Care Theoretical Approaches on Migrants

To reflect on the care approach to people from other cultures, it is important to introduce a few theorist who study about this specific context. Some of them are from the Nursing field, but the way they talk about the care approach could be useful for all the health professionals.

In fact, the naked human being doesn't exist: each person has to be conceived in his own cultural system (Cattaneo, 2003). This concept introduces the relation patient-nurse as an encounter between two different cultural universes. These ones contain different values, symbols, and acts through which any individual explains and organizes his own life experiences (Diasio, 1995).

Each time this encounter happens, five different kind of barriers could interfere with the interaction patient-professional.

1) Pre-linguistic level: it considers the inability of the patient to express her/himself and her/his illness' experience;
2) Linguistic level: it is related to the different spoken languages;
3) Meta-linguistic: it considers the symbolic meaning of words which is mainly related to the own culture;
4) Cultural level: it considers all the elements related to the natural acquisition of the belonging culture;
5) Meta-cultural level: it is related to the values' dimension and to the own life's view (Colasanti e Geraci, 1995).

The consciousness of this possible obstacles in the comprehension of the *other* is really useful to build an effective relationship with the patient.

Nursing, the other health scineces, as well as Anthropology, starts from the basic assumption that the human being is an open and integrated system, always in interaction with the environment (Manara, 2004).

One of the Nursing theorist, who considers the connection between these two sciences, is **Marie Françoise Colliere** (1930-2005). She describes each care scenario as something in which the person is included in her/his environment which needs to be always considered.

Madeleine Leininger (1925-2012) introduces the concept of *Transcultural Nursing*, described as a Nursing field which starts from the comparative study of the different cultures, in relation to the care activities, to guarantee an effective caring, and to guarantee the respect of the patient cultural values (Leininger, 2004). Leininger elaborated the *Theory of culture care diversity and universality*: even if care is a universal phenomenon, the related models, expressions and processes changes in each culture. That's why a nurse should be able to provide a culturally competent care, respecting the elements of each specific culture care (Manara, 2004).

The Leininger's theory is represented with the Sunrise Model, created to catch the meaning of health and care in each culture. It is made by four interdependent levels representing the factors which influence the health and the care, in the different cultures. The first three levels give the knowledge necessary to provide a culturally competent care, while the last one represent the operative part with the decision making process (*Ibidem*).

The main principles of the transcultural care are following described.

1) The care activities have to be supported by a transcultural knowledge.
2) The nursing care plan has to considerate the different values, beliefs, and care models, specific to each culture.
3) The transcultural care knowledge is fundamental to provide a congruent and quality care.
4) The respect of cultural beliefs, values, and practices in the health care is a human right.
5) The nursing decision making should be driven by the patient's cultural values, meanings and models.
6) Before using the nursing assessment data, it is recommended to evaluate and understand the traditional models of care and cure (emic), together with the conventional ones (ethics).
7) The transcultural Nursing required to first be awareness of the own cultural universe, and of the way to approach the different cultures.
8) The transcultural Nursing starts from the knowledge of the cultures' similarities and differences to provide an evidence based humanistic care (Stievano, 2006).

Josepha Campinha-Bacote interprets the cultural competence as a becoming process in which the health care professional try to juggle the different cultural backgrounds. The cultural competence is described as an integration of five elements:

1) Cultural awareness as a result of a deep knowledge of the own cultural background, and of own stereotypes and prejudices;
2) Cultural knowledge of other ethnical groups, in terms of health believes, and values, relevant diseases, and biological differences;
3) Cultural skills to provide a cultural assessment;
4) Cultural encounter requests a real involvement of the nurse in the intercultural interaction, to manage stereotype and prejudice;
5) Cultural desire which means the nurse motivation toward the cultural competence. It starts from the intention to be open, and it includes the determination in respecting differences (Campinha-Bacote, 2002).

The **cultural competence** is a combination of behaviours, attitudes and politics to work in an efficient way, in an intercultural context (Cross et al., 1989). It represents the skill to effectively operate in a context characterized by different values, beliefs, and behaviours (Chiarenza, 2012).

To evaluate the cultural competence, Campinha-Bacote suggests the professionals to reflect on the following elements, presented with the acronym *ASKED*:

1) *Awareness*: am I consciousness of my pre-concepts/prejudices?
2) *Skill*: do I have the skill to collect data for a culturally sensitive assessment?
3) *Knowledge*: do I have enough knowledge about other cultures' views?
4) *Encounter*: am I able to interact with people coming from different cultures?
5) *Desire*: do I really desire to be culturally competent?

Campinha-Bacote describes her models as a volcano to shows the eruption of the desire till the influence of each care interventions.

Milton J. Bennett developed the Dynamic Model of Intercultural sensitivity, introducing the continuative cultural experience as a precondition to develop the cultural competence. Each person has her/his world vision through which people manage the relationships. Developing the cultural sensitivity means to recognize and respect different visions. The model has six steps which describe a change of perception and relation with the differences (Hammer et al, 2003). The first three steps have an ethnocentric orientation, the last ones are ethno-related (Gillert, 2000).

1) **Negation** of the cultural difference: the individual perceives his own culture as unique and real, refusing any other world view. It could act with isolation or discrimination forms.
2) **Defence** from cultural differences, perceived as real, but stereotyped. The individual sees his own culture above all the other ones, and he feels threatened by the diversities. His world view divided in a really strongly way the ingroup and the outgroup.
3) **Minimization** of the cultural difference: in this step differences are dumbed down, or idealised, anyway there's a try to ignore the differences.
4) **Acceptation** of the cultural difference with a new curiosity toward the other world views, which are respected and accepted, even considering the values' differences.
5) **Adaptation** to the cultural difference, trying to change the own world vision, and trying to acquire new values and behaviours, as an evolution of the human being.

6) **Integration** of the cultural difference with a reconstruction of the own identity, and a reduction of the cultural schemes which categorize the differences (Bennet, 1993).

All these theories could be considered as a **transcultural approach** principally focused on the culture of belongings.

Another kind of approach is called **intercultural**: it studies the influence that the cultural imprinting has in the perception of the people needs, and in the related care answer. This approach is above the concept of integration: the focus is not the culture, but people as interpreter of her/his own culture. The culture is considered a net of meanings which let the coexistence of different cultures, able to talk and to understand each-other, in a new vision of the culture as a process, instead of a product (Manara, 2004). The individuality of the human being, core element of the Nursing, becomes the main care object. The outcome of this approach is the real knowledge and the comprehension of the other.

The intercultural model defines three difference kind of competences, following described.

1) The cultural competence is related to the own cultural identity which expresses the behaviour of the own group.
2) The individual competence is related to the perception of the health need and of the competences able to answer it.
3) The disciplinary competence is the combination of art and science (WHO, 1978), resulting from the using of the evidence based practices, the own experience, and the relationship skills (Manara, 2004).

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