Dignity and indignity experienced by immigrant women on long-term sick leave

A qualitative study

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OG AKERSHUS**

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ABSTRACT

The aim of this field study was to explore how immigrant women with chronic pain experience their daily life at home and at the workplace when they are on long-term sick leave.

The study has a qualitative design and builds on Ricoeur's hermeneutic philosophy of science. Participant observation was carried out at an outpatient clinic, during two rehabilitation courses from a sample of 14 immigrant women with chronic pain, and was combined with qualitative interviews with the women after the rehabilitation period.

The dataset generated three papers. The findings in the first paper show that the women experienced their daily lives as lonely and humiliating when being excluded or not feeling sufficiently needed, wanted or valued by colleagues, leaders or even by family members. The humiliating domestic and workplace-rejection reinforced the women's experience of shame and avoidance of telling anybody about their illness, and consequently more days on sick leave. The findings in the second paper show that the chronic pain made the immigrant women suffer, as they experienced the pain as threatening, incomprehensible and an unreal force, without meaning or the ability to be controlled. Despite the experiences of suffering and humiliation, the third article emphasizes the participants' experience of dignity in their everyday lives. They experienced that they could maintain dignity through love and friendship, by getting connected with their "historical selves", by supporting relatives and in being strong despite sickness. Moreover, they were respected, believed and understood by other patients and by health care personnel. In addition, religious faith and hope for the future gave an experience of meaning, peace and dignity.

The main findings show that the struggles the women experienced as immigrants in Norway increased the demands on their already difficult lives, which led to them feeling humiliated.

Their suffering bodies made them feel caught bodily, in their domestic sphere, and the pain controlled their lives, which made them feel constrained and invisible. To be met with dignity made the women realize their own potential, led to a more healthy body and gave them inner peace and strength in their suffering.

These findings are discussed in the light of theories of suffering, humiliation, dignity and recognition, in addition to earlier research on immigrants, chronic pain and sick leave.

In conclusion, the study indicates that the immigrant women experienced ill health because of the strains from migration, meaningless pain, and humiliation at work and in the family, by being made to feel invisible, not understood, degraded, stigmatized and marginalized. On the other hand, the immigrant women were able to move forward, adapt, learn and endure.

Moreover, they found strength in personal relations in their families and with God, and demonstrated a solid integrity, inner strength, proudness, self-respect and acceptance. Hope and dignity served as a healing force for the immigrant women.

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DEFINITIONS AND ABBREVIATIONS

Definitions

Ethnicity	The fact or state of belonging to a social group that has a common national tradition.
Immigrant	Persons born abroad of two foreign-born parents, who at some point have immigrated to Norway.
Ethnic minority	A group that is in the minority in a large society, which is politically relatively powerless and which exists as ethnic category over a certain period.

Abbreviations

CMP	Chronic Musculoskeletal Pain
HL	Health Literacy
HME	Healthy Migrant Effect
EU	European Union

LIST OF PAPERS

Paper I

Nortvedt L, Lohne V, Kumar BN & Hansen HP (2015a)

A lonely life – A qualitative study of immigrant women on long-term sick leave in Norway.

International Journal of Nursing Studies

Paper II

Nortvedt L, Hansen HP, Kumar BN & Lohne V (2015b)

Caught in suffering bodies – A qualitative study of immigrant women on long-term sick leave in Norway.

Journal of Clinical Nursing

Paper III

Nortvedt L, Kumar BN, Hansen HP & Lohne V (2016)

‘Dignity is what I mean to others...or what my value is’ A qualitative study of immigrant women on long-term sick leave and their experience of dignity.

Submitted to Scandinavian Journal of Caring Sciences, 30 May 2016

APPENDICES

1. Research permit from REK South-East
2. Permission from the outpatient clinic
3. Information and informed consent sheet – immigrant women
4. Information and informed consent sheet – rehabilitation course leaders
5. Theme guide for participant observation
6. Theme guide for interviews of immigrant women

1. Introduction

1.1 Problem area

The project will examine how immigrant women on long-term sick leave with complex/chronic muscle disorders, experience their rehabilitation period while they have contact with an outpatient clinic at a rehabilitation hospital in Southern Norway. Migration can be defined as a process of population movement, which implies relocation of residence involving the crossing of a political or administrative boundary over a relatively long period of time (UN, 2011). Statistics of Norway defines an immigrant as a person born abroad with two foreign-born parents and four foreign-born grandparents (SSB, 2014). In 2015, the number of asylum-seekers coming to Norway increased, especially those from Syria, Afghanistan and Iraq (SSB, 2015a). The number of immigrants in Norway, however, mostly consist of immigrants reuniting with family (36%) and those entering the workforce (33%), and secondly by refugees (19%) and students (10%). By 1 March, 2016, 16% of the population in Norway was immigrants, whereas in Oslo the percentage was 33% (SSB, 2016a).

The participants in this project were women from collectivist¹ cultures in Asia and Africa, and will henceforth be known as “immigrant women”. In this group of immigrants, there are more persons on sick leave than among immigrants from Europe and North America (Kumar, 2008). Immigrant women in general are not a homogenous group in relation to ethnicity, culture and traditions; socio-economic and religious background; origin or cause of

¹ A collectivist culture can, according to Triandis (2001), be defined as cultures where “people are interdependent within their in-groups (family, tribe, nation, etc.), give their priority to the goals of their in-groups, shape their behavior primarily on the basis of in-group norms, and behave in a communal way”. Whereas in “individualist societies people are autonomous and independent from their in-groups; they give priority to their personal goals over the goals of their in-groups, they behave primarily on the basis of their attitudes rather than the norms of their in-groups”. (Triandis, 2001, p. 909).

immigration (SSB, 2016b). On the other hand, women from minority backgrounds have much in common, such as having to deal with a new culture, a new language, Norwegian healthcare, western notions of health, a changed social network, Norwegian social norms/values and their own experienced strains in being an immigrant (Abebe, Spilker, & Hjelde, 2010). Within every cultural group, we will find great variations. Although the individual's ideals, views and customs might be grounded in culture, they will also be distinctive to that person. Culture can be defined as "the system of shared beliefs, values, customs, behaviors, and artifacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning" (Bates & Plog, 1990, p. 7). In relation to diverse perceptions of people in different cultural groups, there are still gaps in our understanding of dignity. The immigrant women's experience of dignity and indignity and their opportunities and constraints related to employment are emphasized.

A review study shows that migrants and ethnic minorities in Europe have poorer self-perceived health, compared to the majority population (Nielsen & Krasnik, 2010). Moreover, the literature shows that the prevalence of chronic pain is higher among immigrants in Europe than the native European population (Michaelis, Kristiansen, & Norredam, 2015). Wigers and Finset (2007) point out that Norway is the 'European champion' in the incidence of chronic pain, with a prevalence of 30% here and an average of 19% in Europe in general.

Furthermore, they explain chronic pain from a biopsychosocial model, where biological and psychosocial factors play equal roles. Matters that can maintain and reinforce each other are muscle pain, a sensitized nervous system, and physical de-conditioning as well as sleep disturbance, catastrophic thinking, hypervigilance and a high negative stress level (Wigers & Finset, 2007). Regarding level of stress, a Canadian study examined changes in health status and reasons for health status change among 23 immigrants with different lengths of residency (Dean & Wilson, 2010). In-depth interviews revealed that those who perceived their health to

have worsened related it to stress associated with migration, and the aging process rather than the adoption of an unhealthy lifestyle. Moreover, a Norwegian qualitative study among Africans over the age of 50 showed the importance of integration and social inclusion as having a vital impact on their health and wellbeing (Gele & Harslof, 2012). These findings are supported by a Danish study (Jervelund et al., 2016) which underscores the importance of reaching the political goals of integration to ensure the health of immigrants. In Norway, a National Strategy for immigrants' health was implemented in 2013 (Helsedirektoratet, 2013), but it is unclear whether the intended aims have yet been achieved.

According to the Norwegian Labour and Welfare Organization (NAV), musculoskeletal disorders are the most frequent reason for sick leave in the general population in Norway, while the second common cause is mental suffering (NAV, 2014). NAV confirms that the first quarter of 2014, 8,3% of people on self- and doctor-certified sick leave were women, while for men the percentage share was 5,0 (NAV, 2014). The authors explain this gender-determined difference with variance in choice of profession and traditional family and caring roles, biological health differences, differences in morbidity and unequal illness behaviour.

Claussen (2008) shows that a higher proportion of immigrant women have muscle disorders than immigrant men and that the lower social classes have greater incidence of muscle and skeletal pain than in higher social strata. It also appears that when adjusted for age and sex, immigrants receive disability pensions more often than ethnic Norwegians do. Adjusted for income and nine occupational groups, however, the difference falls away (Claussen, 2008). Another study from Claussen and co-authors shows that the risk of disability among non-western immigrants increases with heavy work and lack of control, because of unskilled, low-status jobs (Claussen, Dalgard, & Bruusgaard, 2009).

Moreover, significantly more sickness absence for non-Western immigrant women compared to native Norwegians has been explained partly by occupational factors. In addition, some immigrants might have had worse nutrition, worse primary health care facilities, a greater infectious burden and possible exposures to serious traumas, such as war, torture or famine as well as the stressful migration process (Hansen, Holmås, Islam, & Naz, 2014) (will be elaborated under section 2.1).

Regarding living conditions amid immigrants in Norway, the Statistics Norway (SSB, 2010) explored the living conditions among 10 different immigrant-groups from Eastern Europe, South-Europe, Asia, the Middle East, Africa and South-America. Three thousand immigrants were interviewed, and it was found that, in general, immigrant women are more lonely than men. Moreover, immigrant women rated their Norwegian skills as inferior to those of immigrant men, and women spent far more time on housework (cooking, cleaning, washing and care of clothes) than men did (SSB, 2010).

The concept of dignity is considered a core concept in medical and nursing ethics (Gallagher, 2004; Rendtorff, 2002). The understanding and experience of dignity among people with minority ethnic backgrounds is, however, explored only to a minor extent (Chandler, Malone, Thompson, & Rehm, 2012; Chen, Lai, & Yang, 2013; Collins, von Unger, & Armbrister, 2008). As immigrant women on long-term sick leave due to chronic pain constitute a vulnerable group, they are in an exposed position in regard to experiencing their dignity being violated (Herz & Johansson, 2012; Hynie, Crooks, & Barragan, 2011), and it is important to include them in qualitative research. Hence, research on how they experience their daily life at home and at the workplace when they are on long-term sick leave has been essential to explore.

1.1.1 Perspectives on health and illness

According to the World Health Organization (WHO), “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This definition has been criticized for being too ambitious, whereas health and disease are culturally determined and appear to be two extremes that most people do not recognize, because they are located somewhere on the scale between these extremes (Eriksen & Sajjad, 2015; Magelssen, 2008). This is relevant in my study, which deals with women being on sick leave and at the same time working. Health promotion strategies in health promotion were extensively described in the Ottawa Charter of the World Health Organization in 1986. An important principle is that health should focus on the individual's resources, not only on diseases and problems, in other words on empowerment (WHO, 1986). The term “disease”, according to Hofmann (2008), points towards a health professional identification and/or a classification of a bodily or mental condition, accordingly “to have a disease”. Even if the concept “disease” is important for both society and patients, it seems that health professionals have a particular tradition of using this perspective. The target within the disease perspective is to assess and classify to be able to diagnose, treat and relieve and to give care (Hofmann & Ribe, 2008). Furthermore, the term “sickness” can be defined as a social sick-role or what society perceives as disease or being on sick leave. This emphasizes people’s need for treatment, sick leave and sick pay; in other words, social status and rights. The term “illness” however, contains the personal perspective and is often used in the sense of one’s own negative experiences or “being sick”. The patient’s experience of pain and suffering is in focus, and the state contributes to the request for professional help (Hofmann & Ribe, 2008). Both disease and illness are culturally determined (Eriksen & Sajjad, 2011). According to Hanssen (2005), in other cultures the illness experience may be considered as important as the observable changes, and the person’s experience of illness or lack of health is emphasized as

much in the diagnosis process as the objective signs. Many immigrant patients can therefore be used to clinicians who take their time to listen to the patient's description of his/her medical history and current condition. A consequence of the Norwegian health workers' straight to the point-oriented and time-controlled manner might, for these patients, be perceived as dismissive and lacking empathy (Hanssen, 2005). This is also thematized in my second paper.

Furthermore, Arthur Kleinman, and his co-authors have examined anthropologic and cross-cultural perspectives on the concepts of illness, disease and care (Kleinman, Eisenberg, & Good, 2006). They assert that illness represents personal, interpersonal and cultural reactions to disease or discomfort. Moreover, how we perceive, experience and cope with disease is based on our explanations of sickness, specific to the social positions we occupy and the systems of meaning we employ. How we communicate about our health problems, the manner we present our symptoms, when or to whom we go for care and how long we remain in care are affected by our cultural beliefs. In other words, we learn "approved" ways of being ill. The consequence is, however, that the physician and the patient often view the clinical reality differently, which might lead to insufficient or poor care.

Kleinman and co-authors have solved this dilemma in developing a clinical strategy by training clinicians and students to bring about the patient's explanatory model and his/her therapeutic objectives, as well as the psychosocial and cultural meaning of his/her illness with a few simple, direct questions. Finally, the practitioner will have to negotiate between the explanatory models, and assess where the inconsistencies lie and whether they affect care (Kleinman et al., 2006).

1.2 The health politics of welfare and rehabilitation in Norway

In 2009, the Norwegian government created a committee to describe and evaluate the challenges for the Norwegian welfare model due to increased migration across national borders. The commission was formed to assess the elements of the welfare model that affect and are affected by migration and the rights that immigrants and emigrants have, universal welfare programs for income maintenance in case of illness, unemployment, disability, old age, transfers to families etc. (Brochmann, 2011). The consequences and recommendations from the commission were that due to the increasing immigration of people with low qualifications, it is unlikely that the Norwegian welfare scheme would be able to last in its current form. The committee members therefore proposed to continue free core time in kindergartens in immigrant-dense areas and reduce or restrict the different kinds of subsidy schemes intended for immigrants. This was to improve incentives for labour force participation. Additionally, they recommended improved conditions for Norwegian language training and increased use of gradation in all the health-related benefits to substantiate working capacity (Brochmann, 2011). In an interview three years later, Brochmann stated that their main message was more integration, primarily in the workplace. They recommended continuing an equal treatment policy, which implied integrating more immigrants into the workplace and work against discrimination (Lepperød, 2014). Due to increased arrival of employment immigration over 10 last years and increased asylum-seekers in 2015, the Norwegian government formed a new committee in December 2015, led by Brochmann. Their mandate is to assess to what degree the augmented immigration might affect unity and trust in Norway, in addition to the socio economic consequences and how the Norwegian economy should adapt. Moreover, they will analyze the relationship between welfare and immigration and outline alternative strategies to meet the challenges related to continued high

immigration. There is, however, little focus on aspects of immigrant health. The committee's report is to be submitted in February 2017 (Justis & beredskapsdepartementet, 2016).

In this regard, a Swedish study with immigrant female Iranians underscores the importance of counteracting discrimination (Akhavan, Bildt, & Wamala, 2007). They found that discriminating behaviour at the workplaces affected their health negatively and might cause physical pain.

In short, one can say that it creates great expenses for society when many people are not working, a situation which has led the Norwegian politicians to again attempt to fortify the rehabilitation of work matters.

A Delphi study on the follow-up service of people on long-term sick leave aimed to identify issues and proposed changes in the provision for sick leave in general and specifically for the "Quicker return to work" scheme (Skarpaas, Aas Wågø, & Berg, 2013). The study concluded that the biggest challenges ahead is to find models for interaction mid-market the three main players: the workplace, NAV and health. Furthermore, they recommend strengthening the requirements for the services as well as developing and implementing strategies for the use of knowledge in the field (Skarpaas et al., 2013).

A white paper from 2015 recommended that the "Quicker return" should be directed to a higher degree towards groups who are often at sick leave, that is, groups with common mental disorders and musculoskeletal disorders (St.meld. nr.19, 2015). These groups also represent the context of this study.

1.3 Aim and research questions

The aim of the study was to explore how immigrant women with chronic pain experience their daily life at home and at the workplace when they are on long-term sick leave. The main question is:

How do immigrant women with chronic pain experience their daily life when they are on long-term sick leave?

The research questions are:

- How do immigrant women on long-term sick leave experience their family life and their working life?
- How do immigrant women on long-term sick leave experience their pain and their suffering?
- How do immigrant women on long-term sick leave understand and experience the maintenance of their dignity during their period of rehabilitation?

1.4 Outline of the thesis

This thesis is based on empirical data from participant observations and qualitative interviews with immigrant women who are submitted to rehabilitation at a “Quicker return” outpatient clinic due to chronic muscle pain. It comprises two published scientific articles, one submitted article as well as this introductory presentation. The three articles aimed to examine how the immigrant women on long-term sick leave experience their everyday life during their rehabilitation period. The first article focuses on how the women experience illness, relationships at work and in the family and how they narrate these important issues concerning their lives. The second article deals with the women’s experience of pain, in addition to how pain is affecting their daily lives. In the third article, the women’s experience and maintenance of their own dignity is explored.

The following chapter elaborates the knowledgebase of the study, and chapter 3 presents the central theoretical concepts and perspectives that inform this study. Chapter 4 presents the design of the project, followed by a description of the process of producing and analysing the empirical material for this thesis. Chapter 5 provides summaries of the three papers in this study and a brief presentation of their findings. In the sixth chapter, these findings are

discussed in light of the analytical approaches and the aim of the study. Chapter 7 ends with concluding remarks and implications for practice as well as suggestions for potential areas for further research.

2. Background

The review of the literature builds on frequent and systematic searches in Medline, CINAHL, PsychINFO and SocINDEX (from January 2011 to February 2016). The key words that were used in different combinations included chronic pain, dignity, humiliation, immigrants, loneliness, sick leave, suffering and women together with synonyms in different combinations. In addition, I carried out “berry picking” (Bates, 1989) which means picking up articles from other reference lists I found through the more systematic search, along with searching for specific authors, known items or subjects of interest. Moreover, academic books were found using BIBSYS and Oria.no.

2.1 Migration to Norway

The proportion of immigrants in the total population of Europe has grown quickly, from 7% in 1990 to about 10% (76 million immigrants) in 2015 (UN, 2015). Likewise, the immigrant population in Scandinavia has been gradually increasing since the end of the 1960s, with nearly 50% of the immigrants originating from Asia, Africa and Latin America and 50% from Europe and the United States (Pettersen & Østby, 2013; SSB, 2016a). Similarly, the immigrant population in Norway has been rapidly growing since the late 1960s because of the developing oil-industry (Østby, 2013). In 1974, Norway did, however, introduce an immigration ban on labour immigration, and the majority of immigrants from low and middle-income countries have been refugees, asylum seekers and those reuniting with family. Pakistani immigrants were the first to arrive around 1970, and other groups from Yugoslavia, Turkey, Morocco and India came in groups of the same size in the beginning. The Pakistani remained the largest group of immigrants in Norway until 2006, when Polish labour immigrants surpassed the statistics (Østby, 2013). Those with the longest residencies in

Norway are from Pakistan and Vietnam, while those with shortest period of residence are from Poland, Lithuania, Iran and Somalia (SSB, 2016b).

In 1970, immigrants and Norwegian-born persons with immigrant parents comprised of 1.5% of the population, while by 2016, this group had increased to 16% of the population. The proportion coming from Asia, Africa and Latin America increased from 6% in 1970 to about 50% in 1991. In Oslo, 33% of residents are either immigrants or born in Norway with immigrant parents (SSB, 2016a).

2.1.1 Female immigrants

In 2015, the percentage of females among all international migrants in Europe was 52, 4% (UN, 2015). Another trend is that women are not only moving after their spouses have established themselves but are also migrating independently as the family's main breadwinner (Egden, 2012).

When it comes to employment in Norway, there is a rather big difference between men and women among immigrants from Africa and Asia, where men's employment rate was 8% higher than that of women in 2015. Statistics from 2014 show that the labour participation of men and women from these continents was as low as 42% for African and 56% for Asian adults. Whereas for ethnic Norwegians the labour participation was 69, 4% (SSB, 2015b). According to the official Norwegian report NOU 2011:14, there are relatively more people with low educational attainment among immigrants than in the general population, and the low level of education reduces employment opportunities. Immigrants with background from Somalia, Pakistan and Thailand are the worst off in terms of education. Many women from Africa and Asia have little or no education which may partially explain the low employment among these women (NOU 2011:14, 2011). According to Kolbeinstveit, the educational level increases the longer the group of immigrants have stayed in Norway (Kolbeinstveit, 2010). In

addition to the language barrier, several immigrants do have education from their homeland, which they do not get credit for in Norway. There seems to be large differences in level of education for immigrants depending on the country they immigrated from, while the socioeconomic background is the most important explanation for lower employment rates (Kolbeinstveit, 2010).

2.1.2 Migration as a health risk

People who migrate are traditionally considered healthier than the population they originate from. This is presumably because the chronically ill are less likely to migrate and because those who actually migrate, are particularly courageous, innovative and socially skilled individuals (Razum, Zeeb, Akgun, & Yilmaz, 1998). A Danish cohort study of certain subgroups of migrants did not, however, completely support the “Healthy Migrant Effect” (HME), showing that both refugees and family reunited immigrants had a higher disease burden only five years after arrival for most diseases with the exception of stroke and cancer (Norredam et al., 2014). The same study concluded that the HME is wearing off over time and that people migrate for diverse reasons, such as due to political persecution, famine, family reunification and maybe even poor health.

According to Siem (2010), the immigrant career starts with disruption from the home, and the migrant leaves the familiar and generally safe place, will lose affiliation and breaks bonds. Although migration is desired, and the immigrant might enjoy his/her new surroundings, many develop depression, anxiety and homesickness after a while. Many immigrants experience feeling dependent on others to succeed, and that it can be complicated to get help and understanding (Siem, 2010). Kumar (2010) notes that it usually is healthy, young people with a willingness to take risks who emigrate. New environments, however, increases the risk of getting a disease, both based on changing lifestyles and changes related to losses, which in

turn leads to increased levels of stress (Kumar, 2010). Additionally, Blom (2008) asserts that the incidence of diseases increases sharply with age among immigrants, more than in the population as a whole. This includes diabetes, “other metabolic diseases”, angina, heart attack and arthritis. For immigrants the panorama of diseases augments in the age group 40-54 years while for the general population the age group is 55-70 years (Blom, 2008). Helman describes the health risks of migration, such as loss of individual identity, social structures, traditional leaders, religious authorities and local landmarks such as religious sanctuaries or ancestral graves. The risk factors leading to mental illness may depend on age, social class, occupational status and ethnicity on one hand and culturally biased diagnostic methods on the other (Helman, 2007). This means that immigrants’ mental illnesses increase because of delayed diagnosis.

A relatively small group of refugees (19%) of the immigrants from Asia and Africa who come to Norway have been exposed to severe trauma in the form of torture, war and other humiliating treatments in prisons and refugee camps (Brunvatne, 2006). After arrival in Norway, many immigrants are nevertheless exposed to lifelong strain, such as having to acquire another culture’s language and set of rules, and find a foothold in the new context without discarding the old as well as having to deal with marginalization, which can contribute to fatigue and illness (Mirdal, 1997). Furthermore, Mirdal (1997) holds that life as migrant involves elevated risk of crises and trauma, such as unemployment, racial assaults, extreme humiliation and diseases determined by stress, which may result in Post-Traumatic Stress Disorder (PTSD). Midtbøen and Lidén (2015), who claim that immigrants in Norway experience discrimination at schools, in workplace, in the housing market and in health care services, support this. These are among others forms of discrimination, such as that - exemplified by teachers, who lack cultural competency; applicants with foreign names are less likely to be called in for a job interview; and language problems and inadequate

interpretation services contributes to structural discrimination in the public service system (Midtbøen & Lidén, 2015).

Døving (2006) also describes a loss of safety as the migrant break up with their roots, undermines the stability, predictability and overview. Distance and concern for family in the home country characterizes many immigrants, in addition to the lack of social networks, broken family relationships, loneliness and the fact that loyalty to their own values are challenged (Døving, 2006).

A report from the HUBRO study (Kumar, 2008) examining the healthiness of the general Oslo population in light of immigrants' health showed large differences in health between the five immigrant groups which were tested, included those from Turkey, Iran, Pakistan, Sri Lanka and Vietnam. The five immigrant groups reported more chronic diseases compared with the Norwegians and immigrant women reported more musculoskeletal disorders than men did. Studies from Sweden and Britain also show that immigrant women experience more chronic pain than immigrant men and natives (Mullersdorf, Zander, & Eriksson, 2011; Palmer et al., 2007). Other factors that stood out for the immigrant women in the HUBRO study were less physical activity and more instances of being overweight, and they reported psychological distress to a greater extent. The main results also showed that men were generally older than the women from the same country were; the men had higher levels of education than the women, especially those from Turkey and Pakistan; more men than women had full-time jobs; and a higher proportion of men lived alone. Immigrants reported a higher number of visits to the family doctor and specialists compared to Norwegians. Self-reported health showed that the Norwegians more frequently had good health compared to immigrant groups. On the other hand, most of the immigrants had a low consumption of nicotine and alcohol as well as low blood pressure, and some groups, particularly the Turkish women, had a high intake of fruits and vegetables (Kumar, 2008). In addition, immigrants might be

affected by the contagion in the country of origin (Bruvatne & Heldal, 2010) and suffer more frequently from disorders such as sickle cell anaemia, vitamin D deficiency and hereditary disabilities than ethnic Norwegians (Helsedirektoratet, 2009).

What kind of knowledge immigrants have about body, health, disease and Norwegian health care is also crucial to the ability to maintain their health. An example of this could be people with type 2 diabetes who have difficulties understanding the health information they receive from health professionals (Finbråten & Pettersen, 2012). Health Literacy (HL), can be defined as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (Nutbeam & WHO, 1998). Finbråten and Pettersen (2012) highlight the development of training programs to improve patients’ HL, thus improving their ability to cope with and prevent chronic diseases. Training is, however, dependent on the individual understanding the language the provider uses (Finbråten & Pettersen, 2012). According to Berg (2011) language difficulties create misunderstandings, which may have implications for treatment outcomes. Furthermore, the supply of services could be deteriorated, and important information does not reach the patient (Berg, 2011; Meuter, Gallois, Segalowitz, Ryder, & Hocking, 2015).

To address the health risks of immigration, immigrants should be treated with respect and understanding. Hence, patients with immigrant backgrounds are dependent on health professionals with multicultural skills and cultural sensitivity.

Cultural competence is defined as “the attitudes, knowledge, and skills necessary for providing quality care to diverse populations” (The California Endowment, 2003). Bøhn and Dypedahl (2009) also point out the importance of being able to see the world from someone else’s point of view, developed through experiences, knowledge and reflection. In addition, to observing similarities and differences and adapting one’s actions accordingly. Then one can find a common platform, so that there is room for a constructive dialogue (Bøhn & Dypedahl, 2009).

2.2 Rehabilitation – the context of the study

The context of this study was in a setting of rehabilitation at an outpatient clinic. The concept of rehabilitation might be given different meanings, for example: “to be capable of functioning again” or “giving the satisfaction of honour” or “restoring dignity” (Bredland, Linge, & Vik, 2011). Ploug Hansen and Tjørnhøj-Thomsen (2007) point out that rehabilitation is not about healing – or to get healthy but rather through various measures to normalize and integrate the individual within a personal and societal context (Hansen Ploug & Tjørnhøj-Thomsen, 2007). A definition of rehabilitation often used in public documents, textbooks and professional publications in Norway, is from White Paper 21, published in 1998: “The time-limited, planned processes with well-defined goals and means, in which several players work together to give the necessary assistance to the user’s own efforts to achieve the best possible ability to function and cope, independence and participation socially and in society” (St.meld. nr. 21, 1998). According to Solvang and Slettebø (2012), The White Paper builds on rehabilitation as a process, with a wide range of areas of life, and therefore involves many different health and social actors. The definition has patient participation and independence in focus. Furthermore, Solvang and Slettebø point out that many service users experiencing rehabilitation as a lifelong process such that the emphasis on processes of limited duration do not match exactly with the time it takes to replicate a well-functioning everyday life. Moreover, the authors emphasize that we have a social turning point in the field of rehabilitation from looking at rehabilitation as restoring bodily functions to looking at rehabilitation related to both training and the facilitation of the surroundings (Solvang & Slettebø, 2012). For example, one can say that paralysis is not a disease; rather the problem is a non-inclusive working life.

2.2.1 Quick return to work

The type of rehabilitation given at the outpatient clinic where I recruited my informants is part of what makes up the term vocational rehabilitation (“Arbeidsrettet rehabilitering” ARR).

According to Aas Wågø (2012), the abbreviation ARR has been used for vocational rehabilitation in Norway in recent years, especially the type offered in specialist health care. ARR is seen both as an individual process for each employee, as a service offered throughout the population and as a discipline and a research field. Over the last 10 years there have been major changes in the ARR field. In 2001, the Department of Social Affairs and Health introduced the “inclusive labour market”; in 2004, the health authorities made agreements with training institutions to conduct vocational rehabilitation; and in 2007 “Quicker Return” was introduced by the Sick Leave Committee. The “Quicker Return” scheme now operates approximately 200 different services offering ARR to persons on sick leave or those who are at risk of having to take it (Aas Wågø, 2012).

The outpatient clinic offered a rehabilitation course aimed at being specially adapted for immigrant women (Hansen, 2015). However, I have not been able to find similar courses for immigrants with chronic muscle pain in other health institutions in Norway. Nonetheless, research from other European countries, including a survey of the Netherlands shows that less than half of the surveyed rehabilitation institutes and rehabilitation departments had implemented one or more program adjustments for non-natives pain patients. Institutes that had made adjustments in their rehabilitation program for pain patients treated more immigrants than other departments that were surveyed (Sloots, Dekker, Bartels, Geertzen, & Dekker, 2011). Another aspect is that many immigrants find the concept of rehabilitation to be foreign. A qualitative study consisting of 28 interviews with staff members in a rehabilitation centre in Austria revealed that some cultures considered only two conceivable consequences to sickness: death or full recovery (Dressler & Pils, 2009). Many minority

patients also communicated that they expected the health professionals to treat them without having to get actively involved themselves and that they expected the family's attention and to be taken care of day and night. This implied that the patients did not see the need to recover independence, because they expected the family to care for them (Dressler & Pils, 2009). Moreover, a study which explored the understanding of the relationship between culture, race, ethnicity and the rehabilitation of immigrants with rheumatic diseases found that the patients felt helpless and anxious in contact with medical personnel (Adebajo & Alegbeleye, 2007). In addition, they had low expectations for rehabilitation programs, for cultural reasons, without apparently explaining those reasons. According to Adebajo and Alegbeleye, health personnel who are not culturally competent may additionally reinforce thoughts about low expectations. Furthermore, they point out that many non-Western immigrants find the concept of self-training and empowerment more difficult than Europeans do. This is related to a distrust of health professionals as well as reduced access to health care because of economic or linguistic barriers (Adebajo & Alegbeleye, 2007). Moreover, Daniel Côté holds that in some cultural groups therapeutic choices and processes are considered a family matter, which means that one might be in danger of bringing these groups into disfavour or excluding them if one has only autonomy as a value in the rehabilitation process (Côté, 2013).

2.2.2 Immigrants with chronic pain

Pain that last longer than the usual course of acute injury or disease, is called chronic or persistent pain but seems to have a problematic status as a pathological unit. Arnaudo has discussed chronic pain in the light of the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Arnaudo, 2013). She promotes a dualistic approach to the aetiology of pain; that it is seen as due either to a psychopathological cause or to a physio- pathological one is complex. Her conclusion is that the stigmatization of chronic pain patients, is grounded in the vast gap between those

disorders seen as psychogenic, and therefore to a certain degree unreal, and those with a measureable organic cause, seen as having a higher degree of reality (Arnaudo, 2013). According to Helman (2007), in traditional societies,² there is a more direct connection between physical pain and the social, moral and religious aspects of everyday life, and therefore it greatly affects how people perceive their own poor health. Moreover, he says that convictions about the meaning of pain, the context in which it occurs and feelings associated with the context, can affect pain sensation (Helman, 2007). Johansen (2006) provides an example of how meaningfulness can affect pain perception when she describes Somali women's pain after infibulation, which becomes greater in exile with the assumption that cultural meaning disintegrates simultaneously with condemnation from the mainstream society. She further argues that the cultural meaning attached to ritual pain, along with the novice experience of community and shared frames of reference, can help the pain to become meaningful, easier to bear, and probably less painful (Johansen, 2006).

In addition to the verbal and perhaps vocal expression of pain, Helman (2007) holds that nonverbal pain behaviour can also be influenced by culture. It can include immobility, grimacing, restlessness, and restless movements, crying, yelling or using special hand movements. Non-verbal expression can also include other changes in pain behaviours such as withdrawal, fasting, prayer or self-medication. In this regard, it is noted that in the Chinese culture one defines somatic complaints as the main disease, although psychological symptoms are also present (Helman, 2007), presumably because mental disorders are not completely accepted. Kleinman and Becker (1998) are, however, skeptical that it is meaningful to use the term a "sociosomatic" because they claim it is normal to communicate mental illness/discomfort with the body. They suggest that it may be understood as a "sociosomatic"

² A traditional society denotes a society characterized by an orientation to the past, not the future, with a predominant role for custom and habit (Langlois, 2001).

language to express themselves physically (Kleinman & Becker, 1998). Varvin (2008) elaborates this when he asserts that chronic pain can be associated with a chronic post-traumatic condition explained by overwhelming experiences which are not made to something that the psyche can work with (Varvin, 2008).

Chronic pain is, according Helman (2007), often closely associated with social and psychological problems. Interpersonal tensions can, for example, cause the development of chronic pain and vice versa. For many families and cultural groups, a “pain-demonstration” is the only way to signal personal suffering regardless of the cause (Helman, 2007). A Danish study showed, however, that when patients with a minority background expressed pain in a strong manner, they were at risk of losing their credibility with the nurses. The nurses called it “ethnic pains”, as they were unsure if these patients were in as much pain as they expressed (Nielsen & Birkelund, 2009). The article’s authors maintain that the Scandinavian attitude towards pain expression is that one should neither understate nor exaggerate; if not, the health personnel will not take him/her seriously.

2.2.3 Chronic pain patients and rehabilitation

A similar dilemma, even for ethnic Norwegians is, according to Ahlsen, that individuals who are undergoing rehabilitation due to chronic muscle pain may be considered to be under great distress. The public does not look upon them as sick, and they cannot be considered healthy, as they are not capable of working and enjoying social life. Their forthcoming ability to work and receive wages also remains very unreliable (Ahlsen, 2014).

Another aspect is that, according to research, there is a difference between how men and women experience pain. A Dutch study with 909 men and 1178 women with chronic musculoskeletal pain (CMP) showed that risk factors with sex-specific association with CMP were work status, being overweight and being of older age (Wijnhoven, Vet, & Picavet,

2006). Furthermore, a Spanish study with 190 men and 210 women with chronic spinal pain presented that women had significantly higher levels of pain anxiety and pain intensity, even if they had higher levels of daily functioning than men, which revealed psychological resilience as they accepted the pain and managed to cope with its negative consequences (Ramirez-Maestre & Esteve, 2014). A Canadian study with 287 men and 441 women with chronic pain revealed that work status, pain intensity and use of certain types of pain medication as well as pain management strategies and pain beliefs were significantly associated with a particular gender (Racine et al., 2014). To sum up, it seems important to differentiate between gender when assessing and tailoring rehabilitation programmes for chronic pain patients. Moreover, a Norwegian study showed that one's experience of work demands might influence sick leave for women with musculoskeletal diseases (Aas, Thingb, Holte, Lie, & Lode, 2011). Qualitative interviews with eight female employees in human service organizations and in the first-line public sector generated the knowledge that most of their demands were cognitive and emotional (in contact with clients and customers), and the employees seemed to place much of the responsibility of the work on themselves.

There is not much research on immigrant women from low and middle-income countries and their experiences with chronic pain during rehabilitation. A Swedish qualitative study with 26 immigrants showed, however, the importance of taking the patients concepts of pain seriously and that trust is of decisive importance for getting better. The participants were 16 - 45 years of age and on sick leave, and the study showed differences in attitudes towards pain and in qualities of pain anxiety (Löfvander, 1999). The informants were grouped according to the qualities of meaning given to the pain. The type 1 or "meaning minded" cluster had concepts about a disorder, expressed worries about their future health and tended to check their diagnosis repeatedly and relatively few were back to work at follow-up. The type 2 or "pain-minded" cluster, on the other hand, had no or only vague ideas about the pain and held a more

fatalistic-optimistic view, with many of them working part-time at follow-up after three and eight months. Moreover, the cluster 1 individuals tended to be more sceptical towards doctors' and physiotherapist's treatments, while those in cluster 2 seemed to have more trust in doctors. In her conclusion, Löfvander (1999) underscores the importance of focusing on the patients' concepts of the pain and its implications for the future.

Moreover, immigrants often perceive pain as a barrier to initiating and maintaining physical activity (Horne, Skelton, Speed, & Todd, 2013), which also seems to be a challenge during rehabilitation. A qualitative interview study with Indian, Pakistani and ethnic British adults in their 60s showed that pain was frequently reported to be a limiting factor, resulting in a hesitancy to exercise and a tendency to activity. Additionally, the immigrants reported reasons for not being physically active, such as a lack of time because of work and supporting the family, and a lack of fluency in English, which was a barrier to learning about accessible opportunities and following instructions in group exercises. The Asian informants also mentioned that prayer could be in conflict with scheduled timing for activities and that religious fasting could be a barrier for physical activity as well as lack of facilitating gender segregation for Muslim women (Horne et al., 2013).

3. Theoretical framework

In the following, I will present the theoretical framework, as it has influenced the understanding of interpretations of the texts involved in this study. My aim is to explore how immigrant women experience their daily life when they are on long-term sick leave and to identify how they experience their family life and working life, their pain and their suffering and the maintenance of dignity in their lives. My starting point when I began the fieldwork was that I, together with the immigrant women on long-term sick leave at the outpatient clinic, should gain insight into the women's experiences during their phase of rehabilitation. In my analysis of fieldnotes and interview texts, I took inspiration from a variety of theoretical perspectives. In the following, I provide a framework of the main perspectives used in advance of the data collection and during the analysis. The immigrant women experienced suffering from pain and humiliation, and I will firstly outline some of the contributions to the understanding of suffering from theorists within nursing and medicine. Then I present influential theory about the phenomenon of humiliation. Finally, I will introduce the phenomenon of dignity, from philosophical, medical and nursing perspectives, together with some critical reflections.

3.1 The phenomenon of suffering

According to Pullman (2002), unrelieved pain and suffering are described as depriving human beings of their dignity, and the phenomenon will therefore be elucidated in the following. Many authors within the field of nursing science, together with contributors within medicine, sociology and anthropology, have explored the phenomenon of suffering. In her book "*The suffering human being*", Katie Eriksson (2006) determines that nursing aims to relieve suffering (Eriksson, 2006). Some central themes in Eriksson's theory of suffering are pain, loneliness, hope and meaning, and in the following, I will look at these in relation to other

theoretical views. Eriksson asserts that the concepts of suffering and pain are not synonymous. The individual might suffer without having pain, or be in pain without suffering. Moreover, she explains that if we lack the words to give voice to the suffering, it might be converted to pain, anxiety or a physical expression that can be observed. An article from Chapman and Garvin supports this view in that one can have pain and not suffer. They claim that if the bearer of pain understands its origin and perceives it as non-threatening, the pain does not cause suffering. Yet, the presence of pain greatly increases the probability that an individual will suffer (Chapman & Gavrin, 1993). Moreover, they elaborate on how suffering might be a product of a threat to self-image or body image or simply the awareness of the threat of death. Cassell also underscores the aspect of threat, when he says that suffering continues until the threat of disintegration has passed or until the integrity or intactness of the person can be restored (Cassell, 1982, 1999). Cassell also maintains that people in pain report suffering “when they feel out of control, when the pain is devastating, when meaning of the pain is dire, or when the pain is chronic” (Cassell, 1982, p. 641). Correspondingly, Ferrell and Coyle found that pain which continues without meaning, turns into suffering. In line with Eriksson (2006), they also claim that suffering takes place when an individual feels abandoned or is unable to give words to his/her experience (Ferrell & Coyle, 2008).

Eriksson (2006) asks if loneliness, when not being observed by anyone, might be the deepest form of suffering. She brings to the forefront the experience of not being understood and feeling that no one can meet one’s needs. Moreover, the exclusion from friendship or all forms of communion, a lack of position, not being taken seriously or being deprived of something one once had or wishes to have, leads to suffering (Eriksson, 2006). This can be seen as a dilemma, where the sick person may long for fellowship with others while at the same time feeling troubled by reliance on others (Ferrell & Coyle, 2008). On the other hand, Chapman and Garvin (1993) hold that suffering may start with a disease that can lead to

isolation, alienation and loss of social status or incapacity to work, which again can be experienced as loneliness. This is consistent with Cassell (1982), who emphasises that the ill person's reluctance to talk to others about their pain and distress may cause social isolation, which enhances the person's suffering. Charmaz (1999), however, focuses on preserving the moral status, the dignity and the control of the ill person, as silence about the suffering might evade shame and judgement from others. Nevertheless, Eriksson (2006) claims that the premise for growth is when the person receives confirmation of his/her suffering when sharing about it.

Eriksson (2006) holds that as long as there is movement in the suffering, there is hope, which consists of a drive towards desire and the meaning within suffering and life. The suffering requires hope to be relieved, and when struggling between hope and hopelessness, life and death, one can find meaning in suffering, if life prevails (Eriksson, 2006). Furthermore, Eriksson asserts that one can find meaning in the suffering through personal growth, through accepting one's destiny and in finding the courage to have faith in one's potential. This is in line with Morse and Penrod, who maintain that the development of hope gives the sufferer a renewed perception of life, which they categorized as "a reformulated self". This new viewpoint enables the sufferer to set new goals, to become sager in tolerating the past and to face a changed future (Morse & Penrod, 1999).

3.2 The phenomenon of humiliation

One of the research questions in this study deals about the experience and maintenance of dignity. According to Eriksson, suffering humiliates a person's dignity, and to disrespect human dignity is to cause suffering (Eriksson, 2006). Therefore, it is relevant to give a more extended presentation of the theory of humiliation in the following. As stated by Donald C. Klein, "The humiliation Dynamic poisons relationships between individuals and groups and...

is a major weapon in the oppression of women, people of colour, and of other stigmatized groups” (Klein, 1991, p. 2). In a focused study of humiliation, Klein (1991) coined the term the “humiliation dynamic” to refer to the relational nature of humiliation that he described as involving the interaction of 1) a humiliator (those who impose scorn), 2) a victim (those who experience it as scorn) and 3) a witness (those who observe and agree what happens). The experience and fear of humiliation are associated with feeling vulnerable and a variety of mental illnesses and also produce anger (Klein, 1991). Furthermore, Klein defined humiliation as the experience of being degraded, put down or belittled for who one is rather than for what one does. Klein explored how people experience humiliation and found four themes, which involved some form of interaction with others: 1) being put down 2) being excluded or made to feel less than, which threatens one’s personal integrity by not being recognized or acknowledged for one’s ideas or potentials 3) “loss of face”, which entails harm to one’s identity and sense of self and 4) invasion of self, which is the result of having one’s personal borders disrupted and one’s personal space overrun. Moreover, Klein claims that the fear of humiliation seems to be one of the prevailing motivators of the individual and collective human behaviour, as people often do not achieve what they want in life. This can be explained by the tendency to avoid feeling powerless and put down, being derided and experiencing deprivation and a sense of deterioration at the hands of others - in this way, being victims of humiliation (Klein, 2005).

According to Klein (1991), shame, as distinct from humiliation, is the feeling of failing to live up to one’s ideals in one’s own eyes as well as the eyes of others. Moreover, he argues that “People believe they deserve their shame, they do not believe they deserve their humiliation” (Klein, 1991, p. 23). Likewise, he explains how guilt differs from the humiliation dynamic, as it is an indication warning against intolerable thoughts and deeds, and involves a completely

internalized conflict in which one's good self is in conflict with unacceptable facets of one's being.

The humiliation dynamic is confirmed and elaborated by Hartling and her co-authors (Hartling, Lindner, Spalthoff, & Britton, 2013). She asserts that one can feel humiliated but refuse to be ashamed by being capable of upholding one's dignified self-respect and sense of worth. Furthermore, she presents humiliation as a powerful, pervasive factor, which has a damaging impact on the behaviour of individuals, groups, organisations and nations. She also points out that humiliating exclusion might cause withdrawal and even lead to detachment and a lack of capability to have compassion for others. In addition, humiliation may lead to feeling powerlessness and depression, whereas the opposite, dignity, has a healing potential (Hartling et al., 2013).

3.3 The phenomenon of dignity

When beginning this project, the phenomenon of dignity was an overall theme. I will therefore present the phenomenon from the perspectives of different nursing and medical theorists and from certain philosophers. The Universal Declaration of Human Rights states clearly, "All human beings are born free and equal in dignity and rights" (UN, 1948). This statement speaks about the dignity and infinite worth of all human beings and underscores the duty and responsibility that all persons have with regard to one another and the inter-dependence of all humans. A WHO study with data from 41 countries showed that to be treated with dignity was the second-most important nonclinical aspect of nursing care, only surpassed by the quick accessibility of health care (Valentine, Darby, & Bonsel, 2008). To maintain the patient's dignity is regarded as one of the main objectives in health science (Edlund, 2002; Eriksson, 1996; Gallagher, 2011; Haddock, 1996; Stabell & Nåden, 2006). The deepest ethical motive in all care is respect for human dignity (Eriksson, 2002). Jacobson

(2007) elaborates on this when she points out that those seeking to explore or apply the dignity concept within a health context should clarify whether one refers to human dignity or social/societal dignity. She points out that social dignity is about the ways dignity is either maintained or threatened through social interaction in specific health-related situations. Human dignity is, nonetheless, an inherent, independent value belonging to all human beings by virtue of being human and can serve as an important function in the research field and in the struggle for “right to health” (Edlund, 2002; Jacobson, 2007). In this study, I consider both human and social dignity appropriate.

The two great philosophers from Germany and Denmark, Immanuel Kant (1724-1804) and Knud Ejler Løgstrup (1905-1981), respectively, examined the concept of dignity in quite different ways, which I will briefly explain in the following.

Kant believed that common sense is man’s genuine core (Kant & Storheim, 1970). Reason gives man his sovereignty, and dignity is linked to the cognitive or one’s ability to think. According to Kant, reason and autonomy therefore give man his special dignity. Moreover, one can maintain dignity by avoiding using a human being as only a means but also as a goal. Kant introduces the universalization principle or the categorical imperative. This is explained by the obligation that motivates action and not that one allows oneself to be affected by the person one acts towards. Humans have, by virtue of their common sense, a freedom, that is, a sense of autonomy (Kant & Storheim, 1970).

Løgstrup, however, criticizes the notion that man gets value and dignity by being a rational creature or based on what one can achieve and argues that this implies contempt for the weak and dependent (Løgstrup, 2008). Løgstrup’s main thesis is that man has value and dignity by virtue of creation, something one cannot become qualified for. The human being is a purpose in oneself and has dignity in virtue of being created. Creation or life is God’s gift to man. In

other words, humans have dignity through being created with a body, emotions and reason. Man, as created, is in a dependency to other people, embedded in each other's lives and surrendered to one another. We have something of the other's life in our hands, as well as the other's life story in our hands. According to Løgstrup, we are vulnerable to and influenced by dependency and trust in our relations. In this regard, Løgstrup is concerned with the ultimate power that lay in human relationships, where asymmetry is obvious in that the immigrant women are in a vulnerable position both in contact with the health care setting and with working life. "Sovereign expressions of life" as trust is detected in crisis, and trust as a phenomenon is perceived in crises, while discovery of dignity when there is undignified situations. "The ethical demand" is, according to Løgstrup, to take care of the trusting others. Moreover, he asserts that the demand is understood based on lived life (not reasoning, as Kant upholds), and one can respond to the demand through insight, imagination, understanding and judgment. We serve others through words and deeds by means of social norms, conventions and discretion. Furthermore, man cannot demand but rather have confidence that one is taken care of by the person one shows confidence in. The demand is therefore unilateral, not reciprocal; we can therefore not claim to get something back. Finally, dignity means that we are created interdependent, and, according to Løgstrup, dignity is maintained through the trust met by the demand (Løgstrup, 2008).

3.3.1 Recent theories on the phenomenon of dignity

Within the field of nursing and medicine, several theories of dignity have been put forward over the last two decades. In the following, I will present some of the most central theories from seven professors of either medical or nursing ethics. Most of the theories put forward from professors in the health board are based on the fact that the human being is unique and distinct from other beings (Edlund, 1994, 2002; Jacobson, 2009; Leget, 2013; Nordenfelt, 2004; Pullman, 2001). Moreover, the professors assert that the human dignity is irrefutable,

cannot be generated or ruined and is tied to the fact of being human (Jacobson, 2009; Nordenfelt, 2004; Pullman, 2001). In addition, three professors hold that man is created in God's image and is thereby dignified (Edlund, 1994; Leget, 2013; Pullman, 2001).

The concept of dignity is mostly divided into two categories: "human" or "basic dignity" (immaterial, universal quality of value, cannot be generated or ruined) and "social dignity" (can be measured, violated or endorsed and is created among persons, collectives and societies) (Edlund, 1994; Jacobson, 2009; Pullman, 2001). Pullman (2001), however, makes a distinction regarding the latter category, as he calls it "personal dignity" which deals with the manner in which people see themselves and what gives their lives meaning, determination and integrity. Nordenfelt (2004) explored four notions of human dignity and is also concerned with integrity in addition to the subject's self-image, which is placed in his fourth category: "dignity of identity". He links "dignity of identity" to our history, our future and our relations to others. The three other notions of Nordenfelt's human dignity are "merit", "moral stature" and "Menschenwürde" (a universal human dignity). Dignity of "merit" refers to an individual's role, rank and position in society and is associated with concepts of rights and respect, whereas dignity of "moral stature" refers to a sense of self-respect and moral identity in addition to a dignified character and a dignified mode of conduct as well as having a moral standard (Nordenfelt, 2004).

Several of the other authors are, like Nordenfelt, concerned with self-respect and integrity. Jacobson (2009) sees self-respect, self-worth, confidence and integrity as part of the "dignity-of-self", whereas Leget (2013) uses the label "subjective dignity" regarding one's self esteem and self-respect. Edlund (1994) also mentions integrity when looking at the relational part of dignity.

Mann (1998) has explored dignity by focusing on its violation and has included two components in the concept of dignity: "one internal (how I see myself) and the other external

(how others see me)” (Mann, 1998, p. 32). Furthermore, he made a provisional taxonomy of dignity violation that included “not being seen”, only being seen as a group member, violation of personal space, and humiliation. He also underscored that the violation of individual and collective dignity has an impact on physical, mental and social well-being, and may represent a pathogenic force (Mann, 1998). Furthermore, Jacobson (2009) points to encounters where indignity appears, such as being in a position of vulnerability where the other actor is in a position of antipathy, relations characterized by asymmetry, harsh circumstances or an order of inequality (Jacobson, 2009). Moreover, Gastmans (2013) is concerned with vulnerability, care, and dignity in his foundational framework for nursing ethics. He defines the ethical essence of nursing care “as providing care in response to the vulnerability of human being in order to maintain, protect and promote his or her dignity as much as possible” (p.146). By providing dignity-enhancing care, one has respect for the patient’s totality, including the bodily, relational, psychological, social, moral and spiritual dimensions (Gastmans, 2013).

3.3.2 Critiques on the phenomenon of dignity

The concept of dignity has been exposed to critique from various sides. Ruth Macklin (2013) holds that dignity is only unclear restatements or simple catchphrases that do nothing to enhance an understanding of the theme. In the medical context, she asserts that dignity seems to have no other meaning than respect for the individual and, avoiding discrimination and abusive practice together with respect for autonomy. Furthermore Macklin demand for criteria on violation of dignity and concludes that dignity is a useless concept in medical ethics (Macklin, 2003). Moreover, Steven Pinker (2008) asserts that dignity is a squishy, slippery, ambiguous relative and fungible concept. Pinker concludes that dignity is just another application of the principle of autonomy and respect for persons (Pinker, 2008). Likewise, George Agich also comments on the concept of dignity, viewed in the context of elderly care. He holds that dignity does not seem to offer a self-governing basis for policy but rather should

be placed next to other concepts, such as rights, freedom or welfare. Furthermore, Agich points to a problem with care based on merit or wisdom for people with dementia who lack basic cognitive capacities. He also underscores the loss of independence in a communal/institutional care environment and that dignity should be “grounded within a specific cultural, political, religious, or social context that gives it specificity” (p. 489) to frame the care (Agich, 2007).

3.4 Summary of the theoretical framework

As we have seen from this overview, the ideas of suffering, humiliation and dignity are interconnected in many ways. Humiliation, together with unrelieved pain and suffering deprive people’s dignity. Social, personal or relational dignity also include integrity, autonomy, self-image, self-worth, self-esteem, confidence, meaning, reason and determination. Moreover, “Menschenwürde”, or the universal human, basic or absolute dignity is seen as an independent, irrefutable, inherent value by virtue of being human or due to being created in God’s image.

The central concepts in this study are the concept of dignity and indignity related to the concept of suffering, emerging from chronic muscle pain experienced by immigrant women on long-term sick leave. Concerning the main research question of this thesis, these perspectives are the most important in giving a deeper understanding of the everyday lives of immigrant women in Norway.

4 Study design

The thesis builds on a field study with empirical data generated by qualitative methods. In this chapter, I give an account of the steps and choices made during the process of generating, systematizing and interpretations of texts. In other words, I describe the setting of the data collection, the interviewed and observed informants, the hermeneutical analysis and interpretations, research ethics and finally a critical reflection on the research process.

Additionally, in each paragraph I describe the limitations with the chosen steps. When collecting, organizing and analysing the dataset, I was inspired by the hermeneutic approach, and I have chosen to base my research design particularly on the French philosopher Paul Ricoeur's philosophical understanding of hermeneutics.

4.1 Hermeneutic approach

According to Ricoeur, "hermeneutics is the theory of the operations of understanding in their relation to the interpretation of texts" (Ricoeur, 1981, p. 43). Essential to Ricoeur's theory is his understanding and interpretation of text - explicitly is his concept of distanciation, a standing separate from or being objective in relation to the text. He underscores that distanciation is the critical moment and the condition of understanding, which leads to an achieved objectification of the text. Furthermore, his perception of appropriation is to "make one's own what was initially alien" (p. 185), which is the aim of hermeneutics (Ricoeur, 1981). The idea of interpretation as appropriation "lies the final brace of the bridge, the anchorage of the arch in the ground of lived experience" (Ricoeur, 1981, p. 164). This means that distanciation and appropriation are in a dialectical relation to one another and culminate in understanding (Ricoeur, 1976).

Wiklund et al. (2002) point out that the text that one wishes to interpret can be any written document, and it is possible to consider human actions as text, such as interviews, videos and

field notes. Moreover, the authors uphold that the hermeneutical approach performed by Ricoeur is about the text's interpretation, which is not to realize or understand the intentions of the narrator but to understand the meaning of the text (Wiklund, Lindholm, & Lindström, 2002). To understand the text is to follow its movement from the manifest description of what it wants to communicate. When one follows the text behind the situation and the intentions of the author, and behind the situation of the reader, the text reveals possible ways of being that can be appropriated (Ricoeur, 1981). In this regard, Ricoeur emphasizes both a descriptive approach and the "singular causal explanation", in order to explain actions or how they make things happen (Ricoeur, 1984), meaning that actions are not events or happenings, but they become accessible by language, and are analysable as literary texts (Ricoeur, Kemp, & Kristensson, 1988). For this study, this implies that my participant observations, informal talks with the immigrant women and the formal interviews were actions that became accessible as texts. Moreover, Ricoeur underscores that a hermeneutic approach allows the reader to understand more than the author: "What the text says now matters more than what the author meant to say..." (Ricoeur, 1976, p. 29).

According to Ricoeur (2002), the text as a concept is a distant testimony of the human experience. When what is said was transcribed to text and was subjected to analysis; the text was released from the informants and was projected as a description of a world. By this, I understand that reading takes place in a discursive process between explaining and understanding; this is detached from the context in which I interviewed, which is to speak and understand. When I was in dialogue with the text, I had to interpret to understand more than the text itself provided. When this happens, the text is detached from the storyteller and stands for itself (Ricoeur, 2001).

4.2 Setting of data collection – The outpatient clinic as a research arena

The setting for the study had its point of departure at an outpatient clinic at a rehabilitation hospital in the southern part of Norway. A field study is a methodology (Silverman, 2006) and implies having personal contact with people under study in their own settings (Patton, 2002). The researcher gets close to the persons under study through physical proximity for a period of time as well as through the development of closeness in the social sense of shared experience (Patton, 2002). In this study, the setting was firstly bound to the outpatient clinic, and secondly to the informants homes and/or to my office when interviewing them.

4.2.1 The outpatient clinic

The outpatient clinic was located in a former approximately 100-year-old hospital building in the western part of Oslo, surrounded by a park. The clinic was equipped with offices for the healthcare personnel, a waiting room and a bright room accommodated for group session activity, with big windows and an oval table, spacious enough for about 10 persons.

Furthermore, the floor area was suited for activities such as relaxing practice lying on mats and pillows for 10 persons. The group session room also had a whiteboard, a mirror and a small bookshelf with some books about Mindfulness and cognitive therapy.

The outpatient clinic is involved in an effort to reduce absence due to sickness, called “Raskere tilbake prosjekt” [Quicker return to work], initiated by the Norwegian Government in 2007. The outpatient clinic, which is part of the Norwegian rehabilitation and welfare system, includes patients with complex/chronic muscle disorders and possibly with mental health problems. The clinic offers wide-ranging, specialized, multidisciplinary patient evaluation that lasts between 24 and 48 hours. Together with the patient, the team aims to get an overview of the various bodily, emotional and social aspects of the situation. The recommendations can include advice about medical assessment and treatment or conditions

that must be attended to in the work place. In relevant cases, the individual may be offered treatment at the outpatient clinic, either individually or on a group basis.

The outpatient clinic offers a rehabilitation course for immigrant women on long-term sick leave within 52 weeks or if they receive other benefits when the sickness absence period has ended. The course is also for persons who are at the risk of being put on sick leave.

4.2.2 The health personnel and the rehabilitation program

Two experienced health personnel, a physiotherapist and a social worker, led the rehabilitation course. They had had several years of experience with rehabilitation courses for Norwegian patients with musculoskeletal pain, using a psychoeducational program, built on cognitive therapy (Beck, 1991; Berge & Repål, 2008). This included teaching about stress-coping strategies with the aim of reducing pain, tiredness, anxiety and depression (Hansen, 2011). The course leaders told me that they did not have very much experience with seminars for immigrant women. The rehabilitation course for immigrant women was scheduled to last for three hours one day per week in eight succeeding weeks. In addition, the course leaders offered two follow-up reunions one-and-a-half months after the last group-session. The schedule for each session was more or less the same each time, as follows: The participants were asked to share information from their everyday lives since the last group session, with a special focus on how they had completed their “homework”, at the same time as receiving counselling. Each course day the immigrant women were given a task, such as to reflect on their own contribution in order to gain as much as possible from the course, to focus on breathing when walking or doing exercises, reflection on how to cope with their pain, and how to set limits for themselves. After the sharing in the group, it was time for a walk to a nearby park, practicing elements of mindfulness. Back at the outpatient clinic, the course leaders gave clinical lessons on such themes as breathing and muscle tension, how to cope

with pain, and unhelpful thinking styles. During the lessons, the participants were encouraged to share their own experiences with and meanings related to the theme of the day. Each group session was closed with indoor gymnastics, such as bioenergetic exercises and relaxation techniques. The participants were also given a DVD about bioenergetic exercises.

4.3 Participants

The sample of this study was defined to be participants from two specific rehabilitation courses, which consisted of two groups involving eight women in the first group and six women in the second. Their General Practitioner referred patients to the outpatient clinic, and the course leaders recruited them when meeting for individual conversations prior to the course. The immigrant women received verbal information about the study from the course leaders. They also received an information sheet sent from me as a researcher. At the same time, the course leaders asked for their consent to join the study. The study sample was quite heterogeneous with immigrant women originating from different low- or middle-income countries aged 30 to 56 years, and their length of living in Norway varied from six years to 32 years (Table 1). Three of the women were asylum-seekers and 11 came to Norway to reunite with family and/or due to employment immigration.

Of the 14 women, 11 were on partial sick leave and three were on 100% sick leave. Three of the women were skilled workers and 11 were non-skilled workers; most of them had demanding physical work. One of them had five years of primary school attendance, 11 had completed high school and two had attended university. All the women were mothers of either small children, teenagers or grownups. Of the 14 women, 11 were married; three of them were divorced and lived together with one or more of their children. All 14 participants had lived in the eastern parts of Oslo, Norway for more than five years, and they were acquainted with the Norwegian health care system (Table 1)).

The participants were included in the study according to the following criteria: Immigrant women:

- 1) From the working population with ancestry in Asia and Africa on long-term sick leave.
- 2) Able to speak Norwegian at a level that enabled them to exchange their experiences and to understand the lessons in the rehabilitation course.
- 3) Referred by their general practitioner to a rehabilitation course at the outpatient clinic caused by nonspecific chronic muscle and/or soft tissue pain.

None of the 14 informants in the study withdrew during the participant observation period.

However, in the first group, one of the participants dropped out of the rehabilitation course three weeks before it terminated, most likely because she did not find it suitable for her needs.

Another woman did not wish to participate in the interview with me because she was in good health again, and a third woman was not available to participate in the interview.

Table 1: Demographics

Age	Continent	Single motherhood	Number of children	Employment	Norwegian language skills	Length of residency in Norway
30-35	South Asia		1	Assistant in kindergarten	Fluent	More than 10 years
45-49	South Asia		2	Assistant in kindergarten	Proficient	More than 10 years
50-55	South Asia		2	Primary school teacher	Fluent	More than 10 years
55-59	South Asia		4	Assistant in kindergarten	Conversational level	More than 10 years
40-45	South east Asia		2	Handcraft	Conversational level	More than 10 years
50-55	South east Asia		2	Technician	Proficient	More than 10 years
35-39	Central Asia		4	Assistant in kindergarten	Conversational level	6-10 years
40-45	Middle East		1	State enrolled nurse	Proficient	6-10 years
45-49	Middle East	X	2	Nursing assistant	Beginner Level	6-10 years
50-55	Middle East	X	7	Grocery store assistant	Conversational level	More than 10 years
35-39	North Africa		2	Assistant in kindergarten	Conversational level	More than 10 years
35-39	North Africa		2	Assistant in kindergarten	Conversational level	More than 10 years
40-45	North Africa		4	Assistant in kindergarten	Conversational level	More than 10 years
35-39	East Africa	X	2	Cleaner	Beginner level	6-10 years

4.4 Data collection

The field study as a method of collecting data was chosen because of the potentials to get an in-depth understanding of the complexity of the immigrant women's experiences of their daily life when taking part in a rehabilitation program. To obtain a deep knowledge of the informants' everyday lives would be difficult to explore in other ways, such as to study social interaction where the subjects reside. Participant observation produces knowledge about themes that the individuals might think are not important but that are still significant. The combination of interviews and participant observation may therefore provide insight into the border area between told events and unspoken, yet momentous happenings (Nielsen, Hansen, Huniche, Swane, & Johannesen, 2007; Silverman, 2010). Furthermore, in line with Kelly (2010), the qualitative interviews gave an in-depth understanding of the knowledge, experience and perspectives of the informants, produced in interaction, with attention to reflexivity and subjectivity.

The data were collected between May 2011 and April 2012. I started with participant observation at two rehabilitation courses at the outpatient clinic, followed by qualitative interviews with the immigrant women. The data generated from the observations gave me first-hand experience with the setting and the informants and enabled me to understand and comprehend the context within the participants interacted. The data from the observations were, however, largely used to contextualize the interviews, as it was limited to a terminate setting and a relatively short period of time. In the findings, I have therefore used more data from the interviews than from the field notes in the articles. Additionally, the data from the observations served as a background during the interpretation process, which helped me to understand the interview texts. As the participant observation was adapted to only a certain event at the outpatient clinic, namely the rehabilitation course, the interview method could be used to get a deeper understanding and to study events that were not possible to study in the

course. Examples of occasions distant from the rehabilitation course took place in their past lives, before coming as immigrants to Norway, which is in line with Atkinson and Coffey (2003) and Maxwell (2005). The combination of methods though, contributed to illuminating both beliefs and values together with the biographical details of the informants' everyday lives (Warren, 2001). Moreover, interviews can be seen as speech-acts and may thereby be regarded as types of actions in their own right (Ricoeur, 1981, p. 13). This means that the act of speaking in interviews was freed from its original situation to be directed towards the unknown reader of the future, whereas the field notes from the participant observations were events narrated by the observer and were of great use because not all of the women were fluent in Norwegian.

4.4.1 Participant observation

The purpose of the participant observations was to collect data about what was going on in the rehabilitation course, which, according to Polit and Beck (2014), is to observe people and their environments. This specifies that my intention was to describe the setting, the activities that took place at the course, the participants and the meanings of what was observed (Patton, 2002). In accordance with Silverman, participant observation was also used to gain a better understanding of how the women experienced the rehabilitation course, including how they experienced work and sick leave. The participant observations gave insights into the tacit elements exemplified in gestures and physical activities in order to better understand the interface between the informants' spoken words and the courses of events (Nielsen et al., 2007). Before entering the field, an observation guide (Appendix 5) was developed, covering the following main themes: 1) What is the substance in the group meeting?, 2) What happens in the group process? and 3) Is dignity or indignity a theme, which is put in question/discussed/experienced by the informants?

The participant observations during the two rehabilitation courses, were spread over 10 days during the course of eight weeks in addition to the two follow-up reunions (totalling 45 hours). The observations took place around activities, such as group discussions, clinical lessons, indoor exercises, relaxation practises, doing elements of mindfulness and during walks to a nearby park. Carrying out participant observations over a number of weeks made it possible to become acquainted with the women; to learn about their worries, perspectives and sentiments and to develop rapport with them while observing what was going on (Emerson, Fretz, & Shaw, 2011). Additionally, it was valuable to observe the in-group interactions, the peer-group influence and how the women learned from one another while exchanging thoughts and experiences. In this way I could, as Emerson et al. (2011) points out, collect data about the immigrant women's reflections about their rehabilitation process, which were expressed when interacting both during group sessions and during breaks.

I reflected continually on my influence on the field as a researcher, as the course leaders might have been stressed by and weary of my presence, thinking that their actions might be published in the future. Therefore, the course leaders might have adjusted their way of acting because of my presence - but unrevealed to me. Moreover, according to Behar, the observer "never observes the behavioural event which would have taken place in his absence" (Behar, 1996, p. 6). My position as a researcher could possibly have been on the "outside", such as not sitting around the table but rather in a corner just observing. This could likely have created some stress, insecurity or suspiciousness among the research participants (Fangen, 2010), consequently I participated in almost all situations. Furthermore, I tried to dress more or less in the same way as the participants in a casual style with jogging shoes, aiming to fit in with the group interactions. Allen (2010) points out the importance of reflection about aspects of one's identity, as age, ethnicity and gender might affect the research relationship (Allen, 2010). If I had been a man, participant observation would probably not have been possible in

the setting with immigrant women, many of them being Muslims. Moreover, as I am a middle-aged former nurse, I found it rather easy to establish field relationships. If I myself had been an immigrant woman, this would maybe have increased the easiness of making rapport, but on the other hand, it could perhaps have made me desensitized to interesting features. To sum up, my role as a participant observer meeting and conversing with the women over an extended period of time seemed to make the women and myself acquainted, intimate and comfortable with our interaction with one another to a certain extent.

Throughout both courses, field notes were taken during group discussions and clinical teaching or noted down as keywords and phrases in my notebook, right after walks outside or gymnastics inside. Conversations around the table could be cited more or less literally. I tried not to be evaluative or normative in my jottings, but rather noted down as many concrete details as possible. The handwritten notes taken during the course sessions were transcribed into unfolded texts or stories, including preliminary reflections, thoughts and themes, immediately after each session. Other indoor and outdoor activities were also described as precisely and detailed as possible after each session. In retrospect, my field notes could have been more useful if I had included more description, as large parts of my field notes are dialogues or citations from the research participants. Moreover, the field notes could to a greater extent have been detailed portraits of settings, people, incidents and actions (Emerson et al., 2011). The reason for this new insight is that, during the analysis of the field notes, I sometimes found myself short of rich descriptions that could portray actions with sights and sounds to a greater extent. On the other hand, there is, according to Emerson et al. (2011), always more going on than the researcher can observe, and it is impossible to register all that can be perceived.

The contextual information generated from the participant observations made it easier to understand the women's situations and pose questions in the formal interviews to get a deeper

understanding of the immigrant women's everyday lives. It also provided important insights for the analysis of the fieldnotes and the interviews. Furthermore, the participant observation contributed to a broader understanding of the women's family life, their migrant history, their thoughts about health and sickness and their experiences with working life and sick leave. Moreover, I learned about their rehabilitation process concerning co-operation with different health personnel and diverse rehabilitation institutions. The observations also generated better awareness of the importance of religious activities and being close to their families and the trials they faced as immigrants when they were unable to understand the Norwegian social system.

4.4.2 Qualitative interviews

The aim of the interviews was to increase my understanding and thorough interpretation of the dialogues and exchange of views, which is in accordance with Maxwell (2005).

Furthermore, I could get access to a deeper knowledge of the experience and perspectives of the informants through the conversations. One or two months after each rehabilitation course, qualitative interviews were conducted to provide me with insight into the women's experiences with their daily lives and the meaning behind their experiences.

I carried out in-depth interviews with 11 of the 14 women. The interviews were semi-structured, meaning that I retained flexibility while also allowing a greater degree of standardization than "field interviews" (Kelly, 2010).

An interview guide was developed (Appendix 6), which covered the following five main themes: 1) opening questions, 2) experiences of being on sick leave, 3) experiences of working, 4) experiences of being on rehabilitation 5) and finally their understanding and experience of the concept of dignity. The concept of dignity was sometimes explained with synonyms by the researcher, such as value, respect, to decide, to choose etc. Specific interview questions were designed within the main themes but not always followed

systematically. They were rather used as a reminder when the conversation revolved around a certain topic area. It turned out to be rather challenging to bring the concept of dignity out in the field; asking specific questions about how the immigrant women perceived and experienced dignity in their lives. Even if I tried to explain the concept with other words, I was unable to translate “dignity” into their mother tongue, as, for example, in one of the languages, the word does not exist. Therefore, this concept was introduced towards the end of the interviews. On the other hand, some of the women had clear opinions about the content of concept of dignity and spoke about dignity experiences in their lives.

The interviews lasted between one and two hours. One interview lasted for only 35 minutes due to an urgent appointment of the participant. However, the average time for all the interviews was 70 minutes, and they were digitally recorded and later transcribed verbatim. Eight of the interviews took place in my office and six of the interviews in the informants’ homes, depending on the preference of the participant. Particularly during two of the interviews, the informants gave responses that to some extent surpassed the scope of my original questions, and storytelling followed at the most unpredicted times. These two interviews were held in their homes, and in retrospect, I have reflected on how the context of the interviews might have influenced how their stories were presented and perceived. As a guest in their homes, I felt very welcomed by the women, who expressed a desire to serve me a meal, for me to sit in a nice sofa or to be assured there was not too much noise from the children being at home. At the same time, I got a feeling that they were relaxed and comfortable in their own living room, which might have been the reason why they gave me rich and detailed stories from their lives.

To ensure a better understanding and a comprehensive analysis, three of the women who spoke Norwegian fluently and who had been on long-term sick leave for a lengthy period were selected as key-informants and were interviewed twice. In addition to speaking fluently,

the key informants were talkative and were able to give rich portrayals of their everyday lives. They were willing to do an additional interview, a willingness, which the other informants did not make evident. The lack of an apparent readiness to do an extra interview might have been that they had already told me what was to be told, because it was time-consuming and because the rehabilitation period was something of the past. On the other hand, as a researcher, I might have been too hesitant in requesting an extra interview, afraid of being too intrusive. According to Maxwell (2005), one should reflect on the danger of “key informant bias”, in that there is no guarantee that these informants’ views are typical. On the other hand, the homogeneity of the sample was not an explicit aim in this study but rather that they should represent immigrants from low- or middle-income countries who had more or less similar experiences with the Norwegian health care system, social authorities and workforce. This will be elaborated under section *6.1 Methodological considerations*.

To maintain confidentiality and privacy, I did not use an interpreter during the interviews. The women were not explicitly asked whether or not they wanted an interpreter, but during the rehabilitation course, many of them stated that using an interpreter was outdated. Moreover, some of the women said that they did not want to include an interpreter in health care settings because of the relatively small linguistic groups in Oslo and the disagreeable feeling of being recognized or “unveiled”. Additionally, I became accustomed to the women’s ways of speaking Norwegian during the courses, and in that way learned to recognize their “interlanguage”. Selinker (1972) coined the term “interlanguage”, which refers to the linguistic systems that an immigrant (L2) learner constructs as he/she progresses towards the target language (here, Norwegian) (Myers-Scotton, 2006). In order to be part of the labour force in Norway, knowledge of and fluency in Norwegian are necessary. Therefore, a large majority of the subsample of working immigrant women will be fluent in Norwegian except for those with cleaning jobs or factory work. On the other hand, one could perhaps anticipate

that the data would have been richer and on a deeper level if I had used an interpreter during one or two of the interviews, as the women's language skills varied significantly.

During the research interviews, I learned that the rapport made with the participants from the rehabilitation course could both "open" as well as "close" rapport according to what women told me. An example of when my pre-understanding contributed to diminish rapport was that through intimate conversations with one of the women from South Asia I learned that her husband had a drinking problem. In the interview-situation a few weeks after the last day of the course, she said, *"So I'd rather not sit at home, because then it gets worse. My home situation is so"*. I replied, *"So you were on sick-leave from 50% of your job then?"* I knew from before that her husband had an alcohol problem and that it was difficult for her. From what I knew, I chose, however, not to go ahead, in spite of the information I probably could have gotten about her challenging situation at home. My reluctance was both an ethical reason for fear of being intrusive together with my shortage of experience of doing qualitative interviews. Another example where my pre-understanding from the rehabilitation course helped to open the dialogue was an interview with a woman from a North African country. At the rehabilitation course, she told me that her husband during periods had been suicidal. In the interview, she expanded on this difficult situation, and then I could ask follow-up questions, which helped enhance my understanding of her situation. Knowledge and pre-understanding might lead the researcher to overrule, and can therefore contribute to "closing" the interview situation by signalling in what direction I wanted the contents of the interview to progress. At the same time, pre-understanding can be fruitful in that it allows for conversation at a deeper level.

4.4.3 The researcher: pre-understandings, roles and positions

The hermeneutic arc involves, according to Ricoeur (1981), our pre-understanding, followed by explanation and interpretation to end with a new understanding. Our understandings and

theories are influenced by our initial view of things, including our opinions, experiences and culture and traditions, also labelled as our pre-understanding (Ricoeur, 1981). When we try to open up and move further than our pre-understanding, we appropriate new ideas and make them our own (Ricoeur, 1974).

By opening up towards the immigrant women in the dialogues, my horizon changed when sharing the same sphere of meaning, which, according to Ricoeur (1981), illuminates the process of appropriation. Explanation is a way to distance oneself from the pre-understanding rather than an attempt to disconnect oneself from it. Understanding emerges within hermeneutics as both a process and an outcome, which does not guarantee that one follows the other. When I distanced myself from my pre-understanding, my horizon could change, which according to Ricoeur is the perception of new meaning, or the process of appropriation (Ricoeur, 1981).

Getting to know foreigners as a grownup has modified some of my comprehensions about people from other continents. Regarding my pre-understanding in relation to immigrant women on long-term sick leave, I was influenced by my training as a nurse. Furthermore, my master's in nursing and my 23 years of professional experience as a nurse in the rehabilitation field have contributed to guiding my interests in regard to research focus and research questions.

As regards immigrants and rehabilitation, I had experienced that many immigrant patients had an expectation about others making them healthy. They seemed to believe that they would become healthy by being passive or lying in a bed and receiving various therapeutic interventions. This was in contrast to my professional point of view, as the rehabilitation process is centred on the patient's wishes and goals, based on participation and a willingness to perform active efforts to improve one's own health.

To get a brief overview of the rehabilitation programme at the outpatient clinic, and before initiating the project, I asked for two structured individual dialogs with the doctor at the outpatient clinic and the social worker who runs the rehabilitation courses for immigrant women. The results of these discussions about their experiences with rehabilitation of immigrants were also part of my pre-understanding in relation to the topic of immigrant women on long-term sick leave.

Theory and research papers about immigrant health, dignity and indignity also influenced my pre-understanding. For example, I became more aware of the challenges immigrants meet with when learning a new language and attempting to get a job or the risks that influence their health when they migrate. Moreover, my pre-understanding was limited to my Western background experience, in that I have not resided outside Europe. My preunderstanding characterize my own research interests and my role or position in the field of research. When working as a nurse in the rehabilitation field, I did not have many immigrants as my primary patients. In the interdisciplinary team at the rehabilitation hospital, we did, however, often have discussions about patients with different ethnic origins in relation to how to best inform, motivate and interact with them in the therapeutic work. These experiences gave me a desire to gain more insight into immigrants' experiences with rehabilitation.

My interest in the course of rehabilitation for people with chronic illness led me to research on immigrant women on long-term sick leave. Although I knew some of the professionals at the outpatient clinic before I started the project, I had not worked with the two therapists who ran the rehabilitation courses. My knowledge of the clinic and the staff might have had some impact on my researcher position in that I had confidence in them as experienced health personnel. I informed them that I as a researcher desired to do the same as the participants during the course, to interview them afterwards and to write research papers and a doctoral thesis. In the first group however, I experienced that the course leaders actually treated me

more as a participant, and not so much as a researcher. When the participants were asked to share around the table, and it came to answer questions such as “What do you do to cope with the pain, and what is pleasurable for you?” or “How has the homework been, such as practising and doing stretching exercises?” – I was also asked to answer. Then I realized that I had not clarified my roles well enough with the course leaders before the project started. In advance of the next rehabilitation course, I therefore had a meeting with the two therapists, and we talked about my role as a participant observer. In this context, it was important to reflect on my position as a researcher, which, according to Atkinson and Coffey, was to be aware that I could affect the participants by taking too strong of a participant role (Atkinson & Coffey, 2003). Consequently, and in accordance with the course leaders, when the group was asked specific questions from the course leaders, I passed the turn to the next person sitting beside me. Furthermore, I did not ask the participants therapeutic questions or avoided giving them advices or counselling, even though I saw many opportunities for what would be regarded as therapeutic interactions.

Many years of experience with the group-based rehabilitation of people with brain injury also affected my pre-understanding in the setting at the rehabilitation course for immigrant women. Fog (2004) points out the importance of clarifying one’s interests and feelings to get a good balance between closeness and distance concerning the informants. Emotions can unconsciously affect a research project. Therefore, I did a thorough self-examination before the project started to clarify both my resistance and commitment to the topic. I posed myself questions such as: What personal experience do I have with immigrants, muscle pain and sick leave? Moreover, how did my vocational training and role as a nurse affect my attitudes towards suffering, humiliation, dignity and rehabilitation? In this way, I got an overview of how my pre-understanding could influence the study instead of unconsciously not noticing it (Fog, 2004). On the other hand, I as a researcher might never be fully aware of my

preunderstandings; nonetheless, by examining parts of my pre-understanding it might, according to Nyström and Dahlberg, have been possible to open up for new understandings, ideas and meanings (Nyström & Dahlberg, 2001).

According to Nielsen et al. (2007), researchers should seek to engage personally in the life world of the informants through active involvement in their concrete life. The goal is to get close to and experience this life-world itself. Although the context was limited to the rehabilitation course, I could experience to getting involved and learning from my own experiences and the immigrant women's reactions to my active presence.

Through both participant observation and qualitative interviews, it was essential to ensure that I was well prepared when I went out into the field. Thorough preparation will provide the basis for asking good questions (Fangen, 2010). My old horizon of understanding, such as research and theories about immigration health and dignity and my experience as a nurse within the rehabilitation field, gave an overall picture of and a basis for interpreting. Nielsen et al. (2007) also point out that the interviewer has the opportunity to ask relevant and meaningful questions and understand the answers and the intended meaning because of the common frame of reference arising from shared social experience, which also increases the understanding. On the other hand, it might be a disadvantage to read or to be all too informed, because one may be in danger of being inflexible in one's ideas about what has been done previously instead of meeting the field with an open mind (Fangen, 2010).

By being critical in regard to my own proximity to the field, I intended to prevent preconceptions from threatening the validity of the study. During the research process, I tried to understand why I put certain questions into the area of research, and why I followed up on some questions while others were left behind. In the qualitative interviews, I learned that knowledge of the participants from the course could serve to both "open" and "close" my collection of data. Knowledge and pre-understanding can lead to overruling, and can therefore

contribute to closing the interview situation by signalling which direction I want the content of the interview to take. By not asking leading questions and avoiding breaking the silence and pauses, I found it easier to avoid leading the conversation in specific tracks, as Fog (2004) indicates.

4.5 The hermeneutical analysis and interpretations

Ricoeur refers to discourse as an incident where “someone says something to someone about something” (Ricoeur, 1981, p. 138). Ricoeur further states that an individual becomes aware of his/her participation in the world by talking about it (Ricoeur, 1976). Moreover, he holds up that when the conversation is transcribed and fixed as letterings, the text is released from the conversation context and thus becomes autonomous. What it expresses no longer necessarily coincides with the narrator’s intentions (Ricoeur, 1981).

In accordance with Ricoeur, the interpretation of this study had three stages: a naïve reading, a structural analysis and a critical interpretation (Ricoeur, 1976, p. 74), which is described in the next subsection (4.5.1).

The field notes were transformed into text using verbatim quotations and descriptions directly after each course session. I transcribed verbatim the digitally recorded interviews immediately after each interview.

4.5.1 The process of coding subthemes and themes

“Data are never pure but, rather are imbued with and structured by, concepts in the first place” (Emerson et al., 2011, p. 198). Furthermore, Emerson et al. highlight that the analysis of fieldnotes is not just dealing with discovering what the data comprise, but the researcher further selects out some events from the amount of field notes, gives them focus and comes to understand them in relationship to others. We conducted a qualitative analysis of both field notes and interview data. I conducted the main analysis, but all the three supervisors

contributed in the discussion of the findings. To ensure the consistency of the analysis, the supervisors read parts of the data set, and consensus was acquired for each identified theme.

Firstly, I read the data set several times in order to get what Ricoeur describes as “a naïve grasping of the meaning” (Ricoeur, 1976, 1981), which means to have an immediate, unreflected-upon understanding of the text (Ricoeur, 1984). This naïve understanding was both overruled or confirmed and extended as my understanding proceeded and developed (Geanellos, 2000). Through the naïve reading, the first interpretation of “what is spoken about” arose, where I tried to read the text with an open mind. Reflections were noted in the margins when reading, and talked over with my supervisors. Later in the analysis, the notes contributed to forming themes and sub-themes. When no more reflections emerged, a summary of each interview was written and was used as a guide in the process of the analysis.

Secondly, the structural analysis was carried out to validate and adjust the naïve interpretation and to reach a deeper understanding. The structural analysis involved identifying and formulating themes. This implies identifying the essence of the meanings that arise from different parts of the text. The themes reflect both explanation and understanding, as I formulated preliminary themes from my explanations of main details of the texts, which again generated a deeper understanding when I went beyond the details. As Ricoeur (1981) indicated when explaining the text by extracting its objective content, I looked at the meaning of the words by analysing the internal relations of the text. According to Ricoeur, the structural analysis addresses the identification of a meaningful context: quotations such as “what it says” to the primary interpretation “what it talks about” (Ricoeur, 1976, p. 88). The meaning units could be a few words, a sentence or a whole passage. In the movement from what the text said to what it talked about, substantial parts were identified leading to the construction of key themes, sub themes and patterns. The condensed meaning units were read

through while watching for likenesses and dissimilarities. The main themes that appeared as essential occurrences were lastly added into a matrix.

Thirdly, I developed a deeper understanding of the text by taking into account my prior understanding regarding what I knew about the women and about the context of the interviews, which was informed by the field notes. My understanding was based on the synthesis of all the women's histories and the participant observations. In addition, my theoretical knowledge and my experience as a healthcare worker influenced the analysis. My pre-understanding, the literature review and the context of the study (Ricoeur, Hermansen, & Rendtorff, 2002) validated the interpretation. Relevant research and literature were integrated into a discussion of the advantage of one or more appropriate interpretations (Ricoeur, 1976). Reflecting on theoretical perspectives on loneliness, suffering, pain and dignity, provided me with some new insights into the informants' and my own experiences with the phenomena, which in turn informed new theoretical understandings. The amount of data provided a more comprehensive understanding through the process of interpretation and, as Ricoeur (1981) denoted, I obtained an "appropriation of meaning".

4.6 Research ethics

The project was approved by the Regional Committee for Medical Research Ethics (REK, nr. 2011/662a; Appendix 1). Prior to entering the research field, I obtained permission from the team leader of the outpatient clinic to conduct the participant observation at two rehabilitation courses, followed by qualitative interviews with the participants Appendix 2). On the first day of the course, I reiterated the purpose of the research to the participants (which they had already been told by the course leaders prior to the course) and that they could withdraw from the study at any time. After familiarizing myself with the immigrant women, I reflected on their real ability to understand what they had signed up for. Some of them were not fluent in

Norwegian, especially not in reading and writing. In retrospect, I therefore learned that in two or three of the cases, I should have translated the information about the project into their first language. Some of the women, however, took the information sheet home to read before they returned the inscribed copy. In this way, they might have got help reading and understanding the text from family members or friends. Moreover, I reflected on the relative power of languages, as some participants did not speak the dominant language in the country (Norwegian) fluently and were thus unable to give voice to all their thoughts, opinions and feelings. The women did, however, express that they did not want to have an interpreter because of the quite small linguistic groups in Oslo and the unpleasant feeling of being identified or disclosed.

The two course leaders were asked to take part in the study, and were given written and verbal information about the study before I applied to the Regional Committee for Medical Research Ethics. They were not interviewed, but they were included as informants in the participant-observation as they were observed together with the immigrant women. Informed written consent was obtained from all the immigrant women (Appendix 3) and the two health care workers (Appendix 4).

Participation was voluntary. The immigrant women were informed that they could withdraw from the study at any time, and they were informed that they would be given a new opportunity for another rehabilitation course if they dropped out.

Confidentiality has been respected throughout the study, and I was neither entitled to seek information about the informants from the patients' medical records nor from the staff working at the outpatient clinic. This implied that I mainly mingled with the immigrant women during our breaks, not with the course leaders.

My role as a participant observer could imply that I influenced the participants; they might for instance have felt stressed by my presence. Therefore, it was important for me as a researcher

to take a position, which was not importunate (Fangen, 2010). Thus, I put emphasis on talking a bit with each participant when we went for walks and during breaks to ensure that everyone could get to know me as a person. By performing much of the same activities as the women in the course, I found that most of them gained confidence in me, and dared both to chat with me about “this and that” and to speak about themes that were more confidential. As a researcher, one is always at risk of doing potential harm, which implies that the informed consent is an ongoing process. On one occasion, I felt like I was invading the privacy of one of the immigrant women just because of my presence, taking notes around the table when they shared about their everyday life. During the actual instance, the woman spoke about her depression, which got worse when doing her “homework” which was to write down her wishes and desires (O, 9/11, p. 2). Furthermore, she said that what she needs she cannot get, and she started crying while looking at me and my pen. I therefore laid down the pen and put my hands on my lap; however, she did not continue to talk.

The health personnel might also have felt uneasiness regarding having me as a researcher “looking over their shoulder” while they were leading the course. They never express such, however.

The immigrant women could also gain indirect benefits, such as the advantage of being a research participant when feeling helpful and useful. Several of the women expressed thankfulness after the interviews because of the positive experience of being listened to. On the other hand, the informants might have experienced a power imbalance in our relationship, as it involved both ethnicity, class and education (Kelly, 2010). Being an immigrant woman can be perceived as a stigmatized position, in addition to having a chronic muscle disorder, which is also a stigmatizing condition, making them utterly vulnerable. Even if the treatment at the outpatient clinic had more or less ended, I reflected on the informants’ being concerned over whether their access to treatment could be at risk (Kelly, 2010) dependent on what they

told me. Presuming that they were somewhat reluctant to tell me “everything” might, in other words, be seen as a bias.

The anonymity of the women’s identities has been warranted throughout the process and in all publications. As the immigrant women in this study represent a rather small group, their nationalities were not mentioned, rather their continent of origin. This was done to protect their identities. The immigrant women were informed that the digital data would be erased after the data analysis.

In Norway, personnel from Health Services and Social Services closely follow up with women on paid sick leave, and we had an oral agreement about follow-up treatment with the health personnel at the outpatient clinic, if needed. However, this turned out not to be necessary.

4.7 Critical reflection on the research process

Lincoln and Guba (1985) introduced the four research process criteria of credibility, dependability, confirmability and transferability, and these will frame the following critical reflection on the research process.

4.7.1 Credibility

Credibility refers to the value and believability of the findings (Lincoln & Guba, 1985), and involves, according to Houghton and co-authors, conducting the research in a believable manner and being able to demonstrate credibility (Houghton, Casey, Shaw, & Murphy, 2013). Malterud (2011) underscores the importance of reflexivity as a fundamental condition in producing scientific knowledge. This implies making clear and communicating one’s pre-understandings, posing critical questions regarding what we find and the way we have conducted the research and finally to be transparent through documentation of the different stages of the research process (Malterud, 2011).

In this study, data were gathered from the two sources, participant observations and interviews, which “overlapped” each other and made it possible to obtain and compare the findings.

My presence as a researcher in the field might have influenced the validity of the data. The participants at the rehabilitation course were, however, new to one another, just as myself, so the reactive effects of a new member in the group was not an actual challenge. On the other hand, I was different from the other participants, in not being an immigrant woman, and not being on sick leave. Furthermore, I took notes much of the time and asked questions, which nobody else did.

Working with informants over a period of time made me familiar with them, which is recommended by Shenton (2004), as a prolonged engagement contributes to establishing a relationship of trust. Moreover, by doing mostly all of the same activities as the informants, I experienced becoming a natural part of the two groups. On the other hand, I was aware of the risk of becoming a total part of the group with the danger of influencing my professional judgements. The fact that the course was held only once a week, however, gave me a distance from what I observed and possibilities to reflect over my field notes and my role as a researcher between each course day (Fangen, 2010).

When transcribing the digitally recorded interviews, I tried to be as faithful as possible towards what the participants said, by writing the interviews verbatim. This turned out to be a challenge, though, because of the lack of fluency in Norwegian for some of the immigrant women. Therefore, one of my supervisors, who is fluent in both English and Norwegian, validated my translations to English. The participant observations were described as accurately as possible, including situations, ways of talking and conversations. To systemize the field notes and thus improve their reliability, as suggested by Silverman (2006), I took short notes during the rehabilitation course sessions. After each session I expanded them,

noted problems and ideas that arose during the stages of the fieldwork and made a running record for analysis and interpretation. On the other hand, an objective description is impossible, as my preconceptions and my previous knowledge influenced what I saw, heard and noted down as field notes.

My competency as a researcher could be questioned in the sense that this was the first time I performed participant observation. On the other hand, to arrange and run courses for different kinds of patient groups was well known to me as a method in my previous experience as a nurse. Moreover, I had experience with qualitative interviews doing my master's degree.

Member checking is another method to ensure credibility. During the interviews, I often asked the informants if I had understood them correctly, especially those who were not fluent in Norwegian, making it possible for them to correct me. Member checking gives the informant the chance to assess the researcher's interpretation (Polit & Beck, 2014).

Furthermore, *peer debriefing* was carried out when preparing the research with research fellows, health care professionals and supervisors, and refers to reviewing and exploring different aspects of the study with peers (Polit & Beck, 2014). As described under section 4.5.1. *The process of coding subthemes and themes*, I discussed all steps in the analysis with my supervisors. Moreover, a study group of PhD students lead by two professors further stimulated me by challenging my thinking.

4.7.2 Dependability

Dependability refers to how stable the data are over time and conditions, and the question is, according to Polit and Beck (2014), whether the study findings could be repeated if the study were to be replicated with similar participants in a similar context. The changing nature of the contexts and the informants in other interviews, however, renders such provisions problematic (Shenton, 2004). The process within the study should nevertheless be described in detail, making it likely for another investigator to repeat comparable research. To demonstrate

trustworthiness throughout the study, transparency has been important. I have aspired to be thorough and systematic throughout the entire research process, which has been demonstrated in my thesis. Here, it is possible to follow the process and choices made concerning the planning of the study, the description of the procedures and analyses as well as interpretation and presentation of the findings.

Reflexivity throughout the research process is of vital importance to avoid the data being influenced in a biased way, as “no research is free of the biases, assumptions, and personality of the researcher and we cannot separate self from those activities in which we are intimately involved” (Sword, 1999, p. 277). By reflecting upon my own influence and potential biases, I was in all probability closer to producing objective knowledge. Brinkmann and Kvale (2015) explain this as “being reflexive about one’s contributions as a researcher to the production of knowledge. Objectivity in qualitative inquiry here means striving for objectivity about subjectivity” (p. 278). This means that we can make informed judgements only on the basis of our pre-understanding, which enable us to understand something.

4.6.3. Transferability and confirmability

Transferability refers to whether or not the findings can be conveyed to another comparable context or situation, while still preserving the meanings and interpretations from the completed study (Lincoln & Guba, 1985). The dataset about the experiences of the immigrant women may say and explain something about other patients in similar situations, as such female immigrants in Norway. The findings, therefore, may have transfer value to similar groups of patients in terms of teaching about these issues and in the formulating or framing of policy. Moreover, transferability concerns detailed descriptions for readers to make informed decisions about the transferability of the findings to their specific context (Houghton et al., 2013). Descriptions of and quotes from the participants have been outlined, aiming to let the

readers check the background of the discussion and the conclusion. The reader might have other viewpoints, but it should be likely for him/her to comprehend our understanding and realize that there are numerous conceivable options for interpretations.

Confirmability concerns objectivity and neutrality or the potential for resemblance between two or more independent researchers about the data's truthfulness, applicability or meaning (Polit & Beck, 2014). The findings reflect the participants' voices, which is confirmed by careful documentation and discussions about coding of themes with supervisors.

5 Findings

5.1. Paper 1: A lonely life at home and at the workplace. A qualitative study of immigrant women on long-term sick leave in Norway

The first article presents the findings on the following research questions:

- How do immigrant women, on long-term sick leave due to musculoskeletal disorders, experience illness and relationships at work and in the family?
- How do these women narrate these important issues concerning their lives?

The aim of this article was to explore how the immigrant women on long-term sick leave in Norway experienced their daily life, their own illness, their work and their family life.

The two main findings presented in the first article were “Shut inside the home” and “Rejected at the workplace”. According to the women’s stories their daily life was experienced as lonely and humiliating, when being excluded or not feeling sufficiently needed, wanted or valued by colleagues, leaders or even by family members. The immigrant women lived a lonesome life and felt shut inside their homes due to pain, depression, language problems and/or family problems. The informants could not prioritize their need for rest and recuperation in their homes because of high demands in caring for their families. Many of them were alone with the economic responsibilities, dealt with violent or sick spouses and lacked a social network. Additionally, the women were excluded at the workplace, where they were met with a lack of understanding regarding their health situation and a lack of willingness to make workplace adjustments and include them in the work community. Despite humiliating and discriminative attitudes at the workplaces and their own bad health, some of the women forced themselves to go to work in fear of losing their jobs and subsequent poverty.

We concluded that the immigrant women on long-term sick leave live in triple jeopardy: being ill and being lonesome both at home and at the workplace. This can be labelled as a vicious cycle, where the humiliating domestic and workplace-rejection might reinforce both the women's experience of shame and avoidance of telling anybody about their illness and consequently lead to more days on sick leave, during which they are again secluded and lonesome.

5.2 Paper 2: Caught in suffering bodies. - A qualitative study of immigrant women on long-term sick leave in Norway

The second article presents the findings on the following research questions:

- How do immigrant women on long-term sick leave in Norway experience their pain in their everyday lives?
- How does the pain affect their daily lives?

The analysis revealed one main theme, "Bodies marked by onerous experiences", as well as two subthemes: "It is in my body" and "Invisible pain". According to their stories, the immigrant women fought with invisible, chronic pain, which they attributed to physically tiring workdays and stressful life situations. Furthermore, they felt that their experiences of discriminatory attitudes at the workplace led to loss of social status and again worsened their suffering. Their own psychological distress intensified their pain, leading to a vicious cycle. When not understanding the origin of the pain, being ashamed of being controlled by the pain, and unable to escape from depressive thoughts and their influence on the pain, suffering was evident. Many of the women had worries about their own and their husbands' health, their economic situation, and the parenting of their children. Some of them experienced intimate partner violence, and they felt caught in their suffering bodies.

We concluded that the chronic pain made the immigrant women suffer, because they experienced it as a threatening, incomprehensible, and unreal force, without meaning or the ability to be controlled. Their suffering bodies took control over their willpower and their psychological distress exacerbated their pain and made them feel caught in their suffering bodies.

5.3 Paper 3: “Dignity is what I mean to others...or what my value is”-

A qualitative study of immigrant women on long-term sick leave and their experience of dignity

The third article presents the findings on the following research questions:

- How do the immigrant women on long-term sick leave in Norway experience dignity?
- How do they maintain their own dignity?

The analysis revealed three main themes: “being seen, respected and believed”, “having and protecting value and integrity” and “living in faith and hope”. In our earlier papers, the focus is on the women’s experience of being lonely and humiliated and therefore bearing physical and mental burdens, which made them suffer. However, despite the experiences of suffering and humiliation, we found that the participants respectively also experienced dignity in their everyday lives. The immigrant women experienced to be met with respect, understanding, acknowledgement, competency and empathy by the health personnel at the outpatient clinic. Moreover, they experienced to be seen, heard and supported by fellow course participants, by family members and by doctors in their homeland. Their experience of being valued was articulated in holding on to their own dignity, even if their families, friends, colleagues, discriminative attitudes or their own health problems called for indignity. Additionally, their faith in reincarnation, in God or the Holy Scriptures, made them hopeful, feeling valued, strong, confident, peaceful and accepting of their life situations, which again protected and maintained their dignity during their phase of rehabilitation.

Based on the women's statements, we concluded that the immigrant women on long-term sick leave experienced maintaining their dignity through love and friendship, which strengthened their self-esteem and self-worth. Moreover, to reconnect with their "historical selves" when visiting their homelands, to restore their dignity by supporting their relatives, to appear strong in spite of sickness, to fight humiliation and to be honest and respect others were decisive factors for the women to maintain their dignity. To be respected, believed and understood by other patients and by health personnel, together with a reinforced integrity, preserved their dignity. Both the health personnel at the outpatient clinic and the doctors in their homelands spent enough time with each patient, which was a dignity enhancing experience. We also concluded that their faith in a God, spiritual comfort, faith in destiny and hope for the future gave an experience of meaning, peace and dignity.

5.4 Summary of findings

The immigrant women suffered from bad health, both physically and mentally during their period of rehabilitation. They experienced humiliation, which represents a pathogenic force that might lead to pain and suffering. On the other hand, we saw that dignity was experienced as a healing, health restoring force. The main findings are summarized in the following items:

- The struggles the women experienced as immigrants in Norway increased the demands on their already difficult lives. All of this led to them feeling humiliated (papers 1 and 2).
- Their suffering bodies made them feel caught bodily, in their domestic sphere and the pain controlled their lives, which made them feel constrained and invisible (papers 1 and 2).

- To have and to be met with dignity made the women realize their own potential, led to a more healthy body and gave them inner peace and strength in their suffering (paper 3).

6 Discussion

6.1 Methodological considerations

The inclusion of immigrant women from eight different nationalities might be considered both a limitation and a strength. The weakness might be understood as that the sample is not a homogeneous group, which indicates that not all immigrants share the same resources, cultural norms, expectations and potential stigma in an illness event in a host culture. One of the strengths of the sample is, however, that all the informants came from low or middle-income countries, and their origins were from collectivist cultures. On the other hand, the nationality of the largest group of informants in the sample represented one of the largest immigrant groups in Norway. Moreover, the in-depth interviews generated insights about individual experiences and perceptions from their everyday lives. The results may have been richer if we had continued to interview all the informants twice, but that was not an option because of time limits and lack of willingness from the informants. The contextual setting for participant observation was the outpatient clinic. More extended observations at the informants' workplaces, for instance, and/or interviews with their employers and with NAV could have given additional data about their everyday lives. It is also important to mention that we do not have any family data, so it is difficult to know exactly what goes on in the women's homes.

The perspective of health care professionals is missing in this project, even if I had some informal conversations with them, and is possibly a limitation, as the health care personnel at the outpatient clinic could have given supplementary perspectives. The purpose of the study was, however, to explore how the immigrant women experienced their daily life, their bodies, their dignity and their indignity during rehabilitation, as they are an understudied group.

The findings should also be subject to reflection, as they are limited to the study's participants and to their personal experiences from a certain rehabilitation context. The findings can be

acknowledged in other rehabilitation settings with immigrants, and the findings may offer valid knowledge there. To ensure transferability, a thorough description of the rehabilitation-context has been given in section *4.1 Setting of data collection*.

One weakness of the study might be in relation to the theoretical perspectives. The discussion about the degree to which the theoretical knowledge might have influenced my pre-understanding during the data collection or analysis has been given in section *4.5.1 The process of coding subthemes and themes*. Still, I am aware that during the process analysis of the empirical data; the chosen theoretical perspectives about suffering (paper 2), humiliation (paper 1) and dignity (paper 3) became the theoretical lens and the theoretical groundwork of the study. This has enriched and influenced the interpretive process in certain ways. On the other hand, the findings from this study could have been developed in other directions by using other theoretical frameworks, which could have resulted in alternative approaches toward the explored theme. However, the discovery of Honneth's theory about recognition (Honneth, 1995) during the ultimate analysis and synthesis gave my understanding a new dimension in this thesis.

6.2 General discussion – an introduction

The general discussion is introduced with a principal discussion of my papers, in light of earlier research on immigrants, chronic pain and sick leave (6.3). Regarding the structure of the further discussion, the findings are seen in light of Honneth's theory about recognition (Honneth, 1995), because he is scientifically engaged with both disrespect and dignity (6.4). Additionally, theories from researchers that focus on dignity has been useful during this general discussion. The discussion places emphasis on how the immigrant women experienced being granted dignity and recognition by others, or the contrary, suffering humiliation and disrespect, and how this affected their lives during rehabilitation. In section

6.5, I discuss how the immigrant women protected their dignity. Section 6.6 discuss the women's self-respect and moral responsibilities in the community when being on sick leave. Different perspectives on the immigrant women's contribution to the fellowship will end the discussion (6.7).

6.3 On long-term sick leave because of chronic pain

The main reason for my participants being on long-term sick leave was their chronic pain. In the following, I will therefore discuss their pain situation in light of their origins from collectivistic societies and in light of being on sick leave. It is, however, important to note that there is a danger of using collectivism if it becomes a simplification of the understanding in people from individualistic and collectivistic cultures, and it is essential to retain that belonging to a culture is not a social convention and that people might stick to some norms while selectively declining others (Cherny, 2012). A quantitative study about culture and gender effects in pain beliefs among a study sample from the United States and India showed that the participants from India did not have the belief that the overt expression of pain was less appropriate than did the participants from the United States. The American participants, however, expressed a greater willingness to express pain due to the belief that pain is perceived as bad, that it need not be endured and that it should be quickly eliminated (Nayak, Shiflett, Eshun, & Levine, 2000). Research shows that it is challenging for Norwegian nurses to understand the minority patients' pain expressions (Alpers & Hanssen, 2013), and when the participants in my study had problems with describing how the pain affected their lives, they experienced failure to be understood. In this regard, research shows that it is more difficult to establish trusting relationships between patient and healthcare workers when the cultural backgrounds are different (Epner & Baile, 2012). Moreover, many of my participants, together with many other immigrants, have problems giving voice to their pain, which underscores the importance of using interpreters and to extend the average consultation length

with the doctor (Ruppen, Bandschapp, & Urwyler, 2010). My participants did not feel they have control over their pain, and thereby they experienced suffering (paper 2). In this regard, a Swedish qualitative study with five physicians in primary health care and five foreign-born patients showed that the patients missed a more holistic approach to their health, including previous health experiences or other important events in the patient's life. To provide a more comprehensive picture of their medical background would have led them to have more trust in their physicians (Akhavan & Karlsen, 2013). This is relevant for the immigrant women in my study, who also wished that the doctors took time to get to know them more thoroughly to be able to understand their pain situation. This could have led to the participants increasing their understanding of their discomfort and an increased tolerance for it and thereby an augmented feeling of control over their pain.

Just like my participants, certain people from collectivistic societies tend to believe in destiny. The immigrant women did not, however, seem to specifically accept their pain as their fate; instead, they talked about their whole life situation as their fate. This is different from what Dressler and Pils (2009) found, where staff members at a rehabilitation centre experienced their minority patients to be hindered by their fatalism, as they were not willing to work on reducing or defeating their ill health. The immigrant women in my study did, however, to some degree decline to do physical activities because of muscle soreness. This is in accordance with Dressler and Pils, who also found that the minority patients had the opinion that the pain had to decrease before they could carry out activities (Dressler & Pils, 2009).

The women in this study had multiple jobholding, and they were exposed to psychosocial stress. Compared to men, their role expectations are more all-embracing, especially because of more family care and other responsibilities at home. Such gender differences are utterly complicated in the elucidation of immigration (Llacer, Zunzunegui, del Amo, Mazarrasa, & Bolumar, 2007). According to Llacer et al. (2007), immigrant women experience greater

challenges than men due to the migration process, labour market integration, discrimination and social isolation. This might explain why women from low-/middle- income countries have the poorest self-reported health (Llacer et al., 2007), which again can explain why many are on long-term sick leave. Moreover, the high sickness absence rates among individuals from Asia (men and women) and Africa (men), is explained by health risks related to immigration, social exclusion and norms towards sickness absence (Dahl, Hansen & Olsen, 2010). This is especially due to immigration from refugee-sending countries, and regions where there has been war, famine, natural disasters, political persecution, etc. “They are likely to have been exposed to social stress both before and after immigration, which can lead to higher sickness absence” (Dahl, Hansen & Olsen, 2010, p. 48). Dahl et al. (2010) also determine that socio-structural factors might be more important than culture in explaining sickness absence, such as post –immigration stressors and a low level of control over one’s work. These are also the most relevant factors for the participants in my study, as only three of the 14 participants were asylum-seekers. This is similar to and can be seen in accordance with a Norwegian study among elderly Pakistani women with chronic muscular/skeletal pain (Sverre, 2016). Sverre (2016) found that painful life experiences in the form of substantial identity challenges and extensive bodily and mental pain could be understood as reactions to the many challenges within the life of a migrant, including alienating meetings with the Norwegian welfare society in general, and health care in particular.

To sum up and viewed in a general sense, the immigrant women in this study experienced having been met with dignity during rehabilitation, despite their experiences with pain, suffering and different kinds of humiliation. According to Siegert and Ward (2010), human rights are relevant in rehabilitation, including setting minimal standards for acceptable living conditions, justifying services to enhance empowerment and ensuring the conditions necessary for people to get on and live a good life with dignity. Additionally, the authors

point to human capabilities as an approach to rehabilitation or the opportunity or freedom to lead the kind of life where one has reason to experience value (Siegert & Ward, 2010). As I see it, vocational rehabilitation for immigrant women with chronic pain should be distinguished by cultural competency, as put forward by some British researchers (Narayanasamy, 2002; Papadopoulos, Shea, Taylor, Pezzella, & Foley, 2016; Papadopoulos, Tilki, & Ayling, 2008). The rehabilitation should also be person-centred and involve the patient in the decisions that are made and building trust, for example by using an interview guide identifying the rehabilitation needs of immigrant women with chronic pain, as developed by some Swedish researchers (Zander, Eriksson, Christensson, & Mullersdorf, 2015).

6.4 General discussion – in light of the theory of recognition

Dignity can be seen as embedded in our connectedness and recognition (or acknowledgement) of the other and our common experience of vulnerability and suffering (Aranda & Jones, 2010). The German philosopher Axel Honneth (1995) developed the Hegelian model in the struggle for recognition, which plays a key role in his approach to human dignity. Honneth wanted to show that dignity finds its support and even its natural environment in the relationships of recognition. He underpinned his theory using Meads social psychological theory; Winnicotts object relations theory and recent sociological and psychological research. Recognition, humiliation and reciprocity are key concepts in recognition theory. Reciprocity in terms of giving and receiving recognition is common to the three forms of recognition. To understand what recognition is and how to achieve recognition, Honneth believes that we need to understand what it means to be humiliated. This is applicable to my study, where the informants spoke about different kinds of humiliation in their daily life but at the same time expressed experiencing dignity enhancement. Furthermore, Honneth distinguishes between three forms of recognition and three forms of humiliation. What constitutes the theory's three

recognized forms are recognition through love, recognition through legally institutionalized relations and networks of solidarity. The key is that these forms are interrelated, affecting each other and are each a prerequisite for another. For every new form of mutual recognition, the individual's capacity to self-realization is strengthened (Honneth, 1995). The three forms of humiliation are bodily humiliation (harmed bodily integrity such as sexual assault), legal humiliation (when a person is being waived his/her legal status and rights within a society) and finally humiliation of a person's form of life and contribution to the community (bullying, shame, racism or stigma), which all were experienced by my informants. Human dignity is for Honneth a basic social ethical value, precisely because of the dynamics between humiliation and the struggle for recognition. When we are recognized, we live a dignified life. When our dignity is violated, or when the recognition is absent and we are neglected, we live unworthy lives. Concurrently, Honneth's understanding of dignity is connected to his multidimensional concept of recognition in the sense that you live a dignified life only when you have received confirmation through all three forms of recognition, which are love, respect and contribution (Honneth, 1995).

6.5 The immigrant women protecting their dignity

The immigrant women on long-term sick leave in this study were protecting their dignity by emphasizing how they valued themselves and how they were valued by others, to preserve their rank, position or integrity and be strong despite illness and challenges at home and at the workplaces. According to Honneth (1995), humiliation creates motivation for a struggle for acknowledgement. Although the participants in my study experienced love and affection in their families, they also experienced being rejected, slandered and maltreated by family members in different ways. One could say that this duality characterizes the lives of all the participants in different ways or that there are many factors that act in concert with one another, and we do not know which. Honneth (1995) holds that the experience of disrespect is

rooted in subjects' affective experiences in such a way that it can motivate social resistance and conflict - a struggle for recognition. For the participants, this implied finding meaning in their illness, by supporting relatives economically, being strong despite of sickness, and respecting and encouraging others. Love is the first level of mutual recognition, because the subjects here gave mutual confirmation, thus recognizing each other as beings in need of love (Honneth, 1995). The immigrant women experienced reciprocal love between themselves and some members of their close family. However, concurrently, many of them experienced either physical or psychological abuse at home. This led to a sense of shame, mainly connected to the uneasy family situation. As mentioned in paper 1, Donald Klein asserts that shame often leads to self-blame (Klein, 1991). My informants did, however, not seem to condemn themselves. Moreover, they neither demonstrated nor spoke about anxiety, even though many of them talked about depressive symptoms. According to a review study about cultural aspects in social anxiety and social anxiety disorder, it appears that originating from a collectivistic society could imply higher social significance of embarrassment (Hofmann, Asnaani, & Hinton, 2010). Hofmann et al. also revealed that shame has a more important effect on social anxiety in Southeast Asian cultures compared to its effect in Americans, because embarrassment is more common in collectivistic cultures since it is induced by external sanctions. On the other hand, guilt and self-blame are more customary in individualistic cultures as they are induced by internal sanctions. Additionally, shame-prone behaviour seems to be given positive purposeful value in some Asian societies, whereas the Western culture is likely to exclude shame-prone behaviour and instead emphasize a demonstration of one's authority and capability (Hofmann et al., 2010). For the participants in my study, this could imply that one would feel that they were burdened by their shame because of troubled family situations, the experience of poverty, rejection from colleagues and not speaking Norwegian as fluently as they wished. They did not, however, seem to

blame themselves, but instead they demonstrated resilience in the sense of strong integrity. They experienced inner strength despite of sickness, they demonstrated strength when facing problems and they had their faith in God as a strong force to keep them going. This can again be understood, as they were proud and resilient women, maintaining and protecting their dignity. Being resilient can be seen as part of the absolute or universal dignity, described by Edlund et al. (2002). Absolute dignity relates to being inviolable and experiencing value, freedom, responsibility, duty and service. There are several definitions of resilience. Resilience in this study is “a stable trajectory of healthy functioning after a highly adverse event; a conscious effort to move forward in an insightful and integrated positive manner as a result of lessons learned from an adverse experience”, and moreover, “the capacity of dynamic systems to adapt successfully to disturbances that threaten the viability, function, and development of that system; and a process to harness resources in order to sustain well-being” (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014, p. 11). On one hand, the participants in this study periodically had unstable trajectories of healthy functioning. On the other hand, they partly had a healthy form of functioning, an effort to move forward, the capacity to adapt and the ability to learn from and to endure harsh conditions.

6.5.1 Personal relations and sociocultural adaptation

When the immigrant woman experienced that close family, friends and even colleagues at their workplaces turned away or rejected them, they felt humiliated. As being part of a sparsely populated social network, which for some of them lacked recognition, they felt alone, lost and abandoned. Some of the women even experienced physical abuse, which according to Honneth (1995) is a form of disrespect embodied in experiences that threaten the person's basic confidence. Furthermore, Honneth maintains that a liaison is understood as all primary relationships consisting of strong emotional bonds between a few people along the lines of love relationships, friendships and relationships between children and parents. Many of the

immigrant women missed these forms of relationships, especially the affectionate relations between themselves and a loving husband or close friendships with other women.

Simultaneously they were burdened with physical pain. This contributed to depraving or disturbing their understanding of themselves. The individual's identity and understanding of oneself are strengthened and confirmed through recognition (Honneth, 1995). When the recognition, however, is held back, the development of a secure identity may be impaired, and according to Charles Taylor: "Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being" (Taylor, 1995, p. 225). For the immigrant women their suffering was also experienced as imprisoning, and as something objectifying, as they expressed a detachment from their bodies and that their bodies became unfamiliar. Honneth (2005) calls such an objectifying or reification for a "forgetfulness of recognition". By this, he means that the relation between people takes on the character of a thing, or that one treats others and oneself as things (Honneth, 2005). Therefore, when the participants in my study objectified their painful bodies, it might have been a way to endure the lack of recognition in their domestic sphere and at their workplaces.

Honneth (1995) sustains that to be valuable to each other happens when one experience being recognized and accepted for the unique person one is, regardless of behaviour. Moreover, recognition is a constitutive element in love because a confirmation of independence is accompanied and supported by affection. Furthermore, Honneth (1995) maintains that basic self-confidence has to do with the underlying capacity to express needs and desires without fear of being abandoned as a result. On the other hand, when lacking recognition or affection in their close relations, the immigrant women had to protect their dignity. This protection was experienced when some of the women were not recognized by family members or they were abused, then some searched for recognition where they could get it, for example by helping

others. Others, however, experienced being appreciated and loved by their close relatives, especially by their children. Furthermore, not wanting to show their children their weakness could have been a way to protect this important dignifying liaison. This is concurrent with the findings from a study with Indian women who experienced intimate partner violence (Shanthakumari, Chandra, Riazantseva, & Stewart, 2014). They reported remaining strong for the sake of their children, who were an inspiration to them to be resilient. Even though some of the women in my study talked about their teenage kids as dissociating themselves from their mothers because of the mothers' complex life situations, most of the children seemed to be inspired by their mothers. Living in a new culture, these close and respectful relationships between mothers and youngsters were, according to the women's stories, a resource for the children and have encouraged them to be strong, too.

In relation to being esteemed, this can be seen in conjunction with what professor of public mental health Tom Fryers writes about work, identity and health (Fryers, 2006). He maintains that in Western society, work provides social legitimacy for our lives; it may be a principle source of personal identity, as being a valued individual, which is essential for self-esteem. On the other hand, he asserts that work is not the only source of identity, as for my participants, they related their identity even more to being mothers, daughters, sisters, aunts, friends and neighbours. Some of them were both wives and grandmothers. Their main identities were built on personal relationships (Fryers, 2006). The question is, however, whether the immigrant women were able to build or base their identities on the mentioned relationships, or if after residing in Norway for some years they saw themselves as obliged to be part of the working force. This might again be due to their acculturation, which, according to Bøhn and Dypedahl (2009) involve changes that occur when people from different cultures are exposed to each other. This adaptation is termed in two ways: a) socio cultural adaptation, where the ability we have to learn new communication patterns of social interaction makes us

able to cope well with daily life in the new culture, and b) psychological adaptation, which refers to the extent to which we are happy with life in the host culture (Bøhn & Dypedahl, 2009). I cannot conclude that the immigrant women were fully adapted to a new and different culture in the Norwegian society. They seemed however able to deal with their daily lives, even if they struggled with different health complaints.

All the participants had been a part of the working life for several years in full-time or part-time positions, so in this way they had adapted to Norwegian workplaces. Several of them expressed, however, that they disliked or did not have the intention to work full-time. This was due to health complaints but also to a wish to have more time with their family. Fryers (2006) asserts that without a clear sense of identity, it is problematic to have the self-esteem we need to function well as autonomous individuals in an inter-dependent society. Devoid of a clear sense of identity, we become vulnerable to emotional harm and at risk of psychological distress and social detachment (Fryers, 2006). Accordingly, some of the immigrant women expressed that they had to work to feel accepted by the society, and those who had greater difficulties in their domestic sphere seemed to need the work-identity even more than those who had a kind husband or other close relatives. This is perhaps not so surprising, since they lacked the affectionate recognition of their families, which is a basic need according to Honneth (2008). To be working and earning money helped them, however, to feel proud, autonomous and independent, which contributed to the enhancement of their dignity. On the other hand, moving from a collectivistic society to an individualistic, work-focused society - and for many of them not a voluntary migration but rather decided by their husbands, due to flight, or as asylum seekers - the encounter with working life was new and unfamiliar. This is partly in accordance with Grzywacz et al. (2007), who found that immigrant Latino women (who were employment immigrants) in North Carolina, working in poultry processing, were fatigued to the point that it was difficult for them to engage in

regular family activities. Moreover, they reported more frequent work-to-family conflict than men, and that beliefs about women's responsibilities for maintaining home and family care elevated the potential for conflicts (Grzywacz et al., 2007). Additionally, Sandhu (1997) asserts that women from collectivistic societies in Asia are challenged to re-examine their traditional gender roles in the context of a Western culture from passive and docile roles as wives at home to more active, independent and working women; whereas Asian men consider their new household responsibilities degrading and an affront to their masculine identity and their roles (Sandhu, 1997). In my study, several of the women described conflicts with their partners, which might partly be understood as their hardship in adapting to an individualistic society.

6.5.2 Encounters with their gender and suffering

At the outpatient clinic, the immigrant women experienced being met with recognition and acceptance for the unique persons they are, regardless of behaviour. This is in accordance with what Gastmans asserts is dignity-enhancing care. He holds that in providing care in response to vulnerability, by respecting the patients' psychological, relational, social, moral and spiritual dimensions, dignity is protected (Gastmans, 2013). Nevertheless, the immigrant women also told about humiliating incidents in contact with the health care system, such as a lack of time, compassion and understanding, which made them vulnerable. This has similarities to a Danish qualitative study with non-Western immigrant women living with chronic pain (Michaelis et al., 2015). These women felt that their doctors considered their pain to be a psychological problem, which they interpreted as scepticism and as unsupportive, because they saw it as a physical problem themselves. This is in line with what Malterud calls "unexplained" medical signs/disorders, when the physicians do not understand (Malterud, 2000). When immigrant women experience not being trusted, they might experience it as

humiliation. As an alternative, Malterud (2000) puts forward that the physician should acknowledge that the woman is suffering, even if it is difficult to understand, helping her to accept the situation and to maintain hope and dignity. Malterud also problematize the gender, as women with unexplained disorders often have men as their physicians, who in her view perhaps are not able to understand their female clients' lives. Women are designated to do reproductive work and- family care and experience abuse and violence more often than men do (Malterud, 2000). For the women in my study, who all had children and several of them had abusive or sick husbands, this aspect of gender could be an actual aspect to consider. Many of the women did, however, explain that they chose to have female doctors, as they found it easier to communicate and to be intimate with them, which has also been found by other Norwegian researchers (Småland Goth & Berg, 2011). Nevertheless, Malterud points to the risk for the health care system to reinforce and reproduce oppression: "Patients from underprivileged positions, such as race, class, gender or type of disorder, run a special risk of humiliation and shame when their symptoms do not fit neatly into the medical framework" (Malterud, 2000, p. 609). As I see it, this gives health care personnel a great responsibility to be aware of the extra burdens immigrant women with "unexplained" chronic pain might endure. Two Swedish studies with immigrant patients highlight the importance of general practitioners (GPs) conducting structural conversations and thorough interviews and enabling the possibility of frequent visits to the GP (Löfvander & Engstrom, 2007; Löfvander, Engstrom, & Iglesias, 2006). This is in order to alleviate suffering and to prevent very different views on pain between the immigrant patient and the multidisciplinary team. Moreover, the women in my study experienced pain as meaningless suffering that according to Pullman (2002) represents a threat to bodily integrity, and thereby their dignity, which underscores the importance of making the pain understandable and manageable for the women.

In contact with health care personnel or when suffering, patients can, just as the immigrant women in my study did, experience hope-hindering features, such as uncontrollable pain, isolation, and devaluation of the individual. At the outpatient clinic, they were, however, met with gentleness that, according to Coulehan (2012), might have fostered deep hope, as the health care personnel were present and listened and by that demonstrated respect. This maintenance of hope and thereby dignity can, according to Coulehan (2012), be said to be an antidote to suffering.

6.5.3 The importance of religion to experiencing dignity

The participants also described being loved by God, and they felt that their religious faith gave them meaning and self-confidence. Fryers holds that identity and self-esteem originate from a sense of personal value or worth, of being needed and loved for what you are. Furthermore, people of faith will claim that God is loving, which entails the ultimate value of a human being (Fryers, 2006). Additionally, Iranian nursing-researchers Cheraghi, Manookian and Alireza found in their studies with Muslim and Christian hospitalized patients in Tehran that respecting their dignity required adapting for religious rituals (Cheraghi, Manookian, & Nasrabadi, 2014; Manookian, Cheraghi, & Nasrabadi, 2014). This was demonstrated as “religious support according to patients’ desires and value system. It seems that being knowledgeable about patients’ religious orientation or cultural values would lead to providing dignified care” (Manookian et al., 2014, p. 329). Furthermore, the authors found that “providing dignified care for culturally different patients requires recognizing their unique needs, which may be influenced by specific religious values, beliefs, costumes, and practices” (Cheraghi et al., 2014, p. 9). For my informants, this could imply health personnel’s and employers’ respect for, and tailoring of, the immigrant women’s practice of their religious faith. The findings revealed that some of the women prayed during their breaks both at work

and at the outpatient clinic, which according to the literature might have enhanced their coping (Baeke, Wils, & Broeckaert, 2012) and the preservation of their human dignity (Nåden & Eriksson, 2004). Additionally, the strength they found in prayer and their religious beliefs can be considered to have maintained their relational dignity.

Moreover, my participants also felt they were able to secure their sense of value and worth by experiencing a divine presence. This is in line with the study by Karin Sporre, who wrote in her thesis about African American, Asian and European women who experienced oppression, but experienced their value and dignity to be strengthened because of the presence of God (Sporre, 1999). She examined three feminist theologians work and discussed their texts about women's lives globally and concepts of oppression, moral agency, ethical knowledge and vision. She found that women who are subordinated men are accordingly treated as unequal and discriminated against. Moreover, she identified several strategies for women under oppression, such as the divine presence each person can experience as foundational for her own sense of value and worth and a spiritual force that will assist persons in resisting oppression.

My participants' experience of the presence of God was expressed as being able to be consoled and having trust in their prayers to their God, believing in reincarnation and accepting their destiny as the will of God. This might be seen as a kind of resilience, which also was described in a study on Indian women who experienced intimate partner violence, but who found that their faith in God gave them hope to find solutions (Shanthakumari et al., 2014). For the women in my study, accepting their destiny may, however, be seen as a paradox, as they also experienced being humiliated both in their domestic sphere and at their workplaces. One could think that this kind of acceptance would be a contradiction for their experience of dignity. A health survey of 11- to 16-year-old students and their caregivers in

the northern part of Afghanistan might, however, provide us with some clarification (Eggerman & Panter-Brick, 2010). The study revealed that despite exposure to war and poverty, the informants demonstrated resilience and explained that they did not have any options but to accept God's will "and hope that everyday perseverance will be rewarded with His mercy and protection" (p. 81), which again was a key to social functioning and individual dignity (Eggerman & Panter-Brick, 2010). These findings are in accordance with other studies, which concluded that acceptance with hope is an important part of being resilient and is associated with better psychological and physical health, fewer depressive symptoms and reduced levels of post-traumatic stress symptoms (Southwick, Vythilingam, & Charney, 2005). Moreover, it seems that acceptance is not similar to passivity but is rather a stoic and hopeful attitude regarding that some circumstances are beyond control, which can lead to a process of searching for new pathways to well-being (Theron, Theron, & Malindi, 2012). Moreover, Kristiansen and Sheikh assert that for Muslims, it is possible to find relief in knowing that Allah is aware of any suffering they experience and that trials are signs of love (Kristiansen & Sheikh, 2012).

6.6 The women's self-respect and moral responsibility in the community when being on sick leave

Some of the participants experienced both physical abuse in the family and degradation at work. In this regard, the second form of disrespect is, according to Honneth (1995), the experience of degradation that damages the person's moral self-respect. Experiences of social degradation and humiliation threaten human identity to the same extent that diseases pose a danger to one's physical life. Prevention of disease has its parallel in socially guaranteed recognition to the greatest extent possible to protect the subjects against disgracing experiences (Honneth, 1995). For the immigrant women to be socially excluded, their

personal autonomy was limited and restricted by the use of power, both from employers and from their spouses. The consequences of this seemed to be the feeling of losing self-respect and not having status as an adequate and equal interaction partner. In this regard, Mann (1998) describes emotional responses to different kinds of humiliation as “shame, anger/rage, powerlessness, frustration, disgust, a feeling of being ‘unclean’, and hopelessness” (Mann, 1998, p. 34). Moreover, he connects these feelings to poor health and asserts that injuries to dignity denote a pathogenic force with a damaging capacity towards physical, mental and social well-being. Additionally, Malterud (2010) explains that offensive life events can generate lasting traces that the body transforms to pain. Meanwhile, negative thoughts and feelings related to the interpretation of symptoms might help to create unfavourable cycles that maintain symptom experiences (Malterud, 2010). From this, one could determine that the immigrant women’s experiences of physical abuse and degradation might have been important contributors to reduced self-respect, psychological distress and painful bodies. Concurrently, it is important to note the fact that ethnic Norwegian women also experience being on long-term sick leave, due to problematic life events and caring responsibilities along with lack of support from relatives and the joint effect of paid and domestic work exposure (double burdens) (Batt-Rawden & Tellnes, 2012). Moreover, Norwegian women also can experience the sick role as influencing identity and make them vulnerable to being stigmatized. Additionally, another study on ethnic Norwegians revealed that for the female group, the presence of children who are sick or have other problems and the effect of having a troubled relationship with their partner, in addition to life strains experienced during childhood and adolescence contribute to greater vulnerability to ill health (Solheim, 2011). Immigrant women experience the same stressors as these ethnic Norwegian women, and, in addition, they live under the strains experienced before, during and after the migration. From this, we can conclude that the feelings of being degraded both at home and at work, where

their autonomy was restricted and limited, reducing the participants' self-respect - in addition to migrations strains - made them vulnerable to ill health.

According to Honneth (1995), the individual can develop a complete identity and keep an already acquired identity only to the extent that they accept the attitudes of social and collaborative activities that exist in the organized social group to which he/she belongs. For the immigrant woman, however, her identity is challenged when the attitudes towards for example job attendance, is very different from the society she resided in before the migration. Honneth (1995) refers to Mead, who holds that in belonging to a community, our self-respect is dependent on our recognition of ourselves as self-respecting citizens. Therefore, not being properly rooted in any culture, it might be difficult to be self-conscious when one is divided or split between the "old" culture from the homeland and the "new" culture in Norway.

Furthermore, Fryers points out that sickness certification gives people permission to not be working without losing dignity or losing identity (Fryers, 2006). For some of the women, the sickness certification seemed to be experienced as a relief and understood as a given legal right, but for others it was connected to shame. One way to understand this is that being on long-term sick leave was experienced as humiliating. To experience it as shameful or embarrassing can be seen in relation to the views in parts of the population which indicate that one "only" receives support and thus is seen as one that exploits the social security system. For some of the participants in my study, to be on long-term sick leave was not, however, an uneasy issue. For the women being obliged to stay at home for a longer period, who linked sick leave to shame, they were concerned with the consequences, such as poverty, being victims of slander and experiencing themselves as different from their neighbours and others in the society. This can be seen in relation to a qualitative study with 20 Korean immigrant women in New York, suffering with depression which was expressed somatically, bodily and metaphorically (Bernstein, Lee, Park, & Jyoung, 2008). The study revealed that the women

perceived themselves as ineffective in achieving their moral and family everyday jobs, which made them feel ashamed and socially useless. Moreover, the researchers found that the inability to maintain their expected roles brought shame to the family “to lose face” (Bernstein et al., 2008). Alternatively, several of the participants in my study demonstrated a strength or a stubbornness where they forced themselves to go to work even if they were burdened with pain. Some of them explained that this was because they both feared losing their jobs and feared the shame of poverty. They did, however, also demonstrate resilience, as they were working as much as they could, taking on the economic responsibilities in their families and sending money to relatives in their homelands. This is in accordance with Shanthakumari et al. (2014), who found that for the women in their study, work gave them a sense of control, self-reliance, dignity and respect in society. In other words, work enhanced their resilience. For many of the women in my study, their experience of incomprehensible chronic pain intruded upon their sense of control, which made it complicated or almost impossible to remain a healthy and coping employee. In this regard, Malterud asserts that it is possible to recognize patients’ experiences and knowledge of chronic pain and thereby change the focus from shame to coping, possibilities, hope and dignity (Malterud, 2010). She states that if women who are burdened with chronic pain learn to understand the complex interactions of the physical phenomena, this insight can lead the women daring to be physically active, because they will realize that subsequent muscle soreness does not necessarily mean danger.

6.6.1 Experience of self-respect and resilience despite language barriers

In my study, the women struggled to put into words their pain, loneliness and misery due to language problems, and they experience the difficulty of not being understood. In this regard, Coulehan holds that in the stage of “expressive suffering”, the sufferer seeks to understand the experience by finding a language in which to express it; such reflection might be therapeutic

but at the same time hindered because of pain, isolation, distress and social or cultural barriers (Coulehan, 2012). On the other hand, the women in my study also revealed another reality in their lives. Despite language problems and discrimination, several of them had the courage to fight for their rights at their workplaces. They described health care personnel who were culturally competent, and, in general, they had positive encounters with the public health care system and they felt their suffering to be alleviated. Moreover, the immigrant women demonstrated dignity and resilience when they used their resources and helped people in their neighbourhood, respecting and encouraging others. Additionally, their experiences of fellowship among the women at the rehabilitation course was conducive to the maintenance of relative dignity. As stated by Edlund et al. (2013), fellowship strengthens person's desires for responsibility, value as a human being and independence.

The participants in the present study had concealed and very different kinds of life stories compared to the majority population, such as being obliged to help their parents by earning money as young as 10 years old or enduring the tough experiences when leaving all their loved ones, their acquaintances and their culture in their homeland in fleeing to another country, knowing that they may never get back. These life experiences are quite unlike the lives of ethnic Norwegians. Moreover, one can wonder if it is possible to be recognized or feel integrated or a part of the community when important parts of one's life have been obscured. To be considered a morally sane actor presupposes, according to Honneth (1995), a form of mutual recognition that confirms the individual not only as a member of the community but also as an entity with an individual life story. This means that the absence of solidarity recognition entails exclusion, scorn, devaluation, stigmatization and humiliation. Moreover, it might be impossible to be recognized as a "morally sane actor" when the immigrant women are not able to express their individual life history in Norwegian. In this way, we can wonder, as posed by Spivak, if the subaltern can speak. In line with Spivak, the

informants in my study can be defined as “subaltern”, or ranked below, inferior in status or quality, as they were unable to put their situation into words, as the natives might do (Spivak, 1995). Spivak is concerned with whether “the other” can speak on a global scale, if their voices can be heard, where decisions are taken which also impact their lives. In the context of the immigrant women, it seems that they could be at risk of being left in the shadows - at their workplaces, in their homes and even in health policy issues - because their voices were not sufficiently heard. When it comes to health policies in Europe, research shows that established national policies to improve migrant health are deficient (Mladovsky, Rechel, Ingleby, & McKee, 2012). Moreover, migrants in Europe are disadvantaged in regard to access to health services, as the information given about the health system, the promotion of health literacy, the development of cultural competence among health workers and the assessments of interventions are lacking (Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013). To sum up, the participants struggled to express themselves in Norwegian, to be fully understood and to reveal their individual, concealed life stories. At the same time, some of them managed to use their resources to be satisfactorily heard. Moreover, despite the lack of a general national health policies until 2013 (Helsedirektoratet, 2013) and a lack of cultural competency in health service, the immigrant women were met with skilled health care personnel and possibilities for dignity-enhancing fellowship, which strengthened their self-respect.

6.6.2 Experience of self-respect despite invisibility and silence

The participants in my study experienced humiliation in regard to their abilities and skills, such as lacking access to parts of working life because of diseases and lack of Norwegian skills. Then the women became “invisible”, which, according to Honneth (2001), happens if the individual is not being recognized in the community or in fellowship. Being invisible resulting from a lack of working life can be compared to a lack of attentive listening, which is

needed for a meaningful conversation, conjuring the face of the person to whom we are listening, or, said in another way, “first when we have faces” (Sporre, 1999). Further, Sporre points out that Asian women who are oppressed are hindered from expressing their full humanity. This causes them enormous suffering, and their dignity has to be fought for. If, however, they did not fight, but resigned themselves to suffering and pain, it is considered a sin. “What restricts actions by subjects under oppression,..., are lack of access to public arenas (such as work), violence against them, social norms supporting violence, the eventual acceptance of their own passivity whereby agents silence themselves” (Sporre, 1999, p. 525). Moreover, certain women were silenced when their experience was not recognized. This is in line with the wishes of some participants in my study who did not want to talk about their illness at their workplaces due to a fear of slander, the feeling of compromising oneself and because they did not think, they would be understood anyway. The freedom to act or to speak is, however, severely reduced and circumscribed under oppression, while at the same time being devalued and deprived of rights. Sporre concludes that when lacking power, we can strive to preserve our dignity and challenge power and in this way keep our integrity (Sporre, 1999). This was also the case for the immigrant women, as they demonstrated a strong integrity while simultaneously striving to maintain personal worth. At the same time, they communicated that they had what Edlund et al. (2013) calls an absolute dignity, without struggling, as they could rest in the fact that they had human worth and freedom in terms of how they related to their situation in addition to responsibility for others (Edlund, Lindwall, von Post, & Lindstrom, 2013).

The women in my study experienced what we can call indirect bullying as employees. Their fear of slander could be associated with workplace bullying, as some of the bullying tactics can include defaming another’s reputation, blaming, criticizing, humiliating (Namie & Namie, 2009) and insulting personal dignity (Hallberg & Strandmark, 2006). The idea of a correlation

between health and bullying is supported by findings from a Canadian study with 18 women on sick leave who were targets of workplace bullying. The study showed that there was a clear correlation between the bullying and the women's physical and mental health complaints (O'Donnell, MacIntosh, & Wuest, 2010). For the women in my study, we can determine that they were partly victims of workplace bullying, and anticipate that some of their humiliating experiences were the reason behind some of their health complaints. We saw that they experienced humiliations such as rejections at their workplaces in not being included in social gatherings and in not being understood due to their non-visible illness or cultural and linguistic differences as well as a lack of making workplace adaptations. Some of the participants did, on the other hand, demonstrate a kind of proudness, or they expressed that they respected themselves because of the love and affection of others, and because they were able to stand out as strong, accountable and honest women. In this regard, Nordenfelt lifts up a sense of self-respect and moral identity and links it to the dignity of moral stature. He describes it as a dignified character and dignified conduct as well as having a moral standard (Nordenfelt, 2004), which is close to what the immigrant women expressed as being proud. Self-respect creates an awareness in man that one can respect oneself because one deserves to be respected by everyone else (Honneth, 1995), just as my informants were gratified and respected themselves because of love from certain family members and friends.

6.7 The women's contribution to the fellowship

Some of the immigrant women experienced in different ways not being recognized for their contributions in the domestic sphere or at their workplaces, and for some in both settings. In this regard, Bonanno et al. asserts that most people are exposed to one or several events that threaten or cause serious personal harm or injury (Bonanno, Westphal, & Mancini, 2011). Moreover, they hold that many of these individuals continue to demonstrate stable, healthy

adjustment or resilience because of social support, personality variables and positive worldviews or beliefs about oneself. In this regard, Honneth (1995) is concerned with solidarity and self-esteem. He asserts that esteem in the horizon of the values of a particular culture, or the solidarity within a cultural climate, contributes to acquired self-esteem. This can be linked to the dignity of merit, which according to Nordenfelt (2004) refers to the individual's role, rank and position in the society. An urge toward self-realization requires a special form of recognition, since we are dealing with a social identity, fulfilled in relation to others. The identity must be recognized by others to acquire the value that we want it to have (Honneth, 1995). Concerning the participants in my study, the kind of self-realization they were engaged with highlights the importance of realizing themselves at work or the significance of being recognized for being good mothers, wives, daughters or sisters. According to my findings, they were concerned with doing the best job possible in their workplaces, demonstrating responsibility, reliability, integrity and taking great care when doing their work tasks. Additionally, they were constantly concerned and worried about their children; they seemed to have a humble and serving attitude towards their husbands together with a wish to support their relatives in Norway and in their homelands in different ways. According to Honneth, self-realization is a process where the subject develops skills and abilities that have unique value for the social surroundings, such as in the family and at work, and where the subject can only convince herself about that value through interaction and appreciative reactions (Honneth, 1995). Moreover, Honneth (1995) links self-realization to the experience of socially useful work. The individuals can only respect themselves fully if they can identify their positive contribution to the reproduction of the community within the objectively given division of labour (Honneth, 1995). This might, however, be challenging for immigrant women if they do not see the purpose of contributing to the community with a paid full-time job but rather give more of their time, energy and abilities to their extended family.

On the other hand, the women seemed to be pleased with and to take sympathetic stances towards themselves concerning taking responsibility for holding the family together. In this way, they maintained their dignity.

Moreover, some of the participants in my study had so-called “low status jobs”, and one of them did not have the authorization for her exams from her home country that would have given her the credentials for a “high status job”. In this regard, Honneth writes about invisibility in the moral dimension - the act of recognition or lack of it - by using the concepts of invisibility or visibility that are compared to, whether we acknowledge or recognize another person (Honneth, 2001). As mentioned earlier, the participants experienced becoming invisible due to their reduced access to working life because of illness and unsatisfactory Norwegian skills in addition to not being understood because of non-visible health complaints or cultural and linguistic differences. They are a part of the workforce yet do not have a position where they are seen or acknowledged but, as Honneth denotes, instead they are disregarded or overlooked, which can be understood as humiliating ignorance. For my informants, this might indicate that feeling obliged to apply for a low status job, may, to some degree, have given the women the experience of doing useful social work. They did, however, also experience a lack of acknowledgement, as they were overlooked at their workplaces, which again undermined their self-esteem and self-realization. In this regard, Rugkåsa (2010) wrote in her doctoral thesis about the qualification of migrant women to work in the Norwegian welfare state. She found that one of the positions the immigrants were put in was “the invisible”, as they live according to their own cultural practices and ethnic network yet are taking part in working life and education and adjust to the majority in these arenas, but what they do beyond this is less interesting for others (Rugkåsa, 2010). This is also how I see my participants; they were invisible in a double sense, as they experienced both being disregarded at their workplaces and in general in the society. Otherwise, as Honneth describes

it; without recognizing the other, we would not be able to formulate meaningful knowledge about them (Honneth, 2005), whereas my study does, however, attempt to formulate some meaningful knowledge about the immigrant women.

To think of oneself as the owner of a legal right is, according to Honneth (1995), to be proud; it is to have the minimum of self-respect that is required to be worthy of others' love and esteem. "And what is called 'human dignity' may simply be the recognizable capacity to assert claims" (Honneth, 1995, p. 120). For those of the immigrant women who could neither be a part of the workforce because of illness nor bring their claims about their rights to have sick pay, we may assume that they do not feel to be as worthy citizens.

Honneth asserts that as the person's skills and achievements are evaluated intersubjectively regarding to what degree they contribute to the realization of the culturally defined values, it is society's cultural self-understanding which supplies the criteria for the social valuation of people (Honneth, 1995). This is interesting when looking at Norwegian values or the values in the Western world, where it is estimated that everybody should take part in the workforce, to contribute to the welfare state. According to Bjørnson (2001), women entered the labour market in Norway during the 1960s due to the expansion of the public sector. During the late 1960s and early 1970s, the child care sector in Norway expanded together with improvements in maternity leave, and reached its top in 1993 when mothers were given the right to 46 weeks' leave on full wages or 52 weeks on 80% wages (Bjørnson, 2001; Vollset, 2011). The offering of relatively long maternity leave and the political aim of full coverage for kindergarten in Norway is quite different compared to the welfare system in low- or middle-income countries, where such welfare benefits are more or less lacking. For the immigrant women coming to Norway, where one has placed such an emphasis on the importance of labour participation, one could anticipate that this must have been a challenge to get used to and to

readjust. It is, however, understandable if they do not adapt to the culturally defined values of the Norwegian society in its totality.

6.7.1 The “other”

The immigrant women experienced being “silenced” at their workplaces, as many of them did not speak or write the Norwegian language well enough to stand up and request their rights as their ethnic Norwegian colleagues did. The abilities needed, such as understanding the Norwegian cultural discourses as well as the Norwegian language, might also have hindered them in taking part in the official debates. When one disrespects individual or collective ways of life, it can, according to Honneth (1995), be corresponded to what we call insult or degradation. If some forms of way of life or outlook on life are disparaged as inferior, the subjects are deprived of opportunities to give their skills social value (Honneth, 1995). Some of the participants experienced being distrusted and misunderstood both by General Practitioners and by their employers, which might have been caused by outlooks and labelling in the general opinion. In this regard, Eide and Simonsen have through the Norwegian press history, documented the changing and preservation of attitudes and stereotypes from 1902–2002 (Eide & Simonsen, 2007). They claim that the mass media constitute the majority through separating minorities out as deviations and contrasts but also that the media can question the public discourse. In a globalized world, it is, according to Eide and Simonsen (2007), important to keep this discussion alive so that more voices gain the real power of definition. The authors give examples from the press, where immigrants often are described as assaulters or criminals or with metaphors that are linked to natural disasters (“stream”, “flooding”), which we must protect ourselves against. Moreover, the focus on fear, violence and conflict in minority coverage, without nuances, can contribute to fear among those being discussed. Eide and Simonsen (2007) conclude that belonging to a minority might imply

being regarded as uninteresting and to a small degree be recognized or understood by the majority. The mass media in Norway have often contributed to the exclusion of vulnerable groups and thus cooperated with restrictive power elite. Discursive frameworks which in turn creates singular expectation horizons, and that can develop into a vicious cycle (Eide & Simonsen, 2007) limit the role repertoire for people in minority ranks.

Eight of the immigrant women chose to prioritize to be at home with their children as much as possible and work less than 100%. Moreover, they seemed to have other priorities, expressing their lives in a different way, having a different appearance, speaking differently and belonging to or practising different denominations than the majority population.

Consequently, this might have led health care personnel, neighbours, colleagues and employers to classify them as “the others”. The concept of “othering”, launched by Spivak (1995), is relevant in this regard, and is said to be the process through which the empire creates its others. Through a colonial discourse, “the other” becomes the excluded or the mastered subject. In the context of my study, “the other” can be seen as a category that occurs as a result of an imbalance of power. Canales (2000, 2010) has created a theoretical framework for analysing how we engage with others, termed “Othering”. She holds that central for interaction and empowerment is for the nurse to take the role of the other and try to interpret and understand the world from the other’s viewpoint (Canales, 2000). However, exclusionary othering, influenced by the prominence of one’s otherness, comprised of skin colour, accent, language, physical capabilities and gender construct one’s identity as other (Canales, 2010). Moreover, a Norwegian study of physiotherapy students and their perceptions of cultural diversity in practice showed that in contact with Muslim women, the students were characterized by “othering”. This means that they regarded their Muslim patients as modest, shy and untouchable, which hindered them from negotiating with the women (Fougner & Horntvedt, 2012).

One could question whether the immigrant women become sick because of the stigmatizing and marginalizing or the “othering” from the society, more specifically from health care personnel, neighbours, colleagues and employers. Attitudes and conduct made apparent within the public health services indicate that there is a need for more teaching and education about cultural sensitivity to restrain the further practice of stereotyping or “othering” and thereby replace it with a dignified rehabilitation. Alpers (2016), who did a qualitative study with 10 immigrant patients from Asia and Africa, recruited from a Norwegian hospital, support this. She found that for the patients to be met with friendliness, encouragement and to be seen by clinicians who hold cultural competency, may counteract distrust and the process of “othering”, and instead create trusting relationships between the immigrant patients and the clinicians (Alpers, 2016).

Moreover, despite the immigrant women experiencing humiliation both from society and from personal relations, they demonstrated to be resilient, in that they partly came back to work and were coping well with their lives as homemakers and mothers. Coulehan (2012) confirms that hope and perceived dignity are antidotes to suffering, while Mann asserts that the violation of dignity may represent a pathogenic force (Mann, 1998). I completely agree with Mann’s idea that dignity has a healing force, in this case contributing to reinforcing both the physical and mental health of the immigrant women in this study. Hartling et al. (2013), who hold that dignity has a healing potential, confirm this.

6.8 Critiques on the theory of recognition

Even if Honneth’s theory of recognition has been fruitful to discuss my finding on a new level, the theory is criticized from several quarters. Varga and Gallagher (2012) assert that the notion of elementary recognition is imprecise. They claim that recognition could be more accurately described by turning to developmental science and the idea of primary

intersubjectivity perceived as a basic form of interaction involving affective proximity. This is further explained as providing “a normative perspective that can more easily be studied in interdisciplinary collaboration with developmental psychology, cognitive neuroscience, and philosophy of mind, phenomenology and psychiatry” (Varga & Gallagher, 2012, p. 256). Furthermore, Soroko (2014) states that Honneth’s third form of respect - recognition of the individual as particular, unique and valuable - is unclear in terms of whether he means acceptance or approval. In addition, it is problematic to see how approval for difference can be granted equally; and thirdly it is unclear whether it can be claimed in the same way as legal recognition. Soroko also holds that it is difficult to see how claims to respect are evaluated and adjudicated, accepted or rejected (Soroko, 2014). Moreover, Lysaker (2011) maintains that the experience of humiliation in Honneth’s theory assumes that people have been adequately socialized to be able to relate to their own experience in a relevant way. He proposes an existential basic condition described as bodily in the sense that the body is common and unalterable for all people and is thereby not chosen and not removable (Lysaker, 2011).

7 Summing up and conclusion

The aim of this thesis was to explore how immigrant women with chronic pain experience their daily lives when they are on long-term sick leave. In this study, the women's everyday lives included the experience of illness, specifically their pain and suffering, their relationships at work and in the family and their experience of humiliation and dignity in addition to how they maintained their own dignity during the period of rehabilitation.

One main finding is that the experiences of the participants in the present study can be described as dualistic. This is manifested in different ways, such as being both humiliated and dignified, both suffering and being partly healthy, both feeling shameful and at the same time being proud and experiencing pain as meaningless and simultaneously describing it as meaningful.

An important aspect is that the participants had unstable trajectories of healthy functioning, as their health, being partially functioning, made them occasionally capable to be partially working, and at the same time they were able to move forward, adapt, learn and endure. Their suffering was experienced as imprisoning and objectifying. To objectify their bodies was, however, a way to tolerate their suffering. A lack of recognition and affectionate relationships became evident during the interviews and observations, and disturbed their self-understanding and the developing of new identities. Some persons within the family seemed to value them, more than their relationships at the workplaces; nevertheless, they built their identities on personal relationships.

The findings suggest that the women and their children found a reciprocal inspiration to be strong, while as employees the women experienced being humiliated because they partly lacked abilities due to illness and lack of skills due to a deficiency of fluency in Norwegian. Our findings also show that physical and psychological abuse in the family led to shame. Moreover, being on long-term sick leave was experienced as shameful and at the same time

humiliating and apprehensive because they feared losing their jobs and thereby poverty. At the same time, they experienced being invisible in a double sense, as they were disregarded at their workplaces and not recognized in general in the society. Concurrently, we achieved broader insight into the informants' capacities not to be burdened by shame, to avoid blaming themselves, and instead demonstrate a strong integrity, inner strength and resilience. This was demonstrated among other factors such as working as much as possible and taking economic responsibility despite chronic pain.

The study shows that the participants prioritized time with their families over working full time, even if they felt they had to work nearly 100% to feel accepted by the society. At the same time, earning money made them feel proud and autonomous and contributed to the enhancement of their dignity. When experiencing bully-like actions, such as rejections at their workplaces, they revealed a dignified character: being proud, having self-respect and strength and being accountable and honest.

During the study, focus was also directed towards different kinds of humiliation, such as being degraded at home and at the work place, where their autonomy was restricted and limited, which reduced the participants' self-respect, while at the same time bearing the strains from migration, made them vulnerable to ill health. Moreover, they were distrusted and misunderstood by General Practitioners, and their lack of time and compassion made them vulnerable. Stigmatizing, marginalizing and othering contributed to the ill health of the women. However, the study also reveals that encounters with well-run health care, which made the participants experience hope and dignity, was an antidote to suffering. Moreover, their experience and enhancement of dignity have been a healing force during their course of rehabilitation.

Despite humiliation from society and personal relations, the study confirms that the women were resilient by coming partly back to work and managing as homemakers. Moreover, the

study demonstrates that they were strong women with solid integrity, while striving to maintain their personal worth. This was demonstrated when they fought for their rights at their workplaces, and when respecting, supporting, helping and encouraging other people. Additionally, the tailoring of practising their religious faith, enhanced their coping with their daily lives, maintained their hope, preserved their dignity and made them resilient. The women's acceptance of humiliating incidents was an important part of being resilient. Furthermore, the study reveals that the gentle, acknowledging, accepting and respectful encounters at the outpatient clinic contributed to maintaining hope and dignity. In addition, the fellowship at the outpatient clinic maintained their relative dignity by strengthening their desires for responsibility, value as human beings and their independence. Accordingly, they maintained their dignity by thinking positively about their priorities and their self-realization, which consisted of spending a great part of their work time in holding the family together. Finally, the women also experienced having absolute dignity, without struggling, as they rested in the fact that they had human worth and freedom in regard to how they related to their situation in their daily lives.

7.1 Conclusion

In conclusion, the study indicates that the immigrant women experienced ill health because of the strains from migration, meaningless pain, humiliation at work and in the family and by being made invisible, not understood, degraded, stigmatized and marginalized. On the other hand, the immigrant women were able to move forward, adapt, learn and endure. Moreover, they found strength in personal relations in their families and with God and demonstrated a solid integrity, inner strength, proudness, self-respect and acceptance. Hope and dignity were a healing force for the immigrant women.

7.2 Future implications for practice

Many of my findings have implications for practice. The study reveals that the outpatient clinic was a place where the immigrant women were respected and experienced enhancement of their dignity. At the same time, this clinic and other health care institutions should perhaps consider implementing care for the whole family, not only the individual woman placed in a group of women. Moreover, it could be worth trying out some rehabilitation courses for both immigrants and ethnic Norwegians together, which also was proposed by the informants in this study. This could perhaps improve equity in health care, in addition to giving opportunities of integrating the immigrant women and for reciprocal learning from different cultures. Additionally, the client participation should be emphasized, acknowledging the long-term nature of the chronic illness and thereby the patients' experienced-based knowledge to have input in treatment planning. One main finding concerning dignity-enhancing care given at the outpatient clinic was the use of time. Health care workers in general should spend time getting to know the immigrant patient by listening to their unfolding health story over time and having more time for consultations, which is confirmed by other studies (Akhavan & Tillgren, 2015; Monsivais, 2005). Moreover, one could use the women's religious faith as a resource in the rehabilitation course, which, for example, was carried out by researchers at a diabetes education program adapted to the cultural needs of women in Saudi Arabia (Al-Bannay, Jarus, Jongbloed, Li, & Dean, 2013). Additionally, research shows that the use of peer educators or health advisers from the same cultural background and with the same native language as the patients leads to significant improvement regarding self-reported health (Kocken, Zwanenburg, & de Hoop, 2008; Reijneveld, Westhoff, & Hopman-Rock, 2003).

7.3 Future implications for research

The findings could imply further qualitative investigations on immigrant women's experiences with workplace adjustments and how the findings could be used in a quantitative study to provide generalizable results.

Another area for further research might be to focus on equitable health care for immigrants that emphasizes how is it possible to “get there”. This could be done by intervention studies, trying out education programmes for healthcare personnel, providing information to migrants on health problems and services and/or initiating closer cooperation between health care and the work places.

This thesis demonstrates that there is a need for more research to explore whether there are structural conditions in the Norwegian working life that excludes immigrants. Consequently, one should focus on how to avoid the humiliation and discrimination of immigrants at their workplaces and thereby prevent illness and suffering. On the other hand, the values for women concerning to work or not to work or to work full time or part time should be discussed. The Norwegian “arbeidslinja” is perhaps not suitable for everybody or strengthening integration. Therefore, examining how immigrant women participate in voluntary work and in the neighbourhood is important.

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Appendix 1

UNIVERSITETET I OSLO

DET MEDISINSKE FAKULTET

Professor Vibeke Lohne
Høgskolen i Oslo
Pb.4 St. Olavs plass
0130 Oslo

**Regional komité for medisinsk og helsefaglig
forskningsetikk Sør-Øst A (REK Sør-Øst A)**

Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 22 84 55 16

Dato: 24.03.2011

Deres ref.:

Vår ref.: 2011/662a

E-post: post@helseforskning.etikkom.no

Nettadresse: <http://helseforskning.etikkom.no>

2011/662a Langtidssykemeldte innvandrerkvinner og verdighet

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk i møtet 17. mars 2011. Søknaden er vurdert i henhold til lov av 20. juni 2008 nr. 44, om medisinsk og helsefaglig forskning (helseforskningsloven) kapittel 3, med tilhørende forskrift om organisering av medisinsk og helsefaglig forskning av 1. juli 2009 nr 0955.

Prosjektleder: Professor Vibeke Lohne, Høgskolen i Oslo

Forskningsansvarlig: Høgskolen i Oslo

Prosjektet er lagt opp som en kvalitativ studie av 16 langtidssykemeldte innvandrerkvinner med muskel- og skjelettplager med det formål å øke forståelsen for deres verdighet som sykemeldt og hva som skal til for å gjenvinne tilstrekkelig grad av helse til å komme tilbake i arbeid. På sikt håper en å kunne utvikle hensiktsmessige, verdighetsfokuserte rehabiliteringsforløp. Målet er at dette skal kunne brukes til å lage rehabiliteringsopplegg som ivaretar verdighet og at kvinnene raskere vender tilbake til hverdagslivet. Kvinnene skal rekrutteres fra RATI (Raskere Tilbake – poliklinikken) ved Sunnås sykehus og undersøkelsen skal skje ved deltagende observasjon og intervju over en time inntil to ganger.

Det er laget informasjonsskriv til ansatte ved behandlingsteamet og til kvinnene som blir forespurt om deltakelse i forskningsprosjektet. Det fremgår ikke om informasjonsskrivet oversettes til morsmålet eller om det skal gjennomgå sammen med tolk.

Det oppgis som en mulig fordel ved deltakelse at en gruppen som er relativt "taus" vil få komme til orde. Det benyttes tolk, som er autorisert og underlagt taushetsplikt, for å bedre kommunikasjonen.

Komiteen har vurdert prosjektet og drøftet følgende problemstillinger i forbindelse med det opplegget som er beskrevet.

- Dersom kvinnene tilhører en begrenset gruppe i Norge ut fra nasjonalitet eller en gruppe med utstrakt sosial kontroll, vil det trolig kunne være vanskelig å få den informasjonen man ønsker når det brukes tolk.
- For en studie med et kvalitativt design vil det by på spesielle problemer at data skal innhentes gjennom intervju ved hjelp av tolk.
- Studien inkluderer kvinner fra fire verdensdeler. Spørsmål er om disse har så mye til felles at det kan trekkes slutninger av generell karakter.
- Det skal stilles mange nærgående spørsmål om helsesituasjonen. Dette kan medføre en viss risiko for mistenkeliggjøring av kvinnene.

Disse problemstillingene er delvis nevnt i søknaden, men komiteen anbefaler et sterkere fokus på disse problemstillingene ved gjennomføringen av prosjektet.

Vedtak:

Komiteen godkjenner at prosjektet gjennomføres i samsvar med det som framgår av søknaden.

Godkjenningen gjelder til 14.11.2014.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren».

Opplysningene skal ikke oppbevares lenger enn det som er nødvendig for å gjennomføre prosjektet, deretter skal opplysningene anonymiseres eller slettes.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og i samsvar med de bestemmelser som følger av helseforskningsloven med forskrifter.

Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK.

Prosjektet skal sende sluttmelding på eget skjema, se helseforskningsloven § 12, senest et halvt år etter prosjektslutt.

Vennligst oppgi vårt saksnummer/referansenummer i korrespondansen.

Med vennlig hilsen

Gunnar Nicolaysen (sign)
Professor
Leder

Jørgen Hardang
Komitésekretær

Appendix 2

Tilsagn om tilgang til forskningsfelt for doktorgradsprosjekt

Som enhetsleder ved [REDACTED] poliklinikken gir jeg med dette stipendiat Line Nortvedt tilsagn om å gjennomføre en studie med innvandrerkvinner som får behandling ved [REDACTED] poliklinikken vår og høst 2011.

Vi vil assistere Line Nortvedt i rekruttering av informanter på følgende måte:
Hun vil få mulighet til å delta som forsker i to stressmestringsgrupper ved [REDACTED] poliklinikken samt gjøre forskningsintervjuer med pasientene i de to gruppene. Som deltagere i de to stressmestringsgruppene vil vi velge ut første generasjons innvandrerkvinner som er norsktalende.

Etter at Line Nortvedt har fått REK- godkjenning, vil vi ved [REDACTED] poliklinikken sende skriftlig henvendelse om studien til de aktuelle informantene, sammen med innkalling til Stressmestringsgruppe. I tillegg vil informantene bli informert på poliklinikken før stressmestringsgruppene starter.

Med vennlig hilsen

Prosjektkoordinator,.....poliklinikken

Appendix 3

Forespørsel om deltakelse i forskningsprosjektet

Erfaringer med verdighet hos langtidssykemeldte innvandrerkvinner i et rehabiliteringsforløp

”Langtidssykemeldte innvandrerkvinner og verdighet”

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie for å undersøke hva som skal til for at langtidssykemeldte innvandrerkvinner opplever sin verdighet ivaretatt. Du er valgt ut til å forespørres om å delta i studien fordi du er langtidssykemeldt, innvandrerkvinne og har oppfølging fra Raskere tilbake poliklinikken. Høgskolen i Oslo er ansvarlig for gjennomføring av studien.

Hva innebærer studien?

Du har fått tilbud om å delta i Raskere tilbake mestringsgruppe, som vil foregå 8 ganger i løpet av det neste halvåret. Der vil jeg delta som gruppemedlem, og samtidig gjøre observasjoner av det som skjer i gruppa. Når mestringskurset er avsluttet og din oppfølging fra Raskere tilbake poliklinikken er over, vil jeg gjerne gjøre et intervju med deg. Intervjuet vil ta ca 1 time der du forteller om rehabiliteringsforløpet ditt, å være sykemeldt, din kontakt med arbeidslivet, og dine erfaringer med verdighet. Vi vil også samtale om du har opplevd situasjoner hvor du har opplevd verdighet både i kontakt med arbeidsliv og helsevesen. Intervjuene vil bli tatt opp på lydbånd og blir deretter nedskrevet. Det er frivillig å være med i studien. Dersom du ikke ønsker å delta i studien vil Raskere tilbake poliklinikken kunne tilby deg deltagelse i en annen gruppe.

Mulige fordeler og ulemper

Som forsker vil jeg delta som observatør og gruppemedlem. Dette kan muligens oppleves stressende for noen, eller som nyttig og positivt for andre.

Jeg ønsker at du skal “komme til orde” med dine erfaringer og synspunkter, og få en opplevelse av å ha bidratt med ny kunnskap i løpet av intervjuene. Intervjuet vil kunne oppleves belastende når emner som kan kjennes såre og vanskelig blir satt i fokus, men kanskje også verdifulle og berikende, ved at du sitter igjen med ny innsikt om egen livssituasjon. Dersom du ønsker det kan intervjuet foregå med bistand fra tolk, avhengig av behovet. En eventuell tolk vil selvsagt være autorisert og være underlagt taushetsplikt.

Hva skjer med informasjonen om deg

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Informasjonen som samles vil bli slettet innen 14.november 2014. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Identiteten til dere som deltar i studien vil ikke komme frem i det som publiseres, ved at alle opplysninger anonymiseres.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få noen konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte: **Line Nortvedt, tlf. 22 45 38 48.**

Langtidssykemeldte innvandrerkvinner og verdighet.

Ytterligere informasjon om studien finnes i kapittel A – utdypende forklaring av hva studien innebærer.

Ytterligere informasjon om personvern finnes i kapittel B – Personvern og økonomi.

Samtykkeerklæring følger etter kapittel B.

Kapittel A- utdypende forklaring av hva studien innebærer

Kriterier for deltakelse

- Pasienter med muskel/skjelettlidelser som får behandling ved Raskere tilbake poliklinikken
- Voksne kvinner fra Asia, Afrika, Latin-Amerika og Oseania
- Har ønske om og vilje til å delta

Bakgrunnsinformasjon om studien

Prosjektet vil ta for seg hvordan langtidssykemeldte innvandrerkvinner med muskel/skjelettplager erfarer rehabiliteringsforløpet under og i etterkant av deres kontakt med Raskere tilbake. Årsaken til valgte pasientgruppe er at det er gjort svært lite forskning på denne pasientgruppens opplevelse av verdighet. Innvandrerkvinner kan være svært forskjellige både i forhold til etnisitet, kultur og tradisjoner, sosialt, religiøs bakgrunn, opprinnelse eller årsak til innvandring. Samtidig har kvinner med minoritetsbakgrunn fellesnevner som det å måtte forholde seg til en ny kultur, et nytt språk, norsk helsevesen, vestlige forestillinger om helse, et endret sosialt nettverk, norske sosiale normer/verdier samt egenopplevde belastninger i det å være innvandrer. Opplevelse av verdighet hos kvinner samt muligheter og begrensninger i forbindelse med arbeidsliv blir satt i fokus.

Dersom du velger å ikke delta i studien vil du få tilbud om å delta i en annen mestringsgruppe.

Tidsskjema

Etter at samtykkeskjema er undertegnet for alle i en gruppe, vil forsker delta på de planlagte samlingene for mestringsgruppa på Raskere tilbake poliklinikken. Når mestringskurset er over vil forsker ta kontakt med den enkelte for å gjøre avtale om intervju.

Kapittel B – Personvern og økonomi

Personvern

Opplysninger som registreres om deg vil være navn, alder, etnisitet, utdanning, arbeidsforhold i tillegg til det du selv forteller om dine erfaringer fra rehabiliteringsforløpet.

Høgskolen i Oslo ved administrerende direktør er databehandlingsansvarlig.

Rett til innsyn og sletting av opplysninger om deg

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Økonomi

Studien er finansiert gjennom forskningsmidler fra Høgskolen i Oslo.

Informasjon om utfallet av studien

Deltakerne har rett til å få informasjon om utfallet/resultatet av studien, og vil få tilsendt det som publiseres av artikler, dersom det er ønskelig.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien om langtidssykemeldte innvandrerkvinner og verdighet

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 4

Forespørsel til ansatte om deltakelse i forskningsprosjektet

Erfaringer med verdighet hos langtidssykemeldte innvandrerkvinner i et rehabiliteringsforløp

"Langtidssykemeldte innvandrerkvinner og verdighet"

Bakgrunn og hensikt

Du er en del av behandlingsteamet for Raskere Tilbake Poliklinikken ved Klinikk for NevroRehabilitering ved Sunnaas sykehus HF. Denne våren er det planlagt et forskningsprosjekt ved poliklinikken. Hensikten med prosjektet er todelt: 1) Å bidra til ytterligere kunnskap for langtidssykemeldte innvandrerkvinner om opplevelse av hva som skal til og hva som hindrer dem i å oppleve verdighet under sykemeldingsperioden samt 2) Å bidra til ytterligere kunnskap for langtidssykemeldte innvandrerkvinner om opplevelse av hva som skal til og hva som hindrer dem i å gjenvinne tilstrekkelig grad av helse og til å komme tilbake til arbeid. Slik kan en på sikt utvikle hensiktsmessige, verdighetsfokuserende rehabiliteringsforløp.

Dette brevet er en forespørsel til deg om du som del av behandlingsteamet, vil delta under prosjektet.

Jeg er ansatt som stipendiat ved Høgskolen i Oslo/Sykepleierutdanningen. Jeg er utdannet sykepleier og har master i Sykepleievitenskap fra Universitetet i Oslo. Denne undersøkelsen er et doktorgradsprosjekt som jeg gjør i samarbeid med Høgskolen i Oslo. Det får ingen negative konsekvenser for deg om du sier nei til å delta i prosjektet.

Som forsker vil jeg delta i gruppens aktiviteter som observatør. Jeg kommer til å notere ned ting jeg opplever. Jeg har taushetsplikt om alt jeg ser og hører, og kan ikke gi videre opplysninger om personer som er identifiserbare. Jeg kan heller ikke gi opplysninger om personer til ansatte ved sykehuset. Sykehusets ledelse har godkjent prosjektet.

Informasjonen jeg samler blir oppbevart aidentifisert og blir behandlet konfidensielt. Det vil si at jeg lager en kode i stedet for navn, der det handler om personer. Deltagerne i gruppen vil bli intervjuet når oppfølging av Raskere tilbake poliklinikken er avsluttet. Alle notater og bånd vil bli slettet i november 2014. I alle publikasjoner som skal skrives til slutt, vil alle data være anonymisert.

Regionale komiteer for medisinsk og helsefaglig forskningsetikk har godkjent prosjektet.

Hvis du har spørsmål om prosjektet kan du ringe meg på telefon:

Line Nortvedt, Høgskolen i Oslo, Sykepleierutdanningen, tlf. 22 45 38 48 eller mobil: 97789719.

Ansvarlig veileder for prosjektet er Professor **Vibeke Lohne, Høgskolen i Oslo, Sykepleierutdanningen, tlf. 22 45 37 96.**

Ønsker du å drøfte spørsmålet med klinikkledelsen på sykehuset, kan du ta kontakt med:

Klinikksjef Jan T. Engen, tlf. 69818055

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien ”Langtidssykemeldte innvandrerkvinner og verdighet”

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 5

Erfaringer med verdighet hos langtidssykemeldte innvandrerkvinner i et rehabiliteringsforløp

Observasjonsguide

Første møte: Presentere meg selv, min rolle og hensikt (fokus på verdighet)

Punkter for observasjon:

Substans i gruppemøtet

- Hva snakker kvinnene med hverandre om i gruppemøtene?
- Hvilke erfaringer trekker kvinnene frem?
- Hvilke ord bruker de?
- Hvilke spørsmål stiller kvinnene til hvem?
- Språk – Hvordan behersker kvinnene norsk?
- Hva snakker kvinnene med hverandre om i pausene?

Hva skjer i gruppen/gruppeprosessen?

- Kommer alle hver gang/fracfall?
- Dannes det allianser?
- Styrkeforhold i gruppen, dominans, snakker alle?
- Uenighet? Enighet?
- Hvem snakker de med?
- Hvordan oppfører kvinnene seg under opplegg?

Verdighet

- Kommer tema verdighet frem/opp i samtaler/diskusjoner i gruppa?
- Er verdighet et tema kvinnene er opptatt av? Hvordan?
- Er verdighet et tema behandlerne er opptatt av? Hvordan?
- Er sårbarhet/krenkelser et tema kvinnene er opptatt av? Hvordan?
- Er sårbarhet/krenkelser et tema behandlerne er opptatt av? Hvordan?
- Beskrives elementer av verdighet og/eller krenkelser i forbindelse med kvinnenens kontakt med:
 - Helsepersonell
 - NAV
 - Sosialt nettverk
 - Arbeidsplass/arbeidsgiver

Appendix 6

Erfaringer med verdighet hos langtidssykemeldte innvandrerkvinner i et rehabiliteringsforløp

Intervjuguide

Innledning: Presentasjon av hensikten med intervjuet og prosjektet. Frivillighet. Anonymisering og konfidensialitet.

Demografiske data:

Navn:

Alder:

Etnisk bakgrunn:

Utdannelse:

Gjennomgått grunnskole:

Gjennomgått videregående:

Gjennomgått annen form for utdanning:

Mottatt hvilken form for rehabilitering:

Yrke:

Arbeidsforhold:

Innledende spørsmål:

- Det var spennende å følge deg i gruppe på RATI, hvordan har du det nå?

Å være sykemeldt

- Hvordan synes du helsen din er nå?
- Er du sykemeldt nå / aktiv sykemeldt / i jobb? Hvordan har du opplevd det?
- Snakker du med andre om at du er syk? Hvordan? Hvilke reaksjoner får du?
- Kan du fortelle om dine helseplager?
- Har du ubehag nå? Hva synes du hjelper? Er det spesielle hensyn du eller andre tar / noe du gjør med smertene?
- Ønsker du deg tilbake i arbeidslivet?

Arbeid

- Arbeidet du i hjemlandet ditt? Hvordan var det?
- Hvordan er den norske arbeidshverdagen din?
- Er arbeidshverdagen din tilrettelagt for deg og dine behov?

Rehabilitering

- Hvordan har rehabiliteringsforløpet ditt vært?
 - Går det for fort/for langsomt?
 - Føler du at du får for mye/for lite ansvar for din egen rehabilitering?
 - Evt.: Hva tror du skal til for å komme tilbake til arbeid?

Verdighet

- Hva tenker du om begrepet verdighet?
- Betyr verdighet noe for deg? Hva legger du i ordet verdighet?
- Har du opplevd en situasjon der du ble behandlet med verdighet? Fortell om det.
- Hva er verdighet i ditt liv?
- Har du opplevd at du ikke ble behandlet med verdighet? Fortell om det? Har du opplevd krenkelser i rehabiliteringsperioden?
- Hva skal til for at du kan bevare din verdighet?
 - Hva hindrer deg evt. i å oppleve verdighet? I hvilke situasjoner opplever du ikke verdighet? Noe du eller andre kan gjøre?
- Blir din verdighet ivaretatt i forbindelse med:
 - Møte med helsepersonell
 - Møte med NAV
 - Møte med familie, venner, naboer
 - Møte med arbeidsplass/arbeidsgiver, kollegaerHvordan da?
- Har det å være sykemeldt eller i arbeid hatt innvirkning på din opplevelse av din egen verdighet?