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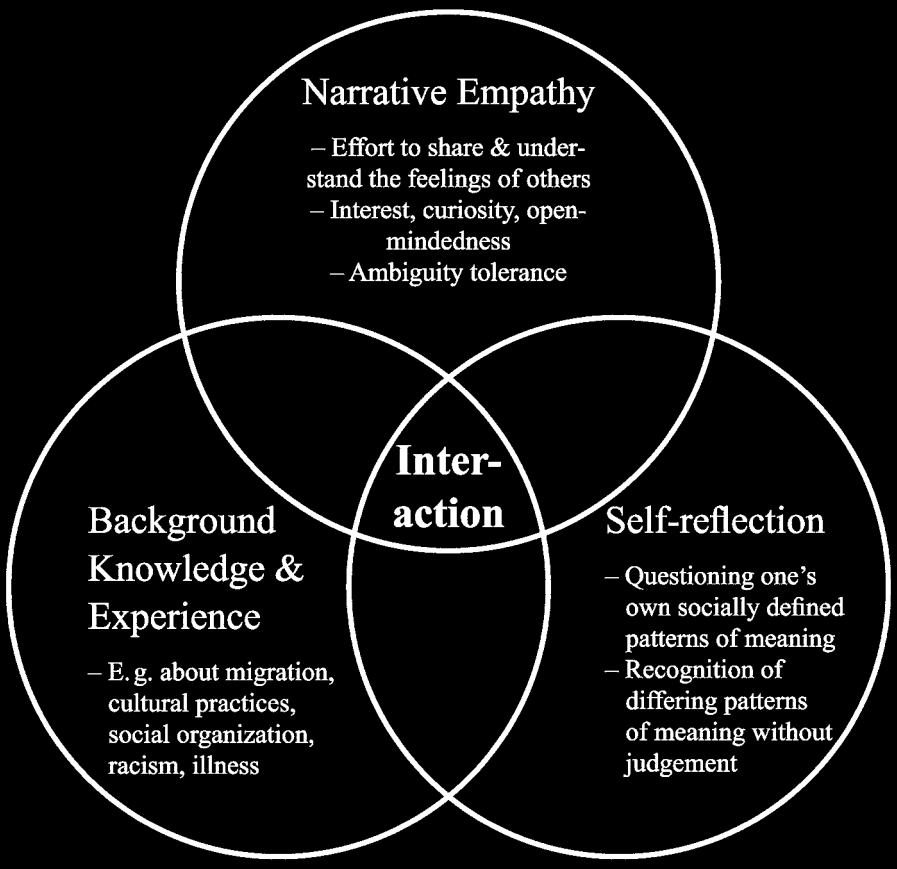

Psychologische Dimensionen in der Medizinethnologie I
Psychological Dimensions in Medical Anthropology I

Zum Titelbild/Front picture *Curare* 36(2013)4:
The figure is titles "Transcultural Competence," and is taken from p. 264 in this issue, article by Rebecca Zimmering.

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Curare 35(2012)4: Objekte sammeln, sehen und deuten. Die Sprache der Objekte
Curare 36(2013)1+2: Medizinethnologische Diskurse um Körpermodifikationen im interdisziplinären Arbeitsfeld Ethnologie und Medizin
Curare 36(2013)3: Gesundheit und Öffentlichkeit: Medizinethnologische Perspektiven

Die nächsten Hefte:
Curare 37(2014)1 Psychologische Dimensionen in der Medizinethnologie II
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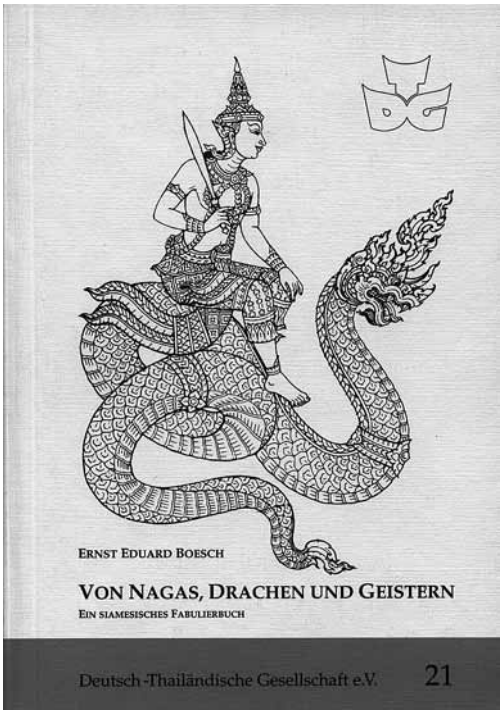

siehe Hommage an Ernst E. Boesch, S. 246–251.

The Term "Culture" in Theory and in Practice: Transcultural Competence in the German and Swiss Public Health Service*

REBECCA ZIMMERING

Abstract The starting point of this analysis is the request to base medical treatment on ethnic-cultural aspects, resulting from the rise of migration. Transcultural training courses with the goal to raise awareness to those aspects within the medical profession are the subject of the analysis. The aim is to designate the concepts of culture and their didactic conveyance, as used by the training instructors. In order to do so, partially structured expert interviews with the instructors and participant observations of their courses were conducted.

During the training sessions different medical anthropology approaches are used and the pitfalls of culturalization and structural barriers concerning patients with a migration background are discussed. This enhances caretaking based on the individual needs of every patient through the promotion of a dynamic concept of culture.

Keywords culture – interculturality/transculturality – intercultural competence – culturalization – migration – education in culture sensitive health care – non-compliance – pain articulation – medical anthropology – diversity

Der Kulturbegriff in Theorie und Praxis:
Transkulturelle Kompetenz im deutschen und im Schweizer Gesundheitswesen

Zusammenfassung Die Analyse geht von der auf Grund steigender Migration entstandenen Forderung aus, Pflege auch an ethnisch-kulturellen Aspekten zu orientieren. Gegenstand der Analyse sind Schulungen zu transkultureller Kompetenz, die Pflegepersonal dahingehend sensibilisieren wollen. Ziel ist es, den von den Kursleiterinnen zu Grunde gelegte Kulturbegriff und dessen didaktische Vermittlung zu eruieren. Dafür wurden Leitfaden gestützte Experteninterviews mit den Kursleiterinnen sowie teilnehmende Beobachtungen in entsprechenden Kursen durchgeführt. In den Schulungen werden u. a. medizinethnologische Konzepte aufgegriffen, die Gefahren der Kulturalisierung von Problemen, sowie strukturelle Barrieren bei der Versorgung von PatientInnen mit Migrationshintergrund erläutert. Diese Vorgehensweise dient dazu, ein dynamisches Kulturverständnis zu vermitteln, um eine an individuellen Bedürfnissen orientierte Pflege zu fördern.

Schlagwörter Kultur – Interkulturalität/Transkulturalität – interkulturelle Kompetenz – Kulturalisierung – Migration – Ausbildung in kultursensibler Pflege – Kommunikation – Non-Compliance – Schmerzartikulation – Medizinethnologie – Diversität

Introduction

Due to an increase of migration the share of the population with a migration background in central Europe societies increases constantly. This increase of people with different national backgrounds has underlined the plurality and homogeneity of those societies and made them more evident in many different social areas such as the public health system. Consequently, new challenges and demands arise from this "newfound" (social) plurality. In the course of the medical treatment of people with a migration background misunderstandings between patients and medical staff occur on a regular base. The medical staffs attribute these misunderstandings primarily to cultural differences between their patients and themselves (STÜLB & ADAM 2009: 90; e. g. ALBAN 1999).

Following this assumption the request to base medical treatment on ethnic-cultural aspects occurs

* *A preliminary version of this paper was presented at the Workshop 37 of the biannual conference of the German Anthropological Association (Deutsche Gesellschaft für Völkerkunde) in Vienna, September 14–17, 2011, which was titled "Wa(h)re Kultur." This AGEM-Workshop was chaired by Ruth Kutalek, Wien, and Ekkehard Schröder, Potsdam, and was titled "*Wie die Medizin auf die 'Kultur' kam. Oder: was hat Kultur mit Struktur zu tun? Medizinanthropologische Ansätze zur interkulturellen Forschung in der Medizin*."/"How 'Culture' came into Medicine. Or: What has Culture to do with Structure? Medical Anthropological Approaches for an Intercultural Research in Biomedicine."

on different institutional levels (e. g. Bundesministerium für Gesundheit 2012: 21).

Within the public and the media these challenges are met with concepts combining keywords as "inter- & transcultural competence", "intercultural opening", and in the context of the health system "cultural sensitive caretaking". To fulfil the requirements of a "cultural sensitive caretaking" external training providers offering courses teaching the above mentioned competences are needed.

Medical staff attending the training courses, which I studied, have certain expectations regarding the outcome of the courses. They require a set of specific instructions/behavioral guidelines for treating patients with certain national/ethnical/religious backgrounds based on the acquirement of country specific knowledge e. g. about lifestyle, gender roles, birth practices, diet, pain articulation and religion. The mentioned 'new demands' as well as the concepts answering them are evidently related to the concept of culture and its definition. Therefore, my research is based on the following question: *On which definitions of/concepts about culture do providers of inter- and transcultural competence training build up their seminars?*

The terms *intercultural competence* and communication can be found in German educational literature since the 1960s, focusing on the intercourse with pupils with migration background. A first concept of transcultural competence for the health sector was created around the same time in the USA by Madeleine Leininger, who combined nursing science and social anthropology (cf. her sunrise-model). Her main book was translated into German (Leininger 1998). In these years a Curare-Special Volume on "Transcultural Nursing" was published as well. The articles brought together nursing and social science on a high theoretical and applied level (Uzarewicz & Piechotta 1997). The current discourse in German-speaking countries regarding the health sectors is primarily based on the book "Transkulturelle Kompetenz Lehrbuch für Pflege-, Gesundheits- und Sozialberufe", edited by Dagmar Domenig (2001, enlarged edition 2007).

A multitude of studies concerning training courses preparing for a (temporary) stay abroad (e. g. a school year or a business trip) can be found. Finding literature within this field concentrating on the health sector, especially with an anthropological bias, is much harder. Here the publications of some of the training providers are consulted, such as ESE (association „Ethnologie in Schule und Erwachsenenbildung" in Münster) and AMIKO („Institut für Migration, Kultur und Gesundheit" der „Arbeitsgruppe Medizinethnologie und Interkulturelle Kommunikation" in Freiburg).

Theory

In order to determine the definition of culture in the training courses, statements made by the providers during interviews addressing the issue, were used. Since an intrinsic understanding of culture is given but not necessarily shown explicitly within the training sessions, it is necessary to identify topics and didactic tools pointing to it. Furthermore, the structure and the practical implementation of the observed courses were considered.

Culture: A "short" definition

As noted before, "culture" is the basic category of my research and an examination of the topic is inevitable, even though it has been discussed countless times within the social science. To shorten the debate I will only illustrate the definition of culture I concluded from my theoretical research.

—"Culture" is the basis of social order, penetrating all aspects of life (Schlehe 2006: 52).

—"Culture" can also be described as socially organized meaning and patterns of meaning (Hannerz 1995: 66). The spectrum of so-called cultural resources on which the systems of order are based, grows rapidly (Schlehe 2006: 53). This leads to the creation of an "order of differences" (Geertz 2007: 68). Culture is at the same time historical and modifiable (Dornheim 2007, Jäger 2008: 333).

—The concept of "culture" does not describe entities or autonomous totalities but is complex, dynamic and hybrid (Wicker 1996: 381, Schlehe 2006: 52). Therefore, it cannot be defined by a set of specified attributes and characteristics (Domenig 2007: 169).

—Culture might be location-dependent but that does not mean that it is bound to the location in question. Due to the formation of transcultural networks through interaction and migration, national affinities are untied (Schlehe 2006: 52). As a result *deterritorialization* becomes a new culture-dynamic and culture shaping principle (Wicker 1996: 382).

—There is culture but there are no "cultures" as in clearly defined and separable complex wholes

as described by Tylor. The closer you look at such seemingly uniform complex wholes, the more heterogeneous they turn out to be (TYLOR 1871: 1, WICKER 2002: 29). That does not mean that they do not exist, but their manifestations should not be identified as "culture(s)." "Culture" is used by those entities in order to create a closed world of symbols. It is impossible to understand or explain "complex wholes" through culture, but only through concepts which deal with social power structures or rather the power of definition. Therefore, complex wholes do not exist due to cultural similarities, but because of the strategic usage of similarities in order to create a "We-feeling"(WICKER 1996: 378, 388).

—In daily use the terms "culture" and "identity" are closely related, identity understood as something multiple and context-dependent (WICKER 2002: 30). The definition of cultural identity in this context follows Rajvinder Singh, who calls it "Self-culture". According to Singh cultural identity results from the assimilation of ones surroundings and therefore is dynamic, constantly changing and affected by the past, the present and the future (Singh 2002: 22). Thus, the individual as an indefinable factor marks the centre of the understanding of culture (UZAREWICZ 2002: 8).

Inter- and transculturality

In the context of the training concepts there is one distinction to be made closely intertwined with the discourse about culture, taking it to an application-oriented level: It is the distinction between transcultural and intercultural competence, both terms are often used interchangeably. Within the scientific discourse a controversy about the definition of both exists. Some points at issue are:

1. The aim of the training: e. g. educational acquisition or increased economic efficiency.

2. The extent to which the transferred knowledge can be generalised: country specific knowledge vs. general knowledge about social practices.

3. The basic definition of culture. (RATHJE 2006: 1)

Even though these points cannot be discussed at length here, the concept of transcultural competence by Dagmar Domenig (Fig. 1) needs to be mentioned, since it has been specifically designed for the health sector and the training courses I have observed are closely shaped according to her model. The concept combines extended social skills with a specific sensitivity for situations regarding the interaction of people in general, not only migrants. The transfer of migration-specific knowledge takes the place of the transfer of country-specific knowledge (cf. DOMENIG 2007). In practice a transcultural nursing anamnesis should be utilised. It includes questions concerning integration, origin and migration history adherent to the biography of the patients. For that reason, it has to be applied differently with every patient (DOMENIG, STAUFFER & GEORG 2007: 302f.).

Anthropological Approaches

Medical anthropology as an anthropological subdiscipline is of significance for this study, especially in the context of the use of anthropological concepts in the examined training classes. During the training sessions different medical anthropology approaches are used, such as the differentiation between "illness and disease" and the three-sector model (Fig. 2) following Kleinman: "*Disease* refers to a malfunctioning of biological and/or psychological processes, while the term *illness* refers to the psychosocial experience, and meaning of perceived diseases." Illness is understood as "the shaping of disease into behavior and experience […] created by personal, social, and cultural reactions to disease". Both concepts cannot be understood separately and outside of "particular configurations of social reality." They

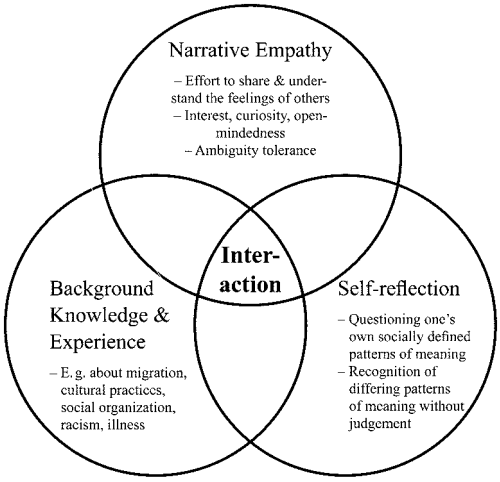

Fig. 1: Transcultural Competence (Based on DOMENIG 2007: 172–180)

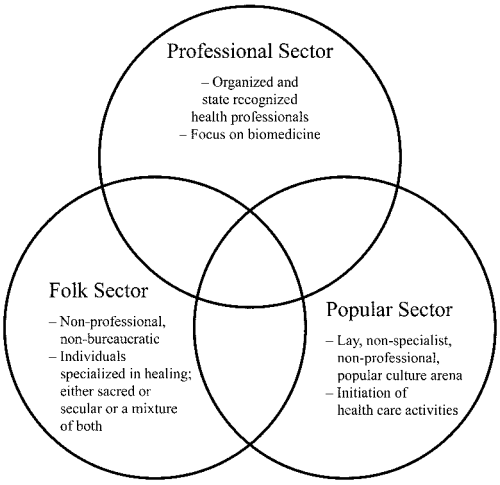

Fig. 2: The three sectors of health care (based on Kleinman 1980: 49–60)

are summarized under the term sickness (Kleinman 1980: 72f.).

According to Kleinman the health care system constitutes of three sectors (see above) between which the patients change back and forth. The biggest sector is the Popular sector and "it is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities are initiated" (Kleinman 1980: 51). Here most patients can be located and the individual ways in which patients experience the specifics of the sector determines how their so called "explanatory models" are generated. These models "offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (ibid. 105). The starting point for all considerations is the basic assumption that all people in the case of sickness react the same: People try to explain their sickness and at the same time try to integrate it into their daily life. Normally sick people name their diseases even without or independent from a diagnosis. Furthermore, all aspects of sickness, the beginning, the cause, the manifestation etc. are combined in order to create an "explanatory model" (ibid: 52, 91, and 105). The "explanatory models" of the "scientific medicine", a part of the professional sector, vary from those of the patients, because "the idioms, metaphors, and logics they employ are substantially different" of those of the lay (ibid: 107). This assessment is essential for the analysis of misunderstandings between medical staff and patients.

Cultural Dimensions

The so called cultural dimensions/standards are another approach of relevance for my research. They work on the notion that within human collectives certain habits/standards are formed and passed from generation to generation. These habits are referred to as "culture" or "cultural system" (Erll & Gymnich 2007: 20, Podsiadlowski 2004: 10). According to Klaus-Peter Hansen they can be found in the areas of communication, thinking, feeling and behaving/acting, which all interact and arise together (Hansen 2003: 45). The most well-known representatives for this approach are the social scientists Edward T. Hall and Geert Hofstede. Hall names space, time and communication as the basic dimensions for human cohabitation (cf. in Layes 2003: 63)

Hofstede developed five dimensions of which the second is the most important for this study and in which he differentiates between collectivistic and individualistic structured societies. In the first case the smallest social entity is the family (group interdependency) whereas in the second it is the individual (self-dependence). Applied to health care every patient can be counted to either one of the two and this influences the behavior in the following areas related to caretaking: social organization, the understanding of what loyalty within the family constitutes (e. g. between generations), role definitions (e. g. male and female), the way one deals with illness and how treatment and care-giving is understood (Domenig 2007b: 207f.).

Looking back at the definition of culture presented above a review of cultural dimensions is in order. One major critic point is that a package of standards is being generalized and transferred onto a national level, implying a static understanding of culture. Dagmar Domenig sees the danger of nations and consequently their citizens being permanently classified as either collectivists or individualist, ignoring individual manifestations of the concepts. She only considers the distinction useful for identifying differences e. g. concerning values and self-understanding, if applied intra-individually rather than between nations or persons. Otherwise she sees the danger of enforcing stereotypical thinking and

categorizing (DOMENIG 2007b: 208f.). Nonetheless cultural dimensions, especially Hofstede's second dimension were part of all the examined training courses.

Migration, Culturalization and the Public health system

For this study it was also necessary to take a closer look at the reciprocity of migration, health, illness and the health system in the country of arrival. Again the question of the significance of 'culture' arises (VERWEY 2003: 279).

The personal review of daily routine situations is based on the background, experiences and enculturation of the member of staff who encounters them. The patients' backgrounds, experiences and enculturation differ from the staffs', so their reviews of the same situations are likely to differ as well. These different ways of "experiencing" daily routine situations are followed by assumptions of the staff about the "nature" of illness of patients with migration background[1].

Terms used on a regular base to describe illness of migrants are non-compliance, multi-morbidity and exaggerated pain articulation:

Patients not following the instructions given by the medical staff are perceived as being intentionally non-compliant, but in most cases the patients, allochthonous and autochthonous alike, do not carry out the instructions not because they are consciously troublesome, but for a lack of linguistic and/or contextual understanding. Making sense to the language of doctors is difficult for most patients, if missing language skills and a different "shaping of illness" are added, a higher rate of "non-compliance" is the consequence which might, but must not necessarily apply to patients with migration background (cf. EBERDING & SCHLIPPE 2005).

The impression that migrants have a higher morbidity is related to them often expressing an "everything-broken-condition" (STÜLB & ADAM 2005: 112) and culturally influenced ways of locating and expressing pain (DIETZEL-PAPAKYRIAKOU & OLBERMANN 2005: 289). Partly due to poor data conditions a higher morbidity rate of migrants cannot be proved. Furthermore, distinguishing between migration-specific and class-specific causes of morbidity is very difficult. Generally it is more constructive to focus on individual life situations in order to procure health, rather than to distinguish between ethnic groups.

A great number of health risks are socioeconomically induced and do not only affect migrants (WIEDL & MARSCHALCK 2005: 22, WEISS 2005: 13, 43). On the one hand this illustrates why and how "culture" is of relevance for the topic. On the other hand it unmasks the social phenomenon of culturalization and its specification within the health system. There the perception of culture is defined by structural conditions such as time pressure and dealing with the topic "culture" is consistently seen as an additional working burden. In combination with missing problem-solving strategies this might lead to resignation, aggressiveness and "knowing incompetence", the refusal of giving adequate care (HABERMANN 1998: 156f.). The danger here is the shifting of internal social deficits and deficits of the public health system to the population with migration background, which inevitably leads to discrimination and discriminatory access conditions. Furthermore, it can be noted that the social stratification is frequently apprehended as an ethnical stratification, due to the fact that migrants are often located at the lower end of the social scale. Therefore, problems of the lower social strata such as high unemployment, criminal and morbidity rates are not interpreted as class-specific but cultural bound. This line of argument constitutes a culturalization of the sources of the problems, often deliberately used to avert from internal social deficits. The consequences are a magnification of prejudices' and an unfavourable starting point for medical treatment (WICKER 2007: 57).

Nonetheless, it becomes evident that 'culture' does play a role regarding the treatment of patients and that it is necessary to take the individual socioeconomic situation and the structural context of all patients, not just migrants, into account. The focus of considerations regarding the care of patients with migration background should be structural risks and social health-risks, in order to avoid negative connoted culturalization (VERWEY 2003: 279, 2006: 217). This assumption constitutes the basis of the training courses featured in my research.

Research Methods and Setting

In the course of my research I combined various methods, such as partially structured expert interviews (ten interviews), participant observation (nine

training sessions varying between one and three days), informal conversation and literature analysis. All the training courses I observed were exclusively visited by nursing staff or nursing staff in training in South-Germany and Switzerland. Only one course was on an entirely voluntary base. More than one training provider tried to reach doctors as well but failed either because they did not see a necessity for the training or because of structural barriers, such as time, funding and missing accreditations to give credit points. Of the ten informants I interviewed and / or observed during their courses five hold a degree in social anthropology, five did or still do work as nurses and one studied medicine.

Findings

The following part outlines a small selection of the topics and didactic tools the training providers are using.

Addressing Culture: Since the basis of the training courses is "culture", I will first give an overview about how the training providers handle "culture" on a theoretical level.

A number of keywords can be identified regarding the principal understanding of culture: deconstruction; self-reflection, diversity, dynamic and process-oriented, individuality, socialization, stereotypes and behavioral rules. To summarize, the elementary definition of culture taught by the training instructors is as follows: Culture is located in-between the individual and the collective, i. e. each individual has its own culture and its own system of order and meaning. Nevertheless, there are social, political and ethnic collectives which, due to the history of the term "culture", are alleged to have a common culture. By moving away from the examination of the macro level such as the state, and taking a closer look at the micro level of the individual, stereotypical collective identities lose their meaning. "Culture" therefore is defined by personal experiences, socialization and care taking should be defined likewise, taking the biography and living conditions of the patients into consideration without being limited by thinking in national and/or ethnical categories. Therefore, the system of meaning understood as the culture of individuals is constantly undergoing changes, due to new experiences made in daily life, e. g. in the process of migration.

National Stereotypes and Migration

At the beginning of the courses the providers make clear that the repeatedly expressed request of the participants for country-specific codes of behavior will not be answered. The instructors illustrate their reasoning in different ways, one being the examination of stereotypes. They ask participants to reflect about existing stereotypes of their own nationality and to what extent these apply to themselves. Rather than concentrating on specific nationalities all of the observed training sessions focused on migration. Facts and numbers of different groups of migrants in Germany and Switzerland and the influence migration can have on life in general and on health in particular are discussed.

This focusing is a result of different goals and ideas: On the one hand the background knowledge about the ways, reasons and conditions of migration is supposed to increase the understanding of and the empathy for migrants. On the other hand individual biographies of migrants are used to underline the necessity to take the patients individual background and biographies into consideration. It is necessary to show that everybody has his or her own story to tell which needs to be contextualised and that migration might be one of many contexts'. At the same time the experiences of nursing staff regarding patients with migration background, are taken into consideration.

The usage of anthropological knowledge

The prensentation of the above mentioned (medical) anthropological topics can vary. On one hand they can be explained on a general theoretical base, on the other hand specific examples for other concepts regarding e. g. illness, health and body can be presented. The important deduction being, as taught by the observed instructors, that even though the starting point of the creation of explanatory models as described by Kleinman (see above) is the same for everyone, its contextualisation and ascription of meaning might not.

In the course of treatment and during diagnostics, incomprehensible localisations of pain and the different naming of diseases by patients with migration background create communication difficulties. In more than one course disease patterns such as "fallen navel", "loss of soul", disease by ancestor spirits, disease as a punishment by God

and the "evil eye" are used in order to illustrate different perceptions of diseases. The illustrations of those disease patterns are—knowingly—used as an exoticization and alienation, in order to show that one's own explanatory models cannot be applied universally. Two instructors explained their intention being to show that there is one's own world and many different others as well—a diversity, our ideas about health and sickness just being some of many. The alienation is meant to lead to the realization of a general diversity and a new view on "the familiar". It is meant to broaden the horizon of the participants beyond their own experiences, values and understanding of culture in general and health and sickness in particular. Like with the transfer of background knowledge about migration an increase of empathy is the wished-for effect (cf. STÜLB & ADAM 2009b: 51). As already mentioned the ways in which pain is expressed especially by patients with Mediterranean origin is often mentioned and problematized by the nursing staff. Terms to describe their as exaggerated perceived pain articulations are: "Mamma-Mia-Syndrome", "Morbus Mediterraneus", "Morbus Bosporus" and "Mediterranean-Syndrome", which is critically analysed by BUNGE (2004). Learning that how one expresses pain is part of socialization and part of once own understanding of illness allows a change of perspective. Another device used by one of the providers to achieve such a change are the so called "Multi-Perspective-Cases" in which work situations are described from the point of view of all the stakeholders involved in the field (e. g. patient, doctor, nurse, family members). The described situation (e. g. an Italian patient articulating pain, and how the staff deals with it) is simulated by the participants. By actually having to put themselves in the position of somebody else, the participants are encouraged to reflect their own behavior and empathise with others.[2]

The usage of Cultural Dimensions

Other reoccurring incidents of everyday work which can be linked to cultural dimensions are addressed by the training instructors as well:

Visitation: Related to the assumed need of rest for recovery, medical staff is often unable to cope with a great number of visitors. The question of how to do justice to all the patients' needs without showing preference for one over the other can create unease regarding the assumed 'cause' of the problem: The visitors and the patient they visit.

Social organization: In the context of migration the relations between men and women and between different generations are often seen as conflictual and problematic.

These two subject areas are discussed with regard to Hofstede's second dimension. The instructors illustrate that in collectivistic societies the family and being surrounded by a great number of people is part of getting well. They also point out that in different health systems the family plays a big part in caretaking, e.g. due to a different definition of the nursing profession, e.g. their duties and responsibilities.

Nonetheless the instructors demonstrate that most individuals are neither 100% collectivistic nor 100% individualistic by asking the participants to assign themselves to either one of the concepts. Most participants locate themselves somewhere in between, some closer to collectivistic and others to individualistic. Thus proving the necessity to talk to the patients, asking them what they need for their recovery.

One last area in which culture tends to be perceived as problematic will be addressed: *Time management:* Patients with migration background who fail to keep their appointment or demand immediate treatment after being late, are perceived as being disrespectful and/or insolent. One of the providers pointed out a fundamental argument, which has been made by all the instructors in one way or another during training-sessions: Taking certain behavior as personal is likely to create a conflict. Most likely the behavior apprehended as disrespectful is not meant to be so, far more probable the person behaving that way has a different understanding of the situation. The person in question might not consider being late as impolite, not considering waiting time as wasted due to a different notion of time management.[3]

Conclusion

The perception of culture in professional day-to-day life is governed by "psychological strain", mainly due to missing problem-solving strategies and structural shortcomings. As a result culture is experienced from a problem-orientated point of view and seen as an additional working-burden rather than being appreciated as a challenge and a way of

gaining new experience. Consequently, so called problems caused by patients with a migration background cannot only be traced back to the culture/country of origin, but are also a result of interactions within the respective resident society (Weiss 2005: 64).

Nevertheless, it is essential to consider that if problems within professional day-to-day life occur, structural conditions often are neglected and the focus lies on the competencies of the staff. Hence, problems become the personal responsibility of the nursing staff, ignoring the fact that there are limitations to competence-building and individual options for action. Therefore, the institutional self-understanding of the public health system has to change, aiming at a transcultural opening on all levels (Sprung 2007: 315f.)

In view of this, training instructors are facing the problem of balancing two partly contradicting maxims: Efficiency increase and promotion of personality development.

Acquiring transcultural competence is a permanent process without the guarantee of establishing certainty. During that process there are no detours, no going astray and no useless costs. Evidently that makes the economic benefit of the training courses hard to proof. Thus, training instructors have to face structural barriers such as lack of time, budget and resources but also (institutional) racism and power structures (Sprung 2007: 320f.)

Another challenge to be mastered by the instructors concerns the following: It is the balance between recognizing and deconstructing the concept of culture. All training instructors are making active and successful efforts to deconstruct the classic, separatist and deindividualizing understanding of culture but are simultaneously unfolding a fundamental dilemma: On the one hand the construct of culture in its classic definition is supposed to be deconstructed. On the other hand it remains to be the basic/key concept. Consequently, the category "culture" which is meant to be disintegrated by the instructors is (re)constructed by them at the same time. This balancing act between deconstruction and construction embodies the difficulty of linking theory and practice. Regarding the transmission from theory to practice the crucial point is the handling and presentation of so called cultural collectives and their associated stereotypes.

In order to avoid the thinking in national and ethnical stereotypes the instructors focus on migration-specific rather than country-specific knowledge. Looking into migration processes enables training instructors to discuss the conditions in the arrival country as well as various factors affecting the large, heterogeneous group of migrants. In the context of the public health system the topic "migration" is especially relevant, because it comprises numerous health related aspects. Here the general objective is to exchange group-specific knowledge (e. g. national categories) with general knowledge about social processes or life defining habits, such as religion. For the broader the range of knowledge about different possible interpretations of social phenomena, the more open one becomes to the all-encompassing diversity one encounters in day-to-day situations (cf. Uzarewicz 2002: 12).

Nonetheless, cultural dimensions as described by Edward T. Hall (1996) and Geert Hofstede (1993) are used in the course of the training but instead of being described as characteristic of the whole (national) collective, they are broken down to the individual, in order to counteract the fixation of culturalized differences. The overall goal for caretaking thereby being defined as to focus on the individual needs of every patient, looking beyond their nationality and their associated needs and behavioral rules, aiming at the communication of general coping skills rather than culture/nation bound coping skills. Now the impression could arise that training courses directed at migrant-specific care are obsolete, given that the primary objective can be identified as a situation based, individual care taking, which is included in the key qualifications of nursing professions, making it a general coping skill rather than one requiring a migrant-specific competence (Adam & Stülb 2009: 93). However, the contemporary social circumstances acquire to define and demand this kind of coping skills within a certain setting, a mainstreaming thus being "migration". Until these kinds of coping skills become a matter of course such mainstreaming and contextualization remains necessary (ibid). It is still a long way to go and a lot of work in different social areas has to be done, showing an enormous need for training on transcultural competence with varying field-specific focuses.

As my research showed the most important aspect considering the understanding of culture of the

instructors is the above discussed detachment from national categories and cultural dimensions. The term transculturality as defined by Wolfgang Welsch (1994, 2005, 2010) does that detachment on a theoretical base and as such marks within my research the defining difference of intercultural and transcultural competence.

Having found a personal distinction still does not enable me to match the observed courses to either one, because the linguistic and contextual discrepancies remain and the on-going scientific discourses also differ from country to country. Furthermore, training providers have to balance between the diverging scientific and public discourse and at the same time have to meet the market demand for training courses. Any scientific discourse, especially an application-oriented one, has to take the social discourse into account. The term "culture" is omnipresent and is used in everyday speech. The day to day usages of the term are significant, because our understanding of culture is formed by the way in which we live it (UZAREWICZ 2002: 3).

Condensed it can be said that a distinction between both competence can neither linguistically nor with regards to context generally be made, since both depend on market demand, general objective and the basic definition of culture. So "culture" will remain a concept in need of clarification. Social anthropologists can partake in this quest by teaching social and "cultural pragmatics" (WIMMER 1996: 419) in order to enable people to see themselves through the eyes of "the alien" (PLATENKAMP 2004: 31) by reflecting and questioning their own certainties and habits, finally being able to understand what "cultural constellations" (SCHLEHE 2006: 56) their partners of interaction embody.

Notes

1 The making of assumptions goes both ways, the assumptions of the patients being ignored at this point.

2 These "Multi-Perspective-Cases" were authored (and named) by AMIKO. In order to increase the empathy of the participants they are written from the point of view of the stakeholders involved.

3 One training participant described how he/she sometimes feels like a dust mop, being put into the cupboard and out again as fancied. He/she actually expressed relieve after this part of the lesson, saying that in future in a similar situation he/she will not take it personal anymore, reacting less annoyed.

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