

EDITED BY  
EMER MCGOWAN,  
DJENANA JALOVICIC  
AND SARAH QUINN

**INTERPROFESSIONAL  
APPROACH TO  
REFUGEE HEALTH**

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



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# II. Cross-Cultural Communication in Refugee Health

*Sandra Schiller and Andreas Wolfs*

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In the increasingly diverse landscape of modern healthcare, effective communication is paramount. Persons with refugee experience often face unique health needs that necessitate skilled and complex interventions. At the same time, they share the cross-cultural communication needs that are typically characteristic of migrant health. Looking at communication in refugee health, this chapter reflects the paradoxical situation in which persons with refugee experience in the healthcare system are at once comparable to other patients and uniquely distinct. The first section looks at the role of communication in fostering a more equitable health system based on the concepts of inclusive communication and inclusive multilingualism. Counselling from a systems theory perspective is introduced as an analytical framework to be utilized in the context of refugee health, and practical approaches to enhance cross-cultural communication are presented. This chapter emphasizes the importance of creating structures and services that are sensitive and responsive to cultural and linguistic diversity, explores cross-cultural communication strategies at the interpersonal level, and provides information on working with interpreters and cultural mediators. The final section of the chapter highlights the significance of interprofessional collaboration in cross-cultural communication within the context of refugee health.

## The Relevance of Effective Communication in a Diverse Health System

How can health professionals deal with communication barriers in a resource-oriented and productive way? This chapter looks at a process that concerns not just individual health professionals and persons with refugee experience, but also policymakers and organizations responsible for setting up structures and services in the health system, including refugee organisations.

Communication is the process of exchanging information, ideas, thoughts, and feelings between individuals or groups through various mediums and channels, generating meanings within and across contexts and cultures. It is a fundamental aspect of human interaction and vital to achieve understanding and convey meaning in personal relationships, organizations, and society as a whole. Communication can take various forms (including verbal, nonverbal, written, and visual). Healthcare professionals must get to know their patients by understanding their cultural and linguistic backgrounds to ensure that they provide appropriate care. Effective communication is an essential basis for fostering good interpersonal relationships and significantly enhances the efficacy of service delivery in healthcare, thereby leading to better results and improved goal attainment.

A resource-oriented approach to addressing language barriers in healthcare recognizes the value of multilingualism and linguistic diversity. Instead of framing language barriers as a negative aspect of care, a resource-oriented approach emphasizes the importance of language access as a resource for improving the quality of care and promoting positive health outcomes. One way to express this approach is to focus on language access as a valuable resource for enhancing communication and building trust between healthcare providers and patients. Another way is to focus on the benefits of language access for promoting patient autonomy and empowerment. In today's culturally and linguistically diverse society, two essential guiding principles can provide the foundation of culturally responsive communication in healthcare:

1. The concept of inclusive communication represents a process in which different strategies are applied to allow people with communication vulnerabilities to feel acknowledged and respected in the communication and to become actively involved in society. Consequently, inclusive communication is adapted to the individual communication strengths and needs of the persons seeking information and requires accessible, individualized resources together with appropriate communication partners that have the necessary skills, knowledge, experience, and attitude (Money et al. 2016).
2. The concept of inclusive multilingualism values the interactive strategies or communicative modes applied by participants in multilingual interactions who use different means to achieve mutual understanding (Backus et al. 2013). This recognizes the importance of linguistic diversity and acknowledges that all communication partners contribute to efficient communication. In the context of refugee health this could mean affirming and valuing the patients' cultural backgrounds, prior experiences and linguistic resources as a contribution to patient agency.

Currently, however, healthcare systems—much like other societal systems and structures—in Europe, including those in countries with significant immigration, are not consistently aligned with these principles. Interpretation services, for instance, are not regarded as an integral part of healthcare provision but often must be organized and financed in a cumbersome manner by patients or healthcare institutions themselves (Robertshaw et al., 2017; Kwan et al. 2023).

The guiding principles of inclusive communication and inclusive multilingualism should be applied to the field of refugee health because communication plays a crucial role in the context of refugee health as it promotes understanding, addresses the specific needs and challenges faced by persons with refugee experience and facilitates delivery of appropriate health services (Patel et al. 2021). Cultural and linguistic barriers reinforce the power asymmetry between service providers and service users, resulting in poorer adherence to treatment plans or

a patient's reluctance to engage in rehabilitation. On the contrary, if patients are given the opportunity to adequately express their symptoms and treatment wishes, unnecessary examinations can be prevented, which are often carried out because clear communication could not be established (especially with regard to symptom and complaint descriptions). At the same time, it is possible to be more responsive to the patients' treatment wishes (Peters et al. 2014). A literature review by Kwan et al. (2023) shows that "patients receiving 'language discordant care' are more prone to adverse events and potentially life-threatening conditions at different stages of hospital care including delay in treatment diagnosis at admission, poor communication for surgical procedure and at discharge which inevitably lead to hospital readmissions and an increase in healthcare costs".

A qualitative study by Pandey and colleagues (2021) examined the effects of English language proficiency on healthcare access, utilisation, and outcomes among immigrants. On page six, the study includes a figure illustrating the adverse impact of insufficient language proficiency on healthcare provision for immigrants, such as reduced access to care, suboptimal quality of care, and patient dissatisfaction.

1. Do you know these factors from your own work?
2. Do additional factors need to be taken into account in the area of refugee health?
3. Which strategies could help to address:
  - the ability of persons with refugee experience to access health information and services?
  - the ability of persons with refugee experience to develop a therapeutic alliance with healthcare providers?
  - challenges associated with engaging language interpreters?
  - existing gaps in healthcare provision and improve health outcomes?

In the subsequent sections of this chapter, key approaches are presented that can contribute to enhancing the communication skills of health and social care professionals in a way that fosters inclusive communication and reflects the appreciative stance of inclusive multilingualism. As an essential foundation for this, the next section describes the counselling

process in the context of refugee health from a systemic-constructivist perspective. This is rooted in the fundamental belief that persons with refugee experiences are first and foremost individuals, like all other people, and that the design of any interaction and communication situation in health and social care must primarily reflect that each person is unique and that refugee experience is only one, albeit a highly relevant, factor.

## Counselling in the Context of Refugee Health

Counselling is always a highly individual process. People who provide counselling as part of their professional role, such as therapists or social workers, encounter a variety of distinct situations with unique individuals for whom they must find goal-oriented solutions.

The fact that there are different perspectives on counselling underscores this individuality. One such perspective is offered by systems theory, which, generally speaking, assumes that all parts of a system are in contact with each other and work towards a common goal (Forrester 1972: 9). Systems theory aids in abstracting the specifics of a counselling situation while simultaneously allowing for flexible consideration of the characteristics of the client and the counsellor. Hence, systems theory provides an analytical framework for retrospectively analysing counselling scenarios and prospectively preparing for future counselling sessions.

The following overview aims to show how the systems theory approach provides a structured understanding of counselling situations involving people with refugee experience. First, the basic principles of counselling processes are presented (see Figure 11.1 below): the structural coupling of the participants in the counselling process, viability, connectivity, and the experience of difference regarding counselling content. Then, the concepts of perturbation tolerance and contingency are introduced as analytical tools to explore possible resistance and obstacles.

A systemic perspective rarely produces entirely new or unknown insights. Rather, it helps to recognize known but possibly misunderstood mechanisms and patterns of action and communication. This is important because only patterns that are consciously perceived can

be reflected upon. Reflection, in turn, forms the basis for learning. Ultimately, a systemic perspective offers professionals the opportunity to further develop their counselling skills.

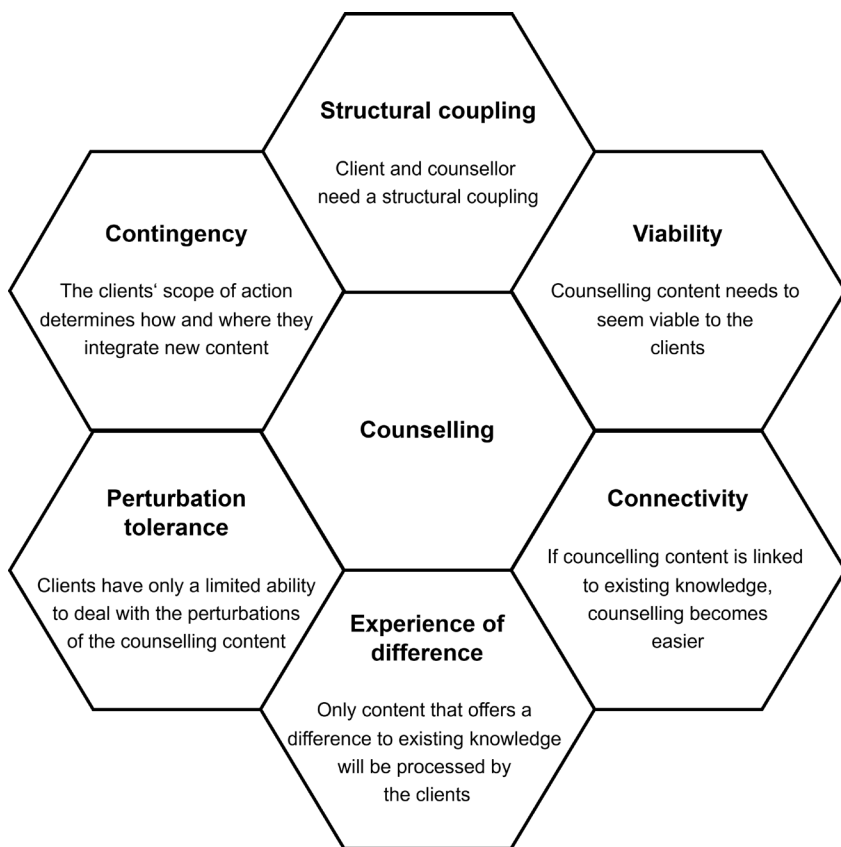


Fig. 11.1 Basic principles of counselling. ©Andreas Wolfs, CC BY.

### Basic Aspects of Counselling

Seeking and receiving advice is omnipresent in people's lives. Whether it is for shopping, choosing a holiday destination, or in healthcare or social work, counsel is offered or sought in many different ways. It is not only an explicit service, such as a coaching session with a trained professional or learning guidance in an educational context; often, it is also an implicit part of health or social services or when dealing with the authorities.

In these instances, the professionals providing the counselling may be experts in their specific fields but may have little or no ability to provide person-oriented advice. Individuals with refugee experience may seek counselling in any of these situations. Being a refugee or asylum seeker might be the reason for the counselling situation, e.g., when people seek assistance with administrative matters. However, an individual may also seek advice for reasons unrelated to their refugee status.

Counselling situations vary considerably not only in terms of content but also in person-oriented approaches. Therefore, the counsellor needs explicit skills to address the individuality of each counselling situation. This includes the ability to determine the appropriate amount of technical content to provide and the level of support needed to enable clients to develop self-learning skills.

In general, in any counselling situation, those who seek counselling and those who provide counselling are of particular importance. In addition, the specific context of the counselling situation needs to be taken into account.

The differences among those seeking counselling, i.e., the clients, are apparent. Each individual has a unique biography, which also encompasses their own counselling biography, including personal experiences with situations in which they have initiated or attended counselling. Additionally, the client's biographical knowledge includes insights into the subject of the counselling, as well as their own interests and inclinations. The same is true for those who provide counselling, i.e., the counsellors. They also have experience and knowledge, such as an understanding of which approaches have proven beneficial or obstructive in various situations for different clients.

Counsellors must continually reflect on whether they are being approached in their formal, professional capacity or whether they are dealing with a more informal request. In both cases, they should clearly identify their respective role and clarify it with the client. However, it should be borne in mind that individuals seeking counselling in a professional context will often assume that the counsellor is acting in a professional capacity, even in informal settings, despite the counsellor making it clear that they are speaking outside their professional remit or expressing their personal opinion. For the benefit of those seeking advice,

professionals should err on the side of caution and refrain from making statements outside their professional scope in such situations.

With respect to the specific context of the counselling situation, the various media that can be employed will be briefly addressed. For example, it is important to distinguish whether the information in the counselling session is presented orally or in writing. If written information is used, it is essential to ascertain whether the available documents are tailored individually for the client or whether a general information brochure is used. In the case of verbal counselling, for example, distinctions must be made between face-to-face meetings, telephone calls, or video calls. Additionally, the necessity for interpreting services for language mediation is a relevant consideration. Each of these setups brings its own relevant aspect to the counselling process. For example, if a general information brochure is used, it is important to assess whether their content adds value for the specific client in the given counselling context, or whether it might actually be more of a hindrance. Counselling based on the maxim 'more is better' is only beneficial in the rarest of cases. In the scenario of consultations conducted via video calls, the skills and technical equipment of all participants need to be taken into account. Depending on the tools and telephone network used, the quality of communication may be unreliable. Each of these factors can lead to significant disruptions, particularly at the onset of the consultation, when the counsellor and client are becoming acquainted with each other.

This brief overview of the relevant aspects of explicit and implicit counselling, whether by professionals or laypersons, the biographical backgrounds of counsellor and client, and the different media used, illustrates the complex nature of counselling. The perspectives on and descriptions of counselling situations are as varied as counselling itself. A systemic perspective is adopted here to analyse counselling scenarios in general, and specifically with persons with refugee experience. The systemic approach allows for the identification of underlying patterns, while at the same time allowing for a detailed examination of specific situations. This analytical framework facilitates both retrospective analysis of past counselling scenarios and prospective preparation for future sessions.

In the following, we will frequently refer to the client, i.e., the person seeking counselling, and the counsellor, i.e., the person providing it, in order to succinctly identify the two main roles in a counselling session: the one seeking an answer and the one assisting in finding that answer. In the following sections, we will explain why counsellors should be cautious about 'giving advice', and instead see themselves as companions on the client's journey of seeking advice.

### The Structural Coupling of Those Involved Forms the Foundation of Counselling or the Counselling System

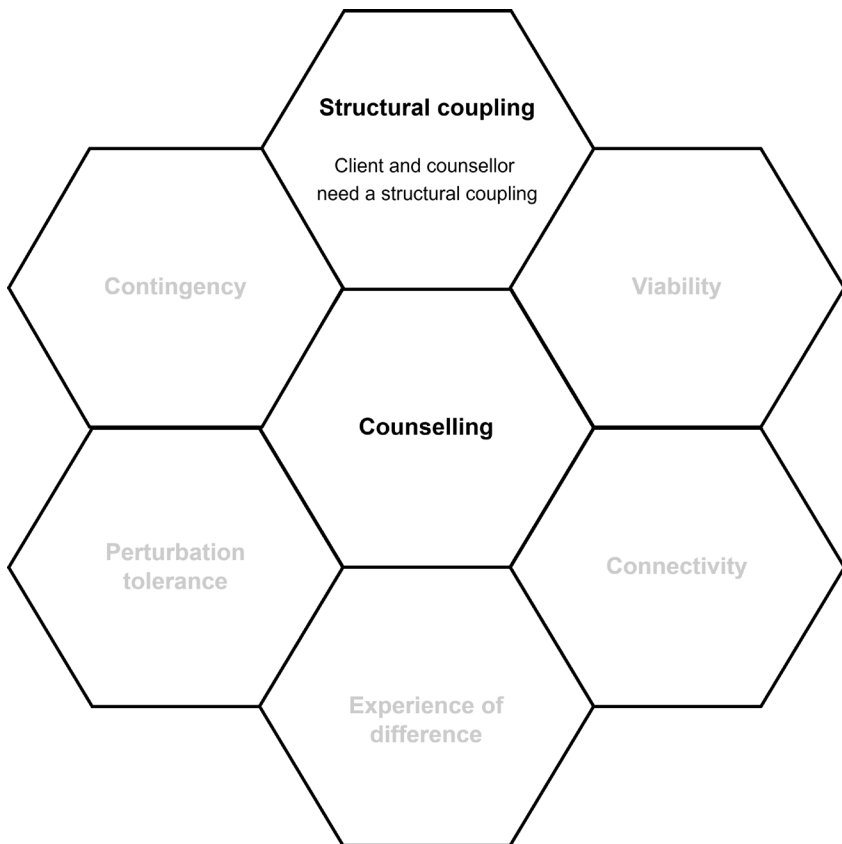


Fig. 11.2 Structural coupling. ©Andreas Wolfs, CC BY.

In a systemic approach, individuals are regarded as self-contained systems that are initially closed to all external influences, including interactions with other people. This approach is based on self-reference, which is characteristic of all closed systems (Luhmann 1985: 403). In humans, statements such as “I’m fine the way I am” or “Why should I learn anything new? I’m fine the way I am” exemplify this concept. Similarly, people seeking advice may express sentiments such as “What can this person tell me that I don’t already know?” or “What qualifies this person to be an expert in my situation (or in my life)?”. Individuals initiating a counselling situation or seeking answers often adopt these or similar attitudes. Conversely, counsellors can use this self-reference to adopt perspectives such as “The way I counsel is the right way to counsel” or “Why won’t the client understand what I’m explaining?”. When such positions dominate the counsellor’s actions, they clearly get in the way of focusing on the client’s needs.

Another consequence of the closed nature of such systems in relation to external influences is that they can only be observed from the outside. Luhmann (1985: 405) describes this phenomenon as a “black box”, explaining that this lack of transparency is often compensated for by assuming that the processes and decision-making patterns in other systems are comparable to one’s own. Applied to counselling situations, this means that counsellors perceive the actions or words of the clients without recognizing the actual intentions behind them. The counsellor will automatically seek explanations for what has been said that are consistent with their own perspective. To counteract this automatic tendency—especially when understanding the reasons behind the statements is crucial—the counsellor should rely less on their own biased perceptions and instead inquire directly from the client. However, even explanatory words are open to interpretation, so the counsellor can only judge whether the explanations seem coherent. A clear assessment of the inner decision-making patterns is therefore not possible.

From a systems theory perspective, this isolation from external influences can be broken through structural coupling with another system (another person) (Maturana & Varela 1984: 85). The basis of

such a coupling is primarily the common interests and common goals of those involved (Siebert 2009: 95).

Basic common goals in counselling may include the desire to solve a problem, clarify a situation, or obtain an answer to a question. Conversely, unsolicited or unintentional counselling initiated by the counsellor is likely to lack these basic elements. It is possible that the other person, not yet in the role of the client, may develop an interest in the proposed topic through the counsellor's initiative, but this requires at least some common interests. Without common interests and goals, it is highly likely that the systems will remain metaphorically side-by-side without structurally binding. In such cases, the counsellor's content may, metaphorically speaking, 'bounce off' the (non-)client and miss its target, while the counsellor might assume that the information has been received. Common interests may relate to the content of the counselling or to aspects independent of it, provided they are comparable for the people involved. The interests of the counsellor and the client must be aligned. This phenomenon explains why individuals with questions about their health situation or healthcare often trust the advice of someone they know more than that of medical specialists or therapists who, despite their professional competence, are initially unknown to them. This trust can only develop once a sustainable structural coupling, based on common goals and interests, has been established. It is important to note that longer-established structural couplings are likely to be more intense and resilient. In conflict situations or when faced with contradictory information, this may mean that clients are more likely to trust those with whom they have long-standing structural couplings, regardless of their professional qualifications.

From a critical perspective, counsellors should also consider the influence of the power imbalance inherent in the counselling situation, particularly when persons with refugee experience are confronted with the authorities' assessments of their circumstances, communication difficulties, psychological stress such as the effects of trauma, and the limited communicability of personal experiences.

The existence of a common language is highly relevant to the establishment of structural coupling. Without a common set of signs, it is

far more difficult to find common goals or interests. One way to mitigate this is to involve interpreters. The interpreter must be structurally coupled with all parties in the counselling system. In practice, there is often an acquaintance gap; either the client or the counsellor already knows the interpreter. Both lack of acquaintance and well-established connections can have a negative impact on the transfer of information. If the structural coupling is weak, the interpreter may not be trusted; if the structural coupling is strong, the interpreter may be reluctant to convey the real content and instead present what they personally believe to be valid. Regardless, bias remains inevitable, for example due to time lags between non-verbal and verbal aspects of communication or potential mistranslations due to misinterpretation of the content of the consultation.

Furthermore, persons with refugee experience often encounter rejection regarding healthcare in the host country (Patel et al. 2021; Nowak & Hornberg 2023). Barriers to access, language barriers, discrimination, and the perceived discrepancy between the healthcare they are accustomed to and that which they experience in the host country hinder the establishment of trust (Nowak & Hornberg, 2023). Power asymmetries can arise from diverse linguistic contexts—where one person speaks the official language and is perceived as an authority figure, while the other is a patient who does not speak the language—which can complicate communication and trust within the process (Dressler 2009).

Cultural aspects can result in situations, actions, and messages being perceived and interpreted differently. Cultural influences can shape the extent to which interactions are contextualised, affecting the emphasis placed on verbal and non-verbal elements of a message, as well as situational information, such as the relationship between participants in the interaction (Altorfer & Käsermann 2021). To identify and address misunderstandings arising from these differences, an initial awareness is required. On the other hand, there is also a risk of culturalization, i.e., overemphasizing cultural factors. This may lead to misunderstandings being consistently attributed to culture, thereby overlooking the actual causes (Frederickson 2015). Another structural cause of language barriers is prejudice. Prejudices

influence perceptions of individuals and create biases that can affect, for example, the extent of empathy shown by professionals towards people, the level of attentiveness provided to them, or assessments of their competence based on the language they speak. This can also impact the general willingness to engage in interaction (Altorfer & Käsermann 2021). Without awareness of these factors, disruptions such as misunderstandings may occur and remain unrecognized or unresolved. This needs to be taken into account as a factor negatively affecting structural coupling in refugee health.

In general, if there are common goals and interests, possibly supported by additional commonalities such as a common language, structural coupling can be successfully initiated, laying the foundation for counselling. In this case, the participants form a new system or counselling system that is distinct from the environment. It is crucial that both the counsellor and the client remain unchanged and independent within this new system; they are only connected through the structural coupling that has been formed (Becker & Reinhardt-Becker 2001: 65).

Once structural coupling has been initiated and counselling progresses, circumstances may arise that alter the interests or goals of the client—whether over several sessions or within a single appointment. Changes in interests and goals should not necessarily be viewed negatively, as counselling often involves change, which can lead to shifts in goals and interests. This aspect is particularly relevant when counselling individuals with refugee experience; sessions that begin in the context of displacement may take very different directions as they progress. If counsellors lose the structural coupling with their client because they fail to acknowledge these changes, or if the structural coupling weakens, the impact on both future outcomes and those already achieved can be detrimental.

Despite these challenges, changes can either weaken or, in extreme cases, break the initially strong structural coupling, ending the counselling system. Counsellors must therefore continuously monitor the current coupling during the counselling process and recognize or inquire about changes in the client's goals and interests.

## Making Counselling Content ‘Palatable’ for the Client: Viability, Connectivity and Experience of Difference

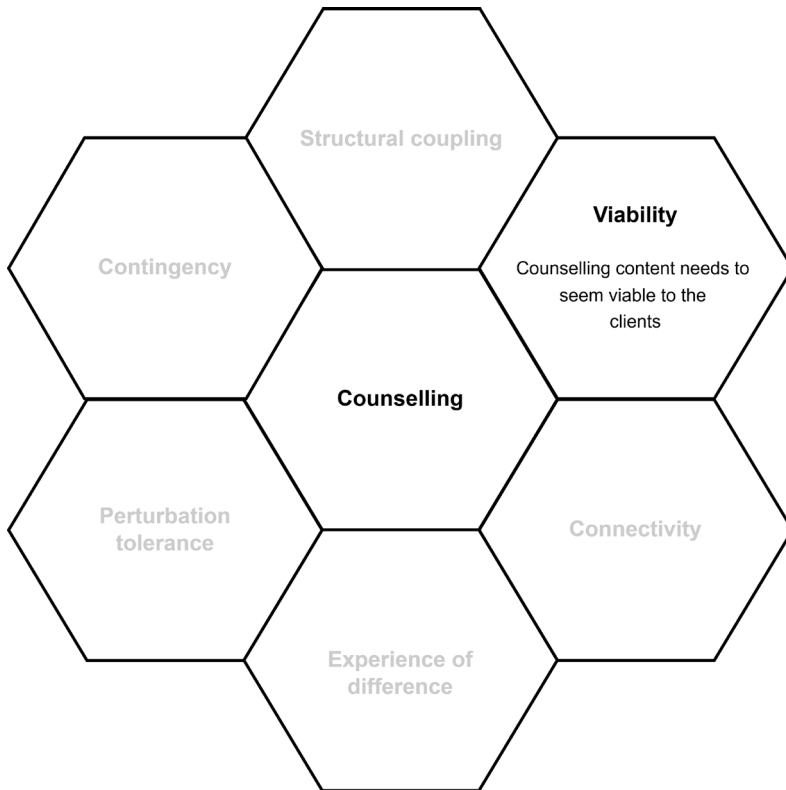


Fig. 11.3 Viability. ©Andreas Wolfs, CC BY.

Establishing a sustainable structural coupling based on common interests and goals is the basis for, but not a guarantee of, successful counselling. Another element to consider is the viability of the counselling content. In systems theory, viability is defined as content that appears relevant, meaningful, or feasible to the client (Glaserfeld 2012: 30). This can be quite challenging for the counsellor. This is especially the case when the counsellor has not only the necessary skills for person-centred counselling but also professional skills in the respective counselling context. It is easy to explain what is relevant and important from the perspective of a knowledgeable person. However, this content may be of little or no relevance to the client. Information that is not relevant for the client is ignored and, to use another metaphor, bounces off the outer shell of the client’s closed systems.

It should also be borne in mind that cultural differences, limited health literacy in relation to the organisation of the healthcare system in the host country, and specificities of the legal situation, among others, pose particular challenges in achieving or formulating viable counselling content. Additionally, it is crucial whether or not the counsellor is aware of the client's experience of displacement. While such awareness may enable the counsellor to take this factor into account, there is also a risk of relying on stereotypes, which can be counterproductive.

The counsellor should filter out aspects that are likely to be relevant. It may be helpful to ask questions first, for example, about the reason for seeking the advice and the exact interest in knowledge, before answering questions quickly. In addition to a clarifying viability, the client's goals can also be specified, and if the counsellor agrees with the goals, the structural coupling can be further strengthened.

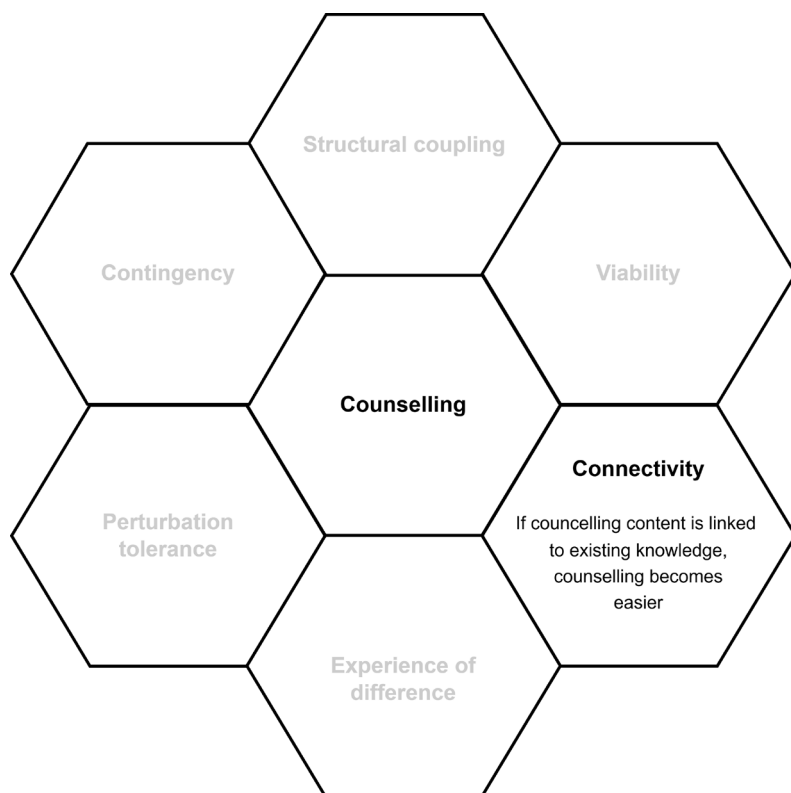


Fig. 11.4 Connectivity. ©Andreas Wolfs, CC BY.

Questioning and the associated experience of prior knowledge and other biographical aspects also promote another relevant aspect: connectivity. Counselling content is connectable if it can be linked to what is already known. This can refer to aspects of the content context of the respective counselling, e.g., in the case of educational guidance, if they are linked to existing information about the desired further education. But it can also refer to aspects that are independent of the content of the counselling. In the example above, counselling content on educational measures could be presented in the context of a hobby or private interest of the client.

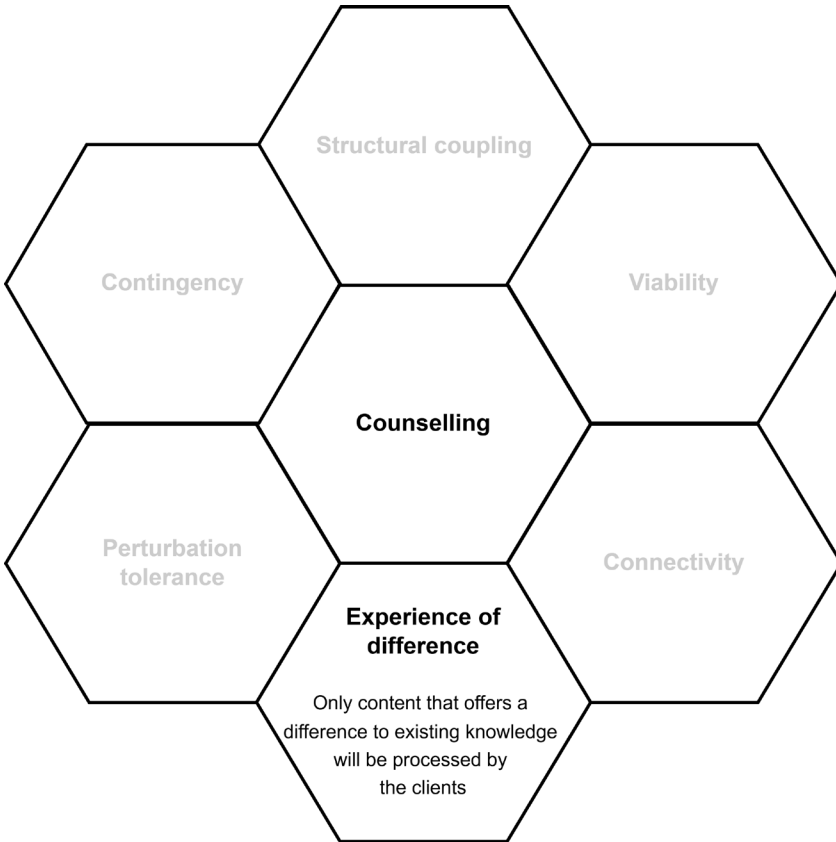


Fig. 11.5 Experience of difference. ©Andreas Wolfs, CC BY.

If counselling content is connectable, it is more likely to be integrated into the client's knowledge network (Arnold 2007: 69). However, connectivity can also result in content from counselling sessions being connected to content other than that intended by the counsellor. It is up to the counsellor to check as best as possible whether the information given has actually been 'received'. This can be done, for example, by asking follow-up questions or by reviewing the action steps resulting from the counselling. However, there is no definitive certainty. The client alone decides whether and where counselling content is linked to existing knowledge.

One aspect that determines whether counselling content is connected, is the answer to the question "Do I already know this?". If the information is already known to the client, i.e., if it does not represent sufficiently an experience of difference from the client's own knowledge, it will also bounce off the outer shell—to stay with the metaphor. What is labelled as "I already know!" is also decided exclusively by the client. In the case of counselling systems that extend over several sessions, the challenge in relation to the experience of difference is for the counsellor to make sure of the client's current status at the beginning of each session. This is not only useful to ensure the appropriate difference in the counselling content, but also helps to review the objective and thus the viable counselling content.

During counselling, counsellors walk a tightrope between content that is compatible, i.e., as close as possible to the client's existing knowledge, and a lack of experience of difference on the part of the client, i.e., when the content is 'too close' or in line with what the client already knows. At the same time, it is always important to look back at the goals that have been set, i.e., to ascertain whether the current path can lead to the agreed goal. This is the only way to ensure the relevance, i.e., the viability, of the current counselling content.

One conclusion to be drawn from the tension described above is that counsellors should give as little advice as possible, but instead support clients in finding the information they need themselves or deriving it from the known and the unknown. When clients are actively involved in achieving the goal and help shape the process and content, it can

be assumed that aspects that lack viability or connectivity will often be directly excluded. Information that offers clients too little experience of difference is also unlikely to be included. This type of accompanying advice requires a high degree of flexibility from the counsellor and, if possible, a willingness to accompany people along paths to solutions that the counsellors themselves would not have chosen on the basis of their own experience. Ultimately, it's about finding content that is connectable and offers an experience of difference. A practical tip could be 'listen and ask questions'. On the other hand, this does not mean that the counsellor should sit back and 'let the client do everything', which would most likely also have a negative impact on the structural coupling. The responsibility for the process and the design counselling remains with the counsellor.

The viability, connectivity, and experience of difference of individual counselling topics are anchored and rooted in the individual biographies of the people involved. People who have experienced forced displacement have often experienced significant breaks and drastic events in their lives. It is less important to compare the severity of these events with those experienced by people without refugee experience. Rather, the different nature of these events is of great importance from the perspective of the counsellor. It is important to regularly question and reflect on situations, counselling content, but also on the objectives and connectivity of the content. This can be done individually, for example by using guiding questions, as well as in a group setting with other counsellors who design counselling situations with clients who have experienced forced displacement. Due to the highly individual nature of each counselling situation, it is also possible to involve the clients themselves. This can take place both during and after a counselling session. For example, it is possible to ask a single question at the end of a counselling session, such as "How did you find the counselling?", or to use a standardized feedback form, preferably written in the client's native language. At this point, it is important to note that (former) clients will only comply with the request for substantive feedback if they recognize the viability, i.e., the relevance of the feedback, and the participants are still connected by means of a structural link. Ultimately, in all forms of reflection, counsellors can

only test content, procedures, and questioning techniques, evaluate the results retrospectively and, on this basis, develop ideas for possible future use prospectively. There is no certainty as to which intervention will lead to which result.

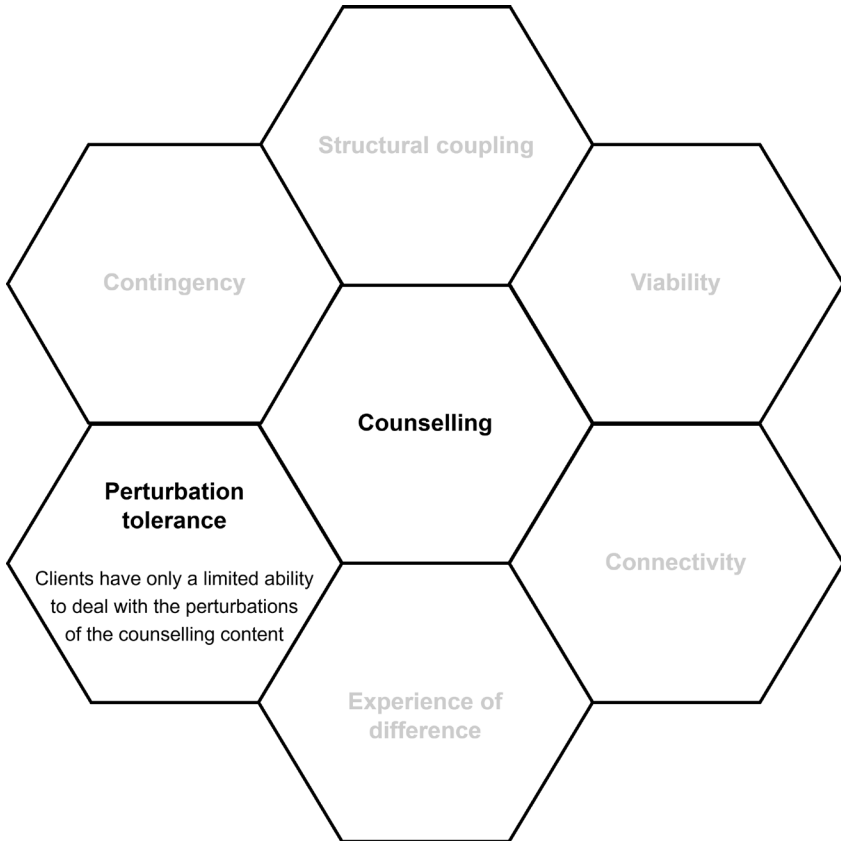


Fig. 11.6 Perturbation tolerance. ©Andreas Wolfs, CC BY.

### New Information as a Disturbance of the Known: Perturbation Tolerance of the Clients

Section 2 on structural coupling has already described how external stimuli to closed systems are initially perceived as disturbances—systemically: perturbations—and, metaphorically speaking, bounce off the outer shell of the system. Information, such as that perceived during

counselling sessions, is also a stimulus and initially has a perturbing effect. However, as Section 3 has shown, counselling content can be integrated into the client's knowledge network, provided that it is viable for them, designed to be connectable, and offers an experience of difference. The basic prerequisite for this is the structural coupling of all relevant participants.

The diverse perturbations that individuals with refugee experience have endured in their lives can, on the one hand, contribute to a significantly reduced tolerance for perturbation. On the other hand, such experiences may also strengthen their ability to cope with external disturbances. Perturbation tolerance can also vary considerably between individuals with similar experiences of forced displacement, even within families. As the disruptive effect of individual counselling content can also vary, a high degree of flexibility and empathy is required on the part of the counsellor.

Even if the perturbing effect can be minimized in individual cases through high-quality structural coupling as well as viable and connectable content, the counselling content still remains disruptive to the client's system. In addition to the counselling content itself, all other stimuli in daily life also have a perturbing effect. This means that counselling can also lead to double perturbation.

Firstly, the individual counselling content perturbs the client's system. If the new content is connected and changes behaviour, further perturbations may arise due to reactions from the client's environment. Unfortunately, it is not possible to make a general statement as to whether an early indication in the context of counselling, in the sense of 'Be prepared for the fact that your environment might react if you change your behaviour', has a mitigating effect on the expected perturbations. On the one hand, clients are prepared for reactions that are new and perturbing for them; on the other hand, this may lead to the new elements not being integrated at all or being integrated differently into their behavioural patterns, which may lead to different feedback or reactions from the environment.

The reference to the family illustrates another aspect of perturbation tolerance, which has already been described in connection with structural coupling: people from the client's environment, such as family

members, may also be relevant to the counselling process although they are not directly involved in it. This is partly due to the structural coupling that the client has with these people. In addition, their perturbation tolerance may directly or indirectly influence the client's potential for change. For example, clients may be ready for the changes initiated by the counselling, partly due to a high tolerance of perturbation, while their (family) environment may react negatively, possibly due to a low tolerance of perturbation. For instance, the client may want to undergo a specialist (preventive) medical examination as a result of the counselling they have received, but refrain from doing so because of negative reactions from their personal (family) environment. The more strongly the connection between the client and their environment is anchored in the client's biography, the more likely it is that the client will take into account the needs of others and postpone their own changes. Through such connections, people from the client's wider environment, who may be unknown to the counsellor, can also be highly relevant to the design of the counselling, highlighting the importance of attentive inquiry and questioning of the context.

In the case of counselling sessions that involve several individual meetings, counsellors should be prepared for such situations and should also question possible patterns of client response that may result from these causes.

In conclusion, it should be noted that the level of perturbation of each individual piece of information, i.e., each stimulus, is just as variable as the amount of perturbations a person can 'tolerate' before their own perturbation tolerance is exceeded and they tend to reject new content across the board, regardless of connectivity or viability. In addition, perturbation is highly dependent on topic and situation. Finally, counsellors must always bear in mind that the counselling situations are only a part of the perturbations to which clients are exposed on a daily basis.

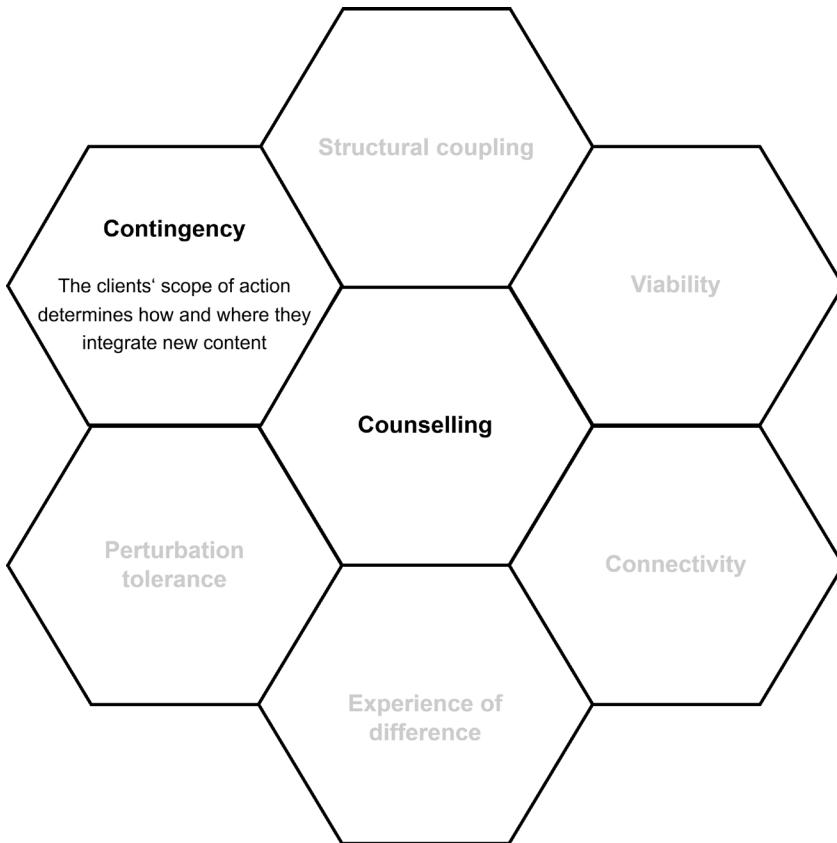


Fig. 11.7 Contingency. ©Andreas Wolfs, CC BY.

### A Person's Scope of Action Determines the Integration of the New: The Contingency of the Clients Seeking Advice

In the context of connectivity, one aspect has already been mentioned in a previous section and will be discussed in more detail in this section: clients connect new content to their own knowledge network in a way that seems reasonable or viable from their point of view. These alternative courses of action are also called contingencies (Willke 2006: 249). In other words, one's own contingency determines whether, how, and where new content is integrated into one's own knowledge network and, moreover, what effect this information has and whether, and if so, how it changes one's own actions. The contingencies of the

participants in a counselling system differ, and actions or reactions may seem surprising or irritating to the other participants, even though they seem perfectly logical and consistent to the person involved.

The client's scope of action is also important in counselling persons with refugee experience. Contingency, as a result of one's own biography, is characterized by the experience of flight as a drastic life event as well as by one's previous life and events before the displacement. These biographical aspects are supplemented by the experiences that have been incorporated into one's own biography since the flight. People with similar experiences of forced displacement may have very different contingencies due to their previous lives. For counsellors, this can be a reason to ask about the circumstances of their clients' lives before they fled. It is always important to bear in mind that it is very likely that the reasons for fleeing and the traumatic events associated with it are also hidden here. The particular scope of action of clients with refugee experience, which can result from the possible influences of this tripartite biography, can be perplexing or confusing for their counsellors. The same is true of possible changes in the scope of action. Counsellors need a high degree of flexibility in dealing with their clients' contingencies and also need to be mindful of the goals and potential solutions that have been set.

In a counselling system, this effect is particularly noticeable when clients, due to their contingency, connect information in unexpected ways, resulting in seemingly illogical actions. From a systemic point of view, however, these actions are not wrong but rather logical, at least for the actors, i.e., the clients. Counsellors need to adapt to this unpredictability of reactions and evaluate them individually.

One evaluation criterion is whether the client's reaction counteracts the agreed goal or represents a potential solution. This requires a high degree of flexibility, as it is not about the path the counsellors themselves would take, but about a path that the clients consider relevant for them. Depending on the outcome of this assessment, a (corrective) response may be necessary or a change in the counsellor's own solution may be required.

Another assessment criterion is the client's perturbation tolerance, as described in the previous section. If, in the counsellor's opinion, this tolerance is exhausted, the counsellor's own reaction should be assessed

with particular sensitivity to possible disturbance of the structural coupling.

Given the above arguments, it seems logical that the ability to assess the contingency of the clients as accurately as possible is particularly relevant for counsellors. On the one hand, it helps if the counsellor has experience of counselling on comparable issues or people in comparable contexts. On the other hand, the duration of the counselling is important. If it takes place over several sessions, experience from previous sessions can be transferred to the current session. However, counsellors should always be prepared for the unexpected. Contingencies may change over the course of a series of counselling sessions, or even within a single session. Ultimately, there should even be changes within the contingency, as the implicit goal of counselling is often to change the client's scope of action, i.e., the contingency.

Each counselling situation and each client must be considered individually. No matter how much experience the counsellor has, the client's contingency remains a black box.

### What Is the Benefit of a Systemic-Constructivist Approach to Counselling in Refugee Health

Overall, counsellors should be seen more as facilitators in the counselling process. Once the goal has been set and the establishment of structural coupling has begun, it is beneficial for the clients themselves to discover the viable aspects and identify the appropriate content. This approach helps to mitigate the risk of a lack of exposure to experience of difference, as the clients can directly reject non-viable information and move on to more appropriate content. Counsellors should act as companions in this process, respecting the autonomy of the clients and supporting them on their individual paths to the agreed goal, possibly providing guidance or helping to structure complex contexts.

This more reserved role can be particularly difficult for counsellors, especially if they believe, perhaps from years of experience, that the path chosen by the client may not lead to the desired goal. It requires a great deal of flexibility and courage to suggest possible paths and then to accept if the client chooses a different one.

As a consequence, asking questions is more important than 'giving advice'. It is never about asking 'why?' with an implicit demand for justification, but about understanding the client's current situation and biography. This understanding is one of the keys to person-centred counselling: on the one hand, the biographical context provides the basis for the client's scope of action and starting points for new information. On the other hand, the current situation provides clues to other relevant people who should also be involved in the counselling process through structural couplings.

When asking questions, the aspect of observation, already mentioned in connection with structural coupling, must be considered. Closed systems can only be observed from the outside. Applied to the counselling system, this means that counsellors can never be sure that clients' responses are not primarily tailored to what they believe is appropriate for the situation. When counsellors are on an official, regulatory mission, clients, especially those with refugee experience, may draw on patterns of interaction with officials in their home countries. This can lead to disruptions in structural coupling or in the connectivity of counselling content.

The quality of the counselling can be assessed by counsellors on the basis of correctness, for example in terms of regulatory or scientific evidence. However, this is of much less importance in systemic counselling. The quality assessment is more likely to be done by the clients. Criteria here could include aspects such as suitability for everyday life and a focus on participation. These are far more subjective than technical, content-related criteria. For example, a counsellor may have 'done everything right', but the counselling was not found helpful by the client. In evaluating their own performance, counsellors should rely on the clients' feedback and accept their 'judgment'. This requires the ability, energy, and willingness to continuously question, reflect on, and adapt one's own counselling skills. In essence, it is not just about content or professional skills, but also about person orientation. Person orientation involves creating and maintaining resilient counselling systems through sustainable structural linkages and developing skills to accompany clients in their search for solutions, for example through topic structuring and follow-up questioning techniques.

A systemic-constructivist approach promotes and necessitates the individual design of counselling sessions and can explain a variety of counselling situations. Establishing a structural coupling and identifying relevant, viable counselling content that provides clients with experiences of difference is the basis for successful counselling. By also considering the client's individual, situational perturbation tolerance and contingency, the main obstacles in counselling sessions can be anticipated and analysed, if not completely eliminated. All these aspects are particularly relevant in counselling sessions with people who have experienced forced displacement.

Building on this conceptual foundation, which preserves the individuality of patients with refugee experience and aims to make refugee health more person-oriented and participatory, the subsequent sections of this chapter present strategies that facilitate effective and respectful cross-cultural communication in patient care across language barriers.

## Strategies for Effective Cross-cultural Communication in Refugee Health

### Setting Up Culturally Responsive Structures and Services

If patient care is to take into account the cultural backgrounds of patients from the perspective of self-determination and equity, appropriate structural conditions must be created. Without suitable structures and space to implement measures, even culturally responsive staff cannot act effectively. Uniform, universally applicable structures must be created at all organisational levels in which culturally responsive patient care is standard (Peters et al. 2014). Measures should include improving workforce diversity, conducting structural analysis, and ensuring competence in planning, policy formulation, and practice (Spitzer et al. 2019). The scoping review by Grandpierre et al. (2018) found that patients and caregivers expressed an appreciation for services that incorporated cultural awareness into practice protocols. This involved services that used culturally appropriate materials and tailored care to meet their needs. Another recommendation was extending the appointment times for patients who do not speak the service language.

An international review conducted by Krystallidou and colleagues (2024) examines the barriers faced by migrants and refugees in accessing mental health services, and highlights the convergence and interconnectedness of communication needs, barriers, and strategies experienced by patients, carers, and professionals alike. A combination of systemic, interpersonal, and intrapersonal factors contribute to a fragmented landscape of language support options, which ultimately affects the quality of communication and, in turn, the uptake and quality of service provision and mental healthcare among migrants and refugees. The review advocates for enhanced cultural and structural competence within the education of health and social care professionals, as well as greater linguistic diversity within the healthcare workforce to better reflect the varied experiences of migrants and refugees. Both patients/clients and professionals appear to strongly prefer communication in the same language, ideally with a shared cultural background as well. Where this is not possible, both groups generally prefer high-quality professional interpreters and translators, which are, however, often lacking or unavailable in mental health settings. Policy makers are encouraged to adopt a systems thinking approach to understanding the complex interactions that influence access to mental health services. In the context of increased global migration and forced displacement, coupled with the high prevalence of mental health disorders among migrants and refugees, the authors assert that language skills should not be viewed merely “as part of individual lifestyle factors, but as an underlying factor permeating all social determinants of health” (Krystallidou et al. 2024).

The Health Evidence Network (HEN), an information service for public health decision-makers in the WHO European Region, has published a report on strategies that have been implemented and evaluated in European countries to address communication barriers for refugees and migrants in healthcare settings (McGarry et al. 2018). This report includes the following policy recommendations (McGarry et al. 2018: ix):

The main policy and practice considerations based on the findings of this review in the WHO European Region are to:

- encourage collaboration between statutory healthcare organisations, non-statutory organisations such as NGOs with

an interest in migrant health, and academic institutions to develop and implement strategies to address communication barriers for refugees and migrants in healthcare settings;

- establish intersectoral dialogues on cultural mediation and interpretation among academic, policy, healthcare, and professional organisations and NGOs concerned with refugee and migrant health to:
- clarify the terminology used to describe the role(s) of mediating and interpreting, and
- develop and implement consistent systems across countries for training, accreditation and professionalisation;
- provide training for healthcare staff in working effectively with cultural mediators and interpreters in cross-cultural consultations with refugees and migrants;
- ensure the use of professionals who have been trained and accredited for mediating and interpreting roles in healthcare settings;
- establish incident reporting systems in healthcare settings where strategies to address communication barriers are being implemented to provide a system level mechanism for reporting, monitoring, and responding to problems and barriers to implementation;
- involve migrants in developing and implementing strategies to address communication barriers; and
- develop a national policy that emphasizes the importance of formal strategies to effectively address communication barriers experienced by refugees and migrants in healthcare settings.

These recommendations underscore that effective cross-cultural communication in healthcare can only be guaranteed if the necessary measures and strategies are implemented at the macro, meso, and micro levels. However, the HEN report also shows that knowledge of a wide range of successful interventions at these three levels already exists. These interventions have been tested and evaluated in practice, and can

be utilized by others to minimize the negative effects of communication barriers experienced by persons with refugee experience.

## Cross-cultural Communication Strategies at the Interpersonal Level

### Effective and Respectful Communication in Patient Care across Language Barriers

Effective communication forms the foundation for culturally responsive care, establishing mutual understanding and fostering patient engagement. Collaborative strategies are instrumental in promoting patient engagement and building partnerships. Key strategies involve comprehending the patient's overall situation, tailoring practices to suit the individual's circumstances and ensuring the patient's comprehension of therapeutic procedures. Patients recommend that practitioners be aware of language barriers and speak slowly to ensure comprehension (Grandpierre et al. 2018). In cases where language barriers persist, alternative forms of communication, such as nonverbal cues, gestures, or drawing, may be necessary to gather information.

In addition, according to the review by Grandpierre et al. (2018), patients and caregivers emphasize the significance of their relationships with healthcare practitioners and the need for collaborative partnerships within those relationships. They value practitioners who share information about their lives, including social, cultural, and historical aspects. Patients and caregivers also express the importance of having a consistent therapist to facilitate long-term relationships. It is often beneficial when the practitioner shares a similar cultural background or gender, as they may be perceived as more familiar with cultural taboos. However, it is worth noting that some patients also express concerns about maintaining confidentiality within their communities when such facilitators are present (Grandpierre et al. 2018).

In situations where refugees and staff are under pressure, maintaining a friendly, patient, and attentive demeanour may prove challenging. Various factors, such as anger, insecurity, fatigue, and pre-existing prejudices, can impede refugees' ability to express themselves, while also hindering staff

members' active listening and respectful actions. Additionally, the power imbalance between refugees and staff can limit open communication, create unrealistic expectations, and heighten tensions (UNHCR n.d.).

When communication problems remain unresolved at the institutional level, it can lead to frustration, which negatively impacts subsequent patient encounters. Barriers that hinder healthcare professionals from fulfilling their professional roles increase the likelihood of patients experiencing discrimination and mistreatment (Lewicki 2021).

Self-reflection exercise:

The UNHCR published a document with tips and strategies for effective and respectful communication in forced . Please have a look at this document, which is available at: <https://www.refworld.org/docid/573d5cef4.html>

Read the key considerations at the beginning of an intervention and the key considerations during an intervention.

Think of the way interactions with patients or service users are typically organized in your workplace:

1. Which of the UNHCR's recommendations do you already observe?
2. Where would micro- or meso-level changes be needed to enable you to implement the suggested actions?
3. Where would you need support from other professionals, volunteers, etc., to enable you to follow the strategies recommended by the UNHCR?

### Utilizing Translation Tools or Services

There are numerous digital resources, such as translation software and apps, that can provide quick and convenient translations for simple conversations. Generative artificial intelligence (AI), such as Chat GPT, can also be asked to translate into other languages. However, it is important to recognize the limitations of these tools and seek professional translation or interpretation services for more nuanced or critical discussions.

Experiment with your own phone: try Google Translator, DeepL, ChatGPT or other translation apps by typing in sentences, or using

voice input. Try to use simple language in your native language. Try translating into another language that you speak and check the translation for errors. The further the language you try is from English, the more errors will occur.

### Utilizing Non-verbal Communication

While language is a primary means of communication, nonverbal cues, such as facial expressions, gestures, and body language, can also convey meaning and facilitate understanding. Utilizing these cues, particularly when combined with limited shared language, can help to bridge gaps in communication.

You can watch the following animated video explaining the concept of positive body language: [https://www.youtube.com/watch?v=6vT6sqjBFrs&ab\\_channel=KristenOber](https://www.youtube.com/watch?v=6vT6sqjBFrs&ab_channel=KristenOber)

Please note, however, that this video does not include a cross-cultural perspective.

### Using Visual Aids

In addition to verbal communication, visual aids such as pictures, diagrams, pictonaries, and other written materials can help convey meaning and facilitate understanding. These tools can be particularly useful in situations where language barriers are severe or when working with individuals who may have limited literacy skills.

You can find specific software for pictograms used in your country. This is an example from Germany. Have a look at the video on the site to get an impression of how to use pictograms: [https://www.metacom-symbole.de/metacom\\_en.html](https://www.metacom-symbole.de/metacom_en.html)

Another internationally used set of picture communication symbols can be found via Board Maker: <https://goboardmaker.com/pages/picture-communication-symbols>

You can also use booklets with pictograms. Here is an example of a translation aid for Ukrainians: <https://piktuu.com/de/piktuu-health-care-digital/> in German, English and Ukrainian. You can order the booklet or use the online version for free.

## Investing in Language Learning

Learn a few words of the language as an icebreaker and to facilitate deeper connections with individuals from different linguistic backgrounds. Learning a new language can also broaden your cultural understanding.

## Working with Interpreters and Cultural Mediators

A worldwide strategy to overcome linguistic barriers is the provision of professional services by interpreters or cultural mediators. These individuals are trained to accurately convey the meaning and intent of spoken or written language, ensuring that there are no misunderstandings or miscommunications. A review by Kwan et al. (2023) shows that the use of professional interpreters reduced interpretation errors that have potential clinical consequences and could improve understanding of discharge diagnoses; in contrast, the use of ad hoc interpreters, or going without the use of an interpreter altogether when the patient needed one, increased interpretation errors. In other words, in situations where language barriers are particularly pronounced or the stakes are high, enlisting the services of a professional interpreter or cultural mediator is strongly advised.

Whereas interpreters are typically only responsible for verbally translating spoken information from one language to another, cultural mediators facilitate mutual understanding by also providing advice on cultural understandings of healthcare issues. According to McGarry et al. (2018) cultural mediation has three main components: language interpretation, a responsibility to mediate cultural differences or facilitate intercultural communication, and knowledge about a specific healthcare topic or health service.

ASHA, the American Speech-Hearing Association, has created a reminder that the interprofessional team should include a variety of experts to enable successful cross-cultural communication. Find out more here: <https://www.thatsunheardof.org/learn-now/whos-on-your-cultural-iq-team/>

Sometimes patients will refuse the use of an interpreter. Several factors could account for this, and it may be beneficial to allocate time to discuss and explain the role of the interpreter. In this way, health professionals can make clear why an interpreter is necessary to ensure effective communication. This approach can reduce the pressure on the patient by shifting the responsibility for decision-making to the service provider.

Despite all the evaluations that show the positive effect of trained interpreters on preventing mistreatment, improving patient adherence to treatment, and reducing healthcare costs, in many countries access to interpretation services is still limited for health professionals. As a consequence, these professionals are regularly obliged to enlist the help of lay interpreters, i.e., staff or family members. This has a massive impact on the quality of the service and thus on the quality of the content of the information. For example, Grandpierre et al. (2018) found that services that failed to provide an interpreter and assumed that the patient would bring someone who could translate were seen as creating a barrier that could negatively affect attendance.

Many communities have organizations that specialize in working with refugees and may have staff or volunteers who are proficient in the languages spoken by refugees. Connecting with these organizations can provide a valuable resource for facilitating communication and supporting refugees as they navigate in the health system.

Using family members for interpretation services is generally considered to be highly problematic. Family members are emotionally biased and only pass on the content of conversations in an adapted form. Children in particular are exposed to content that is not suitable for them. In addition, unwanted role shifts in the family may occur.

### Recommended Further Information on How to Work with Interpreters

ASHA, the American Speech-Hearing Association, has published information on steps to take before collaborating with an interpreter to ensure a successful collaboration: <https://www.thatsunheardof.org/learn-now/collaborating-with-an-interpreter/>

- American Speech-Language-Hearing Association (n.d.), *Collaborating with Interpreters, Transliterators, and Translators (Practice Portal)*. Available at: [www.asha.org/Practice-Portal/Professional-Issues/Collaborating-With-Interpreters/](http://www.asha.org/Practice-Portal/Professional-Issues/Collaborating-With-Interpreters/)
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- UN High Commissioner for Refugees (UNHCR). 2009. *Self-Study Module 3: Interpreting in a Refugee Context*. Available at: <https://www.refworld.org/docid/49b6314d2.html>

#### Self-reflection exercise:

1. What is the situation like in your own workplace? Do you know how to contact available interpretation services or cultural mediators in your workplace or municipality?
2. Can you give examples of situations when you used an interpreter (or would have liked to use one)? Whose services did you employ (or could you employ)?

## Enhancing Cross-cultural Communication through Interprofessional and Intersectoral Collaboration

When different health and non-health services work together and coordinate their efforts, it helps improve how service providers communicate and coordinate with each other to meet the needs of persons with refugee experience. The health sector plays a crucial role in collaborating with other organizations that deal with migration, social issues, welfare, education, and development. This collaboration is essential for promoting the health of refugees and migrants. Refugees often have complex healthcare needs, which means it's important to have a team of professionals from different fields working together. This kind of team helps organize and coordinate healthcare services to address the diverse needs of individuals requiring complex care (Iqbal et al. 2022).

As the European review by McGarry et al. (2018) highlighted, strategies were often put into action by teaming up people from different areas, like healthcare providers, community organizations, and academic institutions. These worked together to come up with plans that could be implemented in one place or spread across a whole region. Evaluation of these strategies showed in most cases that refugees and migrants gained better knowledge about health, improved their health habits, and got easier access to healthcare services. This shows how crucial it is for different sectors to collaborate and for regional and local authorities to create and carry out official plans that tackle communication issues faced by refugees and migrants in healthcare settings throughout the area.

According to Iqbal et al. (2022), there are nevertheless only very few interventions that focus on training or encouraging interprofessional teams in delivering healthcare services. This is in stark contrast to the fact that by working together, these different professions can ensure that patients receive comprehensive, culturally-responsive care and help to identify and address systemic barriers to care, such as inadequate interpreter services or lack of access to culturally sensitive health information. Healthcare professionals, such as physicians, nurses, allied health professionals, psychologists, and psychiatrists can collaborate with interpreters; social workers and community health workers can, for example, ensure that:

- service users understand their diagnosis, treatment options, and care plan;
- service users and their families receive education and support;
- service users receive appropriate care and treatment;
- service users receive support to navigate the healthcare system and connect with community resources and services;
- service users can advocate for their rights and work to reduce barriers to care;
- service users who may be experiencing trauma, anxiety, or depression receive mental health services;
- service users have access to health promotion and illness prevention.

#### Self-reflection exercises:

What can you learn from others? In this short video, physiotherapist Philip Rynning Coker shares his ideas and experiences: <https://www.youtube.com/watch?v=cinUwtgQHfo>

- What is your own perspective regarding the value of interprofessional teamwork to overcome communication barriers when working with persons with refugee experience?

A practical example illustrating interprofessional and intersectoral cooperation with a focus on communication is provided in a video produced by the Philadelphia Refugee Mental Health Collaborative (PRMHC). *Voices of Care: Promoting Wellness in Refugee Health – Communication*: <https://www.youtube.com/watch?v=sJ5nqghC6l0>

In the video, the following scenarios are shown:

- introduction to the patient
  - navigating language barriers
  - communicating the referral process
1. What recommendations are provided in the video? Are they relevant to your own work?

2. How does the video demonstrate the value of interprofessional cooperation in cross-cultural communication with persons with refugee experience?
3. Are there any similar cross-cultural health networks in your own area? Health professionals who have not yet worked with such networks are encouraged to research which health facilities, community services, and refugee organizations they could establish interprofessional or intersectoral collaborations with to enhance their capacity for cross-cultural communication.

In addition to direct interpersonal communication, the creation of culturally and linguistically appropriate education or information material can also be useful to increase the health literacy of persons with refugee experience and contribute to community empowerment processes. The following case story by Lokken and colleagues (2023) provides an example of how interprofessional health service delivery for persons with refugee experience can be improved with the help of educational videos. The videos produced in the project can be accessed here: [https://www.youtube.com/channel/UC35cwxMBKJiR0CYELAWkbUw?view\\_as=subscriber](https://www.youtube.com/channel/UC35cwxMBKJiR0CYELAWkbUw?view_as=subscriber)

This exemplary case story can be used to engage with the topic in the following way:

1. Identify the issue at hand and the cultural and linguistic barriers that presented themselves.
2. Recognize the different professions involved in the initiative and assess the importance of interprofessional collaboration in addressing cultural and linguistic barriers.
3. Evaluate the significance of support from volunteers and community members.
4. Outline the steps taken by the team to address the issue.
5. Assess the outcome and determine what is needed to make it sustainable.
6. Research and identify similar collaborative projects in refugee health within your own area.

## Exercise: Interprofessional Collaboration to Prepare Information Material

Working in small interprofessional teams, participants will be asked to create posters that address different aspects of cross-cultural communication in refugee health. These posters should encapsulate the perspectives of the different professions represented in each team, using strong visual elements (such as pictograms) and minimal text. The posters will then be presented during the plenary session, where participants will explain their design choices.

Key topics for consideration include:

1. Strategies for building trust and facilitating effective communication in the practice of health professionals, and the critical of robust interprofessional teamwork in achieving this.
2. Approaches to enhancing interprofessional collaboration to improve access to healthcare services for individuals with refugee backgrounds, thereby ensuring improved health outcomes.

## Conclusion

To date, cross-cultural communication in refugee health has predominantly been addressed in a rather unsystematic manner. By initiating a reflection on the creation of participatory, person-centred communication environments that effectively address language barriers and challenges in cross-cultural understanding, we aimed to provide a comprehensive framework that goes beyond mere language barriers. Recognizing the potential burden placed on health and social care practitioners due to insufficient institutional and structural support, we focused on the concepts of inclusive communication and inclusive multilingualism as foundational to overcoming these challenges, as these align with the feedback provided by migrants and persons with refugee experience in existing research on enhancing cross-cultural communication in migrant and refugee health contexts. To expand on these ideas, the principles of counselling from a systemic-constructivist perspective were adapted for the context of refugee health. This perspective provides a structural framework for locating refugee experience as

a relevant part of a person's biography in the context of the person's entire history. It can also support interdisciplinary communication and reflection between various health and social care professionals by providing uniform dimensions. With this in mind, specific strategies for effective and respectful intercultural communication in patient care across language barriers were presented at the micro level of individual healthcare professionals and at the meso level of healthcare institutions, such as utilizing translation tools or services, working with interpreters or cultural mediators and enhancing cross-cultural communication in refugee health through interprofessional and intersectoral collaboration.

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