Cross-Cultural Communication with Traumatised Immigrants

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Introduction

Culture affects communication of trauma, coping, help-seeking, and expectations of treatment. Expressions of symptoms of post-traumatic stress may vary according to cultural and contextual factors. Culture affects how people make sense of post-traumatic distress. In this chapter, we discuss cross-cultural communication in clinical settings with patients having an immigrant and refugee background as well as symptoms of post-traumatic stress. Cultural aspects of communication related to language, idioms of distress, discourse systems, help-seeking, and identification of signs of trauma and assessment and treatment will be considered. Barriers to communication and support for overcoming barriers in cross-cultural communication will be discussed. Consideration will also be given to how to create a trustful relationship and therapeutic alliance. Theoretical aspects will be presented together with a case illustrating communication and interaction with health care.

Traumatic experiences can lead to the development of post-traumatic stress disorder (PTSD) but also to major depression and several other psychiatric disorders, such as specific phobias, disorder of extreme stress not otherwise specified (DESNOS), personality disorders, and panic disorders (Foa et al. 2000). Depression is common, especially after personal loss (Silove 2007). The prevalence of post-traumatic stress symptoms varies among refugees. In a systematic review of surveys about

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post-traumatic stress disorders in general refugee populations in western countries, Fazel et al. (2005) found 9 % diagnosed with PTSD, 5 % with depression, and evidence of much psychiatric comorbidity. Refugees who have had severe exposure to violence often have chronic pain or other somatic syndromes (Kirmayer et al. 2011). PTSD is associated with ill-defined or medically unexplained somatic syndromes, such as dizziness, tinnitus, and somatoform syndromes, and several medical conditions such as cardiovascular, respiratory, musculoskeletal, neurological, gastrointestinal, endocrine, pain, sleep problems, and immune-mediated disorders (Gupta 2013).

Refugees often do not have experience of just one single trauma, but of multiple traumas, and hardship related to premigration and migration experiences, and additional acculturation difficulties in the new host society. Most people experiencing trauma recover in socially safe situations. Also, a majority of those having acute stress reactions or PTSD improve, but for some the symptoms may remain for a long time (Pottie et al. 2011). To identify patients in need of help, it is important to recognise that signs of post-traumatic stress can vary and be combined with psychiatric and somatic comorbidity. For immigrants and refugees living in exile, this can be of special concern as people in their new context might have poor knowledge about harsh conditions in their countries of origin and on migration routes.

It is often the case that immigrants and refugees, especially newly settled, have poor knowledge about how the health-care system works, what help they can obtain, and how to communicate their suffering and need for help and support in an understandable way in the new context. It is therefore necessary for health and mental health services and professionals to be sensitive to cultural and contextual aspects of communication.

Cross-Cultural Communication

The term cross-cultural communication refers to situations of communication between two persons of different cultural backgrounds. Most clinical encounters are in a sense cross-cultural as a layperson's perspective on health and illness often differs from the medical understanding. In the literature, the concepts of intercultural communication are more commonly used than cross-cultural communication. Ting-Toomey (1999/2001) relates intercultural to communicating meaning. One person tries to convey meaning and the other tries to interpret it. Both verbal and nonverbal information are important for conveying meaning. When conveying and interpreting are confirmed, a shared meaning is constructed. Also, culture, age gender, and social reference group may all contribute to diversity in styles of communication.

Cross-cultural communication often includes trying to penetrate the immediate surface of words in order to understand the meaning of the other. The anthropologist Ulf Hannerz (1992) discusses communication in culturally complex versus small-scale societies in terms of communication in social situations of greater or smaller cultural asymmetry. He compares communication in situations of small asymmetry with the tip of an iceberg. What is explicitly communicated can be largely tacit as much is known and already shared. In situations of greater asymmetry, more needs to be explained and contextualised in order to attain a shared understanding.

Hannerz argues for taking the perspective of the other in order to create a shared meaning. This view is also emphasised by Scollon and Wong Scollon (2001) who define successful communication as based on sharing as much as possible the assumptions we make about what each other means. They state, ‘When we are communicating with people who are very different from us, it is very difficult to know how to draw inferences about what they mean, and so it is impossible to depend on shared knowledge and background for confidence in our interpretations’ (p. 22).

When health professionals encounter patients with an immigrant and refugee background, much often needs to be asked and explained. What is under the tip of the iceberg needs to be visualised and verbalised. The clinician may only have scanty knowledge of the patient’s context and social background leaving much to be discussed and explained. Vice versa, the patient might have poor knowledge about how the mental health-care system works and what sort of help is available. Trust and confidence are central to good-quality cross-cultural communication. A trustful relation in which the patient and the clinician want to convey and understand the meaning of the other is the basis for overcoming communication barriers.

Language

Language is central to clinical communication and affects patients’ experience and expression of distress. Language provides both possibilities for expression and limits for communication. It is hard to communicate what we lack words for. With language, we can approach and distance ourselves from memories and experiences. Words and phrases do not just have cognitive meaning but also emotional and symbolic meanings (Westermeyer 1990). Language has also a dialogical character, and the meaning of words and concepts are partly influenced by interaction (Bot and Wadensjö 2004).

Cross-cultural communication often involves communication in a second language, translations, and working with interpreters. Westermeyer and Janca (1997) suggest that symptoms are subjectively experiences that are often not easily translated into numerous languages. They exemplify this with words for sadness, anger, anxiety, pain, boredom, weakness, and fatigue that may require more lengthy explanations. The capacity for using a second language may deteriorate due to age, stress, illness, and crisis.

For example, in psychotherapy as a verbal treatment approach, language can also be overrated in cases. If, for instance, a patient with a recurrent depressive disorder (current episode severe without psychotic symptoms) seeks for help in an inpatient mental health-care setting and speaks a different language than the professionals, it happened that the institutions refused to treat the patient with the argument that ‘due to the communication barriers he is not able to take part in the [fundamental treatment component] group therapy’. As a consequence, the patient was refused in different institutions until one offered a treatment focussing in the nonverbal treatment components in terms of building up activities and daily structure.

Health Literacy

Health literacy is regarded as the ‘degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions’ (National Institute of Health 2000, p. iv). Patients with a lower literacy level can have problems reading prescriptions or following medical recommendations. Lower health literacy can lead to poorer knowledge of the patient’s disease and worse clinical outcomes (Rothman et al. 2004). There are specific vulnerable groups that have higher proportions of limited health literacy than the general population in Europe. This includes older people, members of ethnic minorities and recent immigrants, people with lower levels of education and/or low proficiency in the national language, and those who depend on public transfer payments (WHO Regional Office for Europe 2013).

Idioms of Distress

People may use different ‘idioms of distress’ for communicating suffering. The concept, idiom of distress, was coined by Mark Nichter (1981). He defines it as a socially and culturally resonant means of experiencing and expressing distress in local worlds (Nichter 2010). Idioms of distress may convey signals and information about past traumatic events, memories, and present stressors. The concept of cultural idioms of distress was introduced in the American psychiatric Diagnostic and Statistical Manual of Mental Disorders, DSM-5, in 2013. There it refers to linguistic terms, phrases, or ways of talking about suffering among individuals of a cultural group using shared concepts of pathology and ways of expressing, communicating, or naming essential aspects of distress.

In cross-cultural communication, it may be useful to be sensitive to patients’ use of different idioms of distress when communicating experiences of trauma and sequel of trauma. DSM-5 emphasises that idioms of distress may influence expression of distress of PTSD and comorbid disorders. Examples of this are given, e.g. that panic attacks may be prominent in PTSD among Cambodian and Latin American patients due to the association of traumatic exposure with panic-like ‘khyâl’ (Cambodians) attacks (wind-related panic attacks including symptoms of panic attacks and other symptoms) and ‘ataque de nervios’ (Latin Americans characterised by symptoms of intense emotional upset and panic attacks).

In an overview of trauma survivors, Hinton and Lewis-Fernández (2010) discuss the clinical utility of the concept of idioms of distress. They suggest that idioms of distress may influence the personal meaning of trauma-related disorder, shape the course of the disorder, determine the pattern of help-seeking and self-treatment, but also help clinicians understand the patient’s view of distress. Rasmussen et al. (2011) studied refugees from Darfur and identified the trauma-related idioms of distress, ‘hozun’ and ‘majnun’. These concepts shared symptoms with both PTSD and depression but were not identical.

Studying social representation of trauma among Palestinians in the Gaza Strip, Afana et al. (2010) identified three types of concepts communicating post-traumatic distress: the concept 'sadma' referring to trauma as a sudden blow with immediate impact, 'faji'ah' meaning tragedy, and 'musiba' referring to calamity. The authors describe the meaning of the concepts in terms of how they function in communicating the meaning of suffering to others, the context of suffering, and how to mobilise social support.

Various somatic symptoms, for example, headache, pain, and sleeping problems, are common triggers for seeking care for post-traumatic stress. Kirmayer and Young (1998) suggest that somatic symptoms may be a culturally salient idiom of distress. Not only PTSD, but also depression and other mental disorders and illnesses, and conditions of distress can be expressed by culturally patterned idioms of distress. Depression is a major post-traumatic response, especially after loss. Migration often includes several and important losses for immigrants and refugees. In a Dutch study of depressive disorders among female Turkish immigrant patients, depression was characterised by a wide range of somatic complaints with anxiety and agitation (Borra 2011). DSM-5 (2013) points out that there are substantial differences in expressions of major depressive disorders. At the same time, it is emphasised that there is no simple linkage between cultures and symptoms and that clinicians should be aware that in most cultures most cases go unrecognised.

Communicative Style and Discourse Systems

Groups of people can have different cognitive styles and ways of communicating. Analysing intercultural communication, Scollon and Wong Scollon (2001) use the concept of discourse systems. They suggest that discourse systems might differ according to culture, as well as also being related to other factors such as age, generation, gender, and professional affiliation. The concept of discourse system refers to groups having a kind of self-contained system of communication with a shared language or jargon. Scollon and Wong Scollon characterise discourse systems according to the following: (1) ideology, (2) socialisation, (3) forms of discourse, and (4) face systems.

Ideology refers to holding a common ideological position and recognising a set of extra-discourse features defending the group. Socialisation is accomplished especially through the preferred form of discourse. Forms of discourse are performing models for identification and in- and out-group markers. Views about hierarchies and about who is the correct person to talk with might differ between discourse systems. People are members of many different discourse systems simultaneously. Differences in communicative style, and discourse system, between patient and clinician may lead to misunderstandings and prejudice evaluation. Differences can also be a way to manifest group belonging and identity.

With regard to trauma, different discourse systems can be manifested in, for example, different views about when to talk about trauma and who to talk about it with, or even whether or not it should be talked about. In clinical situations, a shared communicative style and discourse system can become a fast track for an in-group communication and relation. In-group communication can, for example, include situations of encountering patients with one's own social and cultural background. For the in-group member, small signals can convey information about communicating likelihood of traumatic experiences. On the other hand, in-group communication may entail a risk of false understandings and of a shared unformulated agreement to avoid sensitive areas.

Culture, Trauma, Emotional Reactions

Communication is both a cognitive and an emotional process in which both patients' and clinicians' emotional reactions affect communication. The clinician's encounter with immigrant and refugee patients with a different cultural background may touch deep unconscious feelings. Comas-Díaz and Jacobsen (1991) use the concept of ethnocultural transference in discussing how culture and ethnicity may be played out in emotional responses. Transference refers to the patient's emotional reactions and countertransference to the clinician's emotional reactions in psychodynamic psychotherapy. The concepts have relevance also outside psychotherapy and show how easy it is to involve one's own stereotypes about the other in communication. Stereotypes can play an important role in the manifestations of transference and countertransference.

Comas-Díaz and Jacobsen exemplify reactions of ethnocultural transference, for example, how ethnicity and culture can be denied to the extent of obscuring and avoiding any issues related to culture and ethnicity. Mistrust, suspicion, and hostility may be reactions to unacknowledged ethnocultural differences. Denial of ethnocultural differences may lead to countertransference reactions of thinking that one is above the cultural or political influence of the society. They also describe the opposite reaction of turning into a clinical anthropologist overly curious about the patient's ethnocultural background.

The encounter with patients who have experienced severe trauma can also evoke strong feelings affecting interpersonal communication. Clinicians may experience, for example, countertransference feelings such as despair and hopelessness but also feelings such as mistrust and denial. If the feelings are not identified by the clinician, they may easily be played out in actions. For example, feelings of despair can lead to avoiding listening to the patient and hopelessness to not trying to help the person, as no way of helping seems possible. Mistrust and denial may lead to not taking seriously information given by the patient.

David Kinzie (1994) discusses countertransference from his experience of treating Southeast Asian refugees. Although Kinzie refers to psychotherapeutic treatment, this has relevance also for other clinical encounters. Kinzie addresses a broad range of possible reactions and emotions such as sadness and depression. He suggests that these reactions may spring from both empathy and a realisation that what happened to the refugees could have happened to anyone. From his experience, anger and irritability to an unknown perpetrator can last for a long time after a patient has left and spill over into other activities and the private life of the therapist. As a frequent side effect for therapists working with traumatised refugees, Kinzie points to the risk of finding it difficult to work with non-traumatised patients, whose problems may appear trivial. In cross-cultural communication with traumatised patients, identifying one's own reactions and feelings may be a way to understand and improve the communication with the patient.

Cross-Cultural Communication Barriers

There are often several barriers facing immigrants and refugees when communicating post-traumatic distress to health professionals. Patients usually do not spontaneously talk about experiences of trauma, not even to health professionals (Westermeyer and Wahmenholm 1989; Norström 2004). Health professionals seldom ask patients with an immigrant and refugee background about previous trauma and signs of post-traumatic stress (Al-Saffar et al. 2004; Shannon 2012). Lack of trust in the health-care system can be a barrier for communication. Patients with a refugee background can even have experiences of health care being a part of a repressive state and of health professionals participating in torture. The lack of communication about trauma means that there is a risk that experiences of severe trauma and signs of post-traumatic stress are not identified.

A study of patients at a psychiatric outpatient clinic in an exposed suburban area in Stockholm with many immigrant and refugee patients showed that patients who had their trauma sufficiently addressed had a better self-related outcome with fewer symptoms of PTSD, were less depressed, and had greater confidence in staff compared to those who had trauma insufficiently addressed (Al-Saffar et al. 2004). The study found that being an ethnic Swede was related to having trauma sufficiently addressed while the opposite was true for immigrant groups. This study points to the importance of asking about trauma.

People can make sense of distress in many different ways. How individuals make sense of post-traumatic stress symptoms influences communication of distress and help-seeking. The distressed person might not connect post-traumatic symptoms such as flashbacks, nightmares, and concentration difficulties with previous traumatic experiences. Symptoms can be seen, for example, as signs of going mad and losing one's mind and be interpreted as stigmatising signs of severe mental illness. This type of meaning making can restrict an open communication about distress and experiences with friends and family members as well as health providers.

Another potential communication barrier is that patients and laypersons often do not have the knowledge that experience of trauma can have an impact on their health. Primary care is often the first contact with health care. In an American primary care study, the refugees' perspective on communication barriers regarding trauma was explored (Shannon et al. 2012). It was found that the refugees hesitated to initiate a conversation about trauma due to cultural norms requiring deference to the doctor's authority and that the patients lacked knowledge about how trauma affected health. From the patients' perspective, two key communication barriers were identified. One was that the doctors did not raise the topic. Another barrier was that the patients had a sense that a discussion of personal experiences and related health problems was not appropriate for a primary care visit. However, most of the refugees wanted to learn more about the impact of trauma on their health and discuss this with their doctors.

Bridging Barriers in Cross-Cultural Communication

There are several ways for overcoming barriers in cross-cultural communication within health and mental health care. Some relate to add additional competence into the health-care system by working with interpreters, culture brokers, cultural mediators, and health advisors and collaborating with local community organisations. These examples of innovative work may facilitate understanding, trust, and communication between the professional and the patient. For immigrants and refugees seeking care, knowledge about how the health-care system functions and confidence in it can be important components for establishing a trustful cross-cultural communication with individual professionals.

For clinicians, next to self-reflection and supervision, literature, travelling, and personal experiences of socialising in other social and cultural milieus can contribute with new knowledge and perspectives that facilitate interpretation of meaning in cross-cultural communication. Approaches that bridge perspectives and facilitate cross-cultural communication for patients can contribute to a sense of coherence between their own frames of meaning and medical perspectives.

The Narrative

Giving time to, and showing interest in, the patient's illness narrative can facilitate cross-cultural communication and understanding. Social science research has stressed the value of narratives for communicating distress in a meaningful way. In the book 'The Illness Narratives', Kleinman (1988) emphasised how the patient's story is central to clinical work and for understanding the particular patient. Kleinman's work has been followed by extensive research on how narratives can contribute to communicative meaning and contextualised information in clinical care. Through the illness narrative, the patient can communicate information about distress from her or his own perspective.

The narrative captures central aspects of the patient's illness experience and social context and serves as a forum for presenting, discussing, and negotiating illness and how we relate to it (Hydén 1997). Good (1997) argues that narratives are central to the understanding of the experience of illness and that the narrative can locate suffering in history and help to place events in a meaningful order in time. For clinicians, patients' narratives may facilitate the formulation of concrete and contextualised probing questions that are a link to both the patients' experiences and their understanding. Questions linked to the patient's context are easier to understand than abstract questions (Scarpinati Rosso and Bäärnhielm 2012). Abstract and decontextualised questions work when there is an underlying shared understanding of meaning (Bäärnhielm and Scarpinati Rosso 2009). Contextual information is of particular importance to clinical communication with patients in cross-cultural situations where clinicians can have poor understanding of the patient's milieu.

The usefulness of patients' narratives for communication of post-traumatic distress was shown in a study of psychiatric diagnosing where the ethnographic approach of the Outline for a Cultural Formulation in DSM-IV was utilised. The patient's narratives facilitated identifying traumatic events and post-traumatic symptoms (Bäärnhielm et al. 2014). While narratives can contribute to communicating meaning in cross-cultural situations, there are limitations for understanding. Kirmayer (2003) draws attention to the importance of a shared world of assumptions and values for understanding a patient's narrative. The clinician's response to trauma is influenced by how the world is imagined. Kirmayer also suggests that refugee patients' narratives of trauma may involve life circumstances outside the experience and imagination of the clinician.

Interpreters

When patient and clinician do not have a shared language, it is essential to have the support of an interpreter, if possible, a qualified interpreter with specialist training in mental health-care interpreting. Westermeyer (1990) differentiates between translating and interpreting; translating refers to the ability to exchange words from one language to another while retaining the same meaning. He sees interpreting as a more subtle skill which includes transmission of emotional and symbolic meaning. The quality of communication with an interpreter depends upon the capacity and training of the interpreter but also on the skills of the clinician as well as how well the patient is familiar with the situation of working with an interpreter.

As clinicians, we need to learn how to ask translatable questions. Wadensjö (1987) points out that an interpreter has to record the meaning of what is said and that this is facilitated by the clinicians not using too long phrases. When the clinician uses long phrases, it becomes difficult for the interpreter to remember, and there is a risk that only a summary is transmitted and communicated. Bradford and Munoz (1993) formulate some key points for psychotherapy and interpretation and stress the importance of interpreting in the first person, with the 'I' pronoun. This is important also in other clinical situations as talking about the patient in a third person can be both confusing and create a distance.

It is important for the patient that he or she understands the role of the interpreter and how the interpreter works. Especially, in the first clinical contact, it is important that the patient is informed about how communication works with the support of an interpreter and that the interpreter is bound by rules of confidentiality. For clinicians, it is important to learn to ask translatable questions. Discussing the need for culturally sensitive diagnostic procedures among Moroccan patients, Zandi et al.

(2008) argue that it is of value to formulate questions using concrete words (e.g. sad, tired, happy) and avoiding abstractions as much as possible (e.g. depression, shame, guilt). Abstract questions can have an unclear meaning.

Cultural Brokers

Cultural brokers, and other forms of cultural mediators, are helpful for bridging gaps of meaning. They function as a resource in helping interpret the cultural meaning of illness and healing, and this transcends linguistic interpretation (Miklavcic and LeBlanc 2014). Information from cultural brokers about cultural milieus, traditions, and meaning of communication can broaden the clinician's framework of knowledge for interpreting a patient's communication. Exactly how cultural brokers or mediators work varies between different settings.

A community-based model with health advisors or health communicators has been implemented in some parts of Sweden (Bäärnhielm et al. 2013). The health advisors meet groups of newly arrived refugees and immigrants and discuss health promotion and how the complex Swedish health-care system works. These issues are discussed in a dialogue form, in the mother tongues of the refugees and immigrants, in local municipalities. The health advisors meet the groups several times and address different topics: acculturative stress, post-traumatic stress, and where and how to obtain help, among others. This type of health promotion work makes it easier for laypersons to recognise post-traumatic symptoms and to know where and how to get help and how to communicate with health-care professionals in an understandable way.

Self-Reflection and Supervision

A self-reflexive stance is a basic element to improve quality of cross-cultural communication. A reflexive stance, or reflexivity, means trying to see oneself through the eyes of the other and is a method used in anthropology (Hylland Eriksen 2004). In situations of cross-cultural clinical communication, self-reflection over one's own communicative style, ways of using language, and reactions of countertransference can be helpful in getting an idea of the perspective of the patient. Professional supervision and peer consulting can be helpful in identifying one's own reactions and contribute to improve quality of communication. Also specific continuing education may trigger self-reflection.

Assessment and the Cultural Formulation Interview

For overcoming barriers in cross-cultural communication in assessment situations, the Cultural Formulation Interview (CFI) in DSM-5 is a new and helpful tool. With a 16-question interview based on the Outline for a Cultural Formulation in DSM-5, the CFI supports a narrative, person-centred communication in psychiatric assessment. This includes exploring the meaning of the other and an interest for idioms of distress, resilience factors, and expectations of help. The CFI includes open questions and is intended to be used with all patients in the initial assessment. For a further exploration, there are an interview directed towards informants' family members and 12 supplementary modules for a deeper exploration of different areas. Some of the modules have been developed for specific groups (e.g. immigrants and refugees, older adults) and topics (e.g. cultural identity; spirituality, religion, and moral traditions; coping and help-seeking). The module on immigrants and refugees includes questions about hardship, violence, and loss.

Adeponle et al. (2012) studied the impact of systematic use of the cultural formulation on patients, referred to a cultural consultation service, with a psychosis diagnosis in Canada. Misdiagnosis of psychotic patients occurred with patients from all ethnocultural groups, especially recently settled immigrants. Overdiagnosis of psychotic disorders was frequent. After using the CFI, 49 % of the patients with an intake diagnosis of psychotic disorder were re-diagnosed as nonpsychotic, and PTSD was among the common disorders diagnosed after the CF interview. Twenty percent of those who had a change from intake diagnosis of psychotic disorder were re-diagnosed as having PTSD.

Diagnostic Categories and Sense of Coherence

The concept of sense of coherence (SOC) may have relevance to how patients can make meaning out of the clinical cross-cultural communication in assessment situations. The SOC concept was developed by Antonovsky (1988) in order to understand how people successfully cope with stress. SOC includes three core components: comprehensibility, manageability, and meaningfulness. Comprehensibility refers to the extent to which one perceives the stimuli confronting one to make cognitive sense. Manageability refers to the extent to which one perceives that the resources at one's disposal are adequate to meet the demands. Meaningfulness refers to the extent to which one feels that life makes sense emotionally.

For patients, some form of coherence between psychiatric diagnostic evaluations and own perspective may contribute to an improved sense of coherence regarding illness understanding (Bäärnhielm 2004). A meaningful communication about medical information, for example, conveying psychiatric diagnostic categories of post-traumatic stress and suggestions for treatment, is facilitated by knowledge about the patient's perspective on illness and meanings given to post-traumatic symptoms. In a review about PTSD, Johnson and Thompson (2008) emphasise the importance of paying attention to patients' expressions of disorder and distress, the meaning they ascribe to post-traumatic symptoms and experiences, rather than focussing on diagnostic categories.

Building Trust and a Therapeutic Alliance

Trust and a therapeutic alliance between patient and clinician are central to the quality of cross-cultural communication. Trust can be created in many ways, in the individual encounter as well as on a community level with information about health issues and how the health-care system works. For establishing a therapeutic alliance, Nussbaum (2013) addresses the importance of active listening in conveying respect for a patient and his or her concerns. He also emphasises that how questions are posed can contribute to establishing a therapeutic alliance and that expressing concern about a patient's well-being is essential.

Trust and a therapeutic alliance can be especially important in cases of sexual violence. In cross-cultural communication about trauma, clinicians have to ask about trauma but also have to be sensitive to when and how the patient wants to talk about it. The clinician has to respect the limits of what the patient wants to say and if he or she is prepared to talk openly about trauma, as this can be affected by cultural norms and traditions. Discussing resilience-oriented therapy with asylum seekers, Laban et al. (2009) stress the importance of the quality of the alliance and that patients feel that therapy is embedded in coherent, reliable, and predictable interactions.

Case, Soran

Some aspects of cross-cultural clinical communication will be illustrated with the case of Soran. Soran's contact with health care and some glimpses from verbal communication with health professionals in the small town of Mårlunda will be presented and discussed. Soran is a 43-year-old man living in Sweden and is originally from Iraq.

Soran telephones the primary care clinic and asks for an appointment. He wants help with fatigue, pain, and sleeping problems. He has not been in contact with the primary care clinic before. Soran speaks fairly good Swedish and does not ask for an interpreter.

At the primary care clinic, Soran meets a general practitioner (GP). The clinical consultation starts with the GP asking about Soran's health problems. Soran responds:

I have headaches, I have problems with sleeping, and I have pain in my left side. I have back pain and something is pressing on my neck. When it is cold outside, it gets worse. I wake up in the night and cannot go back to sleep.

Soran continues to talk about long-lasting sleeping problems that make him very tired. The GP asks about what help Soran has sought earlier.

Soran: I have been in contact with a private Arabic-speaking doctor working here in Mårlunda. He told me to call you here. He said that you could help me.
GP: Did you have any contact with a doctor in Iraq before you came here?
Soran: No, it was not possible; the war was going on. I got sleeping pills from my friends and relatives. Sometimes the pills made me very tired even during the day. But they were very good sleeping pills; they made me sleep at night. I would like to have good pills like those.

The GP asks Soran more about the condition of his health when he lived in Iraq. Soran talks about sleeping problems, self-medication, and lack of medical care. The GP gets the impression that Soran has lived under quite stressful conditions in Iraq and wants to know more about this.

GP: Have you talked about this with your Arabic-speaking doctor?
Soran: No, I have not. He knows how it is in Iraq. I did not need to tell him.

While carrying out a physical exam, Soran asks the GP for some good sleeping pills. The GP becomes irritated and suspicious. Perhaps Soran is addicted to benzodiazepines and has just come for more drugs. Or has he just come for a medical certificate so he can stay away from his studies or work? The GP finds it meaningless to continue with a further examination and consultation without an interpreter.

GP: I think it is better if you come back when we have an Arabic interpreter here.
Soran: I do not want to have an Arabic interpreter. I can speak Swedish.
GP: The interpreter can help us when we do not understand each other.
Soran: I do not speak very good Arabic.

Soran explains that he does speak Arabic but does not understand it completely. Soran's mother tongue is Kurdish. The GP arranges for a new appointment with a Kurdish interpreter.

Soran returns 2 weeks later to the primary care clinic. The GP he met the first time is now on vacation, and Soran meets a female resident physician in family medicine. A male Kurdish interpreter is present. The resident asks Soran about his health problems. Her short questions about Soran's problems lead to a long discussion between the interpreter and Soran. The resident interrupts and asks if there is any problem with her questions.

Soran says in Swedish that he does not understand the interpreter. The interpreter explains that he speaks Kurdish with a Kurmanji dialect and Soran with a Sorani dialect. The interpreter understands Soran but Soran has difficulties understanding the interpreter. The interpreter says that it is important that they ask for a Kurdish-speaking interpreter who speaks the Sorani dialect.

A week later, Soran comes back to the primary clinic. He meets the resident physician and a male interpreter speaking the Sorani Kurdish dialect. The interpreter presents himself and explains that he is going to interpret everything that is said. He also informs the patient that everything said will be treated with confidentiality. Soran's problems have not improved, and the resident physician makes a comprehensive anamnesis about his symptoms as well as carrying out a physical examination. With the support of the interpreter, Soran understands her instructions and collaborates well.

The resident asks Soran to tell her about his background in Iraq and why he migrated. Soran narrates his life in Iraq and why he fled. He comes from the northern Kurdish part of Iraq. As a teenager, together with two cousins, he left his family and went up to the mountains and joined the Kurdish guerrilla; he became a peshmerga. He lived there for some years and participated in several armed conflicts with the Iraqi military. It was during this period that his sleeping problems and nightmares started. He obtained medication from his friends to help him sleep. Sometimes the medication made him so tired that he slept also during the day. After some years as a peshmerga, Soran was captured by the Iraqi military and imprisoned. After 18 months, he managed to escape with the help of some relatives.

The resident physician listens to Soran's narrative and asks what happened in the Iraqi prison. Soran looks at the resident and asks 'Do you really want me to tell you?' 'Yes' says the resident. Soran tells her how he was treated in prison. He was badly beaten and tortured in order to give information about the guerrillas and where they stored their weapons. Today he has recurrent nightmares about these interrogations, the torture, and also his own participation in the fighting. Certain situations, like bright light in a room, when he sees the police, or certain sounds, make him feel as if he is in the Iraqi prison again. He avoids public places as there is a risk of seeing the police. He also avoids political discussions with other Iraqi refugees as he then feels as if he is being interrogated and threatened.

The resident physician asks Soran how he managed to escape from the prison and Iraq. Soran responds 'I walked to Turkey, but I do not want to talk more about that, it is too hard for me'.

The resident respects what Soran says and does not ask any more questions about his journey through Turkey to Sweden. The resident continues to ask about symptoms of PTSD and depression.

In this case, communication between the patient Soran and the health-care professionals started with a discussion about somatic symptoms, fatigue, pain, and in particular sleeping problems. Initially, it was unclear whether Soran was sufficiently proficient in Swedish or if he needed an interpreter. The resident physician started a communication without checking if the interpreter and Soran spoke the same language and without informing and acclimatising Soran regarding how to work with an interpreter. The GP's decision to end the consultation and give Soran a new appointment could have been affected by countertransference feelings of irritation and mistrust.

When Soran was given space and time and someone showed interest in his story, he gave information that shed new light on his nightmares, pain, and problems. However, he was also very clear about how much he wanted to communicate in the present situation. His illness narratives made it easier for the resident physician to formulate probing questions that contributed to clarifying that Soran suffered from PTSD. He previously had periods of depression with high alcohol consumption. When the resident physician discussed treatment, Soran said that he often thought about his own participation in armed conflicts and what he had done to others.

Summary of Key Points for a Successful Intercultural Communication with Traumatised Immigrants

In interaction with the patient

- Listen actively to the patient and his or her concerns.
- Show your concern about the patient's well-being.

- If possible, be generous with the use of qualified interpreters (in Sweden, interpreters are usually free of charge in health care).
- Ask about previous trauma and post-traumatic symptoms.
- Be sensitive to what, when, and if the patient wants to talk about trauma.
- Try to share as much as possible with the patient assumptions about what each of you mean.
- Pay attention to patients' expressions of distress and meanings ascribed to post-traumatic symptoms and experiences.

In interaction with one's own thoughts and emotions

- Be aware that working with this target group requires more time for communication and arrangement.
- Find space and time to reflect about communication irritations.
- Try to find words or expressions to communicate with yourself the emotional challenges of working with this vulnerable patient group.

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