review* 64(2):205-214. <https://doi.org/10.1111/inr.12350>
  31. Chae D, Park Y. (2018) Development and Cross Validation of the Short Form of the Cultural Competence Scale for Nurses. *Asian Nursing Research* 12(1):69-76. <https://doi.org/10.1016/j.anr.2018.02.004>
  32. Oh WO, Park ES, Suk MH, Im YJ. (2016) Development and Psychometric Evaluation of the Transcultural Self-efficacy Scale for Nurses. *Journal of Korean Academy of Nursing* 46(2):293-304.
  33. Songwathana P, Siriphan S. (2015) Thai Nurses' Cultural Competency in Caring for Clients Living in a Multicultural Setting. *Pacific Rim International Journal of Nursing Research* 19(1):19-31.
  34. Albougami AS. (2016) The Relationship between cultural competence levels and perceptions of patient-centered care among Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare sector (Dissertation).
  35. Alsulaimani AA. (2014) Practical competency of Filipino nurses working in Taif city, Kingdom of Saudi Arabia. *Saudi Journal for Health Sciences* 3(2):85-91.
  36. Inocian EP, Atallahb M, Mouflehc M, *et al.* (2015) Cultural competency among expatriate nurses in Saudi Arabia. *International Journal of Nursing* 4(1):58-65
  37. Soriano G., Arana, FCT, Tejada RSO. (2019) Caring Behaviors, Spiritual, and Cultural Competencies: A Holistic Approach to Nursing Care. *Bedan Research Journal* 4:98-115.
  38. Umali KB, Gutierrez AJ, Herrera AN, *et al.* (2013) Towards a culture-sensitive nursing care: Perceived cultural competence among Filipino nurses. (Undergraduate Thesis).
  39. Orina WA, Mwangi GF, Sitati RN, Nyabola F. (2015) Content analysis and a critical review of the exploratory design in the light of mixed methods research. *General Education Journal* 4(2):32-45.
  40. Fetters MD, Curry LA, Creswell JW. (2013) Achieving integration in mixed methods designs—principles and practices. *Health Services Research* 48(6 Pt 2): 2134–2156. doi: 10.1111/1475-6773.12117
  41. Kyriazos TA, Stalikas A. (2018) Applied Psychometrics: The Steps of Scale Development and Standardization Process. *Psychology* 9:2531-2560. <https://doi.org/10.4236/psych.2018.911145>
  42. Arksey H, O'Malley L. (2005) Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, 8(1): 19-32
  43. Mays N, Roberts E, Popay J. (2001) Synthesizing research evidence. In: Fulop N, Allen P, Clarke A, Black N (ed.). *Studying the Organisation and Delivery of Health Services: Research methods*. London: Routledge, pp.188–219.
  44. PRISMA. <http://www.prisma-statement.org/>
  45. DeVellis RF. (2017) *Scale Development: Theory and Applications* (4th ed.). Thousand Oaks, CA: Sage.
  46. Rodrigues IB, Adachi JD, Beattie KA, MacDermid JC. (2017) Development and validation of a new tool to measure the facilitators, barriers, and preferences to exercise in people with osteoporosis. *BMC*

- Musculoskeletal Disorders 18:540. <https://doi.org/10.1186/s12891-017-1914-5>
47. Shi J, Mo X, Sun Z. (2012) Content validity index in scale development. *Zhong Na Da Xue Xue Bao Yi Xue Ban* 37(2):152–5. doi:10.3969/j.issn.1672-7347.2012.02.007
  48. World Health Organization. (2019) NCDs | Global school-based student health survey (GSHS).
  49. Koo TK, Li MY. (2016) Guideline of selecting and reporting intraclass correlation coefficients for reliability research. *Journal of Chiropractic Medicine*, 15:155-163. <http://dx.doi.org/10.1016/j.jcm.2016.02.0121556-3707/>
  50. George D, Mallery P. (2003) SPSS for Windows step by step: A simple guide and reference. 11.0 update (4th ed.). Boston: Allyn & Bacon.
  51. Tabachnick BG, Fidell LS. (2007) *Using Multivariate Statistics* (5th ed.). New York: Allyn and Bacon.
  52. de Winter JCF, Dodou D, Wieringa PA. (2009) Exploratory factor analysis with small sample sizes. *Multivariate Behavioral Research* 44:147–181. doi: 10.1080/00273170902794206
  53. Baghdadi NA. (2014) *Cultural Competency of Nursing Faculty Teaching in Baccalaureate Nursing Programs in the U.S.* (Dissertation).
  54. Education Reform. (2014) Bloom's Taxonomy.
  55. Tan ML. (2008) *Revisiting Usog, Pasma, Kulam: Traditional theories of health and illness in the Philippines.* Quezon City: University of the Philippines Press.
  56. Tuliao A. (2014) Mental health help-seeking among Filipinos: A review of the literature. *Asia Pacific Journal of Counselling and Psychotherapy*. <https://doi.org/10.1080/21507686.2014.913641>
  57. Fogel J, Ford DE. (2005) Stigma beliefs of Asian Americans with depression in an internet sample. *Canadian Journal of Psychiatry* 50(8):470-478. doi:10.1177/070674370505000807
  58. Sanchez F, Gaw A. (2007) Mental health care of Filipino Americans. *Psychiatric Services* 58(6): 810-815. <https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2007.58.6.810>
  59. Javier JR, Supan J, Lansang A, *et al.* (2014) Preventing Filipino mental health disparities: Perspectives from adolescents, caregivers, providers, and advocates. *Asian American Journal of Psychology* 5(4):316–324.
  60. Camorongon MD. (2007) *Factors affecting help-seeking behaviors for mental health services among Filipino Americans.* Theses, Dissertations, and Projects. 432.
  61. Sherko E, Sotiri E, Lika E. (2013) Therapeutic communication. *JAHHR- European Journal of Bioethics* 4(7).
  62. United Nations Educational, Scientific and Cultural Organization. (2001) *UNESCO Universal Declaration on Cultural Diversity.*