Medical Rehabilitation Professionals' Perceptions on Intercultural Interaction, Competence, and Well-being at Work

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Tiivistelmä – Abstract

In the past few years, the amount of immigrant patients has increased in public healthcare, and the ability to work with people from various backgrounds is required more and more from the healthcare providers. For example, the challenges in interaction, the use of interpreters, and the possible traumatic backgrounds of the patients could add to the strain of the work, and thus also affect the well-being at work.

This thesis examines medical rehabilitation professionals' perceptions on intercultural interaction, competence, and well-being at work in relation to working with immigrant patients. The data was gathered by interviewing six medical rehabilitation professionals, after which the transcribed interviews were analysed with the Qualitative Content Analysis method and its directed approach.

Themes such as the role of interpreters in the appointments with immigrant patients, the traumatic backgrounds of some patients, and perceived cultural differences with the immigrant patients came up during the interviews. These aspects may complicate the interaction and make the work more laborious. On the other hand, similar factors often also complicate the interaction and work with Finnish patients. Abilities such as flexibility, previous experience and a professional manner, together with some general knowledge about the conditions in the immigrant patients' countries of origin, are seen to be helpful in the patient interaction. Also, encountering people from various backgrounds helps in future encounters, and the things learned in interaction with immigrant patients can be useful also in all patient interactions.

Working with immigrant patients evokes both positive and negative emotions, and the data implies that most of the issues that might decrease well-being at work are related to the organisation of work, not cultural differences in interaction as such.

This study shows implications for the training of the medical rehabilitation professionals, as well as for the interpretation agencies. Also, the data suggests that changes in the organisation of work could improve the medical rehabilitation professionals' well-being at work.

Asiasanat – Keywords
Medical rehabilitation, immigrant patients, intercultural interaction, intercultural competence, interpreters, well-being at work

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Tiivistelmä – Abstract

Viime vuosien aikana maahanmuuttajien osuus terveydenhuollon asiakkaina on noussut, ja terveydenhuollon ammattilaisilta vaaditaan nyt yhä enemmän kykyä työskennellä eri taustoista tulevien ihmisten kanssa. Muun muassa haasteet viestinnässä, tulkkien käyttö, ja asiakkaiden mahdolliset traumataustat voivat lisätä työn aiheuttamaa stressiä ja vaikuttaa työhyvinvointiin.

Tämä tutkimus tarkastelee lääkinnällisen kuntoutuksen ammattilaisten näkemyksiä kulttuurienvälisestä vuorovaikutuksesta, kompetenssista ja työhyvinvoinnista. Aineisto kerättiin haastattelemalla kuutta lääkinnällisen kuntoutuksen ammattilaista, minkä jälkeen se analysoitiin laadullisen sisällönanalyysin avulla.

Haastatteluissa ilmenneitä teemoja olivat muun muassa tulkkien rooli vuorovaikutuksessa maahanmuuttajapotilaiden kanssa, mahdolliset traumataustat, sekä oletetut kulttuurierot. Nämä tekijät saattavat vaikeuttaa vuorovaikutusta ja tehdä työskentelystä työläämpää. Toisaalta, samanlaiset tekijät usein myös hankaloittavat vuorovaikutusta ja työtä suomalaisten potilaiden kanssa. Muun muassa joustavuus, aiempi kokemus sekä ammattimainen työote koetaan hyödylliseksi, kuten myös yleinen tietämys maahanmuuttajapotilaan lähtömaan tilanteesta. Työskenteleminen eri taustoista tulevien ihmisten kanssa auttaa myös tulevissa kohtaamisissa, ja työtavat, joita opitaan maahanmuuttajia hoitaessa voivat olla avuksi myös muiden potilaiden kanssa.

Työskentely maahanmuuttajapotilaiden kanssa, ja siihen liittyvät tekijät, herättävät sekä positiivisia että negatiivisia tunteita, ja aineisto viittaa siihen, että suurin osa työhyvinvointia heikentävistä tekijöistä liittyy työn organisointiin, ei niinkään kulttuurieroihin vuorovaikutuksessa.

Tämän tutkimuksen perusteella voidaan tehdä suosituksia muun muassa terveydenhuollon ammattilaisten koulutukseen sekä huomioita tulkkitoimistoille. Lisäksi muutokset työn organisointiin saattaisivat parantaa lääkinnällisen kuntoutuksen ammattilaisten työhyvinvointia.

Asiasanat – Keywords
Medical rehabilitation, immigrant patients, intercultural interaction, intercultural competence, interpreters, well-being at work

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1 Introduction

A lot is required and expected from the employees and workers in today's working life, including extensive language skills, knowledge of cultures, communication skills, and the ability to utilise various IT systems. In Finland, like in most so-called Western countries, the division of workforce has shifted from the industrial to the service sector-intensive, which then again emphasises the increasing relevance of interaction between people (Pitkänen & Raunio, 2011). This structural change, in addition to the general reformation of working life, creates new demands for the labour markets, employers, and employees, and these new demands include for instance intercultural competence and the ability to interact with people from different backgrounds, since different nationalities and languages have become more widespread globally. Increased demands and heavy workloads, among other things, add pressure to the workers, and it has become more and more important to pay attention to well-being at work.

The changes in working life are also visible in the healthcare industry. The number of immigrant patients has increased in healthcare during the last decades, and especially in the last few years, as the asylum seekers arriving in Finland in 2015, when there was an increase in the residence permit applications (Finnish Immigration Services, 2020), have recently been granted residence and are now allowed to use the public healthcare services. For example, interactional skills have a more significant role in healthcare work than previously thought, and for instance, by law the patient has a right to receive knowledge about their condition in an understandable way (Tervola, 2019). In order to efficiently work with people from different backgrounds, the healthcare providers need to be equipped with a set of interactional skills, and among these skills needed in today's working life is so-called intercultural competence. For instance Matinheikki-Kokko (2002) states that the readiness to operate in a

working environment where the actors represent different ethnic and cultural groups, acts as a basis for intercultural competence.

In this thesis, I will look into the perceptions medical rehabilitation professionals might have on themes such as intercultural interaction, competence, and well-being at work, and how they link these themes to each other. The aim is to examine what kind of factors affect the interaction between the healthcare provider and immigrant patient, and what skills or personal characteristics are considered to be helpful in these interactions and patient work. Additionally, the objective is to study what kind of positive or negative emotions and experiences the professionals link into these interactions, and how they might be related to well-being at work. The thesis starts by introducing the conceptual framework of the study, including concepts on intercultural work and migration, intercultural communication, and well-being at work. The conceptual framework is then followed by the introduction of data and research methods. The interviews are analysed through qualitative content analysis, and the findings are presented in chapter 4. Based on the interviews, the most relevant and re-emerging themes were selected for the analysis, and they are presented in graphs.

The themes in the present thesis will be discussed particularly from the perspective of healthcare and well-being. In addition to that, a fair amount of the material for the conceptual background includes information taken from the instructions and guidelines from the Finnish Institute for Health and Welfare, as it is one of the most influential authorities that provides information to support the decision-making and operations of the health and welfare sector, for example on how to work with interpreters and immigrant patients in healthcare work. The topic has been previously discussed, especially from the perspective of foreign workforce, e.g. healthcare professionals who come from abroad to work in Finnish healthcare services. The communicative issues between patients and healthcare professionals do not

only apply to the immigrant professionals but the same issues in intercultural or interlingual interaction very much apply to the local professionals as well, who work with immigrant patients.

2 Conceptual Framework

In this chapter, the conceptual framework of the study is introduced. The literature on themes such as intercultural interaction, competence, and well-being at work have guided the focus of the following analysis, and the thesis study as a whole. The framework starts with an overall look into immigration and intercultural work, then moves onto communication and competence in the healthcare context, and finally introduces concepts related to well-being at work, especially from the perspective of healthcare work and intercultural work. Through these concepts, the framework aims to lay out a background for the analysis and discussion, and present the themes around the objective of this study.

2.1 Intercultural Work and Migration

In the past decades, the Finnish welfare society has gone through great structural changes, and globalisation and migration have made the Finnish working life more international and multicultural. One of the reasons for the change at workplaces is the increasing number of foreign customers in the public sector. In 2018, seven percent of the Finnish population was of foreign origin (Terveyden ja hyvinvoinnin laitos = THL).

According to traditional views, in the past, one characteristic of the Finnish working life has been the homogeneity of the workforce (Lämsä et al., 2013). The majority of the staff in an organisation has been seen to shar quite similar worldviews, values, and conceptions about communication norms. However, along with immigration and a change in the composition of the “homogenous and native” Finnish population, the working life has also become more diverse in the last few decades. Not only the workplaces and work communities are becoming more diverse, but also the customers. Of course, from this angle, diversity is only seen to cover the different countries of origin, and different languages, when in reality there has probably always been diversity within working life and society. Different language

and skin tone are something that can be easily observed, which makes stating diversity more blunt. However, other aspects that are maybe not as clearly visible, might be left ignored in terms of diversity, such as ideologies and personal histories which in their part also make people diverse. On the other hand, the easily observable differences might also attract stereotypes and biases where differences are excused as cultural.

Intercultural work refers to the diversification of work communities, and there are representatives of different cultures both as customers and employees in the working environment (Pitkänen, 2006). Like for all areas of the economy, internationalisation and intercultural work also introduce new challenges to healthcare work, to which the workers need to be able to respond. This introduces implications for the training of the professionals, for instance. Especially those who work in the service and healthcare industries have to test their professional skills and knowledge in various intercultural communication situations (Kantelinen & Keränen, 2005). For example, intercultural skills and sensitivity are considered to be among the key competencies at work (Wilenius, 2006).

2.1.1 Culture

In the postmodern society, one way to understand the concept of culture is as a way of producing meanings and customs, with which humans understand and articulate the surrounding world as well as each other (Martikainen et al., 2006,13). One way to examine cultures is to look at national cultures which in European civic societies are often based on common language and history taught in the nation state's schools, other institutions, and mass media. The national conceptions about culture are mainly created according to a certain ideal by teaching the citizens consistent historical knowledge and by developing their ability to communicate together with a common language. (Hammar-Suutari & Pitkänen, 2011).

However, using and categorising nation states as cultural units often over-simplifies the complexity of humans but might be necessary in some research settings.

Among other things, regional characteristics, religion, socio-economic status, profession, language and personal experiences all have an influence on the formation of subcultures within social groups. One should also remember that culture is not static but a dynamic entity which changes constantly (Verma, 1997), so people might form groups based on many various commonalities, and the membership to any of these groups may change over time. Hence, it actually might not be culture at all that connects people to each other.

Among other institutions and authorities, The Finnish Institute for Health and Welfare (THL) has also adopted the notion of "culturally diverse Finland" in their materials and guides. It seems that the concept of culture is firmly integrated in the discourse on diversity and immigration, for instance, and this is why I will also include the concept in the study, and discuss the themes from this perspective, though still keeping in mind the criticism that has become more popular in the current intercultural communication research.

Culture as a concept is a complex phenomenon with a plethora of viewpoints, and it is also widely debated. Because of the prevalent conceptions on culture and its effects on communication, such perspectives on culture are also included and discussed in this thesis. For instance, Martin and Nakayama (2007) define culture as a way to perceive the world that is learned and shared within a specific community, and which further influences communication.

The issues related to the conceptualisation of culture might at worst hinder the true understanding of multiculturalism if the discussion about cultures leads to the unnecessary and harmful emphasis of differences (Hammar-Suutari & Pitkänen, 2011). Putting too much weight on the significance of culture's influence on a person's behaviour might emphasise

otherness and reinforce harmful stereotypes. Usually stereotypes are useful psychological shortcuts to make sense of the surrounding world, but they can also induce conflict in intercultural contexts if they are partial or misleading (Macnab & Worthley, 2012).

In the end, there is a lot of debate on what role culture should have in the discussions about interaction between people, and in communication studies in general. It is important to consider that interaction never occurs between abstract cultures but between individuals (Hammar-Suutari & Pitkänen, 2011). In addition to that, although national understanding and self-awareness can be essential in the formation of social identity, in many arenas, the linkage to other groups, such as work communities or hobby groups are often more significant factors affecting the interaction. So, perhaps culture should not be taken into the discussion at all, but the focus should be shifted into individual differences between people, as well as the situational and contextual factors that might affect interaction.

2.1.2 Immigrants and Health

There might be some characteristics that need to be considered when the patient is an immigrant. According to THL, among the things affecting the health and well-being of immigrants are for example their country of provenance, age, reason for immigration, personal experience on health, and cultural views on health, illness and treatment. Further, factors that might have a negative effect on an immigrant's health, include for example experiences in the former homeland and during the trip to the new country, challenges in integrating to the society, untreated illness, and discrimination. In addition to that, immigrants who have arrived as refugees or asylum seekers are more likely to experience psychological strain and symptoms related to mental health problems. Many of these immigrants have faced war, violence, torture, death, or a dangerous flight from their homes (THL).

The problems in the functional and work ability, and their prevalence varies based on the country of origin, according to THL. For example, studies have shown that physical impairments are more prevalent among people from the Middle East and North Africa. In addition to that, certain mental health symptoms for example seem to be more common in some groups of people with foreign backgrounds, and the Migrant Health and Wellbeing Study (Maamu, 2013) states that people from the Middle East show more signs of depression and anxiety compared to other population. Furthermore, regarding mental illness, THL describes that culture might affect the way people recognise and interpret mental problems, and that mental health is not a well-known concept throughout the world, and there might be stigma and black-and-white thinking related to it.

THL also states that immigrants utilise medical rehabilitation services less than other population, and while there are relatively few studies on the subject internationally, the levels of participation and seeking into medical rehabilitation is low. The Maamu-research (2013) shows that every fifth immigrant from a Russian or Kurd background experience the need for rehabilitation, but the concept of rehabilitation might not be familiar which makes the seeking of treatment more difficult.

2.1.3 Communication and Language Skills in the Working Life

The European framework for language education sets guidelines for language teaching, learning and its evaluation. According to this framework, language skills consist of the communicative and linguistic skills together with the various personal, social abilities and attitudes, as well as the ability to function with diverse people in different communicative situations (European framework, 2003). The framework further suggests that the language skills needed in working life is perhaps best acquired from studies (European framework, 2003). In Finland, such language education that prepares for working life is perhaps most

implemented in universities of applied sciences and vocational schools, whereas in universities the language studies are seldom related to specific professions (Kantelinen & Keränen, 2005). Healthcare professionals mostly study in universities of applied sciences and vocational schools where language teaching is directed at specific professions, but the proficiency requisites have probably changed in the past decades, so there are likely differences in the language skills of working healthcare professionals depending on when they have had their education.

Nowadays keeping the professional skills up-to-date usually requires constant further training and education, which includes the improving of language skills. Often the responsibility of mapping these further training needs falls on the shoulders of the employer (Kantelinen & Keränen, 2005). In some professions, language skills might affect sales and profitability, whereas in others it might be a question of life and death. As an example, successful face to face customer contacts in the service industry require professionally inclined language and communication skills, and the base for this is proficient communication skills in the first language (Kantelinen & Keränen, 2005). Of course, English is also the organisational language of most organisations in Finland, also in the public sector, and most employees need to be able to interact in English in their work.

For example Liisa Tiittula (2005) mentions that the communication is often more successful in third culture situations where the participants use lingua franca, that is, such a language that is not native to any of the participants. Usually the lingua franca in intercultural interaction is English. Compared to situations where the used language is someone's first language, a common foreign language creates a stronger cooperative orientation which is useful especially in intercultural interaction. Despite this role as lingua franca however, English may not be enough in some professional contexts. Multilingualism is necessary as a

result of globalisation and the internationalisation of working life, especially since not all people speak more than their first language, and nonetheless, some kind of communication is necessary, such as in healthcare contexts for example.

Insufficient language skills can be compensated with alternative communication types, such as gestures and expressions. This helps in overcoming difficulties as well as saving face in the working life communication situations (Kantelinen & Keränen, 2005). In addition to that, there are often interpreters helping in such cases where there is no common language between the customer and service provider.

In addition to the various aspects of language skills introduced above, in working life, the required language skills might be differently defined based on who is assessing them. For instance, the employer and the employee might have differing conceptions, perspectives and experiences on what is required in daily work, and what kind of training is called for (Kantelinen & Keränen, 2005). For this reason, in the planning of language training, various perspectives should be considered, as well as the individual needs of the specific work community (Kantelinen & Keränen, 2005).

2.2 Intercultural Communication

The introduction to intercultural communication can be started by looking into interpersonal communication in general, as intercultural interaction eventually is "just" communication between two or more people. Interpersonal communication involves only a small number of participants, which enables the participants to adapt their communication to suit the needs of the other participant specifically. Also, in direct face-to-face interaction, it is possible to convey messages through various sensory channels, such as gestures, expressions or voice changes. These features may be intentional or unconscious, but nevertheless are a target of observation and interpretation. This way, the participants can get feedback from

their interaction by interpreting each other's reactions and nonverbal messages (Lustig & Koester, 2003). It is worthy to note that all communication is contextual and thus takes place in a specific setting. Factors such as the place where the interaction occurs, the social purpose of it, and the nature of the relationship between the participants, all have an influence on how the interaction proceeds (Lustig & Koester, 2003).

Talking about intercultural interaction, Milton Bennett (1993) states: "Intercultural sensitivity is not natural. It is not part of our primate past, nor has it characterised most of human history. Cross-cultural contact usually has been accompanied by bloodshed, oppression, or genocide…. Education and training in intercultural communication is an approach to changing our "natural" behavior. With the concepts and skills developed in this field, we ask learners to transcend traditional ethnocentrism and to explore new relationships across cultural boundaries." (p. 21)

This view on intercultural interaction perhaps slightly too straightforwardly implies that intercultural interaction is a great obstacle to be tackled and conquered, and that sensitivity to other people's differences is not inherently human. Of course it has been over 25 years since the publication of the statement above, and the research on intercultural interaction has greatly developed. Still, such perspectives persist to this day, and sometimes the premise to cultures and intercultural interaction is the otherness of people from foreign backgrounds.

There are many factors that have an effect on intercultural interaction, such as various prejudices and biases that normally guide our actions and behaviour. As humans we have an inherent tendency to categorise people, and in this way form impressions about other groups and their representatives. These often unconscious conceptions can be positive, relatively neutral or negative (Pitkänen & Kouki, 1999, 59-61; Salo-Lee, 1996). Secondly, previous

experiences about intercultural encounters change the way people react to future interactions. Whereas positive experiences promote favourable presuppositions, previous failures often cause preparations for the next intercultural encounters (Hammar-Suutari, 2005). In addition to this, also the nature and the number of encounters have an effect on the interaction. Evidently, there are differences between individuals in this, but the familiarity of the situation naturally helps in being more confident and relaxed, which also contributes to the objectives of the interaction. Although on the other hand, the themes of the interaction and their nature might complicate the progression of the interaction, as the more personal and sensitive topics commonly bring out various inhibitions (Hammar-Suutari, 2005). Subjects related to health and health care are often perceived as quite personal and intimate, and thus are probably topics that are more difficult to discuss openly. This difficulty probably occurs regardless of perceived or imagined cultural membership. Intercultural interaction in the context of healthcare is discussed more in a subchapter below.

Intercultural conflict is an aspect of intercultural interaction (Fall et al., 2013), where the cultural worldviews between two separate cultural groups are incompatible, which causes friction (Ting-Toomey & Takai, 2009). This point-of-view, however, assumes that the worldviews, which consist of values and norms, are always a product of culture. Furthermore, for example Martin & Nakayama (2007) also emphasise the significance of context in a communication situation. Skillful and effective communication requires that the situation and the related social, political, and historical contexts of the communication are understood.

2.2.1 Intercultural Communication In Healthcare Context

In authoritative contact in Finland, the two sides of the interaction are often a foreign customer and a Finnish authority. In their work, the authority often has to act as the mediator

of reciprocal cultural integration without relevant training or sufficient experience of interacting with people from different backgrounds or perceived cultures.

In some cultures, healthcare professionals are seen as authority figures, and the patients might feel that they have to agree with them in the medical interviews. The patient might for example disagree with a treatment or know that they will not be able to follow the treatment plan but will be reluctant to challenge the healthcare professional's authority and say anything. They might additionally refrain from asking questions. This is typical in so-called collectivist and high-context cultures, such as in some of the Asian countries. On the other hand, people from so-called individualistic and low-context cultures mostly feel that open discussion with the professionals is important, and hence are more likely to open up about their questions and issues (Lustig & Koester, 2003). Again, this perspective on cultural differences closely follows the essentialist principles set by perhaps one of the best-known theories on cultural differences by Geert Hofstede (1984) who categorised nations, or nation states based on general cultural differences. As the categorisations are very general, they dismiss the individuality of people, and instead try to explain human behaviour solely by culture.

Unconsciously repeating such characteristics that the customer interprets as negative might lead to mutual frustration and other negative emotional reactions (Brewis, 2005). This could further have an influence on the authorities' well-being at work, if they find themselves constantly in conflict with their customers. Also, recurrent misunderstandings can have a negative influence on an individual's self-confidence and furthermore affect how the individual reacts to people from different cultures. Indeed, encountering unfamiliar behaviour and customs might cause insecurity, distrustfulness, and negative stereotypes because in

uncertain situations, it is a natural human reaction to be mentally on the defensive (Brewis, 2005).

Authorities in customer contacts should be aware about the possible motives behind the customers' behaviour, as the situation might often be stressful for them for many reasons. From this perspective, part of the professional know-how is taking into consideration the customer's emotional reactions (Brewis, 2005). The familiarity of the situation, already mentioned above, also relates to uncertainty and fears, which are also factors that might affect the interaction negatively. The customer could be afraid of the authorities, possibly because of previous experiences. Also the status of the immigrant customers, both in the society and in the present interaction, often causes uncertainty. In contrast, the authority might feel insecure about the new situation or meeting a new and "different" customer. Thus, both sides of the interaction might be nervous about the possible lack of common language, or whether they will get their message through (Hammar-Suutari, 2005).

In some contexts, multicultural or intercultural competence has been introduced as a key qualification and a general professional skill in the globalised working life. More specifically, cultural competence is sometimes conceived even as basic professional know-how, where the concept covers aspects such as general understanding, skills, and competence that are needed to operate in diverse environments with different people (Lasonen, 2005). Further, to be able to function in multicultural working environments, the authorities mostly recognise the need for toleration of change and the preparedness to tackle the challenges in multicultural customer service situations. (Hammar-Suutari, 2005)

In the past, intercultural communication theory has as of yet focused mainly on the representatives of minority cultures and on the integration process of immigrants, even though socio-cultural-integration and intercultural interaction are reciprocal processes that

affect both the receiving population and the immigrants. For instance, Kim (2001) states that the research in the field has only marginally discussed such situations where the receiving population might experience confined adjustment in contact with individuals from foreign cultures or subcultures. The notion that the locals are on their "home ground" is likely to keep the cultural adaptation pressure at a minimum (Kim, 2001). However, this advantage of the "home ground" and the low adaptation pressure does not necessarily apply in authoritative contacts (Brewis, 2005). There are often strict expectations and high pressure that fall upon the authorities about culture sensitive service for the multicultural customer base. In addition to this, the authorities might often be publicly criticised about the lack of intercultural communication skills and understanding. This general and indirect approach to the reactions and cultural adaptation experienced by the authorities does not in reality contribute to neither the development of intercultural communication skills of the Finnish authorities, nor the forming of mutual intercultural understanding (Brewis, 2005).

The many theories on intercultural interaction and communication have also been criticised. For example, Ingrid Piller (2011) describes her disappointment in the research and textbook material of intercultural interaction, stating that the research does not truly consider real life intercultural communication. She continues that the previous research mostly overlooks people who come from diverse backgrounds with linguistically and culturally diverse lives (Piller, 2011).

Seems that there are only few studies conducted on the subject, and even these are mostly over ten years old. Considering the changes in the last decade, and the relatively recent criticism on the concept of 'culture', it seems odd that there are only so few studies done, and mainly about doctors. Buchert and Vuorento (2012) propose that cultural differences have been used in research and reports almost as some kind of an

all-encompassing concept that is seen to explain practically all possible issues and differences.

2.2.2 Interpreters in Healthcare

The increase in linguistic diversity and the need to ensure that the interaction between the patients and healthcare professionals is effective has increased the use of interpreters (Hadziabdic & Hjelm, 2013). Previous research has shown that using interpreters increases accessibility and the quality of healthcare, as they help the patients to understand their condition and different treatment options better (e.g. Zigarus et al., 2003). The use of interpreters has also been shown to increase the patients' trust in the process, and improve the relationship with the healthcare provider (Ramirez, 2003). Additional benefits reported by further studies imply for example that the patients are more likely to keep their appointment times, if there is an interpreter involved (Eyton et al., 2002).

However, studies have also shown that the healthcare providers may experience interaction difficulties when using interpreters. One of the reasons behind this might be the lack of training and instructions on how to operate when an interpreter is involved. (Hadziabdic et al., 2011). For example Tribe and Tunariu (2009) suggest that the education of healthcare professionals should include training and skill development on working with interpreters. Training the healthcare professionals, as well as the interpreters, helps them in working together efficiently, and is also likely to boost their confidence in the interaction (Tribe & Tunariu, 2009).

Having an interpreter present and involved in the patient interaction is often reflected in the dynamics of the interaction, as well as the development of intimacy between the patient and healthcare provider. At any one time, only the interpreter is able to understand the patient's self-disclosures, which might make the healthcare professional feel excluded,

especially if they do not have experience in working with interpreters (Kaur et al., 2014). In the light of this, the presence of an interpreter could hinder the trust building that is important in medical rehabilitation patient relationships. On the other hand, working with interpreters also introduces clear advantages, as they can be an additional resource and asset to the work of healthcare providers, and make the healthcare services more accessible to immigrants. The interpreters can for example provide additional information on relevant traditions, practices or contexts (Blackwell, 2005). Conversely, this epistemic approach of interpreters as mediators between cultures could be problematic, as it cannot be guaranteed that the interpreter truly knows and understands a specific culture, and the claims about knowledge might in fact be harmful. Most often these things are likely negotiated with the patient.

The work and interaction with interpreters can at best enrich the patient–healthcare provider interaction with additional and broader perspective, in addition to the actual interpretation. Nevertheless, there are issues that the healthcare provider must consider when planning the use of interpreters in customer contacts, as their work generally requires sensitivity for instance. (Hadziabdic & Hjelm, 2013).

The ability to work with interpreters is a crucial skill that the healthcare professionals need in order to effectively treat and communicate with their immigrant patients. This, along with other professional and interactional skills constitute the competence which helps people manage with their work. The concept of intercultural competence will be introduced and discussed below.

2.3 Intercultural Competence

In intercultural working life contexts, communication skills, professional expertise and the ability to take into account aspects related to the customer's background are often emphasised. This last aspect is often referred to as intercultural competence.

(Hammar-Suutari, 2005). Some researchers also talk about multicultural competence, which can be defined as a general working life ability, and from this perspective the multicultural abilities are necessary in today's working life in general. Intercultural competence is needed particularly when the different backgrounds, worldviews and attitudes of the interactants might complicate the interaction. Often these differences complicating the interaction are perceived to be cultural, perhaps because stereotyping is somewhat intuitively appealing to people, and we tend to categorise others.

Competence is often defined as a synonym to skills and qualifications, and thus, includes also the ability to manage and perform tasks efficiently. More precisely, competence consists of aspects such as knowledge, skills, experience, relationships, values, and attitudes. It can be either conscious, when the individual acknowledges their ability to manage their tasks well, or unconscious, when the individual can function in their job without really paying attention to it (Hildén, 2002).

Further, THL suggests that cultural competence includes respecting “people with any cultural background”, and promoting a non-discriminatory atmosphere. From the point-of-view of working life, this also means the provision and accessibility of services in such a way that one considers the varying needs of people from different backgrounds. This viewpoint is quite culture-oriented, which is no wonder when talking about cultural competence, but the focus seems to be heavily on the distinction between cultures, and with this approach there is a risk of over-emphasising otherness.

Conceptualisations of intercultural competence have largely focused on the individualistic perspective of intercultural competence. On the other hand, this approach considers the interactants more as individuals who may or may not agree to the cultural aspects of their own heritage and native culture, but alternatively the individualistic approach

might dismiss the effects of collectivist cultures on the individuals from such backgrounds. However, most conceptualisations agree on three main themes of intercultural competence, namely empathy, perspective taking, and adaptability.

Alternatively, for instance Salo-Lee (2007) uses the concept of "cultural literacy", which involves the ability to read, understand, and find meanings of other cultures, and in consequence, the ability to assess and compare different cultures. She further states that in a multicultural society, cultural literacy is as important as the ability to read or write. (Salo-Lee, 2007).

Intercultural competence is often defined as a composition of three different dimensions: knowledge, attitudes, and skills (e.g. Campinha-Bacote, 2007; Hammar-Suutari, 2006; Jokikokko, 2002). In addition to one's own culture, one should also be aware that there are differences in lifestyles and religions between cultures. Also knowledge about societies, social and political interests, and understanding the global dimensions of things, are some of the cognitive qualities of multicultural competence. Secondly, attitudes might include viewpoints on justice, respecting diversity, caring for others, and ambiguity tolerance, among other things. Ambiguity tolerance means the acceptance of habits and courses of action that differ from our own values and cultural basis. Finally, the skill dimension includes criticism of one's own and others' actions, and the ability to see and understand things from multiple perspectives. Also a part of the skill dimension, are interaction skills and adaptability in changing conditions, as well as understanding otherness. Even though these dimensions are conceptual, they are merged together in practice. (Hammar-Suutari, 2006; Jokikokko, 2002). Utilising these aspects can help in developing the operational abilities of intercultural work. The development of these abilities, or transferable skills, additionally requires real intercultural encounters (Salo-Lee, 2005).

In the healthcare context, intercultural competence is especially relevant when the patient and the healthcare provider come from different backgrounds. Amongst other things, people often understand the world through different cultures, and thus also in the healthcare context for instance the patients, their families, and the healthcare providers refer to their own cultural patterns on what is appropriate or expected from the interaction. In some cases, the expectations on the treatments, as well as the interaction in whole, might differ between people from different backgrounds (Lustig & Koester, 2003). These perspectives on cultures are common in the learning materials for healthcare professionals, and while they might be quite essentialist, they are still somewhat prevalent.

The ambiguity of different languages, as well as the differences in the ways people use languages, might introduce additional problems in diagnosing and giving treatment. The risk of misunderstandings rises when the messages can be interpreted to have multiple meanings. Understanding the ambiguous nature of language and taking this into account in intercultural interaction so that messages are mutually understood is a sign of intercultural competence (Lustig & Koester, 2003).

Intercultural training and knowledge on relevant cultures, or traditions additionally often broadens the perspective and world view of the local employees. This then again has a positive impact on prejudice which might even sometimes be subconsciously rooted in one's mind. Prejudice and presuppositions further have a profound influence on the delivery of healthcare. An ethnocentric healthcare provider's treatment and behaviour will be affected by their biases and attitudes. (Anand & Lahiri, 2009). In intercultural interaction, the healthcare professionals have an emphasised responsibility to ensure that they understand their patients so that it is possible to carry out relevant and effective treatment. This requires a willingness to try and understand the cultural background and patterns of the patient, including the

beliefs, values, and interaction norms. (Lustig & Koester, 2003). As stated above, healthcare providers and professionals face increasing expectations and pressure due to the growing number of ethnically and linguistically diverse clients, as a result of globalisation and immigration. It is necessary for the healthcare workers to develop intercultural competencies to ensure that individual healthcare choices and various treatments are understandable to their clients in terms of their own background and experiences (Anand & Lahiri, 2009). These competencies allow the healthcare providers to understand the client's perspective, and adjust their behaviour and communication accordingly to achieve the best possible care. It might be useful to provide training on specific cultures but there is a risk of one-dimensionalising the information or stereotyping individuals (Anand & Lahiri, 2009).

In addition to understanding the patient's verbal messages, effective treatment requires the ability to read nonverbal signs. For example in the case of showing pain, Lustig and Koester (2003) state that in some cultures individuals are expected to describe their experience of pain calmly and logically, whereas in other cultures it is more common to use very emotional and dramatic terms, which again might be interpreted as exaggeration in cultures that are uncustomed to this. This statement and instruction is from a guidebook for intercultural interaction in healthcare context, and it very much emphasizes the differences between people based on imagined cultures. Although these kinds of examples can be useful in some cases, and help understand why someone might react differently than someone else, it is not always about nationality or perceived cultures, but there might be individual differences and experiences in the background as well. Oversimplifying and stereotyping could lead to othering and creating imaginary boundaries between people.

According to Hammar-Suutari (2006), in authoritative work, the cultural competence has been understood in a rather narrow sense, and mostly in the dimensions of skill and

consciousness. Attitudes and operation have not been considered as much in the improvement of everyday work. Although, there are conflicting findings about the influence of attitudes on behaviour. Erwin (2005), for example mentions that there is no simple relationship between attitudes and behaviour and actions, but other factors must be considered as well. Situational factors, and the relationship of different and even contradictory attitudes, among other things, should be taken into consideration. Attitudes form together an entity, where every individual has also competing attitudes originating from various reference groups, and hence also alternative behaviour patterns. For example, prejudice towards an ethnic group, does not necessarily reflect themself directly on the employee's behaviour. Clark (2006) states that the employee should "create space for understanding". By this, he means the process where the employee tries to understand the interpretations about reality that are based on a different worldview and cultural background. Further, it is impossible to understand the experiences of others perfectly but nevertheless, the employee should strive for sufficient understanding. (Clark, 2006).

Different expectations about modesty and the ways to display one's body can bring out quite concrete conflicts in medical examinations where it is often necessary for the healthcare professional to have access to the patient's body. An individual's body is universally seen mainly as something private and personal but in some cultures women are especially expected to cover themselves, and only display their bodies to their closest family members. This can make the medical examination itself a source of intercultural difficulties. In these settings, it is particularly important to acknowledge the cultural expectations about what kind of behaviour is allowed or prohibited (Lustig & Koester, 2003).

Another example of differences between people from different backgrounds is family dynamics. In most welfare societies, the healthcare systems mainly focus on the individual

patient who is in need of treatment. However, in collectivist cultures the role of the whole family is emphasised, and this difference can cause complications, for example, when the family influences how the individual in need of treatment behaves in the appointments or follows the treatment plan (Lustig & Koester, 2003).

On the other hand, Kamali (2002) for example has advised against over-emphasising the significance of cultural factors as it might lead to the marginalisation of immigrant clients. It is only one point-of-view to cultural differences that cultural differences complicate the communication in customer situations and the relationship between the customer and the employee. In addition to the perceived cultural differences, the healthcare authority should also take into account many other factors affecting the immigrant's situation in life and sociological status. Even though there are many reference books and materials that provide the general characteristics of different cultures, it is important to also consider people as individuals who might not share the preferences of their cultural group (Lustig & Koester, 2003).

In general, intercultural competence in healthcare context could be described as the ability to provide efficient, understandable, and respectful care delivered in such a way that matches the patient's beliefs and practices, as well as their language skills (Anand & Lahiri, 2009). In addition to this, the personal characteristics of the individual could be considered to be a part of intercultural competence. These characteristics and their importance probably varies between different fields and industries based on what features are needed in the field-specific tasks.

Teaching various cultural differences and special characteristics of perceived cultures is basically introducing and reinforcing stereotypes. As already mentioned previously, stereotypes can be useful shortcuts, but they might also emphasise otherness and promote

discrimination by reasserting harmful and misleading "facts" about people from specific backgrounds.

Even still, in order to offer effective treatment, health care professionals are expected to try and understand the beliefs, values and interaction norms of their multicultural patients (Lustig & Koester, 2003). This perhaps creates even more pressure and adds responsibility on the health care professionals. Also, the highly personal nature of healthcare services adds more challenge to the complexity of intercultural interaction. This makes the perspective taking more difficult as it often includes the clients' and professionals' values, beliefs, and attitudes (Anand & Lahiri, 2009), and might often not be about culture at all. Well-being at work and its characteristics in the healthcare context, including for example stress and increased demands, will be discussed next.

2.4 Well-Being at Work

As discussed above, the changes in the working life, and the new demands these changes create, might often cause pressure for the employees, and these pressures can manifest as uncertainty and tension, which again may be mirrored into the customer service, and on the overall well-being at work (Hammar-Suutari, 2005). There seems to be no simple and uniform definition for well-being at work but the theories and models have mostly focused on defining individual aspects of well-being at work. However, The Finnish Vocabulary of Safety and Health at Work (Työsuojelusanasto TSK 35) outlines well-being at work as the employee's physical and mental condition that is based on the balanced sum of work, working environment, and free time. Furthermore, Schulte and Vainio (2010) describe wellbeing as a summative concept that consists of aspects such as occupational safety and health, and defines the quality of working lives. Well-being at work can also be defined as the employees' experience of a safe and healthy work, which includes for example good

leadership, competence, organisation of work, supportive work community, and meaningfulness of work (Anttonen & Räsänen, 2009).

Among the factors that influence job quality positively, are factors such as learning possibilities at work, professional skills, self-direction, flexibility of working hours, and the possibility to participate in decision-making (Alasoini, 2016; Anttonen & Räsänen, 2009; Ojala, 2003). Manka & Manka (2016) continue that one of the most important aspects of well-being at work is indeed the sense of control over one's work. This includes having the possibility to influence one's tasks and working pace. In the public sector, the chances of affecting work distribution and pace are often fewer than in the private sector. Many of these aspects of work also relate to work management.

When talking about job quality, the definitions often vary between disciplines, as for example economists focus on aspects such as salaries, whereas sociologists emphasise skills and autonomy, and psychologists job satisfaction (Findlay, 2013). Just as intercultural competence, well-being at work is also a contextual phenomenon, and there are different aspects among people, occupations, and societies that affect every individual and community differently. Regardless of the various definitions it could be stated that the concept of well-being at work is multidimensional, and relates to many different aspects across disciplines (Anttonen & Räsänen, 2009; Schulte & Vainio, 2010). Still, the concept seems to remain at a general level, and does not appear to connect to any specific type of work or industry. However, perhaps one of the most evident aspects of well-being at work is the amount of stress, which will be discussed next.

2.4.1 Stress

As stress is one of the most common ways of classifying well-being at work, and perhaps an aspect that is relatively straightforward to measure, it is also sensible to discuss in

this thesis. The Finnish Institute of Occupational Health (FIOH) is a multidisciplinary research and specialist organisation, which carries out research, and provides services and training on well-being at work. According to the institute, one of the reasons behind burnouts and work exhaustion is the prolonged experience about the imbalance of investments given to the work and the counterparts obtained from it. When work depletes more energy than it gives, it starts to generate negative mental conditions. (Finnish Institute for Occupational Health). In today's working life the attention has turned more to mental well-being at work from the physical stress. Especially in municipalities, a significant amount of employees find their job emotionally stressful; in 2015 up to 71% of municipal sector workers reported their work as mentally stressful. (Manka & Manka, 2016).

Work related stress might also cause mental issues, and the FinHealth 2017 study conducted by the Finnish Institute for Occupational Health (FIOH) shows that every fifth woman and 15 percent of the men have experienced significant mental strain (Koponen et al., 2018). While work has become more challenging and straining mentally, and the working situation is more uncertain for many, mental well-being has become one of the focus points of working life.

A study by the European Agency for Safety and Health at Work on the prevalence of stress in EU countries shows that 42% of Finnish workers experience either much or extremely much work-related stress. The common models of stress suggest that being unable to answer the demands of work is one of the main reasons that creates stress (Manka & Manka 2016). In addition to that, uncertainty and haste also cause stress in work places. To a certain point this stress is usually positive, so-called eustress, and might boost the efficiency, until the stress exceeds the overload limit, after which the stress may cause for example cynicism, sleeping disorders, depression, physical illness, and lowering of

professional self-confidence. At worst, long-term stress could lead to burnout. (Manka & Manka, 2016)

However, for example Hakanen (2019) notes that haste and the amount of work are usually not the biggest cause for work exhaustion. Adding challenges and problem solving might in fact even decrease the risk of exhaustion at work, and the bigger risk factors are for instance workplace bureaucracy and contradictions of roles. Thus, in practice the inefficient systems and ambiguous responsibilities are more stressful than high amounts of work tasks. (Hakanen, 2019).

If the work or the interaction in patient relationships constantly evoke negative feelings, it might be harmful for the well-being at work, or even health in general (FIOH). Certain aspects in the job tasks, work arrangements, or interaction might cause stress for most employees. However, the susceptibility to stress between people varies and depends on the individual differences and circumstances.

2.4.2 Intercultural Interaction

It could be argued that intercultural, or interlingual interaction may evoke negative feelings such as uncertainty and anxiety, especially if the professional is insecure about their ability to handle the situation, or is not accustomed to intercultural interaction. On top of that, for instance misunderstandings caused by different backgrounds and communication cultures might further have an effect on the overall well-being, and undermine one's self-confidence and the perception of their professional skills. However, the notion of constant misunderstandings, which is a prevalent idea in classic intercultural communication research, has been disputed lately, as it implies that cultural differences almost unavoidably are the reason behind these misunderstandings, and that intercultural communication would be more problematic and full of issues and conflict. Misunderstandings and conflicts may and do

appear in all interactions regardless of the partakers' backgrounds, and these issues just as well can negatively undermine the professionals' well-being at work.

On the other hand, these intercultural interactions may also have positive effects. As mentioned above, problem solving and overcoming challenges can help in decreasing work exhaustion and stress, and bring meaningfulness to the work. When it comes to the prevention of work exhaustion, adding to the challenges of one's work can actually be recommended, as long as it is voluntary (Hakanen, 2019).

Having immigrant patients often introduces new demands for the healthcare providers. Intensified demands, especially concerning knowledge and skill -related learning, as the healthcare professionals have to acquire additional language and cultural skills to be able to provide efficient care and treatment for multicultural clients.

Furthermore, intercultural competence helps in ensuring the economic viability of the healthcare industry which is already strained financially and in regard to working conditions. According to some researchers, when organisations develop strategies that provide more culturally appropriate care, the financial pressures will ease, and the care quality will improve (Reynolds, 2004). However, it could be disputed whether it is realistic or even possible to train the healthcare providers so that they are able to offer specifically targeted care based on the background of each individual patient.

2.4.3 Management and Organisation

Promoting well-being at work, and taking into account the needs of the employees when it comes to training and competence, is something to which the management in organisations need to be able to respond.

Diversity at workplaces introduces demands and pressure that are creating the need for professional diversity management and its development (Olsen & Martin, 2012).

Especially sociological factors such as the increasing immigration and internationality in the working life, contributions in gender equality, the ageing population and the growing discussion about the status of minorities have an influence on these demands for diversity management (Puukari & Oinonen, 2013).

Cox and Blake (1991) emphasise the significance of constant development of personnel and management as diversity management. This development should increase the awareness and understanding about diversity, but also improve practical skills which help when facing variety and working with different people. However, the change in attitudes is only the first step in developing the work community. Only after this is it possible to move towards concrete utilisation of diversity and learning from it, which might require profound change in methods and organisational structures (Hammar-Suutari & Pitkänen, 2011). Yet, it is important to approach this cautiously, so as not to overly emphasise stereotypical diversity, or only focus on some aspects of differences, such as languages.

Even if the legislation sets the frame for organisational diversity, diversity management is often seen to be founded on voluntary objectives for improving and treasuring the status of different people in an organisation. The promotion of the positive effects of diversity is nowadays the starting point of diversity management. (Olsen & Martins, 2012). Furthermore, the manager's positive attitude towards organising various training, language training for example, often turns out to be a benefit for the company. Additionally, the willingness to develop the professional knowledge of the employees is usually perceived as an encouragement, and the training improves working efficiency, and also in this way benefits the company (Kantelinen & Keränen, 2005).

3 Method and Data

In this study, the interview data is analysed using qualitative content analysis and its directed approach. In this section, the data and method of the present thesis study are presented. Firstly, the aim of the study and research questions are introduced, followed by the introduction of the data, consisting of the interviews of medical rehabilitation professionals. After this the research method is explained. Finally, the method will be discussed in relation to the data and research questions.

3.1 Aim and Research Questions

The aim of this thesis is to introduce medical rehabilitation professionals' perspectives on working with immigrant patients. I am particularly interested in interviewees' ways of describing their experiences in terms of interculturality and their well-being at work. In order to canvass these experiences, three research questions were formulated, and they are listed below. Then, in the Findings chapter, the research questions and data will be examined based on the conceptual framework presented in the previous chapter, contemplating for instance the role of immigration in the healthcare sector, special characteristics of intercultural interaction and competence in the work of healthcare professionals, and the implications these themes have on the well-being of healthcare workers who treat immigrant patients.

The research questions included the following:

RQ1: What kind of factors in interaction with people of immigrant backgrounds affect the work of medical rehabilitation professionals, and what kind of issues occur when working with immigrant patients?

RQ2: What helps when interacting and working with immigrant patients?

RQ3: What kind of feelings or experiences do the professionals experience, and how are they related to well-being at work?

Based on the definitions of well-being at work, and the conceptual framework on intercultural interaction, especially in the healthcare context, the aim is to see how the medical rehabilitation professionals perceive their well-being at work in relation to perceived interculturality in interaction.

The aim of the interviews, as well as the research as a whole, was to obtain in depth descriptions about the participants' perceptions and personal experiences on working and interacting with immigrant patients, focusing especially on the influence these interactions might have on well-being at work. These themes, such as the patient–care provider interactions, have been previously studied mainly from the perspective of the immigrant care provider in Finland. Also, previous research has examined the professionals' perceptions on challenges and solutions in occupational and mental health rehabilitation but not so much in medical rehabilitation, despite that the fields are closely connected.

As a qualitative study, the results are not generalizable but the answers are examples of different perceptions of intercultural patient interaction, competence, and well-being at work. These answers can then be examined in relation to the conceptual framework introduced in the previous chapter.

3.2 Data

Interviewee	Profession	Worked in their profession	Gender	Interviewed	Length
I1	Children's occupational therapist	31 years	woman	24.4.2019	24:15
I2	Children's physiotherapist	16 years	man	25.4.2019	33:39
I3	Speech therapist	29 years	woman	25.4.2019	29:54

I4	Physiotherapist	20 years	woman	8.5.2019	24:31
I5	Physiotherapist	30 years	woman	8.5.2019	25:44
I6	Rehabilitation councellor	30 years	woman	8.5.2019	27:48

Table 1
Summary of the Interviews

For the present thesis, healthcare professionals in the field of medical rehabilitation were interviewed, including physiotherapists, an occupational therapist, a speech therapist, and a rehabilitation councellor. There were six interviews which were recorded, and produced altogether roughly 166 minutes of recorded audio material, where one interview lasted between 24 and 34 minutes (see Table 1). The interviews were conducted in Finnish, which was the first language of the interviewees and interviewer. The interviewees had between 16 and 31 years of experience in their field of work. Some of them have worked under the same employer their whole career, while others have worked in various positions in the private, public and third sector. Since the participants have already been in working life for decades, the education they have received differs from what education is like today. When they have studied and started working, the interviewees assess that the amount of immigrants has been significantly lower, so there has not been as great of a pressure and need to prepare healthcare professionals for interaction with immigrant patients as there is now.

Medical rehabilitation professionals were chosen as a target group particularly because of the nature of their customer relationships. The therapist-patient relationship often goes on for months, even years, so the relationship has time to evolve, and the interaction may go past the superficial stage. In lasting therapeutic relationships, the patient and the care provider learn to understand each other better, and the patient's trust in the healthcare professional increases which can also be significant to their health (Tervola, 2019).

Furthermore, other healthcare workers, especially doctors, have been studied in multiple cases in the past, while few research has been done focusing on medical rehabilitation where the patient relationship is often longer. Thus, this thesis contributes to this line of study by filling some of the gaps.

The interviews were semi-structured, and the open-ended questions focused on the themes of intercultural patient interaction, intercultural competence and well-being at work. The semi-structured approach was chosen to allow room for the interviewees' additions on themes they found to be relevant, and to gain a broader narration on the issues at hand. The interviews started by asking the participants to describe their positions, job descriptions, and work histories. Secondly, the interviewees were asked to assess the amount of immigrant patients they have, and to compare this to the time when they first started working. The interview then moved on to discuss the perceptions and experiences the medical rehabilitation professionals have on themes such as intercultural interaction and well-being at work more closely. As the research focuses on intercultural interaction and competence, also the interviewees' answers focus on these interactions with immigrant patients as being intercultural, and on the competencies being specifically intercultural. This evidently guides the interviews and answers to a certain direction which should be kept in mind when analysing and interpreting the data.

The interviewees were informed about the research in Finnish, and gave their consent by signing a written form of informed consent. All names are anonymised to protect the interviewees' identities. After the interviews were conducted, the recordings were transcribed and analysed. The analysis method is explained more thoroughly below. Also, parts of the transcriptions were translated into English to provide examples of the analysis.

3.3 Qualitative Content Analysis (QCA)

Content analysis is a widely used method for qualitative research. Content analysis as a research technique has also become more popular in health studies during the past decades. Its increasing usage in research can partly be explained due to its flexibility in analysing text data. (Hsieh & Shannon, 2005). Studies that use qualitative content analysis as a research method focus on the specific features of language as communication, and examine specifically the text's content or contextual meaning, which can be either verbal, in print, or in an electronic form. Moreover, the data could have been obtained in various ways, such as narrative responses, interviews, open-ended surveys, observations, or printed media (Kondracki & Wellman, 2002).

Qualitative content analysis is an objective and systematic research method for describing phenomena and analysing various documents, with the goal of providing understanding on the studied themes (Elo & Kyngäs, 2007; Downe-Wamboldt, 1992). Through content analysis, it is possible to make logical conclusions from the data and its context, in order to gain a better understanding of the phenomena. Qualitative content analysis can also be useful in portraying facts and producing practical guides for action (Elo & Kyngäs, 2007).

Hsieh and Shannon (2005) introduce three distinct approaches of qualitative content analysis: conventional, directed, and summative, all of which are used to interpret meanings of the content in the text data. For this analysis, directed content analysis was chosen. Qualitative content analysis and its directed approach is a suitable method for this present thesis as it can be used to systematically analyse and interpret open-ended interviews. The method provides a subjective way to interpret the content of the transcribed text data and its contextual meanings through the process of coding and identifying themes.

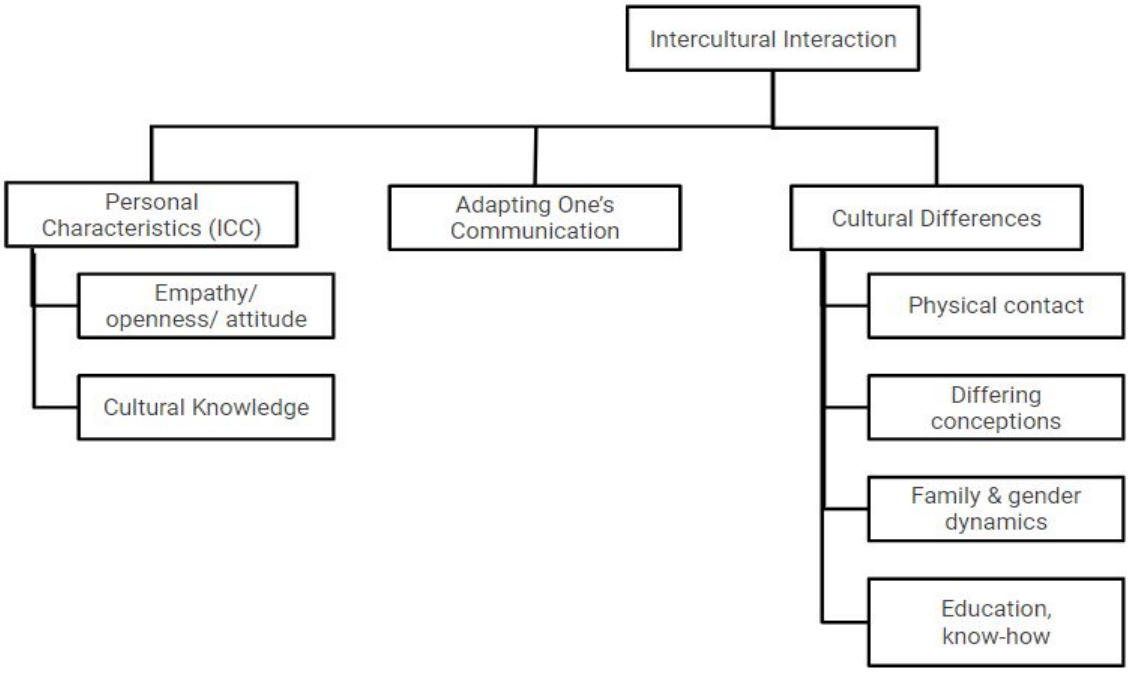
The directed content analysis approach to QCA often starts with the focus on the theory or conceptual framework. Thus, the code schemes are determined on the basis of the theory or relevant research findings before starting the analysis. During the analysis, possible additional codes are defined and developed, and the pre-existing codes are revised. (Hsieh & Shannon 2005). The aim in directed content analysis is to get validation for a theoretical framework, or to extend it conceptually. The pre-existing theories and concepts can also help in defining the research question for the study. In addition to that, the conceptual framework might provide predictions about the relationships between the researched themes, which again aids in determining the initial codes and their relationships. This procedure is often referred to as deductive category application (Mayring, 2000).

When the data is collected through interviews, as in this thesis, they are often started with open-ended questions, followed by more directed questions about the previously assigned categories and themes. After preliminary analysis of the interviews, any text that could not be categorised with the initial coding scheme is given a new code. (Hsieh & Shannon, 2005). The findings obtained from the directed content analysis can offer either supporting or non-supportive evidence for the conceptual framework. The evidence can further be presented through examples and descriptive evidence (Hsieh & Shannon, 2005).

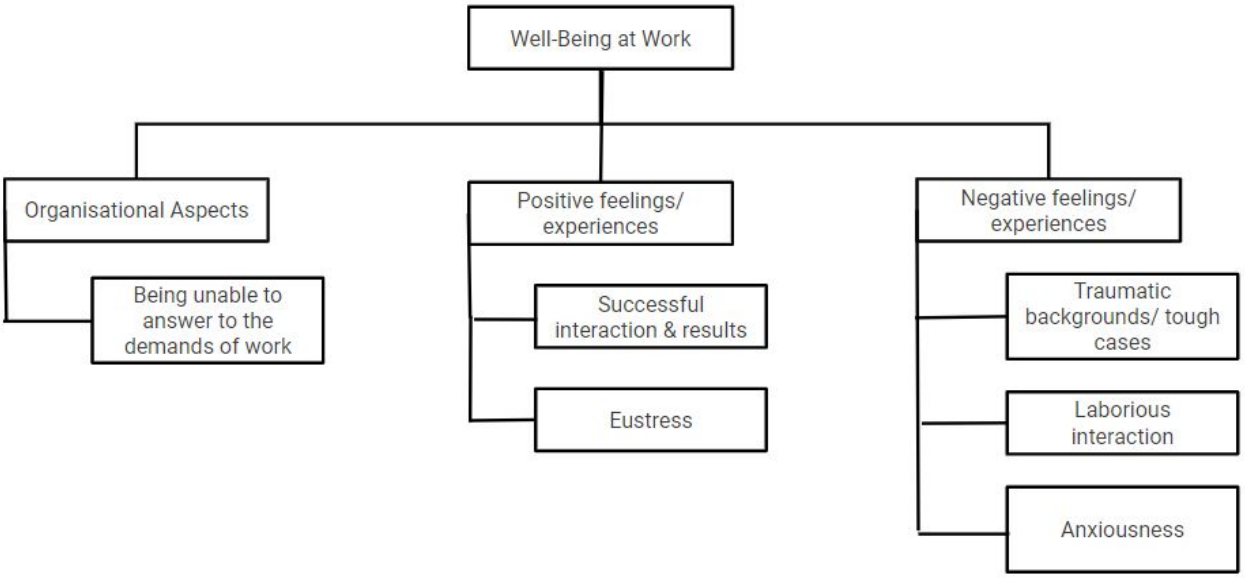
However, qualitative content analysis is only one of many techniques to analyse text data. Still, this directed content analysis approach of QCA was selected for this thesis since it allows the identification of codes before and during the analysis. During the analysis of the text data it is possible to identify and add necessary codes in addition to the initial code schemes taken from the conceptual framework introduced in the Conceptual Framework chapter.

The analysis was started by identifying initial code schemes, or themes, from the conceptual framework. These themes are provided to the reader on graphs 1 and 2 below. For clarity, the themes are divided into separate categories: intercultural interaction and well-being at work, however many of the themes are connected to each other and could be categorised in a different way as well.

Finally, the analysis was continued with the immersion in the data to get insight, and in order to obtain a sense of the whole picture and relevant re-emerging themes. These re-emerging themes were consequently identified as additional themes and added to the graphs. The revised graphs with the themes from the text data are shown later in the findings chapter (see Graph 3 and 4). All of the themes are explained more thoroughly in the next chapter as well.



Graph 1
Themes Linked to Intercultural Interaction

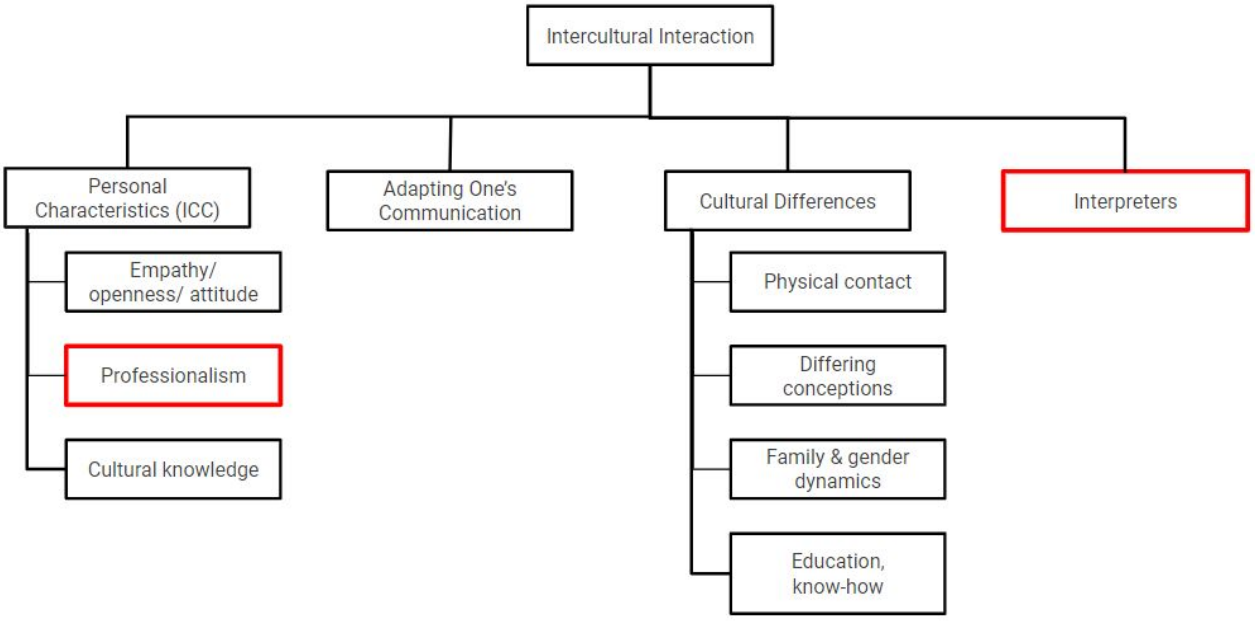


Graph 2
Themes Linked to Well-Being at Work

4 Findings

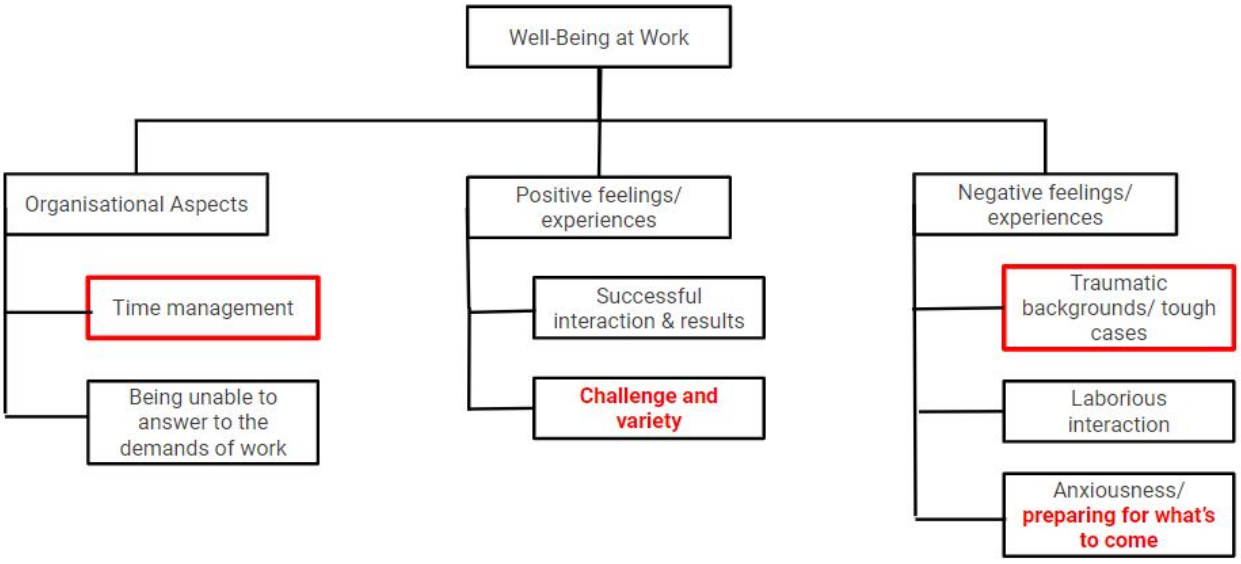
Based on the themes acquired from the conceptual framework and the interviews, the following aspects are analysed more closely in this section: the personal characteristics of the healthcare provider, communication adaptation, cultural differences, interpreters, organisational aspects, positive experiences, and negative experiences. Out of these, the organisational aspects, and the positive and negative experiences are subcategories of well-being at work, and the rest are subcategories of intercultural interaction. Furthermore, these subcategories have additional subclass themes. Although the themes have been categorised like so in order to present the reader with a comprehensible illustration, the themes are interwoven and often contribute to each other in practise. For example, the themes categorised under intercultural interaction might have an influence on the well-being at work, which is also the premise of this thesis, but are nevertheless separated into their own categories for clarity.

First, the revised versions of the graphs (Graph 3 and 4) are presented below, and after that the themes are explained and analysed in their own subchapters.



Graph 3
Revised Themes Linked to Intercultural Interaction

Here, two new themes have been added based on their re-emergence in the interviews: ‘professionalism’ under ‘personal characteristics’, and ‘interpreters’ as its own subcategory to intercultural interaction. The theme ‘interpreters is discussed on its own since all of the interviewees mentioned it as an important factor affecting their interaction and work.



Graph 4
Revised Themes Linked to Well-Being at Work

Here, the former ‘eustress’ theme has been rephrased as ‘challenge and variety’, and ‘preparing for what’s to come’ has been added to complement the ‘anxiousness’ theme. Additionally, two new themes have been added based on the interviews, and these are ‘time management’ under organisational aspects, and ‘traumatic backgrounds/ tough cases’ under the negative experiences that might have an effect on well-being at work when treating immigrant patients.

4.1 Intercultural Interaction

This section covers and analyses the themes of personal characteristics, communication adaptation, cultural differences, and interpreters. Here, the personal characteristics mean such characteristics that help the healthcare provider to interact better with their immigrant patients, and with all other patients as well.

According to the interviewed medical rehabilitation professionals, there are many factors which are helpful in intercultural interaction: personal characteristics, experience and professional skills, and tangible tools among other things. The tangible tools can be for example physical aids that help illustrate anatomy and medical concepts, and these illustrations are equally useful in interaction with Finnish patients, as the medical context can be strange and difficult to conceive for anyone without a medical background. Interpreters can also be included in the tangible tools, and they are probably the most obvious help in interlingual interaction. The role of the interpreters came up in all of the interviews, and was not considered when starting the research. Because of their significance to the interaction, interpreters were added to the predetermined themes, and are discussed in their own subchapter.

As briefly mentioned before, many of the issues introduced above are not only applicable to immigrant patients, and certainly not to all immigrant patients. This is also evident to the interviewees, as they remember to point out. In the analysis the focus is on the immigrant patients but nevertheless, the skills and abilities that might help in the work and interaction with immigrant patients can most likely also be useful in all of the medical rehabilitation professionals' work and interaction, and in life in general. Moreover, the Finnish patients might probably have their own characteristic issues that have an influence on the interaction and on the way the healthcare providers adapt their work methods. For some

reason, culture is brought into the picture here, and used as an explanation and excuse for difficulties that the professionals might encounter in any other interaction as well. There might be an unconscious bias, perhaps based on and reinforced by stereotypes, that makes people perceive their patients in a certain way, and then interpret perceived differences such as looks and language as cultural. Again, also the guidelines set by the health authorities might guide, and are made to guide the way the healthcare workers view and treat their immigrant patients.

4.1.1 Personal Characteristics (ICC)

During the interview, the medical rehabilitation professionals were asked to list important personal characteristics that can be useful in interaction with immigrant patients, and in healthcare work generally. These personal characteristics that help in intercultural interaction can also be referred to as intercultural competence (ICC). In addition to personal traits, this also covers learned skills and abilities. The interviewees came up with characteristics or skills related to intercultural competence that were similar to the ones mentioned in the conceptual background, such as empathy and flexibility.

Empathy and overall attitude. One of the most recurrent personal characteristics in the interviews is empathy, which is a feature that helps in putting oneself in another's shoes, and seeing things from the immigrant patients' perspective. Furthermore, overall openness and positive attitude towards differences and diversity, is one of the most important characteristics when it comes to interacting with people from different backgrounds, according to the interviewees. These personal traits are perhaps similar to such traits that are stereotypically expected from those who work in the healthcare and caring industry, and are generally useful in getting along with other people.

As stated above, empathy came up in most of the interviews. This is also closely linked to attitudes, and interviewee 2 further notes that the basic attitude should be such that one tries to understand, and accepts other cultures and people from foreign cultures, and this open-mindedness is what helps them efficiently interact with their patients. Here the emphasis is on the perceived differences of cultures, and the statement could be interpreted to mean that one needs empathy to be able to interact with people from foreign cultures, which probably is not what the interviewee meant. Empathy helps in understanding the motives behind someone's behaviour, and this is true in all interaction. So, empathy and openness are most likely characteristics that are required from all healthcare professionals in all of their work, not just in interaction with immigrants. Of course, these characteristics could be particularly useful in cases where the patient has notably different experiences and impressions on various conventions, and when it takes more effort to find a common ground.

Professionalism. Professionalism is more of a learned skill or working method that mostly comes with experience. The interviewees state that it is important to approach tough cases and difficult situations in a professional manner, and not let personal emotions affect the interaction or work. They further note that they feel like they are able to handle their work and the tough cases matter-of-factly and professionally.

Professionalism, in a way that helps the care providers handle the patients' emotional bursts, and stay calm whatever the patient's background, is also seen as one of the key factors in successful intercultural interaction, which the interviewees explain is often a result of experience. Most of the medical rehabilitation professionals describe that the ability to deal with the immigrant patients' traumas is something that they have learned through work, not their education. Furthermore, it also takes courage to get involved, and to deal with the crises.

Again, professionalism is something that is helpful and needed in all of the medical rehabilitation professionals' work, and with all patients, not just the immigrants. Professionalism is also needed when interacting with other stakeholders, such as managers and interpreters.

Cultural knowledge. This theme comes from the conceptual background, and for example various guidebooks introduce gaining knowledge of the special characteristic of different cultures as a helpful method for advancing competence in intercultural interaction. This is also something that all medical rehabilitation professionals mentioned as useful or advisable in interaction with immigrant patients. More accurately, the interviewees hope to gain knowledge about the home countries of the immigrant patients so that they can better understand their customs and backgrounds. However, this division into "cultures" might entail othering, and eventually lead to exoticising patients who come from backgrounds different to that of the healthcare provider. It can also be debated whether it is possible to acquire objective knowledge on any so-called culture or its special characteristics. The concept 'culture' can drown the "real" reasons behind people's actions in certain kinds of situations, and if knowledge is what helps in interacting with immigrant patients, it might be one choice to just gain awareness on the many various factors related to worldviews, customs, languages, religions, and so on, thats is things that may influence people's behaviour individually around the world.

For instance differing gender roles, the influence of religion, and the interaction rules between men and women are such perceived aspects of culture that are most seen to cause conflict. Also, I2 points out that knowledge about the history and background of the immigrant's country of origin might give insight on the patient's behaviour, particularly since

some of the immigrant patients have faced war or other traumatic experiences. When asked about what is important in interaction with immigrant patients, for instance I2 describes:

> "Ois jonkunlaista kiinnostusta tai halua hahmottaa niitä kulttuurien välisiä eroja ja sitä kautta niinku varmistaa et oman työn laatu on ihan yhtä hyvää"
>
> Translation:
> "A personal interest or will to find out about the differences between cultures, and in that way assure that the quality of your work is at the same level as normally"

However, the information about the patient's culture is not necessarily equal to the information about the patient's country of origin and its history, and vice versa. In some cases, these aspects seem to automatically be linked together when speaking about culture and historical events. It might be useful to acquire knowledge about current affairs and topical issues in the world to gain perspective. Knowing what kind of circumstances prevail in the Middle East for example, or the reasons why an immigrant has had to leave their home might help when planning treatment, but these aspects are not so much about culture necessarily. Here, too, it is evident how all aspects of life are often explained and excused with culture.

4.1.2 Adapting One's Communication

Interaction with immigrant patients also calls for flexibility, according to the interviewees. They mention that being able to find solutions and compromises to issues and challenges instead of enforcing old practices and communication styles is one sign of flexibility. This flexibility is also needed in adapting one's communication in the interaction with the immigrant patients. The interviewees list that they have to take into account for example the language barrier, differences in customs, the different conceptions on things, or the patient's mindset. These things are mostly the same in interaction with all patients, where one must read how the patient reacts to information for example. The same communication

styles do not have the same effect on all people, and the healthcare providers need to be flexible and adapt to their unique patients. Furthermore, when there is an interpreter present, the healthcare professional also has to take them into account when adapting their methods and communication.

The ability to adapt one's own communication in a way that suits the situation best is seen as a necessity in the interaction with immigrant patients, and this skill could also be classified as an aspect of intercultural competence. This ability could be something that comes naturally to some people, but it probably also requires experience from different situations. Trial and error is one of the ways the interviewees have learned what type of interaction is called for in certain situations, and for example with interpreters.

Interviewee 1, who often works with immigrant children explains that in immigrant patient interactions they always focus on the information the family brings about the child's strengths and challenges at home. They then reflect this information in relation to the standardised medical tests, and try to square them together. On the other hand, they continue that it is important not to overinterpret things. There might be differences in how people from different backgrounds talk about their children and about health in general, and it is important to look at things objectively. Again, this is true for all patients. The parents add another factor to the interaction that needs to be taken into account.

On the other hand, one professional notes that working with immigrant adults is different from working with immigrant children as children often adapt more quickly, learn the new language faster, and are generally more open-minded. Thus, from the perspective of therapy and rehabilitation, it is more productive and effortless. The interaction with immigrant adults takes more time and effort, and in this way the communication is more static.

4.1.3 Cultural Differences

The differences between people from different backgrounds are often interpreted as cultural differences, though speaking a different language for example is no guarantee that the perceived differences are a result of culture. Here, however, these perceived differences are categorised under "cultural differences" as they are seen as such by the medical rehabilitation professionals. Still, the interviewees note that these differences do not apply to all immigrant patients, and generalisations should not be made.

When asked about their perception of culture, one interviewee sums up that culture could be seen as the next thing from family, where it is a kind of context that defines the family or community, their way of living, and courses of action. However, they continue that people from the same country who speak the same language might be very diverse, and different religions can play a greater role than, for example, nationality, and that it could be argued that religion in itself is not something that can define people either as there are many different ways to be a member of a certain religion. For some, religion plays a big role in how they might think or behave, and for some, it is insignificant. The idea that groups of people automatically share a certain culture is called essentialism, and this perspective can sometimes be seen as limiting, and it does not consider that interaction is always situated and bound to a specific context. The essentialist notion of culture does not allow for these variations in interaction, but rather hides them.

Thus, people within a country might identify with different groups, or even groups on the other side of the world. Another interviewee continues that culture is something that involves the whole person, their language and their whole background, including for instance where they have grown up and spent their childhood and adolescence, even their adulthood. According to them, culture shows in the ways they function in society, the way they dress,

how they interact with others, and so on. This view of culture is quite the common perspective on culture, and assumes that culture is something where various groups pass an unchanged and unified "culture" down the generations. Such a notion of culture is arguably quite essentialist, and these essentialist views on culture might be reinforced by the learning material and the guidelines of healthcare institutions, among other things. As seen in the conceptual framework chapter, some coursebooks, guides for healthcare professionals, and even the National Institute for Health and Welfare have discussed culture from this perspective, and these kinds of sources might on their part play a role in how the healthcare professionals understand culture, and in how they react to people from different "cultures".

Interviewee 1 described culture and intercultural competence as follows:

> "Niinku tiedetään ja tiedostetaan se että siin on tämmönen, siin on ikään ku tämmönen et me ollaan... tekemisissä persoonan lisäksi semmosesta isommasta näkymättömästä ulottuvuudesta toistemme välissä, joka on syytä tiedostaa ja ottaa huomioon. Kunnioittaa ja arvostaa niitä vaikka ne ei meniskään niinku oman näkemyksen mukaan niin tota... tiedostaa et ne on kyl myöskin lähellä, tosi lähellä tunnearvoja sitten."
>
> Translation:
> "The acknowledgement that in addition to the personality, we are also in contact with the bigger and invisible dimension between us, and this should be acknowledged and taken into account. [The culture] should be respected and valued even when things do not go according to one's own viewpoints… and that these things are closely, really closely related to emotional values."

In this excerpt, the interviewee describes that to them culture is an intangible dimension which might set people apart on the grounds of differing viewpoints. Here again, culture seems to be perceived as something that dictates people's values. In addition to that, this excerpt shows that the medical rehabilitation professionals understand that differences and diversity should be respected and treated equally, and this might also relate to the emotional skills that the professionals are expected to possess, such as empathy.

Interviewee 5 adds that intercultural competence includes understanding the social, religious and other affecting factors of different cultures, as well as history and the special characteristics of languages. Consequently, knowledge of the way we perceive different concepts, and what kind of concepts are relevant in specific cultures are one aspect of intercultural competence. More concretely, according to I3, an open mind, absence of prejudice, and the ability to put oneself in their position are examples of what kind of characteristics are needed in the encounters with immigrants. Based on this, it could be concluded that to the medical rehabilitation professionals intercultural competence is a combination of personal traits and learned knowledge about the special characteristics of perceived cultures. At least this seems to be the most important and acknowledged part of the competence they need in interaction with immigrant patients.

Generally, the interviewed medical rehabilitation professionals seem to acknowledge that there might be differences between people with different backgrounds, or perceived cultures, in how things are understood, and how things are approached, and they seem to explain these differences with culture. They are aware of the many things that might affect a person's behaviour, not all of which are necessarily linked to country of origin or a specific language for example, but an individual might be a part of many various groups which define who they are and how they perceive the world. It also becomes apparent that the interviewees acknowledge that interaction as well might be affected by cultural factors, or by factors that are often perceived as cultural. On the other hand, they note that culture can be something that cannot be seen, which also implies that the interpretations about cultures are made based on stereotypes and assumptions that certain peculiarities and differences in behaviour and communication are cultural, which might not be the case. For instance, the learning materials on cultural differences and treating foreign patients might guide the professionals' ways of

working with immigrant patients, and how they view their actions and the reasons behind those actions.

In summary, the interviewees' answers indicate that the medical rehabilitation professionals explicate diversity and differences in a strongly cultural way, and that they understand that those cultural backgrounds of their patients should be respected and taken into consideration in their patients' treatment, and that one should respect the differences even if they do not meet one's own viewpoints. It does not become apparent from the interviews how this applies to all patients or all differences. An aspect that could be contemplated, is what kind of patients the healthcare workers consider diverse enough, so that it demands special attention regarding communication for example, or are all Finnish speaking patients automatically not considered as diverse.

Physical Contact. Especially in the context of medical rehabilitation, physical contact is in a significant role, as the healthcare providers need to have access to skin while conducting an examination. Secondly, a typical theme which re-emerges in the interviews is the notion of physical contact and examination, as stripping down is what might often cause issues. I2 suggests that:

> "Ne ei vaan kuulu kaikkiin kulttuurin mut sit taas meiän työssä ni se on lähes poikkeuksetta jonkunlainen edellytys terapian toteutumiselle et me voidaan riisua sitä ihmistä, ja tutkia vartaloa ja kehon toimintaa niin et siinä ei oo vaatteita välissä. Se on ehkä yks suurimpia haasteita."
>
> Translation:
> "It is almost invariably the prerequisite to the realisation of therapy that we can examine the patient's body without clothes in the way, but it is not understood or accepted in all cultures. This is probably one of the biggest challenges,"

Again, probably all patients might feel somewhat uncomfortable removing their clothes in front of a person who is not a member of their family or otherwise close to them, but there are also more strict customs in some communities on how much skin one should show in certain

situations, and what kind of physical contact is appropriate. Situations where the patient and the care provider are of the opposite gender are especially challenging regarding this, note the interviewees. Medical examinations, however, are most likely quite similar all over the world, and people should know to expect the need for undressing. There might be differences in how accustomed people are going to the doctor or having medical examinations, but the interviewees' appear to interpret a certain unwillingness to undress or avoidance of physical contact to be cultural. Yet, culture on itself is probably too ambiguous to explain these things alone.

This issue is approached from a perspective that is again explained with culture by the interviewees. Obviously the research frame might guide the interviewees into this direction, but it could be fruitful to further consider whether the medical rehabilitation professionals might regard the reservedness or reluctance to undress more permissively and accept it when the patient is an immigrant and "from another culture" compared to Finnish patients who do not approve the necessary physical contact during an appointment

Family And Gender Dynamics. In addition to the above, the differences in gender or family dynamics also become apparent in the interaction between the patient and the medical rehabilitation professional. The interviewees introduce examples of the various family and gender roles; there might be differences for instance in who 'does the talking', or in how someone who is of the opposite gender behaves. Being aware that there can be differences in customs, and family and gender dynamics may help in avoiding misunderstandings or conflict. When asked about what kind of differences there might be when working with immigrant patients, and whether these differences cause issues in the interaction, interviewee 1 elaborates:

> "No kasvatukseen liittyvät niiku erot on aika merkittäviä, että tota... et se että... niiku on tulluki ilmi et jossain arabikulttuureissa välttämättä niinku ydinperhe ei kasvata sitä lasta vaan se on enemmän, se on niinku laajemman, se on sukuyhteisön, kyläyhteisön tehtävä.

> "Well, the differences linked to upbringing are quite notable, and well… so that… as it has turned out that in some Arab cultures it is not necessarily the nuclear family that raises the kid, but it is more of the broader family's or the village community's job."

Although, I1 does not directly claim that these differences in upbringing are causing issues in interaction, there might be side issues for example in uncertainties about who takes care of the patient child, and who is responsible for the implementation of treatment and exercises at home. This statement also illustrates that the perceptions about cultural differences are quite general. Also, all perceived differences do not necessarily result from cultural aspects or customs, and there might be various types of family dynamics in all families. However, presenting such examples could be interpreted to mean that in medical rehabilitation certain ways of doing things are perceived to be more prevalent with people from certain backgrounds, in this case from immigrant backgrounds. Of course the healthcare professionals do not have statistics to rely on but they can make assumptions based on their experiences.

Education, Know-how, Starting Levels. The differences related to education are notable between some countries, and there might not be similar know-how than in Finland, and this in some cases can cause issues in the interaction, according to one medical rehabilitation expert. For example, illiteracy can cause fundamental problems right from the start of the therapeutic relationship. Interviewee 2 introduced an example:

> "Kysyin yheltä tulkilta et oisko hyötyä et me tehtäis maahanmuuttajille fysioterapiasta jonkunlainen kuvaus esimerkiks jota lääkärit vois jakaa ni tulkin mielestä se oli erittäin hyvä idea mut totes et puolet ei osaa lukee. Eli se idea niinku haudattiin oikeestaan sit siinä."
>
> Translation:
> "I asked one interpreter if it would be useful to produce for example a description about physiotherapy for the immigrant patients which could then be circulated, and they thought it was a good idea but then stated that half of them cannot read. So the idea was buried right there."

This remark is probably a generalisation and an exaggeration implying that half of all immigrants in Finland would not be able to read. What the interpreter in question has probably meant, is that there are relatively more illiterate immigrant patients than illiterate Finnish patients. Statistically, according to THL and their Maamu-research (2013), most of the illiterate immigrant patients are women, and from poorer conditions, and without an education. It is worth noting that illiteracy is not a result of a certain culture as such, but the reasons are often linked to the structural or political levels of certain countries. The healthcare experts need to be able to react to the different starting levels and education that might come up when treating immigrant patients, as they might not be accustomed to the scale of variety in know-how for instance.

Differing Conceptions On Things. Most of the interviewees mention examples on the differing conceptions that people from different backgrounds have on certain aspects. Most interviewees emphasised the absence, or different impressions of the terms 'physiotherapy' or 'psychiatry' in some cultures or languages, and it evidently makes the work of healthcare professionals more laborious when they have to start by explaining what they do and why. They further acknowledged that some conceptions between cultures, for example about mental health might be quite different or taboo. This usually affects the way things are discussed with the patients. Questions and information must be presented in such a way that they are correctly understood. This adds to the headwork and mental labour of the appointments, which on its part could increase the stress and pressure experienced by healthcare workers. In addition to that, the professionals need to understand that there might be differences in education levels which shows for example as illiterate mothers, and that people might have notably different backgrounds, so that it is often necessary to question

whether it is adequate to present things from the Finnish perspective. Interviewee 4 puts it as follows:

> "[...] ihminen on syntyperältään jonkun muun maalainen ja pitäis osata siinä vaikka harjoitteiden ohjaamisessa ottaa sitten huomioon ne hänen... tapansa liikkua ja mitä ajattelee liikkumisesta ja... mitkä harjoitteet on realistista niinku tavallaan tehä. Et sillee mä sen monikulttuurisuuden tavallaan tähän kuntoutuksen kontekstiin tavallaan ajattelen, et pitäis osata tavallaan huomioida se... mist hän on lähtösin ja minkälaiset arvot on ja mitä ajattelee liikkumisesta ylipäätään. Et kyl joistakin kulttuureista kun tulee ni vaikka ei oo totuttu lainkaan kuntourheilemaan."
>
> Translation:
> "A person who has been born somewhere else, and this should be taken into account in the exercises and instructions. Their thoughts about movement and ways of moving should be considered, and this way it becomes apparent what kinds of exercises are practicable. This is how I see multiculturalism in the context of rehabilitation; We need to be aware of the patient's background and values, and what they think about exercising in general. People coming from certain cultures for example are not used to fitness training at all."

This example about the inexperience of fitness training perhaps falsely and over eagerly implies that people from certain cultures or countries do not exercise on a national level whereas in Finland people are accustomed to physical exercise, and do not need help with it. However, if asked to describe their Finnish patients, the medical rehabilitation professionals would probably describe similar problems of movement and growing numbers of obesity caused by the lack of physical exercise. This too might be interpreted as an unconscious way of creating biased differences between the immigrants and Finnish patients, based solely on the patients' backgrounds. However, it should be noted that there are some statistically typical issues in most populations that might be for example the result of differing education systems or living circumstances.

Interviewee 4 mentions that people from different cultures, or backgrounds also seem to sometimes experience or perceive pain differently. They further explain an instance where the patient might describe their backache as an eleven out of ten on the pain scale, even when using a visual tool. In these cases, it is important to know to ask the right questions, and with

the help of the interpreter calmly try and piece together what aggravates or alleviates the pain. The professional notes that this way they often decipher the most important and relevant information but it sometimes remains uncertain whether they have truly understood the intended meanings. Although, they continue that they have learned to work with the interpreter in such a way that it is seldom unclear whether they have gotten the right answers for their examination. Occasionally though, the interpreter themselves might be the cause of the challenges in intercultural interaction, as I4 states:

> "Tässä pyörii muutama semmonen tulkki ku näkee et hän tulee ni sit tietää että... tää ei voi mennä hyvin. Se on totuus."
>
> Translation:
> "There are some interpreters that when I see they are coming [to the appointment], I know that this cannot go well. That is the truth."

Since the relevance of interpreters came up in the interview data, their role is discussed more in detail in the next subchapter. In conclusion, the professionals might also draw conclusions or make generalisations about certain cultures based on their experience of individual immigrant patients, even if unconsciously. These generalisations could also originate from stereotypes and learning materials, but likely they have also been reinforced by some of their patients. Still, few of the perceived cultural differences are actually cultural but related to other aspects.

4.1.4 Interpreters

The different languages, or in some cases even the lack of a common language, is probably one of the most obvious differences in the interaction with immigrant patients, which understandably brings out challenges to the work of healthcare professionals. Based on the interviews, it also seems that the ability to work with interpreters, and the quality and professional skills of the interpreters are more important in the interaction with immigrant patients than the language skills of the medical rehabilitation professionals.

The role of the interpreters, and their effect on the interaction and therefore also on how the medical rehabilitation professionals experience the encounter, was more significant than thought before the interviews. All interviewees mentioned interpreters at some point of the interview, even though the interpreters were not specifically referred to in the questions. Obviously interpreters are necessary when there is no common language between the patient and care provider but the interviews indicated that in practice there might be big differences depending on the interpreter.

Another interviewee mentions that even the presence of the interpreter might have an effect on what is communicated during the appointment, as the themes discussed with the patients are highly personal and sensitive. However, as language is perhaps the most obvious and biggest challenge in interlingual interaction, it is almost essential to have an interpreter. In the beginning of their career, a few decades ago, an interpreter was needed perhaps once a year, assesses interviewee 1. The increased need for interpreters has also shaped what is demanded of the healthcare providers.

When using an interpreter, the medical rehabilitation professionals often have to think about what is interpreted and what messages come across. An interpreter is always an intermediary in the interaction. I3 describes working with interpreters as follows:

> "[...] välttämättä aina ei voi luottaa että kääntääkö tulkki kaiken, ja kääntääkö tulkki just niinku on halunnu, puolin ja toisin. Et välillä saattaa olla et he keskustelee keskenään pitkään ja sitte sieltä tulee joku pari lyhyttä lausetta ni sitte aina miettii et aha, mitähän siinä nyt sitte oikeen puhuttiin, että niinku semmosia käytännön hankaluuksia välillä tulee ja on oppinu tietysti tässä vuosien varrella huomaamaan et ketkä on hyviä tulkkeja ja... ja ketkä sitte taas vähän sellasia et pitää, pitää rivien välistä lukee, ehkä pitää enemmän ohjeistaa sitte heitä et miten, miten toimia."
>
> Translation:
> "It cannot always be trusted that the interpreter conveys all the messages, and in a way that was intended. Sometimes they [interpreter and patient] have a long discussion among themselves and then they interpret a few short sentences which makes me wonder what was actually discussed between them, so these kind of challenges sometimes arise, and I have in the course of the years learned to spot who is a good interpreter, and similarly who I need to instruct, and with whom I need to read between the lines."

This excerpt illustrates how the healthcare professionals, as well as the immigrant patients, have to face uncertainty when working with interpreters, as it is not always certain that the intended meanings are conveyed through the interpreter. It also seems that some interpreters act against the guidelines for interpretation and withhold some of the things discussed with the immigrant patient. These practical difficulties add to the mental work of the healthcare provider, and might evoke negative emotions, which again could have an effect on the well-being at work. Here, as well as with many other aspects of work, the medical rehabilitation professionals have learned through experience how to work with certain types of interpreters, and what work methods work the best. In this sense too, adaptability and problem solving skills are perhaps the most useful characteristics in overcoming the challenges related to working with immigrant patients.

4.2 Well-Being at Work

The themes related to well-being at work are divided into the subcategories of organisational aspects, positive experiences, and negative experiences. The organisational aspects are then further categorised into subclasses ‘time management’ and ‘number of immigrant patients’. The positive experiences category includes the theme of ‘successful interaction and results’, and the negative experiences are divided into ‘traumatic backgrounds’, ‘laborious interaction’, and ‘anxiousness and preparations’.

According to the interviewees, well-being at work is a balance of many things; the stress of the work, know-how and knowledge, a certain foreseeability, education, and all communication together have an influence on well-being. Also, the basic tasks, job description, and objectives should be defined and clarified to the employee. These are the

aspects that came up in the interviewees when asked about the interviewees' perceptions about well-being at work.

The interviews brought up many comments about what kind of aspects might affect well-being at work, not all of which are included in the official definitions. However, it is often quite personal what has an influence on one's own well-being in the working environment. The interviewees continue that well-being at work is also closely related to the individual's well-being as a whole, and that in free time, one should think about well-being at work in terms of taking care of oneself. This shows that the interviewed medical rehabilitation professionals' understanding of well-being at work is quite wide-ranging and extensive, which implies that they have paid attention to it, and are aware what kind of factors might affect it negatively or positively.

In addition to the environment and working conditions, the individual's personal characteristics and skills might have an influence on how various aspects affect well-being at work. Some skills or abilities are traits that are perhaps taught when studying for the profession or alternatively are learned through doing and experience. For instance, I4 stated that the ability to keep things from getting personal, and being able to differentiate personal and professional matters is essential to maintaining well-being at work. Furthermore, they note that the ability to solve conflicts is essential, and that it is something that develops with time and experience, especially since conflicts are bound to happen now and again in the line of work of healthcare professionals. Still, everybody reacts differently to stress and the challenges of work. Based on the interviewees' reports, it seems that the personal characteristics and skills of the healthcare providers play just as important a role in how they manage and react to the interaction with immigrant patients and what aspects affect their well-being at work.

A part of well-being at work is also the ability to recognise such moments and situations when your knowledge or skills are not enough, or when additional support is needed. This is where the importance of the work community becomes apparent. I6 highlights that work should give a sense of belonging in a work community, and that the work community plays a significant role, as well as how the community operates and interacts with each other. Interviewee 1 also comments on the meaningfulness of work, and states that work should not be exhausting but empowering and give a sense of significance.

In summary, according to the medical rehabilitation professionals, well-being at work consist of various aspects of emotional, physical, and mental well-being. The physical aspects, for example, might be quite practical, wherein the working environment and conditions (also physical) need to be appropriate for the work. The extent of the answers implies that the interviewees have paid attention to their own well-being at work and are aware what aspects could possibly have an influence on it.

4.2.1 Organisational Aspects

The organisational aspects that might have an influence on the well-being at work of the medical rehabilitation professionals when working with immigrant patients include issues related to time management and the general number of immigrant patients. These subcategories will be discussed next.

Time Management. The issues in time management, for example the time pressure caused by too short appointment times can inflict stress if the healthcare providers are not able to answer to the demands of the work, or have to compromise on the quality of their work because of hurry. For some of the professionals, depending on their field of specialisation, the appointment times have been accommodated and extended for immigrant patients, as these appointments usually take more time, mainly because of the language issues

and interpreters. It also takes time to explain certain practices or concepts that might already be familiar to the Finnish patients. Here, apparently the employers have listened to the feedback and suggestions from the medical rehabilitation professionals and made changes and improvements on the organisation of work. Additionally, this likely contributes to the well-being of the employees, as they have less time pressure, and secondly, they have realised that their opinions have been heard and they have an influence on their own work. However, there still remains the question why only some of the medical rehabilitation units have gotten this accommodation, when the time management issues are the same for all. Paying more attention to time management on an organisational level could eventually improve efficiency and results in treating patients, add to the quality of care, and contribute to the well-being of the employees by reducing time pressure and haste.

The Number Of Immigrant Patients. The interviewees describe that they have immigrant patients on a weekly basis, sometimes multiple times a week. Also, according to the interviewees the number has been increasing constantly. Interviewee 2 describes that the change in the number of immigrant patients has been visible in the past 15 years, and that even in Helsinki, the amount was marginal in the first years of the 21st century, much less so in the smaller cities. Especially in the last two years, the effects of the latest immigrant wave have been noticeable in the healthcare services, and there are arguably more immigrant patients than ever before, notes interviewee 2. Further, I3, a speech therapist mentions that up to 40 per cent of their patients are immigrants, and there are even days when all patients are immigrants. On the other hand, other interviewees also mentioned that there might be weeks that there are no immigrant patients, so there can be great differences in the distribution of immigrant patients among medical rehabilitation. In addition to that, during the past decades, there has been a change in the backgrounds of the immigrants. Before, most immigrant

patients have been of Russian background, whereas lately the majority has been refugees from the Middle East and Africa. The increase in the number of immigrant patients also increases the need for interpreters at the appointments, according to the research participants. This on its part puts more weight on the issues that emerge when working with interpreters, and introduces new demands for the healthcare workers, management, and the whole organisation of work. Although, the increase in the numbers of immigrant patients is more noticeable, and thus has a more remarkable effect on their work, depending on their area of specialisation.

4.2.2 Positive Experiences

Most interviewees noted the majority of the experiences and feelings linked to the work and interaction with immigrant patients are positive, and these positive experiences at work help in maintaining well-being. Based on the data, the positive emotions and experiences come from achieving successful or efficient interaction with the immigrant patients, and from getting good results from the treatment. On the other hand, the positive experiences can be for example learning new things about different customs or meeting wonderful people and personalities. The medical rehabilitation professionals most likely get these same kinds of experiences and feelings from the Finnish patient interactions as well, but they are perhaps highlighted when working with immigrant patients, as the appointments seem to be more laborious and "unusual".

Successful Interaction And Results. The feelings of success in all areas of work often help improve well-being at work, and well-being in general, especially when the work requires problem solving. Particularly the challenges in interaction could trouble the healthcare professionals since they make the actual work tasks more complicated. This is why having positive experiences also on the part of successful interaction is in a notable role when

considering what kinds of aspects might have an effect on the healthcare professionals' well-being at work, and how it could be improved.

In addition to finding effective communication methods that work when interacting with immigrant patients, getting good results from the treatment reportedly improves the interviewed medical rehabilitation professionals' well-being at work. As some of the cases of immigrant patients are relatively more challenging or difficult, and as they might have a background of trauma, good results might induce more positive feelings.

One professional simply points out that working with immigrants has greatly enriched their life. Interviewee 6 further states:

> "[...] et se on tosi mielenkiintosta ja se mitä... mä maahanmuuttajaperheitten kanssa työskennellessä ni kyl ne on niinku paljon avartanu omaa katsomusta ja omaa näkemystä ja omaa tätä omas työssä niin ni... niin mä kuulen paljon sellasia asioita mitä mä en ois ikimaailmassa kuullu jos ei ois heitä tavannu et... et ei, ehkä on- he on ihania... [...] ja.. siel on paljon sellasta... mukavaa sellasta yhteisöllisyyttä... mitä- mikä on joskus meille ehkä vähän sellai opiksiki"
>
> Translation:
> "[...] it is very interesting, working with immigrant families, it has really broadened my viewpoint and perspective. And I hear a lot of things I would have never in the world heard if I had not met them. They are wonderful [...] and there are many things… a lovely sense of community, which could also be a lesson for us."

The data implies that at the beginning the overall emotions might be negative, such as feelings linked to the preparations, interpreters, stress, or time pressure, but in the end the topmost emotions are often positive. The positive feelings result from overcoming obstacles and challenges, helping those in need, grateful patients, or the satisfaction for successful appointments and interaction, among other things. The interviewees additionally propose that the success in interaction and the good results in therapy compensate and even more than make up for the laborious work and stress that are associated with immigrant patients. Of course, this is again true with all patients, and especially the positive experiences are

probably quite similar to the experiences the medical rehabilitation professionals get from working with Finnish patients. However, the results are not always as good as hoped because in some cases it is not possible to carry out the same kind of treatment and maintain the same quality of work as with patients who speak the same language and are from a more similar background than the healthcare provider themself, note the interviewees. This might evoke feelings of inadequacy and cause negative experiences.

Challenge and Variety. In addition to achieving good results and successful interaction, adding challenge and variety to the work tasks can increase the meaningfulness of work. Similar things that were mentioned above together with successful interaction and good results could also be the aspects that bring variety to the work of medical rehabilitation professionals. Further, what contributes to well-being, is the complexity of the work in relation to one's level of skills and knowledge, although this too depends on the individual preferences of how much challenge one needs in order to thrive in their work. As I4 notes, for them, repeating the same tasks day after day does not contribute to well-being at work. What could be interpreted from these answers, is that the challenges brought by the somewhat different interaction and work with immigrant patients might in fact increase well-being at work since it adds to the complexity of work and makes one perhaps challenge their own skills and step out of the comfort zone. However, the line between empowering challenge and tiring challenge could be quite vague. and one of the determinators might be whether the individual possesses the tools to solve the problems and overcome the challenges. As stated in the conceptual framework, adding problem solving to the work could promote well-being at work, but this obviously assumes that the challenges meet the individual's skill levels.

4.2.3 Negative Experiences

In addition to the negative experiences caused by issues or challenges in interaction that were already introduced above under the 'Intercultural interaction' themes, traumatic backgrounds, laborious interaction, and anxiousness were themes that came up multiple times during the interviews. These factors are perceived to increase the strain of work and cause negative emotions, thus reducing well-being at work, as presented by the interviewees.

Traumatic Backgrounds. One of the most occurring themes, when asked about what causes conflict and issues in the interaction with immigrant patients, was the patients' traumatic backgrounds. As mentioned in the conceptual background, immigrants who have arrived as refugees or asylum seekers are more likely to have psychological stress and issues related to mental health, and many of them have faced war, violence, torture and death. This likely could have an influence on the interaction with such patients.

For instance, interviewee 5 mentions that what makes the encounters especially challenging are the torture backgrounds of the immigrant and refugee patients. They continue that often the professionals of medical rehabilitation are expected to manage with their current knowledge and skills, which they seldom do, as working with tortured people is scarcely addressed in their education and training. On the other hand, for example I4 states that they have outlined the work in such a way that they are allowed to focus on the physical issues and rehabilitation even when the patient clearly has mental health issues. These outlines help the professionals concentrate their work on areas they are accustomed to but it does not resolve the problem that these traumatic experiences or mental health problems are still apparent and might significantly affect the patient's behaviour, the whole interaction, and the efficacy of the treatment. In addition to that, the medical rehabilitation professionals

might still process the mental issues of their patients in their minds which adds to the mental strain of the work.

Also interviewee 2 describes it as one of the aspects causing negative emotions in their work, that they feel they have not received official training on how to interact with foreign patients, or how to face immigrant and refugee patients. Some of the immigrant or refugee patients might have traumatic history, and the interviews seem to indicate that the professionals have been unprepared to deal with experiences of torture and trauma when they have begun their careers. Years of experience have taught them how to deal with these tough cases but they have mostly had to figure out and solve the issues by themselves through trial and error.

I6, a rehabilitation counsellor, describes her experiences as follows:

> "No niis tilanteis tulee joskus... siel voi tulla, ei siin tilantees mut sen jälkeen jonkunlainen ihan ahdistus koska siel on hirveen vaikeita tilanteita. Et siel voi olla, olla taustalla... taustalla sellasia asioita et mä en pysty niitä edes käsittämään miltä siit ihmisest tuntuu mitä heille on tehty tai... missä... no esimerkiks just nää pako- pakolaisperheet niin siel on ihan, ihan oikeesti murhia ja, ja lapsi on nähny ihan hurjia asioita verrattuna mitä me ollaan niinku täällä meiän maassa totuttu. No kerran menin ihan esimerkkinä menin perheeseen jossa lapselle oli tehty... juuri tutkimukset ja diagnoosi oli kehitysvamma, sitten yhtenä ja... ja äiti oli jotenki aivan outo ja mä ajattelin, et tälle äidille et on se kehitysvamma-asia nyt niin iso asia, mut hän oli just saanu kirjeen, jossa oli kuvat hänen, hänen sukulaisistaan jotka oli siellä murhattu siellä... siel kidutettu siel kotimaassa. Ni se on jotenki niinku niin semmosta et... ei siin, siin niiku... siihen ei oo sanoja niihin tilanteisiin, tai niihin kertomuksiin mitä he kertoo. Et, et se meinaa tulla sit ihan semmosena et joutuu itte käymään niit läpi et... Kun ei niitä voi poistaa sieltä heiän mielestään."

> Translation:
> "In the encounters sometimes… not during the encounter but after, I might experience anxiety even, because there are horribly tough situations. In the background there might be things I cannot even grasp how they must be feeling, or what has been done to them. For example these refugee families, there are really murders and, and the child might have seen dreadful things in comparison to what we are used to seeing here in our country. Once, as an example, I went to this family where the child had just had an examination and the diagnosis was intellectual disability for one and… and the mother was somehow completely strange, and I thought that the disability is a very big deal to the mother, but it turned out that she had just received a letter with pictures about her relatives who had been murdered there… been tortured there in their home country. So, it is somehow… there are no words for those kinds of situations, or the stories they share. So, it comes as… so that I have to work through these things myself… as I cannot erase those things from their minds."

These same kinds of experiences were also shared by other interviewees, however, it was stated that luckily they occur infrequently and are not a part of everyday work. On the other hand, for example I2 notes that regardless of whether the patient is an immigrant or not, after the appointments, the same aspects of the encounter either occupy their mind or not. Whether the issues are related to violence, child welfare or mental problems, all people might have the same issues regardless of their background. So it could be concluded that the cultural aspects, or aspects that are often perceived to be cultural have nothing to do with the issues that might evoke negative emotions in the healthcare providers, but the trauma of the patient is usually connected to the patients' personal history.

The traumatic background of the patients can affect the patients' mood or behaviour, especially if the trauma is recent. In intercultural interaction, just like in all interaction, the state of mind of the interactants are likely to affect the communication and its success, as I1 describes:

> "[...] et siel on niinku isoja traumaattisia taustajuttuja ja vanhemmat, vanhemmistaki et, ihan oikeen silminnähden näkee et kuin ihmiset kärsii ja et... voi huonosti ja on masennus on niin vahvaa jommallakummalla vanhemmalla että, ihan niinku näkee sen siinä tilanteessa, ja, ja et siin on niinku monta, todella, todella monia isoja asioita."
>
> Translation:
> "[...] There are big traumatic background issues, and the parents… It is clear that people suffer and feel ill, and one of the parents might be so strongly depressed that it can be seen in the situation."

In these cases, the parents of the patient might have a bigger effect on the appointment than the patient themself. This is another issue to be taken into account in the interaction and when planning for the treatment. The issues in the patient interaction or appointments are sometimes linked to other factors than the patient themself, and often the negative experiences are not related to cultural aspects at all. However, the interviewees'

narrations imply that these kinds of traumatic backgrounds might be more current with immigrant patients, or at least more visible, which supports the statistics presented by THL. Of course, it should be made clear that not all immigrants fall into this category, but the certain types of trauma are only more typical with those who have fled war for instance. Nevertheless, the traumatic backgrounds and issues with the patient's parents might often also apply to local patients even when their problems and issues might have different causes, and these various types of trauma should also be considered when discussing whether the professionals are equipped with sufficient tools in order to work with patients who have experienced trauma, and process the negative feelings that might arise when facing such patients.

Much of the negative feelings related to the traumatic backgrounds of immigrant patients also result from the laboriousness of the interaction if the personal history of the patient affects their mood or behaviour, and therefore interaction in general.

Laborious Interaction. According to interviewee 5, the biggest factor that causes negative feelings is the challenging nature of the interaction, and the challenges then have an influence on their coping and well-being at work. They continue that the challenging interactions and encounters are more common than the positive experiences on successful interaction. There are individual differences in how people react to factors that might evoke negative feelings, and in what things have an effect on their well-being, and other interviewees report that the positive experiences balance out the negative things at work, as mentioned previously, but that does not mean that the negative emotions are not an issue and can be dismissed. Additionally, as mentioned previously, not all interactions with immigrant patients are more laborious by default, and some of the challenges in interaction might be caused by the interpreter, for example.

During the appointment, the patient might be so stressed and anxious that they are not able to receive messages from their care provider. Or simply, the patient and the healthcare provider do not share a common language (Tervola, 2019). When dealing with an anxious patient, the ability to listen, filter, and recognise the relevant information is important. Perseverance is also needed in making sure that both parties understand each other. This of course also applies to any patient, as even Finnish speaking patients might have trouble fully understand their Finnish care providers. The feelings of anxiety and stress may be quite universal in healthcare interaction given the personal nature of the appointments, and the issues related to the patient's health. On the other hand, being in an unfamiliar context, or having to interact with no common language, among other things, can also induce anxiety and stress in the patients, especially if there are traumatic experiences in the background.

As mentioned before, the longer therapeutic relationships between medical rehabilitation professionals and their patients help in trust-building, and indeed, I1 and I6 describe that achieving mutual trust helps in health care interaction, and furthers the creation of a safe environment for the patient. This safe environment might help relieve the anxiety and stress, and make the mutual interaction less laborious. Again, creating a safe environment and establishing trust will be a base for better, or easier interaction with all patients, no matter their background or past experiences.

For example, interviewee 4 narrates their experiences when asked about what type of emotions or feelings arise when working with immigrant patients:

> "No ensiksi se on jo ehkä semmonen negatiivinen et ne on normaalia raskaampia ku siinä on se tulkki ja eri-, erikulttuurisuus. Ja sit ku he lähtee pois, he on saanu jonkun avun, on se sit tukiliivi tai harjote tai kotihoitokeino, nii se on- se tyytyväinen, ihana... tunne omaan tekemiseen tulee ku he on kyl kiitollisia sit ku he lähtee, ni se tulee itelle hyvä olo, et huhhuh jaksoinhan tän läpi."
>
> Translation:
> "Well, at first it is a kind of negative [feeling] that the cases are tougher than normal when there is the interpreter and different cultures. And then when they leave, they have gotten

> some kind of help, were it a supportive vest or exercise or the means for home treatment, then it is- that satisfied, wonderful feeling about my own work arises since they are so grateful when they leave, and that makes me feel good, like, whew I made it through."

This illustrates how mixed together the positive and negative feelings can be, and shift throughout the treatment process, and that there can be multiple aspects that might add up to the heaviness of the appointments and the amount of labour. Here, again they mention the notion that coming from "different cultures" might have something to do with the interaction being more problematic, and this might in fact relate to the interlingual nature of the interaction, involvement of interpreters, and for example the different starting levels or other perceived cultural differences discussed above. However, culture in itself probably has little to do with the actual issues, but they are still often perceived to be connected. Even though these extracts from the interviews are only examples and individual perceptions, it is still important to take them into account when considering the employees' well-being at work, among other things, since even perceiving things in a certain way may influence how these aspects affect the healthcare professionals' well-being at work.

Anxiousness And Preparations. Many of the interviewees reported that they sometimes have to prepare themself for the oncoming appointments and breathe through the laboriousness of the tough cases. This however, is not so much related to the patient being an immigrant but more specifically to the patient's situation in life and possible traumatic background. Neither does the anxiousness seem to be caused by any perceived cultural factors or differences between the healthcare provider and the patient. When asked about what kind of emotions arise before the appointments with immigrant patients, interviewees 1 and 4 described:

> I1:
> "No sillon aikasemmin ku ne oli oudompia asioita ni etukäteen toki niinku jännitti."
>
> Translation:

> "Well, earlier when these things were more unfamiliar, then certainly it made me feel nervous beforehands."
>
> I4:
> "Negatiivista tunnetta tulee, mikä se tunne on sit, tavallaan voi olla jopa ahdistuski on ollu sellasia, niit on onneks aika harvoin mut et sit kun on... kurjia asioita mitä kuulee niinku kidutuksista ja muista ni ne on raskasta kuulla, mitä ihminen täällä... täällä tota sitte on kokenu ja mitä kauhua on ollu ja muuta että... ne on kurjia tunteita, mitä sitte... et onneks niit on aika harvoin."
>
> Translation:
> "Negative feelings arise, whatever that feeling is then, it kind of could be even anxiety, I have had those, but luckily such cases come quite seldom, but when there are… miserable things that I hear about torture and such, then it is hard to hear what people here… what they have experienced and what horror there has been and so on, so… they are lousy feelings then… but luckily they occur quite seldom."

These examples demonstrate that it might take experience to learn how to manage various emotions that could arise from having to deal with unfamiliar tasks, possibly even without proper training. As suggested previously, it seems that before the appointments with immigrant patients, the emotions appear to be mostly negative. Still, it is important to remember that this probably applies to all patients, not just immigrants, who deal with difficult experiences and physical issues. The medical rehabilitation professionals have to prepare for the appointments and the possible negative feelings that might arise, which supposedly adds to the strain of the work. However, it also seems that the cases of extreme torture or such are quite rare, but it is important that the healthcare providers are prepared to face these kinds of problems in their work. In addition to the mental preparations, more practical preparations could be for instance ensuring that there is an interpreter present for the appointment.

Some of the interviewees stated that they had not been thinking about the relationship between intercultural interaction and well-being at work before the themes came up in the interviews. Even just as small as this kind of observation might change the way the healthcare workers view their work and the related interactions. Awareness is one of the first steps in

managing the changes in the work, as well as the increasing pressure and requirements. I6 puts it as follows:

> "[...] Et mä en oo koskaan just tota työhyvinvoinnin kannalta näitä ajatellu ollenkaa, muuta ku... enkä eritelly vaan muuta ku et jos on paljon maahanmuuttajaperheitä, vaatii multa enemmän asioita, tiettyjä asioita. Mut en mä oo ajatellu et se niinku sen kummemmin työhyvinvointiin.. Ja vast nyt jäin miettimään et nii... kaikki vaikuttaa kaikkeen [...]"
>
> Translation:
> "[...] I have not even thought about well-being at work from this point-of-view, or differentiated these aspects other than when there are many immigrant families, it demands more certain things from me. But I have not linked it to well-being. Only now that I started thinking about it, everything affects everything [...]"

These things might often be unconscious, and simply increasing awareness and making the professionals aware of the themes with which they are working could help in opening the discussion for healthcare management and counselling. On the other hand, it could be contemplated whether the awareness would in fact only over-emphasize and put the issues out of proportions. This might change the perception of one's own well-being at work for the worse.

This chapter has now introduced the findings of the interviews focusing on the themes that were selected through the directed content analysis approach of QCA. These themes included for instance personal characteristics, perceived cultural differences, interpreters, and aspects related to well-being at work. In the next chapter, the research questions and findings will be discussed in relation to the conceptual framework.

5 Discussion

To survey the possible connections between the challenges in interacting and working with immigrant patients and well-being at work, the following research questions were created:

> RQ1: What kind of factors in interaction with people of immigrant backgrounds affect the work of medical rehabilitation professionals, and what kind of issues occur when working with immigrant patients?
>
> RQ2: What helps when interacting and working with immigrant patients?
>
> RQ3: What kind of feelings or experiences do the professionals experience, and how are they related to well-being at work?

First, the data indicated that the factors that seem to most affect the interaction and work with immigrant patients are associated with two main aspects: the perceived cultural differences with the immigrant patients, and the presence and involvement of interpreters.

The data also illustrated that some of the typical differences that come apparent when working with immigrant patients include for instance the different conceptions on things—e.g. conceptions on medical issues and customs—the notion of physical contact, and the levels of education and know-how. These aspects may complicate the healthcare providers' work if they are not accustomed to working with people from different backgrounds, as they have to come up with alternative ways of doing things, or adapt their interaction style. The ability to adapt one's communication can be an example of flexibility which is a sign of intercultural competence included to the categorisations in most of the previous studies.

Secondly, according to the interviewees, the characteristics and skills that are helpful in the interaction and work with immigrant patients, as well as the interpreters, include empathy, flexibility, openness, and a professional manner. Additionally, like mentioned above, the ability to adapt one's own communication and approach is necessary to achieve

best possible treatment. Furthermore, the interviewees suggest that the knowledge about their patients' backgrounds, or cultures, is useful when interacting with immigrant patients. This helps them perhaps better understand the different reasons behind a certain type of behaviour. However, though the interviewees seem to perceive this knowledge on various aspects to be cultural, practically the themes might have little to do with culture. It is also important to note that these skills and abilities can be useful in all patient work, and are often required from people in care work.

The skills and abilities presented above can be classified as aspects of intercultural competence, since they are seen to be useful in intercultural interaction. Intercultural competence in this study is understood as something that helps in all healthcare work. Perhaps one of the most obvious aspects of intercultural competence is language skills, and The European framework (2003) suggests that language skills are perhaps best acquired from studies. However, the interviewed medical rehabilitation professionals have worked in the field around 15 to 30 years, and language requisites have most likely changed since the amount of patients who do not speak Finnish has also increased. Thus also the training and education of healthcare professionals has changed since the interviewees were studying for their profession. Even though the interviewees did not emphasise the importance of language skills so much, this discloses the need for constant training during working life in order to keep up with the changing demands in the healthcare industry. The constant development of personnel and management is a significant part of diversity management (Cox & Blake, 1991), and this development should include increasing awareness and understanding about diversity, and improving practical skills. Among other things, developing these aspects in the personnel helps them face variety and work with different people in general.

The data indicates that the interviewed medical rehabilitation professionals hold quite an essentialist perception on culture. Similar views of culture were found on previous research on the subject, learning material, and even on the guidelines of the Finnish Institute for Health and Welfare (THL). THL provides instructions on how to work with immigrant patients and interpreters, for instance. It could be that these learning materials and instructions provided by different authorities reassert the essentialist view of culture, and even stereotypes, in the minds of healthcare workers. Also, such well-known culture theories as for example Geert Hofstede's cultural dimensions (1984) could be behind these prevailing conceptions.

As introduced in the conceptual framework chapter, people seem to have an inherent tendency to categorise other people and form impressions about those other groups (Pitkänen & Kouki, 1999). In addition to that, previous experiences guide the following interactions (Hammar-Suutari, 2005), so that the healthcare providers working with immigrants might assume something to be cultural based on their previous patients. Furthermore, also the nature and sensitivity of the medical appointment commonly bring out various inhibitions on all patients (Hammar-Suutari, 2005) but the unconscious biases and previous experiences might link these inhibitions and other issues to imagined memberships and perceived cultural differences. This too, could explain why the medical rehabilitation professionals seem to link various aspects behind their immigrant patients' behaviour to cultures.

An essential and perhaps stereotypical view of culture is quite the common perspective on culture, and assumes that culture is something where various groups pass an unchanged and unified "culture" down the generations. Such a notion of culture is arguably quite essentialist, and these essentialist views on culture might be reinforced by the learning material and the guidelines of healthcare institutions, among other things. As previously

discussed, many source materials for healthcare professionals, and even the National Institute for Health and Welfare introduce culture from this perspective, and these sources might on their part influence how the healthcare professionals understand culture, and in how they react to people from different 'cultures'. THL for instance suggests that healthcare workers should consider cultural sensitivity in their work, that is, pay special attention to perceived cultures and differences, which might in reality emphasise otherisation and increase the gap between the patient and healthcare provider. This otherisation that might result from the essentialist views of culture is also quite common in traditional intercultural communication research (Miike, 2003). In regard to essentialist views of culture, there is an illusion that human behaviour would be predictable and excusable solely based on national membership, and often the individual differences between people are dismissed. Obviously, it is the goal of healthcare institutions and services who produce and provide training to educate, and their purpose is that the healthcare workers adopt or consider at least some of the aspects they introduce in their materials, and their intention is well-meant. The material is meant to be beneficial for healthcare workers in their work with patients who come from diverse backgrounds. However, dividing and categorising people into "cultures" might entail othering, and eventually lead to exoticising patients who come from backgrounds different to that of the healthcare provider. It can also be argued whether it is possible to acquire objective knowledge on any so-called culture or its special characteristics. Training the healthcare professionals on cultural differences would most likely include only introducing approximates and examples about the customs that people from certain areas might follow.

Many research and learning materials state that providing efficient care to patients from all kinds of cultural backgrounds requires the development of learning skills and a certain interest and curiosity about different cultures, and that learning to find out about the

cultural and personal beliefs considerately and respectfully might help avoid or overcome conflicts and cultural clashes in an interaction (Anand & Lahiri, 2009). However, these kinds of 'cultural' conflicts in interaction are not the main concern that the interviewees report. Even though they mention that learning about their patients' backgrounds could be helpful, it is not the differences in customs and imagined cultures that cause the biggest issues in the interaction, but problems such as the need to involve interpreters, illiteracy, torture, war and trauma that have the most significant influence on the interaction, treatment and results, and thus also on the medical rehabilitation professionals' well-being at work. A number of other things impact the work of healthcare providers working with immigrants other than imagined cultural differences.

Among the most notable themes that came up during the interviews was the involvement of interpreters in the interaction with immigrant patients. As the increase in linguistic diversity has brought on the need to ensure that interaction between the patients and healthcare professionals is effective, the use of interpreters has also increased (Hadziabdic & Hjelm, 2013). Even though language is perhaps one of the most obvious challenges in interlingual interaction, it is almost essential to have an interpreter involved in the appointments. Many of the interviewed medical rehabilitation professionals had had issues with some interpreters, stating for example that they cannot always trust that everything gets translated correctly, or translated at all. This supports what other research has also suggested that healthcare providers may experience interaction difficulties when using interpreters, and one of the reasons behind this might be the lack of training on working with interpreters (Hadziabdic et al., 2011), and thus this aspect should be included in the training of healthcare providers to help them work together more efficiently and improve their confidence (Tribe & Tunariu, 2009).

On the other hand, the interviewees also mentioned that some interpreters are valuable assets in the appointments, and can for example help explain various customs and shed light on the patient's background and behaviour, and this is also suggested by Blackwell (2005) for instance. The issue with working with interpreters does not appear to be that the healthcare professionals would not be accustomed or trained properly to work with interpreters but the quality of interpretation and some ethical problems with some of the interpreters.

Finally, the medical rehabilitation professionals report that they experience both positive and negative feelings in relation to the work with immigrant patients, both directly and indirectly, and these positive and negative feelings and experiences also somewhat affect their well-being. What kind of emotions the work evokes plays a significant role in one's well-being at work. The answers given by the interviewees indicate that the emotions related to the appointments with immigrant patients are at first negative, but are in the end replaced by positive emotions. As mentioned in the conceptual framework, if the work or the interaction in patient relationships constantly evoke negative feelings, it could be harmful for the well-being at work (FIOH).

However, it is important to note that the emotions or experiences are not caused by the patients' differing customs or conceptions, or even the intercultural interaction per se, but by the additional factors that might add to the total amount of work, such as challenges with the interpreter, or by the tough experiences the patients may have had to live through. As not all medical rehabilitation focuses on dealing with mental issues, it might be taxing to face patients who are visibly affected by trauma, especially if the healthcare professionals are not trained for it. This highlights the importance of focusing on traumatic experiences related to war, war injuries, and torture in the qualification training of healthcare professionals. Further, offering crisis support to working professionals, and development training throughout their

working life are essential in promoting their well-being at work, and keeping their professional skills up to date.

As the experience of healthy work can be seen to consist of many different aspects, such as leadership, competence, organisation of work, supportive work community, and meaningfulness of work, there are many factors affecting the well-being at work of medical rehabilitation professionals as well, and the experience of what type of aspects have an influence on their well-being is individual. Based on the interviewees' answers, the work community at their work functions well in improving well-being as it provides an outlet to vent and open up about the negative feelings the work might evoke. Additionally, the meaningfulness of their work appears to balance the heaviness and laboriousness. However, there are still factors that add mental stress at work, for instance lack of training that might leave gaps in the healthcare workers' competence, time pressure and deficiencies in the organisation of work, as well as issues related to interaction. Many of these issues could possibly be solved through changes from the management.

6 Conclusions

The aim of the study was to explore medical rehabilitation professionals' personal experiences and perceptions on working with immigrant patients. The focus was particularly on what kind of challenges are typical in the interaction, and what kind of influence this type of interaction might have on the respondents' well-being at work.

Among other things, the interviews brought up insight into aspects such as what kind of aspects are important when interacting with immigrant patients, and what could be useful in preparing professionals for interaction with them. Flexibility, previous experience and a professional manner, together with some general knowledge about the conditions in the immigrant patients' countries of origin, are seen to be most helpful in the patient interaction. Also, encountering different people from various backgrounds helps in future encounters, and the things learned in interaction with immigrant patients can be useful also in all patient interactions. Sometimes the gained experience might be more useful to the healthcare professionals since usually there are no universal answers and solutions for the issues in patient interaction.

Most of the interaction between a healthcare professional and an immigrant patient is done through an interpreter which adds another dimension into the complex dynamics of intercultural patient interaction — an aspect that was added into the analysis after its significance came up during the interviews. Many of the interviewed medical rehabilitation professionals had had issues with some interpreters, stating for example that they cannot always trust that everything gets translated correctly, or translated at all. On the other hand, the interviewees also mentioned that some interpreters are valuable assets in the appointments, and can for example clarify the patient's background and behaviour. The issue with working with interpreters does not appear to be that the healthcare professionals would

not be accustomed or trained properly to work with interpreters but the quality of interpretation. In addition to this, the involvement of interpreters also adds to the amount of labour related to the appointments with immigrant patients.

According to the interviewees' perceptions, the intercultural interaction with immigrant patients evokes both positive and negative feelings, and thus can have both a positive and negative effect on well-being at work, and again, this could also be said about any kind of healthcare interaction. Hence, the influence on well-being at work is not clear and unambiguous since all patients are individuals with individual problems and personal characteristics, such as every healthcare professional is an individual with a distinctive personality, who deals with things differently. The data implies that the most notable issues affecting the well-being at work are in reality related to the organisation of work, such as work amount and time management, not cultural differences in interaction. The interviews also indicate that the amount of immigrant patients is still manageable and offers variety to the professionals' work, but were the amount to increase even more, changes would have to be made in the organisation of work. Most substantial changes would be necessary for instance in time management and the frequency of debriefings or feedback sessions.

With the growing number of various cultural backgrounds in customer bases, intercultural competence and cultural knowledge have become necessities in providing successful healthcare and in reaching contented patients. However, it is hardly reasonable to learn about all the specific variations across cultures in regard to health, illness, communication, and other attitudes and aspects relevant in intercultural interaction in the healthcare context. Also, essentialist understanding of culture, and emphasising differences in learning material and instructions might in fact lead to harmful presuppositions and

generalisations based on stereotypes. However, there is still a well-meant intention behind introducing differences in perceived cultures.

The data indicates that in fact, some of the biggest issues the medical rehabilitation professionals reportedly encounter are actually related to aspects other than imagined cultural differences. For example, language proficiency, the need to involve interpreters, illiteracy of the patients, experiences of war and torture or political differences are not really related to culture in itself but are still perceived to be. Only a small part of the issues reported by the interviewees were about different customs or habits, for instance regarding the involvement of the family or undressing and physical contact. The imagined or perceived cultural differences do not seem to have considerable effect on the well-being at work when working and interacting with immigrant patients. Thus, it might be more useful to offer training on issues such as working with interpreters, and facing patients who have experienced trauma.

6.1 Implications For Further Research And Practical Implications

This subject could also be studied from the perspective of the immigrant patients, and the interpreters themselves, to find out what aspects might cause issues in the interaction between the different parties in the healthcare context, especially since the need for interpretation has increased in the healthcare provider -patient interactions. In addition to that, more research could be done focusing on the professional–interpreter interaction.

The perspective of the immigrant patients could also be studied more in relation to their well-being and interactional problems. In addition to that, it would be interesting to examine more how the impressions and perceptions form in peoples' minds about what is cultural, and what factors or sources actually reinforce the sometimes misleading perceptions about certain cultures. Finally, well-being at work should perhaps be studied even more on the perspective of individual operational fields and types of work. Different industries have

individual characteristics that might affect well-being at work, and the research on the subject perhaps cannot be directly applied to all workplaces and sectors of working life. In the healthcare industry,

As this particular thesis only explored examples on what the medical rehabilitation experts personally perceive to be helpful, or on which aspects they wish to gain more knowledge, it could be worthwhile for the future research to examine how helpful these suggestions are objectively. For example, future research could focus on questions such as ‘does knowledge on certain cultures, or perceived cultures help in interaction with immigrant patient who come from those backgrounds’, ‘is management mandated intercultural training or initiative training by the employees more practical and useful’, or whether there is a difference in essentialist culture perspective and individuality focused approach in training and patient interaction. Based on the analysis in this present thesis, in regards to the training, it might be beneficial to shift from the essentialist view of cultures and focus on the underlying motives behind certain types of behaviour and fundamental differences between people. So, when considering the training of medical rehabilitation professionals, and all healthcare providers in general, it should be contemplated whether the focus should be on teaching cultural sensitivity and cultural differences between people, or more generally sensitivity to all diversity and the preparedness to interact with people from different backgrounds and disregard the cultural approach that might inflict unnecessary othering.

For practical implications, this study brought up suggestions for the management of healthcare industry, for example on time management and the training of such medical rehabilitation professionals who frequently work with interpreters and immigrant patients. For instance, to alleviate the pressure and stress of healthcare professionals, the management could consider possible extensions for appointment times when there are interpreters

involved or with immigrant patients in general. In some cases this practice seems to be already in use.

The study also showed implications for the interpreter agencies in how to train their interpreters, as the medical healthcare professionals expressed some concerns on the ethicality and accuracy of the work of some interpreters. In addition to that, according to the interviewees' reports, it seems that there is great variety in the quality between interpreters.

6.2 Limitations

One limitation of this thesis is the relatively small amount of interviewees. The data was also collected in one country, and the respondents of the study all worked in the same workplace. Due to the composition of the sample, no sound generalisations or assumptions can be made but nevertheless, this is still a starting point for expanding knowledge and further research, and even when the number of conducted interviews was relatively low, the answers seemed to be quite convergent and may point out some implications. Still, it could be that with a different sample of interviewees, the results could also have been different.

Based on the data, other themes could have also been chosen for the analysis which would have evidently changed the focus of the study. Many individual aspects came up during the interviews but for this thesis only the most recurring ones were chosen to keep the analysis coherent and meaningful. The interview questions also obviously shaped and guided the interviews, and hence also the interviewees' answers. With a different interview method, different focus points and answers could have also been achieved.

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APPENDIX: Interview questions

Aluksi, voitko kertoa vähän työstäsi ja työhistoriastasi?
Could you start by telling about your job description and work history?

Osaatko arvioida maahanmuuttajapotilaiden osuutta työssäsi? Miten määrä näkyy viikottain?
Can you assess the number of immigrant patients you have? How does it show on a weekly basis?

Osaatko verrata miten maahanmuuttajapotilaiden määrä on muuttunut urasi aikana?
Can you compare how the amount of immigrant patients has changed during your career?

Voitko määritellä seuraavat käsitteet omin sanoin työsi näkökulmasta: monikulttuurisuus, kulttuurienvälinen kompetenssi ja työhyvinvointi?
Using your own words and from the perspective of your work, can you define the following concepts: multiculturalism, intercultural competence, and well-being at work?

Millaiset taidot tai ominaisuudet mielestäsi auttavat vuorovaikutuksessa maahanmuuttajapotilaiden kanssa?
What kind of skills or characteristics in your opinion help in the interaction with immigrant patients?

Onko jotain tyypillisiä haasteita tai ongelmia, joita ilmenee kohtaamisissa ja vuorovaikutuksessa maahanmuuttajapotilaiden kanssa?
Are there any typical issues or challenges that come up in these encounters and interactions?

Minkälaisia tunteita näissä tilanteissa nousee?
What kind of emotions arise in these situations?

Tuleeko ennen tapaamisia/ niiden aikana/ niiden jälkeen joitain tunteita tai ajatuksia esiin?
Do any feelings or thoughts arise prior to/ during/ after the appointments with immigrant patients?

Koetko, että nämä tunteet vaikuttavat työhösi tai työntekoon?
In your experience, do these different emotions have an influence on your work?

Onko joitain taitoja tai kykyjä, joita haluaisit saada, jotka auttaisivat vielä lisää työssäsi maahanmuuttajapotilaiden kanssa?
Are there any skills or abilities you would like to acquire that would help you in your work with immigrant patients?

Miten arvioit omaa osaamista ja taitoja? Ovatko ne tarpeeksi pärjätäksesi näissä vuorovaikutustilanteissa, ja riittävätkö ne tehokkaaseen vuorovaikutukseen?
Based on your assessment, are your skills, abilities and know-how enough to manage your work efficiently?

Oletko aiemmin saanut koulutusta kulttuurienväliseen vuorovaikutukseen, työskentelyyn maahanmuuttajien kanssa, tai vastaaviin aiheisiin liittyen?

Have you gotten any training on intercultural interaction, working with immigrant patients, or any similar subject?

Kenen järjestämiä koulutukset ovat olleet?
Who has organised these trainings?

Vastaako koulutusten sisältö työn vaatimuksia?
Does the training meet the demands of your work?

Mitä toivoisit lisää koulutuksilta?
What would you improve in the training?

Mitä tukea työnantaja tai työyhteisö tarjoaa liittyen maahanmuuttajapotilaiden kanssa työskentelyyn tai muihin haasteisiin?
What kind of support does the employer or work community offer regarding the issues in working with immigrant patients or other issues?

Mitä muuta kaipaisit työnantajalta työhyvinvoinnin parantamiseksi?
What other aspects would you want from the employer in improving well-being at work?

Yleisesti ottaen, koetko että vuorovaikutuksen haasteet maahanmuuttajapotilaiden kanssa vaikuttaa työhyvinvointiin?
Generally, would you say that the challenges in the interaction with immigrant patients has an effect on well-being at work?

Miten näet työhyvinvoinnin yhteyden koulutukseen, tai sen puutteeseen?
How do you understand the relationship between well-being at work and training, or the lack of it?