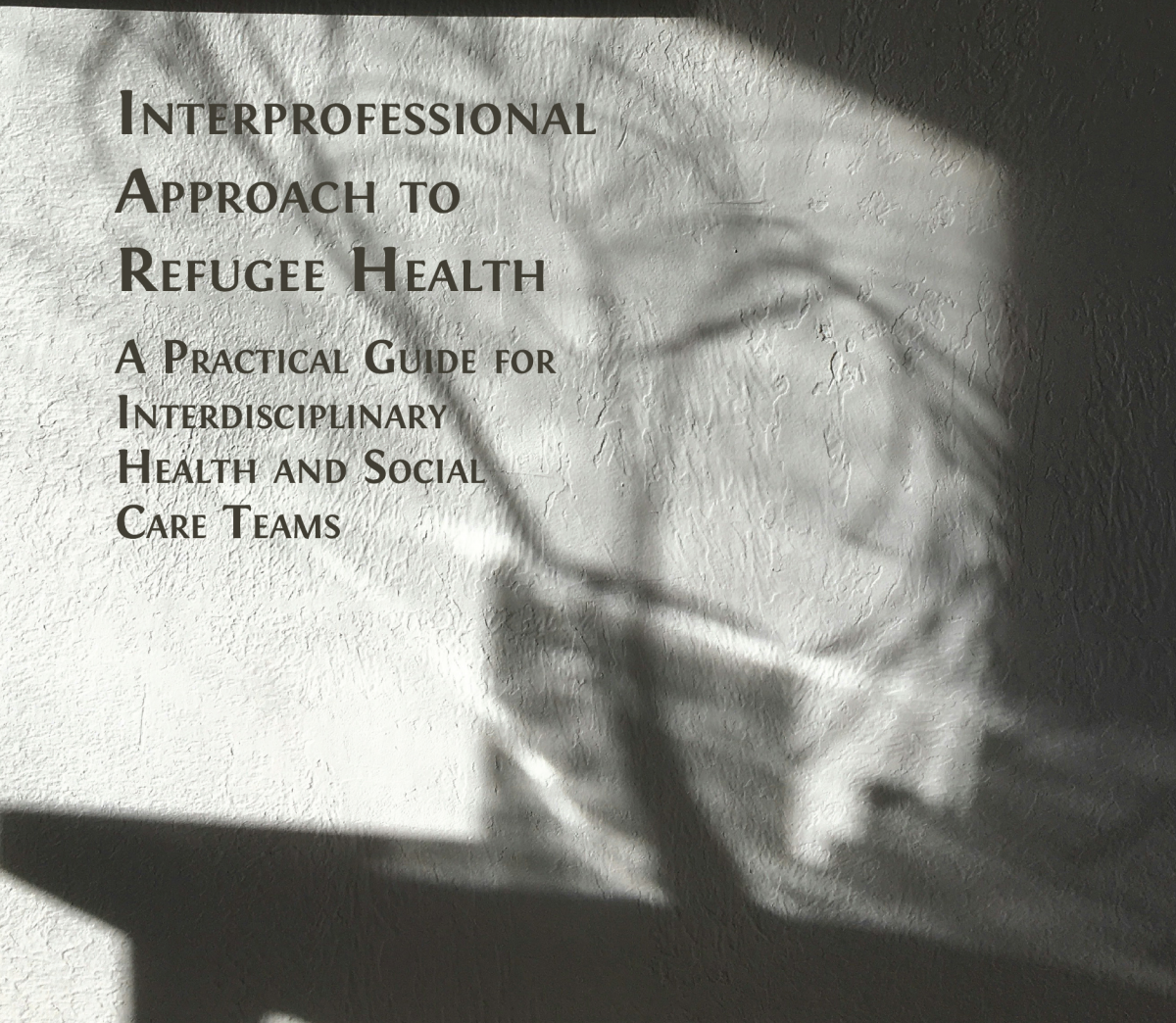


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**INTERPROFESSIONAL  
APPROACH TO  
REFUGEE HEALTH**

**A PRACTICAL GUIDE FOR  
INTERDISCIPLINARY  
HEALTH AND SOCIAL  
CARE TEAMS**



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# 10. Culturally Responsive Practice in Refugee Health

*Sandra Schiller with Angelika Roschka and  
Kathrin Weiß*

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The health of persons with refugee experience is a multifaceted issue, strongly influenced by culture, diversity, and the principles of health equity. This chapter explores these dimensions by introducing key concepts and providing examples of practical applications in the context of refugee health. The first section introduces the constructivist understanding of culture and shifts the focus from merely understanding cultural nuances to appreciating diversity as a critical component of health equity in a diverse society. To illustrate the practical relevance of this approach, in the following section Angelika Roschka describes the role of occupational therapists in facilitating social inclusion. Another important issue is the influence of the cultural backgrounds of both patients and health practitioners on their perceptions and interpretations of illness and pain, which is discussed in the third section of this chapter. Last but not least, the final section integrates international case stories of individuals with refugee experience and case studies on interprofessional practice. This section emphasizes the collaborative efforts required in culturally responsive interprofessional practice to effectively address the health needs of persons with refugee experience. Overall, the chapter aims to outline prerequisites for culturally responsive practice as an essential contribution to a more inclusive and equitable healthcare environment for all.

## Understanding Relevant Concepts: Culture, Diversity and Health Equity

International literature reports that healthcare practitioners sometimes struggle to understand the meaning of culturally responsive practice “due to the perceived complexity and indeterminate nature of the concept of culture” (Minnican & O’Toole 2020). Although culture is a word that is regularly used in everyday language, its exact meaning can be difficult to grasp. Since the term ‘culture’ is understood very differently in academia depending on the epistemological interests of the authors using it, this chapter starts with an introduction of the constructivist understanding of culture (that originated in the humanities) and the related concepts of diversity and health equity in relation to interprofessional refugee health.

### People as Products and Creators of Culture: The Constructivist Understanding of Culture

The outdated positivist (or ethicised) understanding of culture and cultural groups typically equates origin with culture and thus defines people in terms of their (presumed) ethnic, national, or religious origin and affiliation. In this view, cultures are supposedly given entities that can be observed and described, that have clear boundaries to other cultures and that change only slowly. The basic assumption that members of a group share certain characteristics leads to a simplistic description of expected ways that people will think and behave, which hinders the perception of real-life heterogeneity and ambiguities and encourages stereotyping. It also disregards the dynamic processes of human action.

In constructivist theory, cultures are no longer understood as entities to be found in reality, but rather, the ‘reality’ of culture that we believe we can see and describe in the real world is always also a consequence of how we understand culture. This reflects the epistemological basis of cognitive theory: we socially and culturally, i.e., collectively, generate our reality (see e.g., Williams 1983; Grossberg 1997; Barker & Jane 2016). Such an open, process-, meaning- and practice-oriented concept of culture is interested in the learned patterns of how individuals and groups perceive and

interpret the world and how they adapt to it. Worldwide social, political, and economic upheavals and, not least, global migration processes have fundamentally challenged the idea that the world is a mosaic of separate and unchangeable cultures. Current academic debates consequently conceptualize culture within complex, increasingly differentiated and thus highly heterogeneous social contexts.

In health research, a stronger orientation towards the humanities and social sciences, particularly in public health and in the medical and health humanities, has contributed to the realisation that health and illness are not only biological phenomena, but also social constructs that are closely linked to cultural, political, and economic factors and influenced by a specific historical context. In this context, the constructivist understanding of culture refers to a system of beliefs, values, practices, and rules shared by a group and used to interpret experiences as well as behavioural patterns. Culture can thus be described at different levels, including the organizational and group level, e.g., in the context of interprofessional teamwork. According to the constructivist view, culture is something learned, not innate, and, though it may seem persistent, culture is always changing. Since we are all members of different groups, we are all influenced in a unique way by a diversity of cultural backgrounds. Cultures and the people who belong to them are heterogeneous; belonging to a culture does not define the whole person. We all learn culture from many different sources, e.g., parents and other family members, friends and peers, neighbourhood and community members, educational institutions, social institutions, religious affiliations, the media, shared experiences of events, historical traditions, and stories. Consequently, the way in which individuals understand health and illness, and the health/illness behaviour they exhibit as a result, is not only shaped by their language, cultural beliefs, and everyday practices, but also by a range of social and economic factors, by the specific organisation of a healthcare system, and by a person's health literacy, i.e., the ability to understand health and use health services.

### From Culture to Diversity: Health Equity in a Diverse Society

Interdisciplinary research on diversity and intersectionality in health has developed, on the one hand, as a response to the effects of transnational

migration and globalisation processes. On the other hand, it is the result of human rights concerns raised by social movements such as the Black anti-racism and civil rights movement, the women's and LGBTIQ+ movements, or the disability rights movement, which advocated for the recognition of rights and equal opportunities for various groups within a pluralistic society. This research integrates multiple disciplines, including sociology, psychology, anthropology, medicine, and public health, to analyse the complex interactions between diversity, social structures, and discrimination.

The concept of diversity is an approach to understanding the impact of social categories of difference on the life situations and related experiences of individuals (Pincus & Ellis 2021). These categories may include gender, sexual orientation, ethnicity/'race', religion, socio-economic status, disability, and age. The analysis focuses on the relationships between categories of diversity, social hierarchies of difference, and experiences of discrimination.

Research from a diversity perspective postulates that differences are not inherently given but result from social practices of distinction. Consequently, it aims to explore how certain social categories become categories of difference within existing social power relations influenced, for example, by racism, ethnocentrism (hetero)sexism, classism, and ableism, upon which power hierarchies are built (Mecheril 2008).

The concept of intersectionality (Crenshaw 1989) complements the concept of diversity by highlighting the complex interactions between categories of difference that generate inequality, which can influence and mutually reinforce or alleviate each other (Winker & Degele 2010; Collins & Bilge 2020). For example, a migrant woman with a disability may be subject to multiple forms of discrimination.

Typically, categories of difference are created through binary opposition, i.e., the understanding of a person's social identity and position in society is created through demarcation from the perceived other. In social psychology, social identity develops in "fluid processes of identification with personal characteristics and social groups in the context of normative social and societal power relations" (Lerch 2019: 54). As social power relations are firmly rooted in socialisation processes, they are often taken for granted by members of the socially dominant groups and thus become invisible. For example, "the

description and categorisation of people, as it occurs in cross-cultural nursing research and practice, most often takes place from within a White dominant perspective, presented to White audiences, and focuses on description of a non-White or a non-Western group” (Campesino 2008). The term ‘othering’ refers to the socio-psychological mechanisms by which subjects are constructed, classified, and made visible as others or strangers, while the subject positions of members of dominant social groups remain unexamined and unmarked (Rohleder 2014).

Categories of difference are accompanied by norms, stereotypes, and prejudices. They determine which groups are privileged and which are discriminated against. According to Scherr (2008: 2009), discrimination can be understood as disadvantages that “affect social ‘groups’ or individuals on the basis of their actual or perceived membership of a social ‘group’.” Experiences of discrimination occur when people are not only individually affected by a violation of their interests or rights, but are also disadvantaged, excluded, or treated unfairly because of their group affiliation(s). Discrimination is also a frequently discussed, “philosophically challenging” concept in healthcare ethics (Hädicke & Wiesemann 2021). The experience of discrimination in society negatively impacts the health of those affected (Yeboah 2017; Williams et al. 2019; Kluge et al. 2020; Abubakar et al. 2022) and is therefore considered to be one of the social determinants of health. Against this background, it becomes clear that solely focusing on a patient’s (presumed) ethnic-cultural background as the only explanatory variable, while neglecting other factors, amounts to culturalization—i.e., a culturalist interpretation of social interactions associated with stereotypes and prejudices. The German Association of Psychosocial Centres for Refugees and Victims of Torture (BAfF) describes the impact of racism on the lives of persons with refugee experience in Germany and warns health and social care professionals against the temptation of racist and culturalizing explanations in the following way:

In the context of discourse in society as a whole and also specifically in psychosocial work on displacement, trauma and violence, culturalising and racialising assumptions about the situation of refugees are the normal state of affairs. Racism is a solution to many social challenges that has been tried and tested for centuries, since colonialism. It is a

transgenerational body of knowledge that is readily available and can be accessed. It is therefore not surprising that racist and culturalising explanatory patterns are used to explain and categorise complex and overwhelming situations. Often, the solution to these problems lies outside the sphere of influence of individual professions and structures, even though they are active in the context of displacement, trauma and violence, which can reinforce the dynamic of arguing in a racist and culturalising way in order to cover up the powerlessness in the face of structural hurdles and to shift the responsibility to the person. (BAFF and Teigler 2022 – own translation into English)

From a diversity perspective, the situation of persons with refugee experience instead needs to be understood as a complex intersection of various factors such as cultural, ethnic, religious, and linguistic backgrounds, as well as socioeconomic status, political context, and past experiences of displacement and trauma. Health professionals should, for example, be aware of the importance of residence status on a person's life situation—as it influences access to health services, to the education system, to the labour market, possibilities to participate in cultural activities, the right or denial to choose one's own residence, as well as a person's overall future prospects and associated potential psychosocial burdens.

In this context, the human right to health plays a central role, because it expresses the normative conviction that people must not be disadvantaged based on categories or attributions such as social origin, ethno-culturally coded or racialized affiliation, gender or sexual orientation, age, or physical or mental condition. From a social justice perspective, diversity in society and healthcare calls for a commitment to promoting equity and reducing health disparities across diverse communities to improve health outcomes for all individuals, particularly those from marginalized communities. This perspective emphasizes the importance of recognizing and addressing the systemic barriers and social determinants of health that impact individuals and communities from diverse backgrounds, such as poverty, racism, and discrimination (Yeboah 2017; Kluge et al. 2020). This includes an understanding of the significance of socially produced and communicated cultural stereotypes and prejudices, and a critically reflective way of dealing with them.

Self-reflection exercise:

1. Focusing on the context of interprofessional collaborative healthcare practice and racism in the United States, Cahn (2020) explores the possibilities for dismantling structural racism in interprofessional collaborative practice. In this article, the author criticizes the “artificial separation between interprofessional collaborative practice and anti-racism”. It is worth engaging with the arguments he brings forward to substantiate this view. Furthermore, the text characterizes “structural competency”.
2. Do you see parallels between interprofessional collaborative healthcare practice and the situation of persons with refugee experience in your own country? What can you learn from this text regarding culturally responsive interprofessional practice in refugee health?

From the foregoing, it can be concluded that diversity-responsive practice in healthcare is invariably linked to social justice. In 2015, American occupational therapists Pamela Talero, Stephen B. Kern, and Debra A. Tupé developed a model for “Culturally Responsive Care in Occupational Therapy Service-Learning”, which places diversity at its core and relates it to issues of equity and social inclusion. An essential element of diversity-sensitive healthcare education is, therefore, not to separate issues of socio-economic status from so-called ‘cultural’ issues, but to systematically include them in the discussion: “because health care disparities are largely based upon socioeconomic status (SES), socioeconomic status is an effective alternative strategy for addressing diversity issues in health care education” (Gordon 2005: 23).

The reference to human rights is all the more important in an era when dichotomizing social discourses, which tend towards populist argumentation patterns, dominate the topic of culture and cultural identity, so that the demand for the recognition of equal rights is no longer derived from the identification of (alleged) differences.

The discussion in this section has highlighted that health professionals who view culturally responsive practice primarily as a human rights issue, emphasizing social participation, appreciate the opportunities

offered by an intersectoral approach in their field. The concept of occupational justice has empowered occupational therapists to adopt a rights-based focus on enabling persons with refugee experience to participate in everyday activities and occupations. This will be explored from a practical perspective in the next section.

## Practice Experience: The Role of Occupational Therapists in Supporting Persons with Refugee Experience in Germany

Angelika Roschka, M.Sc., is an occupational therapist and a lecturer in the Occupational Therapy programme at Ernst-Abbe-Hochschule Jena, University of Applied Sciences, and a trainer and coach for transculture, anti-bias, and democracy. Angelika has years of experience working with refugees in a small town in Germany. Prior to this, she worked as a community occupational therapist in Kathmandu, Nepal, and then in Cairo, Egypt, conducting and supervising the training of teachers in therapeutic assessment and intervention for children with special needs. The following interview was originally conducted by Bettina M. Heinrich, an occupational therapist working for the editorial team of the German occupational therapy journal *ergopraxis* in 2016. Angelika Roschka received permission to update and significantly expand the original interview as a section for this chapter. It was translated into English by Angelika Roschka and Sandra Schiller.

Q: Occupational therapists' education already provides the therapists with transcultural competences, doesn't it?

Theoretically, you could see it that way, insofar as the education provides understanding and teaches diversity as a cross-cutting theme through all modules. From my practical experience, transcultural competence is multi-faceted, highly complex, and a lifelong learning process. Somewhere I once read the sentence: "No one can know everything about everything at any one time". For me, this describes very aptly the learning mission that transcultural action implies. I don't like the term 'competence' so much, because a competence would be measurable at some point. In my understanding, however, there can be no such thing

as a certificate for being ‘transculturally competent’, because there are no blanket recipes, no ‘do’ and ‘don’t’ lists, no matter how much we may long for them in our dealings with diverse clientele. Rather, I find the term ‘transcultural learning’ more appropriate. Every encounter with people—including those who seem ‘foreign’ to us because of our own conditioning—offers an opportunity for learning. Every person has a ‘universe of cultures’ within them that changes over time and can sometimes be contradictory. This includes e.g., symbols, rituals, value assumptions, and beliefs, as well as all routines and habits of activity in everyday life. In a transcultural encounter, two universes meet. There is communication (verbal, and crucially also nonverbal) and it is almost impossible for this not to be a learning task. We cannot know exactly why our counterpart thinks, feels, and acts the way she/he does.

Q: So, does transcultural competence mean the willingness to open up to cultural differences?

Besides differences, there are always similarities that I notice when I look closely. And it means having the openness to embrace the uncertain. It implies the willingness to let one’s own world view ‘collapse’—if necessary several times a day. And that means triggering the process of transcultural learning within oneself and reducing that diffuse fear of losing control that is so inhibiting.

Q: How do you convey this? How do the participants in your courses learn this?

The process of transcultural learning in an occupational therapy context shows itself in a socially successful interaction with culturally diverse clients. I do not understand culture as something that results purely from a person’s national or ethnic origin, but as emerging in relation to different diversity dimensions, such as age, disability, sexual identity, and sexual orientation or socioeconomic background. And when we talk about diversity, it always means at the same time to consciously deal with discrimination, even if this is not easy for us to accept and to speak about. Discrimination (at conscious or unconscious level) always leads to devaluation and exclusion. Thus, in my current educational work, the consideration of power relations in society is in the foreground, which is also a highly relevant context for occupational therapy services. As an occupational therapist, I reflect on

this and ask myself, for example, through which cultural glasses I read my client's experiences, with which ear I listen to them and to what extent I (unconsciously) practice attributions. It is the permanent confrontation with client orientation and interactive reasoning that we seem to have internalised. But since we are not free of prejudices, there is a constant danger that we will not do justice to people, in the truest sense of the word, due to societal structures, our own influences, and the socially constructed boxes we are used to thinking in. This is why it is important to be sensitive to the concept of prejudice awareness and to realize the connection between society and its individual members.

In my workshops, I invite the participants to take a look inside themselves in order to deal with the question "Where do I come from?"—not primarily in a geographical sense but from a social point of view. Looking at, becoming aware of, and reflecting on one's own cultural imprints and experiences are an important building block of transcultural learning. For example, the way my parents actively involved me in family decision-making processes in my childhood days still influences my ability to formulate my own wishes today. When people grow up in a more collectivist context, ways of thinking anchored in society in terms of 'we' rather than 'I' categories may be prominent. What does this mean in terms of joint goal formulation with the client? How can the question "What is important to you personally?" affect different people? Does it make sense to them? Do we need alternatives beyond verbal language? In my workshops we discuss such questions and constantly refer to our own diverse cultural backgrounds. These processes of reflection make us sensitive to our own privileges that result from our own cultural background and societal influences, as well as to experiences of discrimination that arise from unequal power relations. It broadens our view for the need to be empathic, e.g., in the everyday life of people with disabilities who—according to an inclusive understanding—are dis-abled by their environment rather than being disabled themselves. The ability to adopt a perspective (without claiming to really understand 'the other') is fundamental.

**Q:** Where do you see occupational therapy in the context of support for persons with refugee experience?

I definitely see occupational therapists as having a political responsibility to work with persons with refugee experience and other people who

are experiencing daily occupational deficits on different levels—from occupational imbalance to occupational apartheid. Occupation is a human right! A large number of persons with refugee experience cannot pursue a self-determined everyday life with activities that are meaningful to them, because they are often accommodated for months or even years in collective accommodation centres—i.e., in an imposed setting with limited privacy. Instead, they experience occupational disruption, marginalisation, and occupational deprivation—as international studies on displaced persons in refugee camps have shown. Theoretical knowledge about occupation, meaningful activities and their impact on quality of life, health, and well-being is researched in the field of Occupational Science. However, in order to allow occupational therapists to truly act in a culturally sensitive way, in-depth research practice is needed that includes all diversity dimensions of people, i.e., occupational therapists' clients, and tries to understand their activities in diverse contexts. In order to achieve occupational therapy services that are diversity-sensitive in the true sense of the word, and thus also discrimination-sensitive, the following is needed: further research on occupational therapy theory formation, specific qualifications for occupational practitioners, as well as an even broader anchoring of diversity topics and the associated discrimination in profession-specific educational curricula. In combination with community-oriented work, this offers enormous future potential for the profession.

Q: How can occupational therapists get involved in this field?

I recommend that occupational therapists who want to make contact with persons with refugee experience for the first time approach social workers working in collective accommodation centres, but also caretakers and security guards, and start a conversation. Social workers are important contacts for occupational therapists, as they are very close to people through the social counselling they offer and are familiar with the problems that affect people's everyday lives in a camp. They work closely with staff in public authority, such as the social welfare office or the foreigners' registration office. It can be helpful to note down names (ideally those of cooperating, friendly persons) of people who can be important in accompanying persons with refugee experience to the authorities. Often there is also useful cooperation to be had with interpreting services and it is valuable to know multilingual people

for translation services. Political and church representatives of the municipality are also extremely important to the network for engagement with people with refugee experience. Who are the advocates here with regard to the issues of escape and asylum who honestly and publicly propagate an intercultural opening and support the complex process of the arrival of diverse people in the best possible way, so that the place of arrival can perhaps become a new home? And who are members of civil society who (want to) participate in this challenging process? Are there associations, initiatives, networking meetings, and meeting places for exchange? I would like to encourage occupational therapists to get actively involved in building civil society initiatives. With a handful of people in the community, I was able to set up an initiative for 'New Neighbours' in 2015 and thanks to many great (albeit fluctuating) supporters over the years, the initiative is still operating today and most recently won the Democracy Award (for its persistent commitment).

For a first contact with persons with refugee experience, I recommend occupational therapists not to proceed primarily in a goal-oriented way (as we know it from the Occupational Therapy process), i.e., not necessarily and literally to have a suitcase with materials with them (according to the motto: "We are making Christmas stars today because it is December"), and not to think in advance about what exactly they could do. Some key questions for self-reflection can help, for example: Do I want to do something for persons with refugee experience? In a helping or supporting role? What do I expect from this? Do I want to do something with persons with refugee experience (in the sense of interacting at eye level and with the understanding that everyone has a contribution to make)? It can be helpful to remember that, in the context of escape and asylum, we meet people who are currently stuck in a chronic waiting loop and whose lives are primarily characterized by uncertainty. I do not know their interests, experiences, narratives, but I open myself with awareness of my own prejudices. Accepting the invitation to a cup of tea—as I learned during my work assignments as an occupational therapist in Nepal and Egypt—is a central key to building a relationship. I can offer myself as a listener and a contact person who takes the time to grasp what role meaningful action and meaning-making plays in the lives of persons with refugee experience. I can try to shape their everyday life together with them (within the

framework of legal regulations) and gradually fill it with meaningful activities. I can be a bridge-builder who helps them to arrive in the country of arrival and its society, to gain a foothold, to act in a self-determined way and—ideally—to find a new home.

Q: What do persons with refugee experience need?

Persons with refugee experience have a wide range of wishes, needs, and desires. Sometimes a trauma covers up those wishes and longings. In the area of activities of daily living, there are needs that they—due to the current deficit of a common language—are unable to communicate, or often only rudimentarily. Can you imagine being forced to leave your home country and to stay in a totally new place where you don't know anything at all about its culture? Some needs of newly arrived people may seem quite banal to us. It is part of everyday life in a collective accommodation centre that you will meet people who approach you with a letter from the authorities or a health insurance certificate. Gestures are used to articulate that the person does not know what to do at this point. The person doesn't understand the document and may not know what to do next. And they may also need someone to talk to a doctor on the phone and make an appointment. Accompanying them to the authorities or to medical facilities is a great support, especially in the first months of the asylum procedure, when language courses have not yet started or have only just begun. A 'short line' to medical staff who cooperate easily and their willingness to engage—despite the fact that language translation is often lacking—is enormously helpful, especially in acute situations and in the case of chronic illnesses of people who need multiple types of personal assistance and support.

The everyday life of the new arrivals poses countless challenges because it takes place beyond a familiar environment: where can food be bought that caters for a variety of religious backgrounds and related dietary habits? Is there a prayer room in the collective accommodation or somewhere else? What is the imposition of sanitary facilities and communal kitchens shared by many? Where do voluntary language courses or homework supervision for the children take place—beyond the state-subsidized ones? Where can one simply sit down in peace and quiet outside the room shared with many others? Where is access to free Wi-Fi so that you can stay in contact (possibly even undisturbed) with

your family in your country of origin? Is there a locality or open space to meet natives and persons who have already settled in the new place who can show places to go for a walk, relax, spend time in a pleasant way?

By visiting the accommodation, the occupational therapist can get an idea of the situation and identify the needs and problems of the people living there that can be addressed. The approach can be 'classic occupational therapy' in the sense of a culturally sensitive and diversity- and discrimination-conscious client orientation: which activities are problematic in the everyday life of the people living in the facility? How important are these activities to them? How satisfied are they with their performance? This is illustrated, for example, by the following words of a woman with refugee experience in a collective accommodation centre:

Because of the four children, I can't take part in the language course that my husband has been attending for a few months. Soon he will take his first language exam. One of my children has a mental impairment. I have only learned a few German words so far. Yet I worked as a teacher in my home country. I loved it. How can I go on?

Persons with refugee experience face increasing challenges even once they have obtained residence status. When someone with a 'foreign-sounding' name is looking for a flat, it is not uncommon for this person to encounter prejudices and be hindered or prevented from access to the housing market. The same may happen in the application process in the labour market—the hurdles for people who are considered 'foreign' are enormous—despite the fact that some persons with refugee experience have occupational training or university degrees, which are put to the test in lengthy recognition procedures and do not always bring about successful integration into the labour market. Opening a bank account, which is a condition for employment, stands and falls with the attitude of the bank employees.

At all levels of society, it is important to stimulate institutional opening processes so that participation is made equally possible for everyone and—from the occupational therapist's perspective—the claim of occupational justice can be guaranteed. As an occupational therapist who takes on political responsibility, I act as an advocate for occupational rights and demand what people in their diversity are legally entitled to. The prerequisite for this is that I see myself as a member of the majority

society, who is privileged simply because I don't face these barriers regarding societal inclusion in many respects.

Q: Do you have a wish regarding your occupational therapy colleagues?

I would like to encourage occupational therapists in Germany to start supporting persons with refugee experience in a way that is sensitive towards culture, diversity, and discrimination. This requires us to become aware of the fact that it matters whether people are read as e.g., 'white' or 'black', as homo-, hetero-, bi-, trans-, inter-, queer-sexual or as a person with a disability and not as a person hindered by environmental conditions. With all the appropriate criticism of westernized occupational therapy's (in)compatibility with the needs of people from all over the world, we can focus on something that connects all people globally and is thus universal common ground: we all have an everyday life with diverse activities, we all shape everyday activities and routines, whether we actively reflect on this or not. We are confronted with specific everyday wishes, needs, and occupational imbalances, even if these may vary strongly between people. What can occupational therapy contribute to ensure that occupational justice does not remain the privilege of parts of society?

If we as occupational therapists become involved as advocates for occupational justice and—even beyond a medical diagnosis—sensitively accompany people with refugee experience or/and persons from other vulnerable groups in their everyday lives and support the process of arriving in a home, which may eventually become a true home for them, then occupational therapy is fulfilling its political responsibility. It helps to shape a pluralistic society with its core competence in supporting occupations, which allows all people to be themselves in their everyday lives, to do something meaningful, to feel they belong and to become the person they want to be in future.

To further engage with this text, consider the following questions:

1. How does Angelika Roschka describe the unique professional perspective, role, and approaches of an occupational therapist supporting persons with refugee experience?
2. Which examples does she provide that illustrate the connection between the concepts of culture, diversity, and health equity described in the introduction?

3. If you are an occupational therapist: would you describe the occupational therapy perspective on working with persons with refugee experience in your own country in a similar way? If you are from another health profession: what unique professional perspectives, roles, and approaches does your own profession bring to interprofessional teams?
4. What kind of interprofessional collaborative practice does Angelika Roschka mention? In addition to that, which other types of culturally responsive interprofessional collaboration in refugee health can you describe?

Throughout the 20th century, occupational therapy was predominantly aligned with the biomedical paradigm and focused on clinical settings. In recent decades, however, the profession has become grounded in a more nuanced understanding of health inequalities shaped by macro-economic, environmental, social, and political factors. As the interview with Angelika Roschka showed, this has broadened the traditional focus of community occupational therapists working with persons with refugee experience from merely addressing medical symptoms to considering a person's entire environment and social context, thereby fostering a comprehensive approach to health and well-being. This can provide an example for other health professions, how the divide between health and social care can be bridged.

Staying more within healthcare, adopting a cross-cultural perspective requires health professionals to critically engage with how culturally mediated perceptions influence our understanding of illness and health, as well as our approaches to illness management and prevention. To what extent do we all possess a unique cultural perspective on health and illness? The following section will focus on how cultural influences can affect the individual experience of pain, including pain perception, description, and management. It is crucial for health professionals to consider how to act sensitively with regard to diversity when dealing with pain experiences and behaviours.

## Cultural Influences on Understanding Illness and Pain

Pain is a common symptom of many medical conditions, but for healthcare professionals pain assessment, pain management, and adjustment of pain medication can be challenging. The philosopher Ludwig Wittgenstein's thoughts on pain are also valued by modern pain research. While the tradition of focusing primarily on the individual subject had long prevailed in philosophy, Wittgenstein's philosophy of sensation shifted the focus from the self to a 'we': he regarded human beings as essentially social beings who can only be understood within a linguistic and cultural community. Therefore, pain and other emotions should not be understood as private phenomena known only to oneself (Wittgenstein 2003). Common definitions describe pain as a contextual experience. This context depends on how a person evaluates their pain. Pain originates in the brain and is unique to each individual: it is a highly subjective emotional experience that is culturally influenced and in turn triggers culturally specific behaviours. The culturally determined individual understanding of pain is related to a person's thinking, values, norms, control beliefs, coping strategies, and life experiences (Callister 2003). The culturally transmitted standards for assessing pain, i.e., the individual's experience of pain, develop in childhood and continue to change throughout life. The more experiences are stored in the brain, the more possibilities there are for comparison on how to react to current pain. The experience of pain leads to pain-related behaviours that range from stoically ignoring the pain to wailing and loudly calling for help. The study by Sharma et al. (2016), for example, illustrates the difficulty of describing pain. It compares the words used by people with chronic pain in Nepal to describe their pain with those used by patients in the United States.

Pain is the result of a biochemical process, but can only be experienced "in the isolation of an individual mind" (Morris 1994: 26) and is strongly influenced by the patient's unique socialisation and cultural background (ibid). Living in a diverse society requires healthcare providers to respect and consider the particular cultural backgrounds from which their patients come. Pain is perceived by the patient and can only be reported by the patient. For individual pain assessment, it is important

to understand how a patient experiences their pain, what behaviours result, and how cultural perceptions influence this process. Possible cultural differences only become apparent to others when patients disclose their pain. Communication plays a particularly important role in this context. The more the communicating individuals agree in their cultural perspectives, the more likely it is that a healthcare professional will be able to understand the extent of the patient's pain. However, if there is insufficient agreement or if the interpretation is vague, it is important to first understand the patient's individual culture without judgement. On this basis, an accurate representation of the patient's pain can be created by using the patient's narratives to articulate helpful descriptions and explanations.

#### Self-reflection exercises:

Narajan (2010: 40) provides suggestions for diversity-sensitive approaches to pain experience and behaviour (in terms of pain assessment, helpful/neutral/harmful values and practices). The text includes "self-assessment questions to help nurses determine their cultural norms concerning pain".

The following questions are intended to promote deeper engagement with the topic:

- How do cultural influences and socialisation influence your understanding of illness and health and your approach to illness and prevention? To what extent do you as an individual have a unique cultural perspective?
- What is pain, how is pain relieved? How do cultural influences and socialisation affect your experience of pain (feeling pain, describing pain, dealing with pain)?
- How do cultural influences and socialisation influence the way you as a health professional deal with pain assessment and pain management?

How is pain assessed, quantified, and communicated? How do cultural, institutional, societal, and regulatory influences affect pain assessment and pain management? In a previous project on refugee health, Physiotherapy

and Refugee Education Project (PREP), Victoria Zander, PT, PhD created two short presentations about the impact of migration on pain.

The following questions are designed to support active engagement with this content: [https://play.mdu.se/media/t/0\\_iyg9hny1](https://play.mdu.se/media/t/0_iyg9hny1)

1. How does Victoria Zander describe the healthcare situation of persons with refugee experience in Sweden? What are typical health concerns and determinants of health for people with refugee experience?
2. How does she explain the influence of (forced) migration on the perception of chronic pain?
3. What could be your own profession's role in this context?

The following questions are designed to support active engagement with this content: [https://play.mdu.se/media/t/0\\_417g24xw](https://play.mdu.se/media/t/0_417g24xw)

1. How does Victoria Zander describe the connection between culture, health/illness beliefs, perception of pain, and help-seeking behaviour?
2. How does she characterize the challenge provided to health professionals treating migrant or refugee patients with chronic pain? Which solutions does she suggest?
3. What are your own experiences in professional practice with persons with refugee experience?

“The adequate treatment of pain has been highlighted in recent years with emphasis on the need for a multidisciplinary approach” (Pillay et al. 2015). Chronic pain in particular is a multifaceted process arising from the concurrent interplay of pathophysiological, cognitive, affective, behavioural, and sociocultural factors (Pillay et al. 2015). An approach is needed that encompasses the impact of socially constructed concepts such as socioeconomic factors, power dynamics, ethnicity, and racism in pain care and research (McGregor & Walume 2021). Such a perspective takes into account the complexity and distinctions between socioeconomic factors and ethnicity. Narayan (2010) discusses problems complicating pain management, such as language and interpretation issues, which hinder the effective communication that is

essential for successful pain management and pain education; nonverbal communication patterns, i.e., facial expressions, body posture, and activity levels, which are likely to be misinterpreted; culturally or linguistically inappropriate pain assessment tools, including numeric, visual analogue, and verbal rating scales; underreporting due to patients' belief that 'good' patients do not complain; and prejudice and discrimination. This contributes to a better understanding of the challenges faced by migrant or refugee patients with (chronic) pain and to developing potential responses to these challenges. Health professionals need to respect the beliefs, experiences, and values of patients, their families, and communities. They need to communicate effectively with them, as well as with other professionals, and within interprofessional teams. Additionally, they must be aware of the potentially positive and negative influences of provider and system factors on effective pain assessment and management, and be able to advocate for patients on individual, systemic, and policy levels. In future, the highly relevant calls for the creation of more opportunities for mutual learning through interprofessional pain education (e.g., Gordon et al. 2018; Garwood et al. 2022; Helms et al. 2023) should be combined with the need for culturally responsive practices in pain management outlined here.

As we deepen our understanding of how cultural influences shape perceptions of illness and pain, it becomes evident that health professionals must engage in continuous self-reflection and learning. This is where the concept of cultural humility becomes pivotal. The final section of this chapter introduces cultural humility as the foundation for exploring an interprofessional understanding of culturally responsive practice in refugee health. This process encourages health professionals to develop an intrinsic therapeutic attitude of humility and modesty. The section will feature case examples from refugee health to facilitate interprofessional exchange, highlighting the value of sharing diverse professional insights. Such exchanges prompt reflection on our practices, biases, and attitudes, enriching our ability to provide culturally sensitive care.

## An Interprofessional Perspective on Culturally Responsive Practice in Refugee Health

In a diverse society, healthcare cannot be based on the principle of one-size-fits-all, since patients from diverse social and cultural backgrounds may have unique health needs, expectations, and experiences. Cultural competence has long been seen as an ongoing process of recognising, valuing, and respecting difference (Campinha-Bacote 1999), “through which one develops an understanding of self, while developing the ability to develop responsive, reciprocal, and respectful relationships with others” (Battle 2000). However, as Minnican and O’Toole (2020) point out, the term “culturally responsive practice” has been more strongly favoured in recent years as it “implies the ability to accommodate the cultural needs of the service user rather than being able to function without error in their culture”.

Culturally responsive interprofessional practice in refugee health involves a wide range of healthcare professions working together as a team to provide empathetic, respectful, person-centred care that contributes to equal health opportunities. This includes understanding influences on service delivery at micro, meso and macro levels, and how these can be navigated.

Culturally responsive practice is characterized by recognizing the diversity of individual life experiences and cultural or linguistic backgrounds of patients in diagnostics, treatment, and counselling. It is based on an open, appreciative, and empathetic attitude that takes into account the patient’s individual needs and perspectives. This also requires sensitivity towards one’s own cultural influences and their potential impact on service provision. Culturally responsive practice is characterized by attentiveness to different barriers that could have a negative influence on service delivery or prevent its results from being relevant to the patients’ lifeworld, and looks for ways to minimize or overcome these barriers. It also includes avoiding stigmatizing or stereotyping language patterns that could affect a patient’s identity or self-image. Beyond the immediate therapy situation, the specific social context of the clients or patients as well as the institutional context of service provision are also considered. This demand for analytical skills on the meso and macro level on the part of the healthcare professionals

leads, for example, to a new understanding of therapeutic interaction as collaborative relationship-focused practice (Restall & Egan 2021).

In this context, two diversity concepts in particular have received increased international attention in the healthcare sector: Cultural Safety and Cultural Humility. Cultural Safety is an approach that was originally developed by Maori nurses in New Zealand in response to the ongoing negative effects of colonialism on healthcare and the health status of the Maori (Gray & McPherson 2005; Mortensen 2010). It has since been adopted and further developed in the health literature from countries like New Zealand, Canada, and Australia, i.e., countries where indigenous peoples have demanded their social rights, including health equity within the healthcare system. Within the concept of Cultural Safety, students and professionals must be aware of the influence of the social, economic, and political contexts, as well as historical developments such as racism and colonialism, on the organisation of the healthcare system and its range of services. As power and authority are also embedded in health policies, practices, and protocols, dominant groups and the prevailing health culture need to change and adapt to provide a sense of cultural safety in health services (Ball & Lewis 2011; Peltier 2011).

The approach of Cultural Humility was conceived in 1998 by the physicians Melanie Tervalon and Jann Murray-García as a counter-concept to the widely accepted didactic models for developing cultural competence. They understand cultural differences as an inherent element of the relationship between the equal perspectives of healthcare providers and patients. According to Tervalon and Murray-García (1998: 117), “cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations”. With regard to people with refugee experience, this means being continuously in a culturally sensitive, critically reflexive process in order to examine dynamics between healthcare provider and patient, to perceive power imbalances and to consciously counteract them. Power imbalances can arise, for example, because the people involved in the therapeutic process have a different understanding of their roles. This includes paternalistic experiences in the healthcare system. A flexible and humble attitude that develops in a lifelong process of self-reflection enables healthcare

professionals to let go of the deceptive feeling of security that arises in a stereotype-based interaction, to assess a situation individually and, if necessary, to admit their ignorance in order to then embark on a search for new resources that can contribute to improving their future professional practice (Tervalon & Murray-García 1998).

The three tenets of cultural humility are described and illustrated by case studies in an article by Lea Ann Miyagawa: 'Practicing Cultural Humility when Serving Immigrant and Refugee Communities.' Available at: <https://ethnomed.org/resource/practicing-cultural-humility-when-serving-immigrant-and-refugee-communities/>

Self-reflection exercise:

1. Can you relate to these case studies?
2. Have you already been in similar situations?
3. What facilitated or hampered your actions?

The aspects of culturally responsive practice are often difficult to fully grasp for healthcare professionals who have not been in similar situations themselves. Engaging in mental exercises to place oneself in the perspective of the other party can be highly beneficial. Consider attempting the following thought experiment to cultivate cultural humility.

### Thought Experiment: Interprofessional Culture Tour

Imagine that you are relocated as health professionals to the country of Utopia, which is completely foreign to all of you.

- What information about this country do you need in order to have a basic understanding of its healthcare system?
- What information do you need to be able to get help with a health problem?
- How would you introduce your profession to strangers in this country so that you could be assigned a meaningful professional role in its healthcare system?
- How does Cultural Humility help you in this process?

Both Cultural Safety and Cultural Humility explicitly address discrimination and racism. This is particularly important given that the generic term 'culture' allows for the avoidance of dealing with the existence and effects of racism and other discriminatory systems of difference in the health sector. This issue is demonstrated by models of cultural competence in which this problem is not addressed (Boutain 2005).

The following three case studies aim to inspire a discussion of culturally responsive practice in the field of refugee health with a focus on interprofessional collaboration. They depict situations that have occurred in the same or a similar way within healthcare facilities. In each instance, interprofessional teams were responsible for the treatment of individuals with a refugee background. The questions accompanying the case studies are designed to stimulate discussions among interprofessional teams about these scenarios, fostering cultural sensitivity and the development of cultural humility. By exchanging ideas, we articulate our thoughts and can build upon each other's insights to further refine our understanding.

If possible, form small groups to discuss the case studies and accompanying questions. For those who wish to explore the topic independently, select a case study and record your reflections on the questions presented.

### Narrative 1

Bara'a and her family fled their home in Syria and currently live with her husband and three children in a refugee shelter in Berlin. Bara'a is still traumatized by the birth of her youngest child, Rouba, four years ago. Her hands tremble when she thinks back to that time. Unable to breastfeed her daughter due to psychological exhaustion, Bara'a relied on donations to buy breast milk for Rouba. When the donations ran out after a week, Bara'a had no choice but to feed her newborn with a mixture of sugar and water. Rouba has two older siblings. During Rouba's paediatric examination, the paediatrician notices that Rouba's development is delayed and she tries to talk to Bara'a about the child's situation and the plan for possible therapeutic support by occupational therapy, physiotherapy, and speech therapy. Bara'a barely speaks German and looks at the doctor anxiously, nodding repeatedly in conversation. After a few minutes, Bara'a leaves the room and holds

her daughter tightly against her. She does not show up for the first scheduled appointment of the therapy.

(Inspired by <https://www.globalgiving.org/learn/listicle/13-powerful-refugee-stories/>)

### Narrative 2

David flees from the Gambia with his brother. The brothers' family collects all the money at their disposal to make their escape possible. They flee in a boat across the Mediterranean. David's brother drowns during the crossing. David himself suffers from severe sickle cell anaemia and a shoulder joint restriction. He could not receive adequate treatment in his home country. On the flight, the pain crises worsen. Once in Italy, David receives no health assistance in the refugee camp and continues to flee to Germany. Here he is accepted as an unaccompanied minor refugee in a residential home for young adults and receives support from a counsellor who also helps him to receive good medical care. David then receives psychotherapeutic and physiotherapeutic therapy. David starts a nursing assistant training course. The severe illness leads to repeated hospitalizations and severe pain crises. David fears that he will not be able to complete his assistant training and wants to discontinue it. He is particularly burdened by the recurring pain crises in everyday life, which he cannot hide from others and which are very unpleasant for him. He talks to the doctor about the situation. The doctor asks the supervisor, therapists, and the head of the training program to meet with David for a joint discussion.

### Narrative 3

Sergey flees from Ukraine to Germany with his wife and their little son Yegor. The son is five years old. The family is staying with friends in Germany. The friends approach Sergey about the fact that the little son does not make any contact with them and does not even look at them. Sergey explains that his son has always been a bit slower in his development and he is loved by his wife and him the way he is. The friends recommend that Sergey be examined by a paediatrician friend who works at a social paediatric centre. Since Sergey and his wife do not

speaking German, the family friend offers translation assistance. Reluctantly, Sergey and his wife follow the suggestion to go to the doctor with their son. The doctor has asked an occupational therapist and a speech therapist to come to the examination. The examining paediatrician, after consulting with the therapists, confronts Yegor's parents with the statement that their son suffers from an autism spectrum disorder and is in urgent need of treatment. The parents do not understand the doctor and the translation of the friends. They ask many questions and want to know again and again why the child must be treated, since their son is doing well and they are now safe.

The following questions are intended to encourage a more thorough exploration of the narratives:

1. Reflect on the roles played by the various participants in the situation. What intentions guide their actions and procedures?
2. How can the behaviour of Bara'a, David or Sergey be explained from a culturally responsive perspective?
3. What do you need to know as an interprofessional team to create a safe space for this individual or family?
4. Which aspects of the interprofessional team members' cultural and professional backgrounds, shaped by their own socialisation and the healthcare system in their country of training, might be perceived or interpreted differently by patients with refugee experience due to differing healthcare experiences and expectations in their country of origin? For example, some healthcare systems emphasise patient autonomy and shared decision-making, which may be unfamiliar to individuals from countries where healthcare professionals make decisions on behalf of patients. In some countries, mental health is highly stigmatised or not recognised as a medical issue, whereas in the local context, seeking psychological support is encouraged.
5. How can you enter into this relationship with cultural humility?
6. How would you as an interprofessional team help and support a patient who suffers from fear associated with forced

migration? What is your role as a professional in the team in this situation?

7. What could person-centred care mean in the situation of Bara'a's and Sergey's family and in David's situation?
8. Please develop a step-by-step plan for an interprofessional approach to build a relationship that is culturally safe, trauma-informed, and anti-oppressive.
9. From your respective professional perspectives, consider which tasks of this plan you could competently complete as a team member and share your thoughts on them.

## Conclusion

In conclusion, the health of individuals with refugee experience is a complex issue intricately influenced by cultural dynamics, diversity, and health equity principles. This chapter has delved into these dimensions and tried to offer a comprehensive exploration of key concepts and practical applications within the context of refugee health. Initially, we examined a constructivist understanding of culture, shifting the emphasis from merely understanding cultural nuances to recognizing diversity as a pivotal component of health equity in pluralistic societies that value the diversity of their populations, including the diversity of persons with refugee experience. The role of occupational therapists in fostering social inclusion was highlighted, demonstrating the practical implications of this approach. Importantly, cross-cultural healthcare, as discussed in this chapter, extends beyond the healthcare sector, necessitating a reliable intersectoral approach.

Furthermore, we considered how the unique cultural backgrounds of both patients and health professionals affect their perceptions and interpretations of illness and pain, underscoring the need for a nuanced appreciation of the influence of culture in healthcare interactions. As a consequence, health professionals need to be able to critically reflect on their own cultural influences and biases, as these significantly impact patient interaction. In this context, cultural humility emerges a valuable concept for fostering such critical reflection and professional development. The chapter culminated in a synthesis of international

case stories and studies in interprofessional practice, underscoring the collective efforts necessary for culturally responsive care. Overall, this chapter outlined the prerequisites for culturally responsive practice, advocating it as an essential step towards achieving a more inclusive and equitable healthcare environment for persons with refugee experience.

## Recommended further reading

The following two reviews show the demands for (and gaps in) culturally responsive healthcare from provider and patient perspective:

- Grandpierre, Viviane, et al. 2018. 'Barriers and Facilitators to Cultural Competence in Rehabilitation Services: A Scoping Review', *BMC Health Service Research*, 18, <https://doi.org/10.1186/s12913-017-2811-1>
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