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Interprofessional Approach to Refugee Health

A Practical Guide for Interdisciplinary Health and Social Care Teams

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3. Providing Person-Centred Care, Creating Therapeutic Space and Recognizing the Needs of Service Users

Emer McGowan, Sarah Quinn and Rolf Vardal

> It is very important to listen to the people with refugee backgrounds. Some of them have come from very difficult situations. Sometimes they are carrying the experiences of what they have gone through. It is making them sick. Sometimes, these refugees, they don`t need medical treatment, they only need somebody that can listen. So out of listening, also knowing this person.
>
> — Male economist from Kenya living with refugee status in Norway

The health needs of refugees, and the barriers and challenges that can prevent them from accessing health and social care, differ from those of the host population over the life-course (WHO 2021). By addressing these physical and mental health needs, health and social care professionals can play a significant role in supporting the resettlement of refugees. Taking a person- or people-centred approach is central to this aim. Adaptable, well-trained and culturally competent health and social care workers are needed to provide services that are responsive to the unique health requirements of refugees (WHO 2021). Provision of person-centred care can help to build trust between health professionals and refugees, both at the time of arrival and more importantly during longer-term refugee settlement (Procter 2016). This chapter explores how health professionals can take a person-centred approach when

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providing care and services for people with refugee experience. It discusses the concept of therapeutic space and how this can help to facilitate communication and build effective working relationships with service users. This chapter is aimed at health professionals who are new to the field of refugee health or those with an interest in the area who have not yet gained practical experience.

The concept of patient-centred care was first discussed by Balint in 1969, where it was described as "understanding the patient as a unique human being" (Balint 1969). Since then, patient-centred care has been an evolving concept and has been described using an array of different terms, including relationship-centred care, personalized care and user-/client-centred care (Santana et al. 2017). In this chapter, we use the term person-centred care as opposed to patient-centred care, in keeping with Ekman et al. who distinguished person-centred care as refraining from reducing the person to just their symptoms or disease (Ekman et al. 2011). A person-centred approach is concerned with human connectedness: the capacity for thought and feeling to be received, and lives to be revealed (Procter 2016). When working with refugees, person-centred care will involve:

- Being open to the way a person explains, understands, or interprets her or his or someone else's health problems or illness.
- Taking into account a person's cultural beliefs, and understanding that these will influence the way in which symptoms are presented.
- Considering the person's understanding of health difficulties and becoming aware of differently perceived causes of illness or disease, optimal care, and culturally appropriate support and treatment.

A conceptual framework for the provision of person-centred care was developed by Santana et al. (2017) based on the Donabedian model for healthcare improvement (Donabedian 1988). This model (Figure 3.1) is based on three categories, "Structure," "Process" and "Outcome". The framework demonstrates the need to target interventions and address challenges at different levels (healthcare system, healthcare provider, and patient) in order to provide person-centred care.

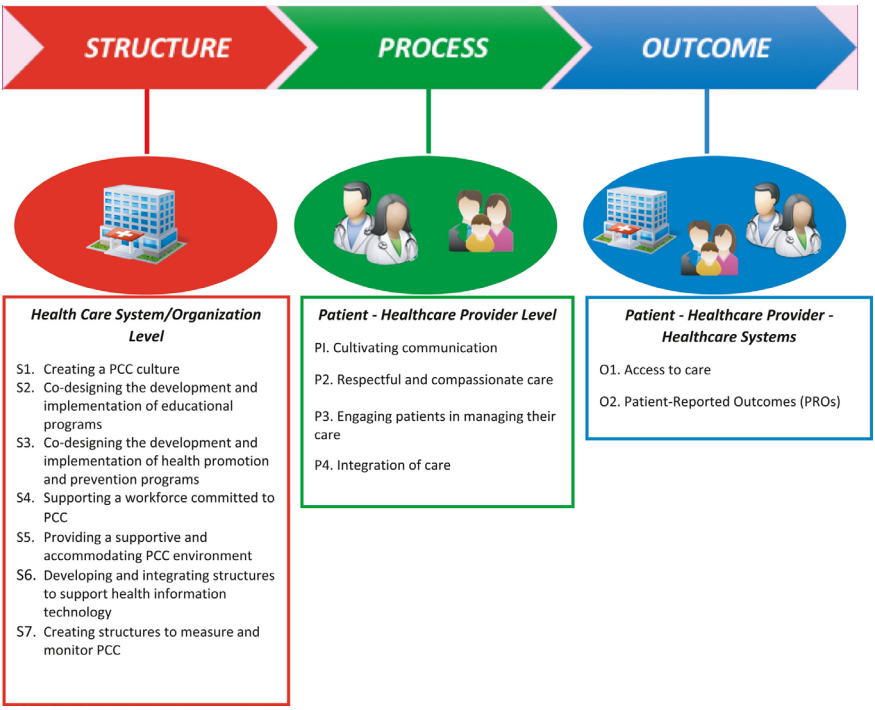

Fig. 3.1 Framework for Person-Centred Care. Reproduced from Santana et al. (2017), CC BY.

The framework lists four Process domains for health professionals to employ to ensure delivery of person-centred care. These are cultivating communication (listening to patients, sharing information, discussing care plans with patients), respectful and compassionate care (being responsive to preferences, needs and values, providing supportive care), engaging patients in managing their care (co-designing care plans with patients), and integration of care (communication and information sharing for coordination and continuity of care across the continuum of care). This framework clearly conveys the importance of not only incorporating the patient perspective but of ensuring that care is also patient-directed, whereby patients have sufficient information and understanding to make decisions about their care (Santana et al. 2017). It also highlights the need to address diversity (including race, ethnicity, gender, sexual identity, religion, age, socio-economic status, and disability), to respect individual patient beliefs and values, and thus to promote dignity and anti-discriminatory care.

Filler et al. (2020) outlined practical strategies that health and social care professionals can implement to aid the delivery of person-centred care in a scoping review, which explored barriers and facilitators of patient-centred care for immigrant and refugee women. A friendly, courteous, and comfortable relationship can be established by assuming a non-judgemental manner, taking time to chat informally, being present, and focusing on the service user (not the computer), becoming familiar with the service-user's culture and migration journey, and potentially learning a few words of the service-user's native language.

The clinical work of any health or social care professional, no matter how willing or keen to help, will be compromised if they do not consider ways to ensure they take a person-centred approach. This approach will also involve family members and caregivers, as well as prevention and health promotion activities (Santana et al. 2017). Service users and communities should play a key role in co-designing health promotion and prevention interventions. These programmes will be better able to meet the needs of all people if they are developed through collaboration with and empowering service-users, patient advisory groups, organisations, and communities (Santana et al. 2017).

One of the four Process domains in the Framework for Person-Centred Care is the provision of respectful and compassionate care (Santana et al. 2017). Compassion is a deep feeling that stems from witnessing another's suffering coupled with a strong desire to help to alleviate that suffering (Goldberg 2020). There are numerous definitions of compassionate care, but there are elements common to many of these: understanding others, choosing to act to help others, actively imaging what others are going through, and reacting to others' needs selflessly (Bivins et al. 2017). Patients who experience compassionate care have been found to have better clinical outcomes, higher patient experience scores, improved hope for recovery, and safer care (Tehranineshat et al. 2019; Goldberg 2020). However, it should be noted that the delivery of compassionate care depends on more than just individual health professionals, and that the wider healthcare team and organisational context in which the care is delivered are key (Tehranineshat et al. 2019). Caring for patients must be a shared responsibility between professional groups within clinical environments that value and respect each discipline's contribution (Bivins et al. 2017). Despite this, health

professionals can face challenges with providing compassionate care in practice due to bureaucratic barriers and time constraints, given the business-like ethos of certain areas of healthcare (Patel et al. 2021).

Mechili et al. (2018) advocated the importance of providing respectful and compassionate care for people with refugee experience. Compassionate care has been defined as "the humane quality of understanding suffering in others and wanting to do something about it" (Halsman 2015). As well as sufficient and appropriate care, vulnerable populations, such as refugees, should be shown acceptance, respect, kindness, empathy, and receive attention to their basic needs. Health professionals need to consider the needs, wishes, and expectations of newly arrived refugees in the context of the transcultural setting. Developing the communication skills and competencies necessary to care for vulnerable groups, and enhancing the cultural competencies of interdisciplinary teams of health and social care professionals present some of the most challenging aspects of providing compassionate care for refugees (Mechili et al. 2018).

In a systematic review of refugee experiences of healthcare consultations in primary care settings, Patel et al. (2021) found that compassionate care aspects of communication were important factors in helping improve comfort and trust between healthcare professionals and refugees. Service users preferred to see health professionals who were kind, patient, and welcoming, and those who took interest in them as a person and were willing to take the time to listen to their stories. Health professionals working with refugees should demonstrate compassion and empathy towards their individual patients, and be aware of their emotions, concerns, and suffering (Patel et al. 2021).The European Refugees-Human Movement and Advisory Network (EUR-HUMAN) project ran for 12 months in 2016 in response to the increased numbers of refugees coming to Europe and the requirement for capacity building among health professionals to meet their needs (Mechili et al. 2018; van Loenen et al. 2018). This project proposed a primary healthcare model for refugee care with an emphasis on the provision of compassionate, comprehensive, person-centred, and integrated care. Factors that enabled the provision of compassionate care included communication skills to better convey adequate healthcare information and psychological support, understanding potential linguistic and

cultural barriers, and training to provide tools and empower healthcare professionals in order to enable them to build trust. Barriers to providing compassionate care for interdisciplinary teams include a lack of capacity in terms of time and resources, unclear division of roles, staff changes, insufficient funding, poor coordination, and lack of a comprehensive monitoring system (Mechili et al. 2018).

Key recommendations from this project (Mechili et al. 2018; van Loenen et al. 2018) for the provision of compassionate care included:

- Preparing all health and social care professionals to deliver culturally competent, compassionate, and person-centred care. The multidisciplinary team should be trained to use proactive outreach to identify vulnerable refugees.
- An individual's values, societal beliefs, wishes and experiences should be assessed by health and social care professionals and taken into account when planning sessions and interventions.
- The health needs and personal preferences of individuals should be assessed at all stages and considered in conjunction with applying evidence-informed, disease-specific recommendations.
- Informal interpreters and using children as interpreters should be avoided as much as possible. Instead, quality interpretation services should be provided for all healthcare appointments.
- Health information and all services should to be tailored and suitable according to the level of the individual's health literacy.

Self-reflection exercise:

Reflect on your own experiences of providing compassionate and person-centred care. Choose a specific example and explain how you adapted your approach to foster person-centred and compassionate care. Include any barriers or challenges you experienced in taking this approach and outline how you addressed them.

Developing a Therapeutic Relationship

> I think people need more information and more time to explain. Because when a person went to a doctor for example in Kenya, they got the time to explain... But here the doctors will want you to say you have problem. "there and there". They are the one who can ask you the question about it. Most of the refugees find that the doctors maybe don`t have time. Because the personal doctors, they don`t have time. They have 20 minutes and most of the time they are writing, and they can think that this doctor just wants to finish with me and go. — Male economist from Kenya living with refugee status in Norway
>
> It is good that those who work with these refugees are updated. That you get a better understanding of what they have gone through and that they are not here voluntarily. That they have come here to save their lives. Their own or to those closest to them. So, we must try to help them in the best possible way, both physically and mentally.
>
> — Female nurse from Bosnia living with refugee status in Norway

The therapeutic relationship, also referred to in the research literature as a therapeutic alliance, a helping alliance or a working alliance, refers to the interpersonal relationship between the health and social care professional and client (Peplau et al. 1997). In the provision of care for refugees, the therapeutic relationship occurs between two human beings, sometimes three, due to the presence of an interpreter. It involves one person defined as (or having) the role of a health and social care professional and another defined as (or having) the role of a patient/client/service user. The interpreter, when present physically or digitally, is regarded as a neutral entity, merely transmitting information between the two other individuals. However, it is essential to emphasize that the interpreter is also a human being whose presence can influence the relationship in various ways. Notwithstanding this, the focus in the following text will primarily be on the space between the health and social care professional and the refugee using their service.

The importance of the therapeutic relationship in healthcare has been widely recognized (Horton et al. 2021) and has been demonstrated to have an impact on clinical outcomes in rehabilitation (Hall et al. 2010; Ferreira et al. 2013; Fuentes et al. 2014). The quality of therapeutic relationships has been understood to be impacted by the extent to which the dyadic partners perceive the relationship

to include particular aspects such as agreement on tasks and goals, interpersonal skills, trust, and shared decision making (Elvins & Green 2008). Relationships that rate highly on these factors are judged to be high-quality therapeutic relationships, and those that rate low on them are perceived to be lower-quality relationships (Elvins & Green 2008).

Developing a therapeutic relationship can be aided by shifting the professional/personal boundary towards the personal end of the spectrum (Finaret & Shor 2006). This shift can be assisted by open communication, an informal work setting (e.g., the client's home) and self-disclosure from the professional (Finaret & Shor 2006). Similarly, Miciak et al. (2018) found that physiotherapists and patients being genuine or themselves during interactions was a necessary condition for building therapeutic relationships. Horton et al. (2021) explored the development of therapeutic relationships between physiotherapists and occupational therapists and their patients, and, specifically, the impact of turning points or critical events on these therapeutic relationships. Constructive turning points that help to develop high-quality therapeutic relationships included progress towards goals, positive feedback from patients, and interpersonal affective bonding with patients. In contrast, non-constructive turning points included setbacks in progress towards goals, interpersonal problems with patients, and negative feedback from patients. These studies highlight the importance of health and social care professionals being open, authentic, and willing to be vulnerable themselves when working with clients to help to develop a positive therapeutic relationship.

Effective therapeutic relationships also demand that health and social care professionals can appropriately respond and manage emotional reactions. To do this they must acknowledge service-users concerns, offer comfort and encouragement during sessions and collaborate with the wider multi-disciplinary team as needed (Filler et al. 2020). It is also important that cultural differences are recognised, accommodated and respected, and that care is personalized to the individual rather than generalized to culture or country of origin (Filler et al. 2020).

Humour may be another strategy that health and social care professionals can employ to cultivate a sense of belonging in the rehabilitation setting (Kfrerer et al. 2023). Humour has been found to improve co-operation, compliance and positive motivation in clients (Leber & Vanoli 2001; Walsh & Leahy 2009) and can help with client engagement in rehabilitation (Gard et al. 2000). In a scoping review exploring humour in rehabilitation professions, humour was found to be a used mainly positively in rehabilitation and was considered to be an effective way to improve client/professional relations (Kferer et al. 2023). Humour was used in a number of different ways to build and maintain the therapeutic relationship, including:

- As a management strategy in therapy—to deflect errors, mitigate awkward situations, distract or restructure interactions, and maintain a frame of joking or light-heartedness during sessions.
- To foster relationships with colleagues within the multi-disciplinary team.
- To negotiate power differentials that can exist as part of the relational dynamics between clients and professionals—humour can be used to either establish power and thus influence the tone of the interaction or to equalize power and break down barriers.
- As a therapeutic modality, particularly in group rehabilitation settings.
- To save 'face'—humour was a way for clients to show that they understand and are aware of their condition and difficulties. It can provide a means to ask for help and laugh at oneself.
- To cope with grim situations—using dark/'gallows' humour to relieve tension during vulnerable or intimate struggles in rehabilitation. It can also provide stress relief when used between health professional colleagues.
- To foster group cohesion—by building trust, emphasizing togetherness and indicating belonging to the group.

Creating therapeutic space

The advice below is from Rolf Vårdal, a physiotherapist in Norway who has extensive experience of treating people with refugee experience. Rolf has been a physiotherapist since the early 1990s and working in refugee health since 1997. He has worked as a member of the team for people who have experience forced migration at the Regional Trauma Centre. Rolf has also been a councillor for people with refugee experience who have resettled in the municipality of Bergen, Norway.

When working with refugees, some factors can create connection, while others may create distance. In the host country, the professional likely resides permanently and generally has a sense of stability and safety that the refugee may not have established. Additionally, the professional holds a certain power in this relationship, which they should be conscious of. The power dynamic stems from the professional's authority due to their profession, representing a service, or even a state, where the patient/client might feel inferior due to the imbalance in roles. The patient/client has a health issue, either physical or psychological, or both, and seeks or expects help from the professional. It is therefore important to assess how the health and social care professional can ensure that the therapeutic space is open and fosters an atmosphere conducive to healing.

Establishing a framework is crucial. Generally, the patient/client will come to the health professional, at least for the first consultation. Expectations for the consultation may vary significantly between individuals, as some may not be familiar with different services or types of therapy. The professional should take time to introduce themselves and explain their role. It is essential that they ask the patient about the concerns to be addressed during the consultation, but they should also inquire more broadly about their general or personal background beyond the presenting health issues. If the professional possesses knowledge of the patient's/client's country of origin, history, culture, or general conditions, displaying genuine interest in the individual can lay the foundation for further contact and contribute to a positive atmosphere. Additionally, 'mapping' the patient's/client's interests, competencies, and experiences helps to establish balance and reduces the top-down approach. However, some patients/clients accustomed to a more submissive relationship with health professionals may require time to understand this rationale and different approach.

For physiotherapy, the physical touch is crucial and can make a significant impact once a safe relationship has been established. However, it may take time to achieve this. Furthermore, gender must be considered, as some patients/clients with refugee experiences may not feel comfortable with a therapist of the opposite gender, especially during the initial phase.

Maté and Maté (2023) contend that compassion is integral to healing. They have outlined five levels of compassion:

Ordinary compassion: "…when somebody is suffering, I feel bad about that, and I don't want them to suffer."

Compassion of understanding: "...I feel bad that you're suffering, I want to understand why you're suffering."

Compassion of recognition: "…I don't see myself as different from you."

Compassion of truth: "...I'm not trying to protect you from pain. I want you to know the truth because I believe the truth will liberate you."

Compassion of possibility: "…I see them for the full, beautiful human beings that they are."

Healing practices vary considerably across the globe, as illustrated in Kirmayer's article (2004) on the cultural diversity of healing. While it is impossible to be fully competent in all practices, building a relationship of trust and cooperation is vital and can be achieved to a much greater extent by all. By understanding and applying these concepts, therapists can work toward creating a therapeutic space that is open, compassionate, and conducive to healing.

> What is important is to know the situation, and a little more about the country they come from. About what they have been through and try to understand and be able to help them better. In other words, health personnel can improve their professional practice by learning from people with a refugee background.
> — Female nurse from Bosnia living with refugee status in Norway

Case Study

In a previous project on refugee health, Physiotherapy and Refugee Education Project (PREP), Patricia Rocca, who works as a physiotherapist for the Swedish Red Cross, created a video telling the

story of Khaled.[1] Khaled is a 45-year-old Palestinian man from Syria who has refugee status in Sweden.

The video explores the interplay between pain and post-traumatic stress disorder (PTSD). It demonstrates the benefits of taking a person-centred approach when working with people who have survived trauma and provides specific examples of how this can be done. The importance of interprofessional collaboration is also highlighted through the close working, co-ordination and communication between the physiotherapist and psychologist. The video acknowledges that the approach presented is one of many methods that can be used when providing care for traumatized individuals with a refugee background. As previously noted, it is important to bear in mind that refugees are a broad and heterogeneous group of people. An individualized approach must be taken, and treatment adapted in response to the client's symptoms, resources, and goals.

The video of this presentation is available here: https://www.youtube.com/watch?v=ug_WEkXeOSo

Abridged case study transcript

Khaled came to Sweden in 2016. In his home country he was politically involved since his teenage years and with that imprisoned three times. The first time for eighteen months and the second time when he was in his late twenties for three years. It was during the second imprisoning that he was tortured. The first year in prison he was tortured daily. He was submitted to suspension by hanging from his wrists, beatings, isolation, forced body positions, waterboarding, and witnessing torture. He lived in a small cell together with 30 other individuals. There was not room for everyone to lay or sit down at the same time, so they had to alternate when resting and sleeping.

The following 11 years he lived in a refugee camp in Syria under very scarce circumstances. At the camp he was kept under close surveillance and was frequently harassed by Syrian military, until he escaped for Sweden. Khaled has no formal education; he only attended school until he was 11. His childhood was marked by poverty and discrimination.

1 Khaled is not the client's real name and parts of the story have been changed to hide his identity.

In Sweden, he lives with his wife and three children in an apartment provided by the Swedish social services. He attends an introductory programme for migrants but finds it very hard to concentrate due to sleeping problems and flashbacks from torture. He's very concerned about his and his family's future in Sweden. He wishes very much to find a job.

Before Khaled meets with his physiotherapist for the first time, he has already met with a psychologist at the Red Cross Treatment Centre. He has been diagnosed with PTSD and the psychologist has informed him about the interdisciplinary teamwork at the Centre and that he will have consultations with physiotherapists, a social counsellor, and a medical doctor.

To receive a PTSD diagnosis, one has to have been exposed to trauma. In Khaled's case, he has both experienced a traumatic event himself and been forced to witness the torture of friends and fellow prisoners. Khaled's father, who was also politically involved, was imprisoned and tortured when Khaled was a young boy, so Khaled has been exposed to various traumatic events also as a son.

Torture is an act that violently and intrusively attacks an individual's boundaries, physically and mentally. The subjective experience is lack of control, a high degree of helplessness, no possibility to defend oneself, and unpredictability. It induces fear, stress, and pain. Torture results in bodily injuries: wounds, fractures, burns, muscle strains, as well as psychological harm. The absence of treatment affects the healing in a negative way. Torture seeks to break its victim through the intentional use of pain to destroy and/or damage the physical and psychological integrity of the individual and by extension the integrity of the family and community.

Torture and trauma results in alterations of an individual's body ego; loss of body awareness means loss of the ability to recognize one's body and one's physical experiences or sensations which can impair one's ability to understand one's needs and emotions. Impairment in the ability to trust one's body evokes a negative body image and dissatisfaction with one's body. Reconnecting to the body in a positive way and learning how to use movements to self-regulate a conflicting inner state is a central part of recovery. Understanding the method of torture used

can aid the physiotherapist in understanding the injuries, and managing the assessment and treatment appropriately and sensitively.

While most physiotherapists may focus on the outcomes of the torture experience itself—that is, scar tissue, fracture, mal-union, persistent pain—it is also of importance that the physiotherapist understands the impact of torture on a psychological level, and the additional stresses that impact the patient's health status and well-being, for example: unsafe journeys, and, upon resettlement, the experience of many losses e.g., loss of status, identity, family, employment, property.

The physiotherapist prepares for the meeting with Khaled by reading his medical journals and consults with the psychologist. When Khaled enters the physiotherapist's room, the physiotherapist starts by asking Khaled to choose a place to sit and asks whether Khaled is okay to be in the room with the door closed. Khaled chooses to position himself so he can see the door. The physiotherapist introduces herself and informs Khaled that, being a healthcare professional, she works under confidentiality laws but that information about patients is shared within the team.

Khaled has had lumbar back pain and shoulder pain for several years. He went to see a physiotherapist once at his healthcare centre, but when he saw all the workout machines, he became scared and never went back again. The physiotherapist asks Khaled how the trauma has affected his body. Khaled describes symptoms of anxiety and stress, never being able to relax, his heart racing and difficulty breathing when being around people, Syrian men in particular. He only feels safe at home and even there he can get jolted by sudden sounds. His coping strategies are walking around in his apartment, or short walks in close proximity to his apartment, and taking showers.

He sleeps two to three hours a night and always with the light on. He is often woken by nightmares, feeling paralyzed, and has difficulty going back to sleep. He has no appetite and very low levels of physical activity. This is all of the information that Khaled is able to share during the first meeting with the physiotherapist.

The role of the physiotherapist during the first meeting is to start building an alliance with Khaled, not to push too deep into Khaled's story. Khaled keeps repeating that he is tired, and he hardly gives any eye contact, his legs are constantly shaking. He is very tense in his

shoulders and he keeps his head bowed; he doesn't take off his jacket. The physiotherapist briefly describes how bodily work can help trauma-affected individuals to relax, and that during coming sessions they will explore self-regulating techniques that might help Khaled to stay present and reduce his anxiety. The physiotherapist describes what they will do next time they see each other so that Khaled feels prepared and to ensure predictability. No examination of his shoulders or back is performed at this point.

At the second assessment, the physiotherapist uses the 'Body Awareness Movement Quality and Experience Scale' to examine Khaled's bodily resources. This is a test that consists of two parts; the first one is an observer-based rating scale where the physiotherapist evaluates the functionality of various visually observed movement patterns. The second part consists of a questionnaire on subjective experiences of the body. Results show that Khaled is very tense in his body; he has poor stability and flexibility. He also shows poor coordination and a shallow breathing pattern. His breath is really never integrated with his movements and Khaled finds it very hard to relax when lying down on the floor. He says it reminds him of how his torturers forced him to lie down on cold floors, sometimes for hours, with the threat of beatings if he moved.

During both assessments, the physiotherapist checks in frequently with Khaled by using questions like, "Is it okay if we continue a bit further, or do you need a pause?", "How are you feeling right now?", "Do you have any questions or reflections on what we just said?" The physiotherapist and Khaled agree on treatment with basic body awareness therapy, an evidence-based treatment form, that aims to establish increased awareness of the body and consciousness in movements, progressing toward less effort and a better function in being, doing, and relating. The physiotherapist also proposes that Khaled should participate in group workouts in order to strengthen his physique, but Khaled feels a bit uncertain about this since he has difficulty trusting other men. The physiotherapist and Khaled decide to delay the group workout until Khaled feels safer. Khaled also meets a social counsellor for psychosocial mapping in order to identify difficulties in his daily life that may become a hinderance for therapy.

He also receives a prescription for sleeping medication from the medical doctor.

Throughout all of the consultations at the treatment centre, the same translator is present in the room with Khaled. She is an elderly Palestinian woman. Early in the treatment process, Khaled, the psychologist, and the physiotherapist make a common healthcare plan. This plan is reviewed every six months, as long as his treatment proceeds. In the plan, Khaled's stress factors and protective factors are described; his recurring flashbacks, insomnia, concentration difficulties, body pains, and a psychosocial situation with no job or income are recorded as stress factors. Protective factors are his permanent residence permit, the support he has from his family, and that he is motivated to engage with treatment.

Khaled's treatment goals are:

- To be able to be around people without fear.
- To sleep five hours a night.
- To be able to concentrate at school so he can learn Swedish.

It is decided that Khaled will attend physiotherapy directly after sessions with the psychologist for stabilization following the trauma-exposing treatment. When you encounter an individual that has been exposed to severe trauma, torture, or any other interpersonal violence, it is essential that extra consideration is given to building an alliance with that individual. Trauma-informed care is an approach that recognizes that experience of trauma can affect all aspects of care, from communication to clinical reasoning.

In trauma-informed care, it is important to make the first encounter with the patient an encounter where the patient feels safe. A good start is to explain the purpose of the meeting and describe how the meeting will progress, if you are working with a translator, let the translator introduce him or herself, explain that you as a healthcare professional, and the translator, are bound by confidentiality laws. Make the patient feel that they are in control during the meeting, for example by letting the patient choose where they want to sit in the room or whether the door should be closed or not. Take time to answer their questions. Allow the patient to take breaks and to decline answering questions and be ready to pause the assessment at any point if the patient shows high levels

of anxiety or distress. Check in frequently on the patient and ensure you have their consent to continue asking questions or examining their bodies during the physical examination. Explain every step beforehand to ensure safety and a sense of control. Avoid rushing the patient or asking questions too quickly because this may recreate a feeling of an interrogation.

Many patients with PTSD suffer from concentration difficulties and it is therefore crucial to portion the amount of information given. Repetition might be of great help to the patient. Continuity in terms of using the same room and same translator creates a space that is safe and predictable. Strong physiological reactions can be triggered in a traumatized individual by different stimuli, for example smells, sounds, touch, body positions, but also inanimate objects such as an examination bed or medical equipment. Therefore, be aware of the patient's bodily reactions, don't be afraid of asking, "I see that you're tensing. How are you feeling right now?".

Every session starts with the physiotherapist checking in with how Khaled's week has been, how he is feeling, and how his body is feeling. Khaled is given the opportunity to discuss the content of the session. At the end of a session, Khaled is invited to reflect on how it went. The physiotherapist noticed that Khaled often is very shaky when sitting in the waiting room and that he avoids eye contact with other people. He sits in a slumped position; his legs are shaking, and he points his gaze onto the floor.

In the room with the physiotherapist, Khaled shows the same pattern. He reacts to sudden sounds and often looks behind his shoulder. The physiotherapist tries to guide Khaled verbally into a more upright position, where he will experience more space for his breath and a reduction of muscle tension in his neck and back. There are a lot of trauma triggers coupled to different movements and positions. The physiotherapist normalizes and validates Khaled's reactions, and a lot of time is spent on letting Khaled reflect on his experiences in the room and how increasing contact with the body and movements can help Khaled regain and reconquer his body after consulting with Khaled's psychologist.

The physiotherapist learns that during the psychological sessions Khaled loses contact with his body; his legs become numb and he can't feel the floor or the chair he's sitting on. The physiotherapist and

Khaled therefore explore different grounding exercises that Khaled can use during the sessions with the psychologist to break dissociation. Education on bodily reactions to trauma memories, and on persistent pain and its relation to PTSD, is given continuously during Khaled' treatment to better his understanding of his reactions and thereby reduce his anxiety and worries about what is happening in his body.

PTSD and persistent pain are frequently seen in the aftermath of a traumatic experience. Torture survivors have an increased risk of suffering from persistent pain. What factors contribute to the development of persistent pain? Factors that are believed to play a role are: initial pain severity, extent of injury, and the level of emotional stress at pain onset, all of which are present at a high degree in a torture situation. Several factors contribute to persistent pain: continued emotional stress, poor sleep, and avoidance behaviour. Pain can remind the patient of the torture situation and therefore many torture survivors try to avoid pain-provoking activities. This can lead to physical deconditioning, social withdrawal, and minimal involvement in daily activities, and can also contribute to physical deconditioning. Catastrophizing, imagining the worst outcome, can lead to increased stress and arousal and enhance the pain experience. Pain-related fear can cause guarding movements such as tensing of the body.

To treat Khaled's back pain, core exercises are introduced. Firstly, only verbal guidance is used but with a growing feeling of safety; more organic guiding is added in order to help Khaled find a more stable and grounded posture.

A few months later Khaled feels that he is ready to try out the group workout. In the beginning, he stands apart and doesn't interact with other participants but slowly he begins to be more confident. The group activity later inspires Khaled to start working out on his own.

Interprofessional collaboration in person-centred care

Integrated healthcare strategies directed at both psychological and physical health, as well as rigorous control of risk factors, are likely to improve the quality of life of traumatized individuals. As the psychologist approaches Khaled's memories of torture, Khaled

experiences bodily reactions in terms of numbing but also back and neck pain. The psychologist encourages Khaled to use body awareness exercises to stay present during their exposure therapy.

The psychologist and physiotherapist always try to have a short talk in between each other's sessions to reinforce each other's treatment strategies. Khaled says that he's found having physiotherapy during and directly after his sessions with a psychologist to be very helpful. He becomes more present and connected to his body. He describes that his head becomes silent when practicing basic body awareness. The safer Khaled feels with the physiotherapist, the more they work with building trust and confidence through couple exercises, for example guiding each other in the room with open and closed eyes.

Khaled is improving; he can now better understand and put words to his physical sensations, and he uses coping strategies when he gets flashbacks or nightmares. Khaled feels more and more that his body can be a resource to stay present even during the toughest trauma-exposing sessions with the psychologist. He also begins putting himself into situations that he avoided before. He can now reach the common laundry room that lies in the basement of his building complex. He walks in the middle of the pavement instead of close to building walls and he dares to close his eyes in public spaces. At school he explores sitting at the front of the classroom and raises his hand to ask questions. It is clear that Khaled is building resilience and expanding his experience of his surroundings.

In reading this transcript/watching the video, please consider the questions below:

1. What are your first impressions about working with a client like Khaled?
2. What practical strategies could you employ in your practice to accommodate the needs of someone who has experienced trauma?
3. Which of your colleagues would you work with to ensure comprehensive care for a client like Khaled? Do you need to broaden your professional network to enable comprehensive care?

This case study provides an example of multiple ways that health and social care professionals can demonstrate person-centred care for a person with refugee experience. The care plan developed for Khaled considers his physical, psychological, and social needs. Instead of focusing solely on his physical pain, the health and social care team addressed his PTSD, trauma history, and struggles with integration. His treatment was tailored to his specific experiences and comfort levels. For example, he initially avoided group workouts due to trust issues, so the team waited until he felt ready. Shared decision making was evident in the way that Khaled was actively involved in his care decisions, such as choosing where to sit, whether the door should be open, and when to begin group therapy. The health and social care professionals demonstrated effective interprofessional collaboration through a treatment plan that was well co-ordinated and aligned with Khaled's evolving needs.

Conclusion

A person-centred approach to care is concerned with human connectedness. When working with people with refugee experience this means acknowledging the unique needs, experiences, and challenges experienced by displaced individuals. Health and social care professionals need to demonstrate openness to the way that someone understands and interprets their health problems. Many refugees have experienced trauma, loss, and disruption, which can impact their physical and mental well-being. A person-centred approach ensures that healthcare services are tailored to their cultural, emotional, and medical needs, fostering trust, establishing a positive therapeutic relationship, and improving health outcomes.

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