Co-funded by the
Erasmus+ Programme
of the European Union

INTERCULTURAL CARE IN THE SOCIAL AND HEALTHCARE SECTOR (I-CARE)

MODULE 6: PREGNANCY, PARENTHOOD, CHILDREN, FAMILY STRUCTURES

www.i-care-project.net

Co-funded by the
Erasmus+ Programme
of the European Union

Project Information

Project title:	**INTERCULTURAL CARE IN THE SOCIAL AND HEALTHCARE SECTOR (I-CARE)**
Project number:	2019-1-UK01-KA202-061433
Sub-programme or KA:	Key Action 2: Cooperation for innovation and the exchange of good practices
Authoring partner:	Blinc and BUPNET
Date of preparation:	June 2021

Introduction

This module aims at developing skills to work with diverse families across cultures. There are different cultural approaches to 'what a family is' and to what is 'good parenting'. This module enables you to think about this from different cultural perspectives. It covers aspects of pregnancy, giving birth and the different approaches to childhood. It also explores culturally different views of what is good parenting, and how children grow up in diverse family settings and what this means to social and health care professionals when working with these families.

Module Aims and Objectives

The purpose of this module is for learners to:

- Get to know cultural differences around the topics of pregnancy, parenthood, childhood and family structures
- Learn how to give support in a culturally sensitive way to (expecting) parents, children, and families

Learning Outcomes

After studying this module, you will be able to:

- Work with (expecting) parents, children, and families in a culturally sensitive way
- Support inclusion of diverse families
- Understand the dynamics of violence within families across cultures
- Avoid cultural bias

Understanding, Skills and Competences developed:

Intercultural competence and Communication competence

Training method applied/ What you have to do:

This module is available as e-learning and can be taught in a classroom or on a virtual platform.
It consists of:

- Reading background information on the subject of the module.
- Self-reflection and group work activities
- A case study on a good practice example

Further Reading

You will also find a range of supporting resource materials for further information, available in the **I-CARE Toolbox** and on the **I-CARE App.**

KEY TO SYMBOLS

	ACTIVITY		TRAINER'S NOTES		SUMMARY
	TRAINER INPUT		ACTION PLAN		

Section 1: Pregnancy and giving birth in different cultures

Trainer input (slide 4, 5, 6, 7, 8)

'Turkish mothers are advised not to leave the house for 40 days after giving birth.'Gönül Y.

'Many Turks believe that cutting the mothers hair will cut the babies life.' Güler Y.

'In Turkey it is commonly said that if a pregnant woman looks at pretty things, the baby will take on unpleasant characteristics.' Erkan Ö.

'In China women are commonly advised not to eat food that is too hot or too cold in order to keep Ying and Yang in balance' Mailin H.

'In Korea the older women often think that they can predict the baby's gender from the shape of the pregnant belly.' Sumi P.

'In Ireland pregnant women commonly wear a medal of their patron saint in order to protect them from evil 'Beth M.

'Russian expectant mothers are advised not to sleep on their back.' Vera I.

Different cultures have different values, beliefs and practices in connection with pregnancy and giving birth. A woman's cultural background can affect her needs and expectations during pregnancy and childbirth, as well as how she and her family take care of a baby.

Many women believe it is important to follow the traditional pregnancy and birth practices of their culture. Often these practices are deeply rooted in the family and cultural traditions.

For example:

- How a pregnant woman should behave (what to eat, what to do etc.)
- How giving birth should take place (where it should take place, who should be there to support the woman; in some cultures, this would be the father whereas in others it would be a woman from the family.
- What to do to take care of the baby immediately after it is born: (who will hold it, any religious rituals to follow?)
- What arrangements follow in the days and weeks after the birth: role of relatives, any religious practices, role of the grandmother?)

Fatima from Syria*:* 'In our family, women are very well cared for during pregnancy, especially by their mother and mother-in-law. They play a more important role than the husband during this time. I also did not want my husband to be present when giving birth but preferred to have my mother present. She also whispered the Muslim call to prayer in my daughter's ear right after she was born. And she made sure that my baby did not meet the evil eye. For this we cover the baby's head with a fine cloth. I also liked that my mother took such good care of me after the birth. The fact that the whole extended family took such an interest in me and had so much advice for me was sometimes nice, but sometimes it made me upset, especially during the time I had to get used to breastfeeding and I was still quite exhausted in the first few days after the birth.'

This statement expresses that traditions and cultural practices may provide security but may cause anxiety. Angela Garbes describes this conflict:

'…look at the way motherhood is typically portrayed in popular movies and television shows. In American culture motherhood is inextricably tied to the language of morality. Over and over, the message reinforced to expecting mothers is that there's a "right" and a "wrong" way to do things: You are supposedly a "good mum" if you abstain from caffeine and alcohol while pregnant, don't gain excess weight, plan a so-called natural birth (…), breast-feed for at least a year and glow with happiness throughout the whole process. You are a "bad mom" if you have the occasional glass of wine during pregnancy, experience anxiety or ambivalence about having a baby, look forward to an epidural, feed your baby formula, (…). This cultural standard is so well established that we even joke about it, proudly proclaiming ourselves "bad mums" when we stray from these expectations.' *(Angela Garbes 2018, p.5)*

What to do in pregnancy can vary from culture to culture. Michaela Schönhoft reports on her experiences in her book "Kindheiten" ("Childhoods"):

'During my pregnancy care my doctor gave me a list of forbidden food. On the top of the list there was cheese made from raw milk. When I dared to buy it , the saleswomen were hesitant to give it to me. Whereas in France, where Camembert is produced, pregnant women are usually allowed to eat this kind of cheese without getting a punishing stare. Though here it is common to keep away from raw salad when being pregnant. In Guatemala pregnant women are advised not to go out when the sun is at its' highest, or it is full moon. In New Guinea it is forbidden for a pregnant woman to eat meat from marsupials. In Mali pregnant women should not stoop when fetching water.'

Schönhoft p.27 f, translated to English by the I-Care project

Trainer's notes (slide 9)

Divide the group into small groups and ask them to discuss the different cultural practises they have expereinced or that they have seen or heard about for pregnant women and giving birth. Ask them to identify 3 of these from their discussions to present back to the group.

Activity (slide 9)

What cultural practices with regard to pregnancy and giving birth have you come across at your workplace when working with diverse families?

Identify 3 practises that are different from those in your own culture.

Trainer input (slide 10, 11, 12)

If there are so many differences, what can we do to advise and support the women?

- Try to be conscious about your own 'moral standards' and do not necessarily apply those to your patients/clients.
- Try to avoid giving advice about what is 'right' or 'wrong'
- Instead try to find out what the mother really needs, what makes her feel safe and what makes her feel insecure?
- Bear in mind that some cultural norms are so deeply rooted in your own life, that you might subconsciously influence the woman's perceptions and expectations – so give room for open communication, make the woman think about her needs and encourage her to verbalise them, show openness for anything that may be different from your own cultural practices.
- Do not underestimate the power of non-verbal communication – your gestures can convey at lot.

Another aspect which has to be considered especially when dealing women from other cultures is that they may be less likely to seek support or to use maternity and other health care services. The potential reasons for this include:

- a lack of awareness of the services available
- doubt about their eligibility to access these services
- fear about the cost of services
- Language barriers and a lack of interpreting services
- the participation of men in group sessions
- lack of trust of some services (e.g. mental health services)

What you can do:

- Inform women about the available services and their eligibility for these services
- Discuss the purpose of referrals and potential benefits of attending
- Inform about the costs of these services, if any. If these services are subsidised or free, emphasise this
- Inform women when, where and how they can seek emergency care, specialist examination, education classes (childbirth, diabetes) and other information
- Ask if the woman requires assistance with booking appointments
- Try to elicit any potential reasons for refusal to use certain services.

The above mentioned tips have been provided by Katie Vasey and Lenore Manderson, Social Science and Health Research Unit, School of Psychology, Psychiatry and Psychological Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University.
https://research.monash.edu/en/publications/cultural-dimensions-of-pregnancy-birth-and-post-natal-care

Section 2: Families and intergenerational relations

Trainer input -Families (slide 14)

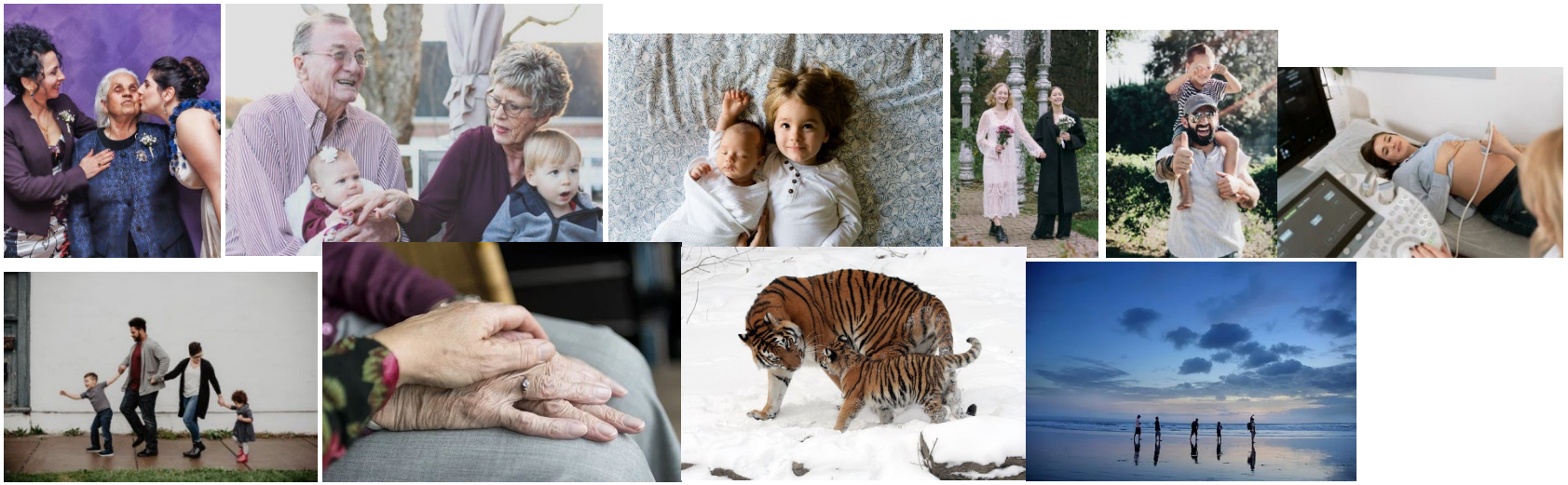
The family is the most important agent of socialisation. Mothers and fathers, siblings, and grandparents, plus members of an extended family, all teach their children what they need to know. However, families do not socialise children in a vacuum. The cultural context in which a family is embedded plays a significant role in socialisation. Within different cultures there will be different perceptions about what a family is, what its functions are and who belongs to a family.

Trainer's notes (slide 14, 15,)

Ask the learners to look at the different pictures and decide which ones they would say were a family. Ask them for their choices and why they have chosen these ones. The pictures have not been numbered because it is important for the learners to have to describe what they are choosing.

Activity (slide 15)

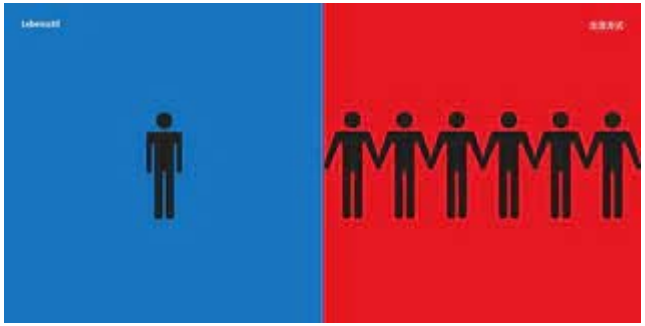
Look at the pictures on the slide and decide which ones you think best depict a family and why you have chosen those pictures.



Trainer input (slide 16,
Some definitions of family.

The family is a social group characterized by common residence, economic cooperation and reproduction. It includes adults of both sexes, at least two of whom maintain a socially approved sexual relationship, and one or more children, own or adopted, of the sexually cohabiting couple (Murdock, 1949 quoted in Steel, Kidd, & Brown, 2012, p. 2).
A network of related kin (Goldthorpe, 1987 quoted in Steel et al., 2012, p. 3).
A group of persons directly linked by kin connections, adult members of which assume responsibility of caring for children (Giddens 1993 quoted in Steel et al., 2012, p. 2).
Steel, L., Kidd, W., & Brown, A. (2012). The family (2nd ed.). Houndmills, Basingstoke England: Palgrave MacMillan.

Concepts of families differ depending on the time period, and also in different cultures. Yang Liu describes the way people live together in different cultures



Picture: "Lifestyle" from Yang Liu from the book "East meets West"

Trainer's notes (slide 17)

Divide the group into pairs and ask them to interpret the drawings from their own cultural viewpoint and then ask each group to present their views on one of the pictures.

Trainer input (slide 18, 19, 20, 21)

In the pictures "lifestyle" two different ways of living are illustrated. On the one hand in many "western" cultures people tend to live in a much individualised way. Many people live on their own or in small families together. The focus is more on individual happiness than on the happiness of the

groups in which people live together. For example, in many families in the “western” world it is taken for granted that children move to another city once they are grown up to live their own life and focus their career rather than taking care of their family

In contrast there are many other cultures where people tend to live in larger families or communities who are very closely connected and often depending on each other.

Hofstede describes the first as ‘individualism’ and the other as ‘collectivism’. What is significant is whether people´s self-image is defined in terms of “I” or “We”. In Individualist societies people are supposed to look after themselves and their direct family only. In Collectivist societies people belong to ‘in groups’ that take care of them in exchange for loyalty.” (www.hofstede-insights.com)

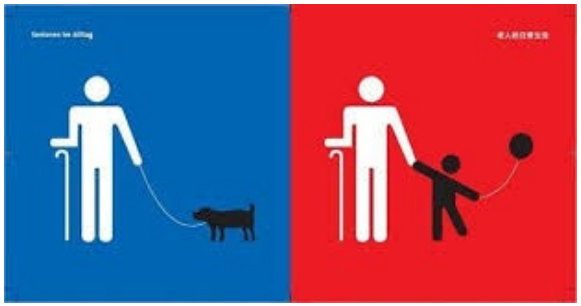
Dagmar Domenig has another expression for this cultural difference. She differentiates between individual-centred and family-centred societies (Domenig p.216).

Heidi Keller (2011) describes similar differences based on her research about different family relations. She developed two prototype models of relations towards children that are connected to different cultural contexts:

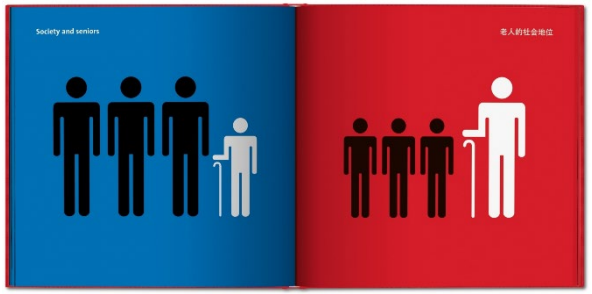
Prototype: Psychological autonomy	**Prototype: Relational attachment**
Accepting children how they are	Family relationships are the focus
Perception of children`s needs and wishes	Children take over relevant tasks within the family
Offer possibilities to develop own skills and competences	Children are embedded in a system of expectations and duties
Respect boundaries of the child	Parents are the experts who know what is best for their children
Praise and appreciation are expressed towards the child	
Equal rights model: questions are asked, and opportunities are offered	

In most cases we will not find pure forms of these “prototypes”, but mixed forms. Though Keller states that it is more likely to find more elements of the “attachment-oriented” prototype in rural areas and more elements of the “autonomy-oriented’’ prototype in urban areas of the Western world. (Heidi Keller 2011: Kinderalltag).

Older people in families:



Yang Liu (2010): Seniors in every-day life



Yang Liu (2010): Society and seniors

- In the two pictures Yang Liu illustrates different kinds of intergenerational relationships which might be related to different cultural backgrounds. Older people might play a “bigger” role in some cultures.
- This is also expressed in the picture of everyday life. Depending on the cultural background, older people can play an active role within the family e.g. by taking care of the grandchildren whereas in other contexts older people are less engaged in this role.

- When working with clients/patients from different cultural backgrounds we may need to consider that the older family members might have more or less influence on the client/patient depending on the cultural background of the family. Grandparents might be a valuable source of support for a family or might interfere in an undesirable way. Furthermore, if we work with older clients/patients we need to be aware of the role they play in their family. Are they well embedded and respected or more separated from them?

EXTRA MATERIAL

Violence within families across cultures:

Unfortunately, violence within families or against children occurs across all cultures. However, what is considered violence can differ across cultures, such forced marriage or genital mutilation. No matter where it appears violence is always a sign of helplessness and a means to exercise power. And this should in no case be tolerated. As a social or health care professional you might deal with clients or patients that have experienced different forms of violence.

The very first challenge for anyone working in families where there may be violence is recognising the violence itself. There are many types of violence, and they are often "invisible" – for example psychological or economic violence. For further information on types of violence and how to recognise and respond to them, see the international First Aid Manual of Emprove Foundation: https://emproveproject.eu/first-aid-kit/

With regard cultural perceptions of violence, make sure to confront your own internal attitudes about this topic – violence IS NOT a private matter, but in some cultures, it is treated as such, leading to hesitation or reluctance to support the victim at an early stage, intervening only in the most severe cases. Violence was rightfully named by the UN the "shadow pandemic" – according to the most recent, comprehensive study on the topic (FRA, 2014) an estimated number of 13 000 000 women in the EU are affected by some form of violence. This affects not just their lives, but also their families and friends, as well as the economic impact (Costs of gender-based violence against women in the EU – est. 226 billion EUR (EIGE, 2014)).

The second challenge is communicating about the violence with the person who has experienced it, especially if it might be culturally approved in his/her context. The first thing to communicate is that THIS IS VIOLENCE, naming it and showing clear expression of disapproval. "THIS IS NOT NORMAL. This is violence" is often the one statement that might open up the trust-link with the survivor of violence. Bear in mind, that sometimes even the word "victim" might cause a wave of denial and rejection if a person did not realise he/she has been experiencing some form of violence (e.g. because it is culturally approved in their social circles). Reframing it as something this person has "survived", subconsciously transmits a feeling of resourcefulness and increases your chances of being heard and may raise awareness or even readiness for change. Often, the people recognising a sign of violence, rush to jump into the role of saviour – however, the focus should be on acting as an empowering force of communication for the victim, legal support, police and psychological experts.

When social and health care professionals are confronted with domestic violence, the first priority is to protect the victim(s). For this to be effective and long-lasting, it can be helpful to analyse the situation from different perspectives:

Legal situation: Helpers should ask themselves what the perpetrators' awareness of the legal situation is. Is the perpetrator aware that domestic violence is a crime? First step in this communication might be to clarify e.g. that hitting children is forbidden, whilst being aware that you may be communicating this to a person who might have been raised with a model of a violent parent-child relationship and modifying such internal attitudes take time and specialised work with a psychologist/therapist. It is highly recommended to have a well-established coordination mechanism between police, health care professionals and psychological support (for both victim and perpetrator) and legal advice (incl. mediators). This coordination of professional services is crucially important and might be a life-saving factor, so do not underestimate your personal role within it and inform yourself about the most effective way to get in contact with these experts as soon as you have identified any potential sign of violence.

Dynamics of violence: Social and health care professionals should seek to understand the dynamics of violence and the psychodynamics of the perpetrator: Is the violence a culturally learned situationally specific behaviour (e.g. a form of discipline accepted within a certain culture or is it unpredictable, repeated or increasing in frequency or intensity?

Different interventions may be required depending on whether the perpetrator acts on the basis of alleged cultural “traditions” or whether there are other influencing factors such as alcohol dependency or mental illness.

Possible interventions: Involving other family members can be a chance to get the family "on board”. Involving the family also makes the situation "public" and communicable. In some situations, however, the survivor of violence may not want to involve other family members due to prolonged intimidation or the family’s unwillingness to accept that there is violence taking place. In any case the person who has survived violence should be given professional psychological and legal support during the process of deciding how to approach the situation and whom to involve. This support and protection must come from an external source not as a “rescue”, but rather as a means to empower the survivors as the determining force of the next steps.

Information summarised from Rüschoff/ Laabdallaiou (2016): Umgang mit muslimischen Patienten.

As a first step, for those who might underestimate the experience of non-physical violence, you might use a language-free videos like this awareness raising violence prevention campaign by Emprove Foundation: https://www.youtube.com/watch?v=zaeFnBgpFH8

Summary (slide 23)

Families can take different shapes and there might be different concepts of the relationships within a family. In most cases they have a significant impact on the client/patient's well-being. Family relationships can be a valuable resource for a patient. Though sometimes unfavourable situation within families can have a negative impact on a patient. Try to evaluate what the family means to your patient/client. What factors contribute to his or her wellbeing, which are hindering it? Try to encourage him/her to find the right balance between the sense of belonging to the family and the autonomy of the individual. But be careful not to evaluate this according to our own cultural background!

Section 3: Childhood Across Cultures

Trainer's notes (slide 25)

Divide the learners into pairs and ask them to reflect on their own upbringing and then look at the pictures and decide if they identify with any of them and why. Also ask them to identify one picture that is very different from their upbringing and discuss what the differences might be.

Activity (slide 25

Discuss your own childhood upbringing and then look at the pictures and see if there are any that you identify with and why. Then chose 1 of the pictures that is the most different from your upbringing and think about what the differences might be.









Trainer input (slide 26, 27, 28, 29,30,31)

Heidi Keller has found fundamental differences in the way mothers interact with their babies between different cultural settings. Keller examined parent-child interaction in early childhood in cultural settings within rural areas in West-Cameroon (Nso people) and in the German cities Osnabrück and Berlin and compared them. She found differences in the socialisation strategies that are applied by the families for their babies. Whereas the German parents were very much orientated towards enhancing the autonomy of their children even at an early age, the Nso mothers in Cameroon focused on raising their children in a way they feel closely attached and connected to their family. Many of the German mothers felt that their child should learn at an early stage to occupy themselves independently and sleep on their own. Nso mothers though have significantly more body contact with their children.

Educational goal for children under the age of three	**Level of agreement rated by mothers from Osnabrück**	**Level of agreement by Nso mothers**
Respecting older people	Rather disagree	Strongly agree
Do what elderly people say	Strongly disagree	Strongly agree
Keep social harmony	Slightly agree	Strongly agree
To assert oneself	Slightly disagree	Strongly disagree
To be different from others	Slightly disagree	Strongly disagree
To express own ideas clearly	Strongly agree	Rather disagree
To develop talents and interests	Strongly agree	Slightly disagree

Table: Educational goals of German middle-class families in comparison with Nso women farmers from Cameroon (Keller 2011: Kinderalltag, p.26)

German mothers, i.e. Western mothers, placed a great deal of importance on their children developing talents and interests in the first three years of life and learning to assert themselves. They did not attach importance to children of this age doing what their parents tell them and respecting older people. However, the Cameroonian Nso placed a lot of importance on this, as well as on the other two attachment-oriented goals (sharing with others and maintaining social harmony). They rejected the autonomy-oriented goals in the list. The profile of the two groups shows clear differences in the orientation towards autonomy and attachment.

Keller concludes from her research that Western educational approaches are often focussed on an I-perspective instead of focussing on the We-perspective. In her view, professional who deal with the development of children should be aware of the different approaches and perspectives of a child's needs.

Cultural conflicts might arise if goals set by the family differ from those set by other agent's socialisation (school, therapist, etc) e.g. is a vegetarian parent is encouraged to serve meat to their child. This can put additional stress on the child instead of contributing to their wellbeing.

If these differences are not taken into account by all the relevant support systems for the child (e.g. the family, the school, the doctor, or therapist etc

and relations between these do not function well as a result the child will be at a disadvantage.

However, be careful not to generalise with a “culturally pessimistic” view in cases like this. As well as being aware of the potential conflicts that can arise from the different goals, we can also ask what can be gained from an increased understanding of these differences. (Domenig p.113ff).

Social and health care professionals can empower children and young people to develop the ability to deal with these contradictions. Helpful guiding / empowering principles in a social or therapeutic context can be:

- I am able and ready to define my own ideas
- I am able and ready to find words for my own goals and values
- I am able to express my feelings and not take them out on other

ADDITIONAL INFORMATION

The Austrian author and teacher Melisa Erkurt has developed a ritual for her culturally diverse school classes to strike a superhero pose at the beginning of each lesson to create a powerful state of mind. (Erkurt 2021). Do not hesitate to find your own way how to empower the families/youngsters/children you work with.

When working with bilingual children and families we should focus on the many benefits rather than any problems. Please find here 7 myths about bilingualism and the corresponding facts:

https://www.healthychildren.org/English/ages-stages/gradeschool/school/Pages/7-Myths-Facts-Bilingual-Children-Learning-Language.aspx

Often social and health care professionals think that the “foreign” languages of their clients/patients are a private thing that has no space in the local educational/therapeutic institutions. However, language is a big part of a person’s identity and different spoken languages should be viewed positively.

Some tips when working with multilingual or bilingual families:

When we want to encourage families to learn the local language we will not succeed with prohibitions

The opportunity for clients/patients to speak in their first language creates affiliation and trust, especially when dealing with younger children

Try to get involved in a conversation with the children, children are often very creative when dealing with communication barriers

If you feel that talking in a foreign language is problematic in a specific situation, try to say something like: “Petra is here with us, but she did not understand what you just said” instead of “nobody understands what you are saying if you are talking in Turkish”. Generalisations like “nobody” often increase feelings of insecurity and of being stereotype, which negatively impacts the level of understanding and does not bring any added value to the conversation.

Switching between different languages is normal when growing up bilingually and should be seen as a sign of creativity and not as a weakness

Use positive rather than negative comments e.g. instead of ‘’I can’t understand you, say, ‘’I wish I could understand Turkish’’.

These tips have been provided by the “Amt für multikulturelle Angelegenheiten Frankfurt am Main (2016).

Section 4: Welcoming culture: Representation matters – how to work with diverse families

Trainer's notes (slide 33, 34)
Ask your learners if there was ever a time in their lives when they have not felt represented. Divide the group into pairs and ask them to discuss their 'superheroes'. Take feedback by listing the superheroes on a whiteboard and discussing the characteristics of each one. Encourage learners to draw their own conclusions from this.


Activity (slide 34)
Describe a "hero" or a "heroine" that you admired as a child?

Then discuss
Which skin colour did your hero(ine) have?
Which ethnic background did they belong to?
Which gender were they?
What were their physical features?


Trainer input (slide 35, 36)

We tend to identify with people that are similar to ourselves and yet many children rarely see themselves represented in the resources and materials they are given, and as a consequence lack figures to identify with. To ensure an atmosphere where families can feel welcomed and respected, it is important to create environments where their individual characteristics are represented, and families can develop a sense of belonging. Social and health care professionals need to critically examine whether and in what form the children and their reference groups are represented – for example, in the books and toys used.

According to Sandra Richter (2014) possible reflection questions could be:

- Are there professionals with a different first language or different ethnic backgrounds?
- Are there different languages represented in your institution or in the material produced by your institution (especially the languages of your target group)?
- Are there books/dolls/pictures that depict socially relevant roles (doctors, pilots, etc.) including people from different ethnic backgrounds?
- Are there dolls and play figures with different skin colours?
- Are there stories in which the main characters wear head coverings?
- Are there books/pictures in which different types of family are portrayed?
- Do you reflect on your own cultural norms and the impact these can have on our assumptions and perceptions of behaviour e.g. eating and sleeping arrangements?
- Do rooms reflect the diversity of the families you work with (e.g. pictures of diverse families, signboards in different languages)?

Summary (slide 37)

All families are different even within the same culture. When working with families with different cultural backgrounds to your own you need to have an open mind. To provide culturally sensitive services you have to listen and respect other people's views which may differ from your own.

Reflection and Action plan

Identify 3 things you have learnt from this module. Identify 3 things that you will reflect on. Identify 1 behaviour you will change as a result of any new knowledge.

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