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Exercise for mental well-being:

A study of psychomotor physiotherapy group

for immigrant women

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OG AKERSHUS

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ABSTRACT

Immigrants in Norway have been studied to be showing various health challenges, physically and mentally. The adult female immigrants tend to face these challenges more than the males. In addition to the health problematic, other issues were also taken into attention such as the barrier of language mastery and mutual understanding of health care service provided. Thus, extensive preventive measures were recommended.

The Norwegian Psychomotor Physiotherapy (NPMP) group in the mental health care service focuses on strengthening the patient's resources by applying its treatment approaches in a group context. What are the group characteristics and what encourages the continuity in participation, when the group is exclusively for immigrant women are interesting to be explored. The same knowledge can be useful to the mental health care service of immigrants' well-being.

This is a qualitative based study that applies the methods of participative observation and unstructured interview. Three findings of content and context of the group, practical doing and continuity are discussed to scope the characteristics of the group for immigrant women and the factors for their sustainability. The first scope includes two perspectives; the structured frames of content and context, and the women's receptivity of the frames. These perspectives lead to further question of implementations that need to be commenced to secure the aims of the group. The sustainability of the group can be represented by manners of acceptance and collaboration, in the interaction among the women and in the patient-therapist relation. Nevertheless, this study also reveals that the sustainability is an ongoing process and it requires all aspects of human to be equally activated. This study provides guidance of physiotherapy intervention in mental health care, to be pragmatically implemented by respective professionals and to be realistically accepted by immigrant women. However, further studies are needed to strengthen the knowledge's compliance.

Key words: Psychomotor physiotherapy, Exercise, Mental well-being, Group, Immigrant women

SAMMENDRAG

Innvandrere i Norge har helseutfordringer, fysisk og mental. Det er blitt vist i studier gjort tidligere, og innvandrerkvinner blir ofte påvist som de som har mest plager. Utfordringer som språkkompetanse og mangel på gjensidig forståelse for helsetilbud har i tillegg bidratt til en utfordrende samarbeid. Dermed blir en rekke tiltak anbefalt for å unngå negativ utvikling.

Norsk psykomotorisk fysioterapi (NPMF) gruppe, som tiltak innenfor psykisk helsearbeid, har fokusert på å styrke pasientens ressurser gjennom dens behandlingsmetoder, samt å se pasienten i en gruppesammenheng. Det er interessant å finne ut hva kjennetegner denne gruppen med innvandrerkvinner og hvilke elementer som opprettholder deres deltagelse. Denne kunnskapen kan være verdifull for den gjeldende fagpersonen, i deres tilnærming innen psykisk helsearbeid for innvandrerkvinner.

Metoden er kvalitativ studie der det blir gjennomført deltagende observasjon og ustrukturerte intervju. Tre sentrale funn; innhold og kontekts i bevegelsesgruppe, praktiske gjennomføring og kontinuitet blir tatt i diskusjon for å finne ut om gruppens kjennetegn og de faktorene som opprettholder kvinnenes kontinuitet i gruppen.

Gruppens kjennetegn består av to perspektiver; de faste rammene for innhold og kontekst, og kvinnenes reseptivitet for disse rammene. På bakgrunn av perspektivenes bestridende utfall for kvinnenes mental velvære, blir det dermed stilt spørsmål om videre tiltak bør settes inn for å ivareta gruppens mål. De elementene som opprettholder kvinnenes deltagelse er anerkjennelse- og samarbeidsmåte i kvinnenes samhandling, og i pasient-terapeut relasjon. I tillegg til de overnevnte kjernefunn blir det også avdekket at arbeid med kvinnenes kontinuerlige deltagelse er en pågående prosess som krever sammensetning av alle aspekter av mennesket på samme nivå. Denne studien anskaffer nyttig kunnskap innenfor intervensjon for fysioterapi og mental helse, hensiktsmessig implementering for helsepersonnel og kan bli realistisk akseptert av innvandrerkvinner. Videre forskningsarbeid er nødvendig for å styrke kunnskapens samsvar.

Nøkkelord: Psykomotorisk fysioterapi, Øvelse, Mental velvære, Gruppe, Innvandrerkvinner

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1.0 INTRODUCTION

This dissertation will present a research study on a movement group (in Norwegian: *bevegelsesgruppe*), also known as motion practice (in Norwegian: *bevegelsespraksis*), for immigrant women. Movement group is based on the principles of Norwegian Psychomotor Physiotherapy (NPMP) which was co-founded by the Norwegian psychiatrist, Trygve Braatøy and the Norwegian physiotherapist, Aadel Bulow-Hansen in between late 1940s and early 1950s. The principles were first aimed at increasing awareness of the bodily resistance in the musculoskeletal system and also increasing access to bodily emotions among patients who underwent psychoanalytic treatment. In the later years, NPMP has become gradually relevant for patients who suffered of musculoskeletal disturbances and pain problematic caused by mild anxiety and depression (Bunkan, 2001; Thornquist, 2006).

Gudrun Øvreberg (cited by Tvedten, 2013, p. 29), who was a student of Aadel Bulow-Hansen extended and applied the foundation of the individual to include a group concept. The group concept has the same elements as in the treatment of an individual, focusing on the awareness and modification of the body's state of being tense by increasing the subject's familiarity and contact with their own body.

The research study focused on the movement group offered to immigrant women as a low threshold mental health care service. The group was led by a Norwegian psychomotor physiotherapist (PP). The purpose of the study is to explore the characteristics of the movement group and the factors for sustainability among the immigrant women.

1.1 Background

The literatures in this section present the challenges faced by immigrants physically and mentally, as well as the conditions necessitating physical activity for mental well-being.

There are various ways for obtaining the status of immigrant in Norway. Statistics Norway (SSB) (SSB, 2017) provides updated key figures per 1st January, 2017 and gives the reasons for immigration in the immigrant population in Norway grouped into major categories as refuge (22%), family (39%), work (33%), and education (6%). In all there were a total of 724987 immigrants in Norway out of the total population of 5,2mill. These immigrants came

from various continents, Europe (53%), Asia (30%), Africa (12%), South America (3%) and North America (1%).

The mental health condition of the immigrants is one of the main concerns in this research study. A reviewed literature about the mental health problems among immigrant populations in Norway was presented in 2014 (Abebe, Lien & Hjelde). The review considered 62 articles in the period of 1990 to 2009 and the subjects were then divided into two groups based on their age, either adolescent or adult. The review of adult mental health showed a higher prevalence of mental health problems among immigrants of age 30-60 years old compared to the adult Norwegian group and also the population in general. The psychological stress was found at the highest rates among immigrants from the Middle-East, and the lowest among South-Asian immigrants. Several risk factors were named such as lack of social support, poverty, series of traumatic experiences and many dreadful life events. In addition to this, the pressure of embracing the Norwegian culture in terms of language and customs increases the risk of acquiring mental health problems. Immigrant women showed a higher risk for mental health problems compared to immigrant men, and the women within age 59/60 showed higher psychological distress than the younger ones. The immigrant women also faced more challenges in their way of social integration due to the difference in culture values concerning the woman's traditional role in the family. These challenges were believed to be reason for the woman's psychological stress.

Studies of physical activity and mental health care for the immigrants here in Norway have unfortunately not shown clearly promising positive results have been achieved. Firstly, the project 'Romsås in Motion' (Jenum & Birkeland, 2003) was launched in year 2000 to study the physical activity in a multi-ethnic district in Oslo, with a duration of 3 years. The results of the project raised concern for the number of unregistered diabetes cases, a high prevalence for overweight and inactivity.

Secondly, the Oslo Immigrant Health Profile in 2008 (Kumar, Grøtvedt, Meyer, Søgaard & Strand) reported health issues of immigrants specifically from Turkey, Iran, Pakistan, Sri Lanka and Vietnam. The immigrant women were reported to have higher musculoskeletal disorders and mental distress than the men. Among the risk factors, inactive lifestyle and obesity seemed alarming. The report urges prevention strategies to be adopted to enhance their potentials and to lessen the peril for the immigrant women.

Furthermore, Qureshi (2005) in his article disclosed more challenges faced by migrants and their mental health care, one of them was being an immigrant patient treated within the Norwegian mental health care system. The lack of ability to master the Norwegian language worsens the immigrant's opportunity to express their disturbances; one has to break through various barriers of cultural symbols and other's interpretation to overcome the challenges.

In another article of Hansteen (2005), an example was given of a comparison of a meeting with the doctor between a "Norwegian-Per" and an "Eritrean-Fatima". Per probably experienced speedy recovery in comparison with Fatima. The reasons for this were his basic language competence, the direct communication with his doctor and most importantly, the mutual understanding of terms used to describe his symptoms. Unfortunately, Fatima had to struggle with these rather basic competences before proper help was given to her.

An article of Ahlberg and Dahl (2005), again, resembled the above issues. They also highlighted the importance of treating the patient within the context of what they faced as today's difficulties than to only focus on the past difficulties and the patient's traumatic history. Current difficulties such as financial downturn or conflict with the local social security office can retard their process of convalescence. They added that mental health for this patient group can often relate to two categories of their physical state, namely psychosomatic disturbances and psychosocial limitations. The first includes bodily disturbances such as pain and fatigue, while the latter one includes the inadequacy of mutual understanding in various perspectives for differing cultural and religion practises.

The issues identified and given above are probably only a few of the many factors that "stack the odds" against the degree of benefit received from any interventions of health and environment care for immigrant patient. Unfortunately, these poorer odds are still considered as being significantly important today.

Despite the aforementioned studies and articles in Norway, there were other studies that did give cause for hope for mental health care interventions. A cross-sectional study published in 1994 (Stewart, Hays, Wells, Rogers, Spritzer & Greenfield) of participants with various chronic illnesses, seemed to come closer to success with consideration of the positive effects of physical activity. The authors found that physical activity promotes physical health, and also indicated positive changes in psychological distress. In Wipfli, Rethorst and Landers' review in 2008 of treatments for anxiety (cited by Daley, 2014, p. 176), the conclusion was

that exercise was an equally efficient or even better method of intervention than other types of treatment for anxiety. Furthermore, it was highlighted that exercise causes zero side effects and is cost-effective when compared to medication and other psychological treatments.

The context in which the physical exercise intervention occurs is also an important key to better mental health. Khan, Brown and Burton (2012) highlighted ways to encourage adults with psychological distress to be more physically active. These included the location and cost of the activity arranged, the choice of same sex participants, the same scheduled session (day and time), supervised activity and activity that involves non-competitive measurement (e.g. dance). The studies of Bailey & Mc Laren in 2005, and Stathi, Fox & McKenna in 2002 (cited by Daley, 2014, p. 175) showed extensive benefits from group exercise; interrelation with others, social integration and opportunity to expand one's social acquaintances.

The World Health Organisation (WHO)'s recommendations for physical activity are based on each individual's age and health condition. It also gives, an important guideline, the individual's own responsibility for its care for own physical health. The WHO is also concerned about the mental health care of the general population. It launched "The Mental Health Action Plan 2013 -2020" which contains four major objectives; one of them being to find ways to promote better mental health (WHO, 2016). In response to the WHO's recommendation of physical activity, the Norwegian government established the "Action plan on physical activity 2005-2008" (Ministries, 2007). This considered the arrangement of the physical environment, the need for easy access and for low threshold activities. In addition to these, a more active way of living was to be encouraged in all areas where there were children and adults. Concerning mental health care, in 1998, the "National Program" for mental health care was introduced to rectify the insufficiencies and inadequacies of the services provided to the patients in earlier years (Norwegian Ministry of Health and Care Services, MHCS, 2005). All targets for the program were crucial, but specifically for this research study, focus will be placed on three of these targets. Firstly, it is necessary by all means possible to focus on the recipient. Secondly is the importance of offering informative sessions to recipients advocating the importance of mental health care and lastly, it is the responsibility of local municipalities to provide community based services.

Our understanding of human well being has expanded over the last few decades; the most significant contribution is that the physical body cannot be separated from the mental state. According to Løtveit and Tønder (2016), one has to acknowledge the human as a whole being

that experiences its lived world through the various mechanisms of the body. The mechanisms consist of the sum of the biological human body, the psychological state of human and the influence on the human of its social environment. These three parts of a human's everyday living is believed to have a great influence in one's health state and capability of coping with challenges.

A cross-sectional research study in 2008 (Breitve, Hynninen & Kvåle) considered health issues among patients who were referred to NPMP compared to the non-referred group of ordinary population. The results showed that most commonly female of average age at 44 were the ones who consulted NPMP. For those referred to NPMP the most common disturbances were musculoskeletal-related, in addition disturbances which were psychologically related with symptoms such as insomnia, anxiety, depression and fatigue.

The Advanced Course in NPMP at HIOA (2016) has encouraged the insights of human well being by looking into its psychological, sociological and biological perspectives. It advocates physiotherapists to assess patient physically, mentally and sociologically, before going on to assist relief of the patient's health burdens and to strengthen patient's health resources. Besides these perspectives, it also advocates therapeutic alliance in order to gain the full compelling impact of a meaningful therapy. The final module of the course, psychomotor physiotherapy and traumatic experiences, sets great focus on group therapy or this is recognizable as the movement group. One of the many compulsory tasks requires the physiotherapist to manage a movement group, this is to be based on the NPMP principles, contain 8 participants and function over a total of 8 training sessions. The physiotherapist is obliged to submit a reflective report at the end of this practical process.

The required learning experience of physiotherapists of managing a movement group has definitely raised more awareness of how group session can affect one. My several years of knowledge and experience at organizing and managing group exercise were enhanced after completion of the course. I became familiar with the meaning of tolerance, more observant of user's existence during session, and the importance of the small conversation interactions I get with the user/users. I also became more curious to find out if I could apply the same approach when my user group is not composed only of ethnic Norwegians.

1.2 Purposes and problem statements of the study

I want to investigate the concept of the movement group applied to immigrant women, to find out of what accommodations are needed and what sustains their participation in the group. Possibly, the study can also contribute useful knowledge to the respective health professionals and organisations concerned in the work of increasing awareness and promoting the physical and mental health of immigrants.

The problem statements of the study are:

(1) What are the characteristics of the movement group for immigrant women?

(2) What encourages the women to attend and to be in the group?

1.3 Thesis structure

Chapter 2 will provide the theoretical framework that concerns NPMP movement group, body phenomenology (Merleau-Ponty), a general understanding of biopsychosocial perspectives with reference to exercise and human, and lastly, group therapy in an intercultural context.

In Chapter 3, I present the qualitative research methods which consist of the basis of the scientific perspectives for health care, the choice of methods, the selection of subjects and setting, the ethical considerations and data collection. Last but not least, I present the choice of data analysis and critical reflections over the methodology.

In Chapter 4, I present the findings of the study.

Chapter 5 will be a discussion of the findings in the light of the theoretical framework, also involving part of the above-mentioned studies in chapter 1.

Chapter 6 summarizes the research study in relation to the problem statements. In addition to its implications for mental health care service and suggestions for further work of researches.

2.0 THEORETICAL FRAMEWORK

2.1 NPMP principles in movement group/motion practice

The foundation for NPMP consists of the assessment of one's body posture, the function of muscles, the pattern of respiration, and the reaction of the autonomic nervous system and how one's body image is perceived (Bunkan, 2001; Thornquist, 2006). The aim for the NPMP treatment can be characterised as either "supportive" (in Norwegian: *støttende*) or "readjustment" (in Norwegian: *omstilling*). The supportive element enhances indications of focus to increase the individual's self regulation, self experiences of its identity, autonomy and interaction with others. The characteristic aim of readjustment is to challenge the individual's defence mechanism through its musculoskeletal and respiration system (Gretland, 2007, p.88); to integrate new demeanour, either bodily or psychologically. It is also advised that the treatments be conducted at a pace and in an environment compatible with the individual's own perception is permissible for (Gretland, 2007, p. 98). Treatment approaches such as massage, form of contact, varieties of positions and movements, assortments of activities and conversation, have to be thoroughly considered in order to avoid confusion, to promote self development and participation (Gretland, 2007, p. 89).

Another key foundation to NPMP is "therapeutic alliance". The successful alliance specifies mutual responsibility and understanding to the established relationship of the therapist and the patient, its goal and progression, in addition to other practical arrangements. The therapist's way of being tends to determine the patient's comprehension of its role in the therapy context. An outspoken therapist takes a rather big space in the relationship, a therapist who waits allows the patient to present their stories whereas a "laid back" therapist opens up spacious therapy context. Therefore, it is important that the therapist is aware of these choices of being and aware of how the choice made will provide meaningful therapy for patient (Løvlie Schibbye, 2012). In Gretland (2007, p. 94-95), the aforementioned therapeutic alliance and the therapist's way of being are also claimed to be crucial presupposed conditions to create a sense of security for the patient.

Based on the movement group's goal and dynamic, these are the recommended focus in exercises offered; the degree of closeness, various stimulations of the sensorimotor system

and emancipation (Gretland, 2007, p.147). Rongved (2016, p. 114) who was inspired by Gudrun Øvreberg gave informative descriptions of motion practice. Her focuses were respiration, firm grounding and stretch, accommodating the natural responses for yawn, sigh, fatigue, playfulness, and lastly, the sense of movement and its modification. She has kept the group framework in stable construction; indoor location, spacious training room, use of music in the background and the number of the participants has been dependent on the group composition. She has offered 12 sessions in the season of fall and 12 sessions in the season of spring. Above all, she pinpointed that she had been consequent in reminding herself not to corrugate the participant's movement's expression, but instead repeatedly reminded the participant to register its breathing pattern as well as movement pattern.

Tvedten's (2013) many interviews with psychomotor physiotherapists who have had decades of experiences with motion practice, concluded that to be able to be adroit at this form of practice, one has to apply own body expressions as the basis for reflections. One must also be capable of combining its professional knowledge, intention and responsiveness in the group context and last but not least, show flexibility in improvising and using creativity.

2.2 The phenomenology of the body

The famous 19th century French-born philosopher, Maurice Merleau-Ponty, contributed greatly to the enlightenment of phenomenology of the body. His concept is widely used in the care of mental health, often excluding the discourse of dualism. Instead, he conceptualised the human being as expressive and carries meanings to its external world. In other words, the body is the medium the human being utilizes to establish contact with the external world; and the body is used to percept, to move, to communicate and to be aware. Perception is based on multiple human senses and it goes hand in hand with the body movement. These form a solid base for the human experience. The body plays not only a role of an object to others and to one self, but simultaneously the role of subject to both parties. He also explained that one's level of awareness is within the grade of determination of one's personal interest, anticipation, atmosphere and performance. The ability of selecting specific focus will not only hinder chaotic impression, it will most importantly assist individual to perceive its surroundings and permits learning (Gretland, 2007, p. 25 & 87).

Other factor, particularly life experiences of different experiential time such as past, present and future are possible to contributors to the impact of one's personal experience of a

situation or event. If the past experience being relived in the present situation or event that has many common features in the past, the body will automatically find its way to perform or tackle the situation. An unknown situation is different; it will require the body to process learning and subsequently modification of the previous terms of handling. The body risks its potential to be an object if, in a situation where the features exceed one's capabilities, one will have difficulty to participate in the experience as a subject. Again, the past and present experiences are predominant in the mechanisms one will choose to face the upcoming situation (Gretland, 2007, p. 27; Duesund, 2008, p. 238-239).

Gallagher (2001) explained Merleau-Ponty's concept of body image and schema in the dimensions of embodiment. Body image is explained as consisting "mental representations, beliefs and attitudes where the object of such intentional states is or concerns one's own body" (p. 149) while body schema consists of "certain motor capacities, abilities, habits that enable movement and the maintenance of posture" (p. 150). When the two cooperated in an intentional task, for example, to brush our teeth, the intention is to get our teeth clean (body image), and the procedures to get this achieved is non-consciously dependable on the coordinated body movement (body schema) (Gretland, 2007, p. 26).

Råheim (2003) exemplified the disintegration of the body phenomenology, when disturbance occurred in a human body, as in chronic pain. The experience of pain is elucidated to breach the contact between body image and schema. The human tends to objectify the part of the body that causes pain. The human's capability of being in presence is somehow disturbed, and the future seems intimidating.

2.3 The understanding of biopsychosocial perspectives of exercise and human

A biopsychosocial feedback model between exercise and the physical self was presented by Lindwall in 2004 (cited by Lindwall and Asci, 2014, p. 97). This model lays out the feedback mechanisms when the human being performs exercise into three categories. These are firstly psychophysiological and biological then psychological and finally sociological. The first category contains hypotheses on endorphin, serotonin and norepinephrine. The psychological category consists of perceived competence-mastery, self acceptance, autonomy and exercise identity or exercise schema. The sociological category consists of belonging to a group, exercise morale and exercise stereotype.

Physical exercise or physical activity has long been an interest for evidenced-based research in various health issues among physiotherapists. Burton, Stokes and Hall (2004) summarized the physiological effects of physical activity; energy source, muscle development, the respiratory and cardiovascular system, not to forget the regulation of body temperature. On the other hand, Martinsen (2004) and in a joined article with Moser (2008) hypothesized on the effects of physical activity to mental health. The concentration of endorphins in the blood increases during intense physical activity, there is activation of the neurotransmitter dopamine, and increase in hormone regulation by the hypothalamic-pituitary-adrenal (HPA) axis. These hypotheses can be recognizable as aforementioned psychophysiological and biological feedback mechanisms by Lindwall (cited by Lindwall and Asci, 2014, p. 97). In addition, Martinsen (2008, p. 175) went further and explained that the brain not only has the capability of regulating one's bodily functions, but it is also capable of regulating the psychological processes such as thoughts, feelings, and behaviour. Simultaneously, these regulated processes affect the brain's capability.

The following researchers studied the relationship between physical activity and psychological effects. These studies are comparable to the psychological feedback mechanisms in Lindwall's model (cited by Lindwall and Asci, 2014, p. 97). In Hannan et al. (2014), a sample of 63 Hispanic women, average age of 34 years old was used. Among the aims of the study was how stress was related to the amount and choice of physical activity. Stress levels were found to be highly correlated with financial difficulties and job situation in the subjects. These were also the most important reasons why the women did not seem to prioritize their physical activity. The study concluded that higher stress level not only affected the women's physical activity, but also associated with the issue of overweight among them. In the 6-years longitudinal study of Gallegos-Carrillo et al. (2013), the authors wished to study the effects of physical activity on depressive symptoms in their own culture. A sample of more than 1000 Mexican adults underwent thorough assessments at baseline and follow-up (Year 6) of the amount of physical activity and the participants symptoms of depression. The study concluded that the relationship was crucial with the results showing that the inactive participants in the sample tend to show higher depressive symptoms in comparison to those participants who were moderately and highly physically active in the sample. Thus physical activity was found to be an effective contributor towards the prevention of depression.

The psychological feedback mechanisms by Lindwall (cited by Lindwall and Asci, 2014, p. 97) are also compatible with Antonovsky's (1996) "sense of coherence" (SOC) in his salutogenic model. SOC brings forward one's potential from being unwell to status of well-being. The degree of SOC is dependent in the individual on the following factors, "wish to, be motivated to, cope (meaningfulness); believe that the challenge is understood (comprehensibility); believe that resources to cope are available (manageability)." (p. 15)

The sociological category aforementioned by Lindwall (cited by Lindwall and Asci, 2014, p. 97) can be compared with Yalom's qualities of group process (cited by Kjølstad, 2004, p. 39). Among the qualities that are comparable are a sense of group belonging, hope, to help another, universality and imitation. In addition to this, the sense of group belonging can also enhance the opportunity to belong to a specific social network, a social network that provides support, psychologically and materially. Cobbs' (cited by Sørensen, Sandanger, Dalsgard & Kleiner, 2008, p. 112 & 117) three specifications for social support; information that makes an individual experiences that someone cares for them, experiences of being respected and valued, and experiences of fitting in to a network of mutual communication and responsibility. Social support is also seen to be crucial in promotion of human's mental health, as it acts as a buffer to prevent further mental strain.

2.4 Group therapy in an intercultural context

Three specific therapist's qualities are mentioned in the model of group therapy in Kjølstad (2004, p. 31); unconditional warmth, genuineness and empathy. Unconditional warmth is explained as the positive base of feelings; the base allows benevolent respect to another individual. Genuineness is probably the most intricate quality needed with the difficulty that the other individual has the capability of discerning the insincere and factitious therapeutic role. To being empathetic, the therapist must first be able to explore own life experiences. The life experiences provide widespread emotions that one will be affected with. The combination allows one to be in another's shoes, but simultaneously knowing that they are not their own shoes. The limiting factor to empathy is that one will never succeed to fully explore another's life situation (Kjølstad, p. 36). In 2002, Greenberg and Rushansky-Rosenberg (cited by Nedrum, 2011) studied therapists' empathetic capabilities when working with patients. Among the factors that were discovered to influence the level of empathetic capability were; active visualisation of the patients' environmental experiences, being conscious of details in

patient's verbal contribution and identifying patient's emotion through their verbal and non-verbal conduct.

However, there are challenges in an intercultural context between the therapist and the patient of another cultural background. The most common challenge is that of intercultural communication. Language mastery has been a challenge among immigrants and this led to misunderstandings in conversation content during counselling and therapy. Use of an interpreter can introduce even more filters that would make the situation to be handled even more complicated. Other challenges are the mutual understanding of word context in language and of the biomedical model (Horntvedt, 2015, p. 107). Galanti (2015) added challenge in other aspect such as time orientation, in which this was divided into two explanations; clock time versus activity time and patient's orientation of the past, present and future. Providing health care will probably require longer time in such cases as more time is needed to mature the process by trial and errors.

Shapiro, Hollingshead and Morrison (2002) established focus groups to find out the attitudes and beliefs of a cultural competent communication. The focus groups consisted actual participants in healthcare namely health personnel such as physicians and pediatricians, and patients of a primary care clinic. The outcomes of the study were fairly similar among the different health personnel; having a common language to communicate and sharing the common ground of cultural knowledge were essential factors to adequate communication. However, the patients turned out not to be as inhibited as the health personnel by cultural competence. Instead they were more affected by the way they were noticed during consultation, as they phrased it "Ethnicity is not important. If there is good-will, we can work out our differences", and "What is most important is not an Indian doctor, but a doctor who cares" (Shapiro, Hollingshead and Morrison, 2002, p. 753).

3.0 METHODS

This chapter will provide information from the approaches of qualitative research to the research design, the selection of subjects and setting, the ethical considerations, the data collection and analysis. Lastly, it will lay out critical reflections of the whole process of methodology.

3.1 Qualitative research methods

This study is based on a qualitative research method designed mainly to uncover the purposes of the study and its problem statements. The qualitative method allows the study to recruit the subject in the general population, the subject can be communicated directly and the end findings can possibly be of significant benefit to the society (Johannessen et al., 2010, p. 31). The qualitative approach that seems relevant for this study is phenomenology. Phenomenology concentrates on the understanding of human experience or quoted by Manen in 1997 (cited by Wilson, 2015, p. 38), "the way that a person experiences or understands his or her world as real or meaningful". Wilson (2015) added the five crucial keys to choosing this approach; research question of individual's lived experience, design creativity, number of subjects, data of narratives and lastly, theoretical foundation and the work of interpretation.

All the reasoning for the qualitative approach is relevant in this study, based on the given facts beforehand; the increasing numbers of immigrants in Norway, their individual ways of perceiving the Norwegian culture and context, adapting to their present body and mental functions, and the urgency to explore their potentials of remodelling their newly-experienced world.

3.2 Participative observation and unstructured interview

The data collection methods consisted of participative observations and interviews. Johannessen et al. (2010, p. 118) wrote that observation allows direct access to the research material or field. However, an even better access of observation is participative observation (Fangen, 2010, p. 12-15); the researcher has knowledge of first hand's happenings of the subject in the field, the flexibility of own interpretations as part of the data, and lastly an extended room for the researcher's re-interpretation. One must, however, be reminded of the

main purpose of participative observation is to being able to describe what the subject says or does in a setting that is not structured by the researcher, the setting being the subject's habitual environment. The happenings refer to events, actions, norms and values of the subject or setting one choose to immerse into (Fangen, 2010, p. 94). The descriptions of the happenings are written down in field notes; specifically into words to describe what has been seen or heard by the researcher during observation, descriptive words of researcher's own spontaneous reflections or incipient interpretations over a happening and the subject is camouflaged from its real identity. The access to field notes allows the researcher to read the collected material repeatedly and to reinterpret them. In the phase of data analysis, field notes will be analyzed systematically in order to gain the real meaning of the underlying data (Fangen, 2010, p. 102-105).

Participative observation cultivates closer understanding of the subject and setting even before one goes ahead with interview (Malterud, 2011, p. 149). Fangen (2010, p. 172) added that participative observation is opportune for sensitive issues when a follow-up interview is performed. "Interview" as defined by Schatzman and Strauss in 1973 (cited by Fangen, 2010, p. 172) is "to listen to the subjects during participative observation, informal conversation or structured interview." The first two strategies were preferred in this study after a prior evaluation of the subjects' language competence. The strategies allow the researcher to confront the subject either spontaneously or after an observed scenario. The confrontation opens up one's understanding for the subject's lived world, through the subject's own explanation of their attitudes and actions, and also explanations to such decision making.

Consequently, participative observation will produce the practical data of actions while the preferred interviews will produce data of self reasoning (Fangen, 2010, p. 172). Both types of data material collected will validate each other's method of data collection. At the end of the data analysis, the researcher will be able to reconcile the interpretations obtained from both methods and involved actors in the study.

3.3 Selection of subjects and setting

I posted a notice to the Facebook group for PPs, requiring acquaintance of a PP that leads a movement group for immigrant women. The notice led to contact with a PP, then my secondment with the movement group in a local-based mental health care service in Oslo. The secondment was aimed to gain an overview of the content and context of the group, and at the

same time to enable prior evaluation if it was relevant to the research. The research was subsequently engaged and plan was made for the next moves.

According to the PP, the movement group is a low-threshold service, offering activities aiming to better the women's health awareness; to advocate them the connection between their psychological distresses and their physical disturbances, sense of presence and to relieve pain. There are several ways in which the women come in contact with the group. These are firstly the centre's own awareness plan; secondly by doctor's recommendation and thirdly by sharing of knowledge among countrymen. The most common health issues faced by these women are body pain and the emotion of reduced vitality. Each session has an average attendance of 10 women; these women are mainly from the Middle Eastern countries, Eastern and Northern Africa. Their age ranges between 30 to 60 years old. Most of the women are married and have children, either young ones or adults. The session takes place once a week, at noon, for 60 minutes.

The training hall is constructed with changing rooms for male and females, and a small storage room. All rooms are fitted with proper lightings. Training equipments such as treadmills, rowing machines and stationary bicycles are also placed at the corner of the hall. There are long-glassed windows and a glassed door facing the sidewalk to the main road, and a full length mirror. Other necessary equipments such as stereo system and training mats are easily accessed.

3.4 Ethical considerations

Based on the selection of subjects and setting, a formal notification to the Norwegian Centre for Research Data (NSD) (undated) is required. NSD assists researchers with the necessary legal and ethical guidelines. The project plan and the letter of request participation were sent to NSD for approval prior to executing the data collection.

The women in the movement group attended a short meeting where information of the project was given together with the purpose and the process of the research. The meeting also highlighted the degree of confidentiality; the women will not be identifiable by their actual names or the centre in which they attended the group. They will instead each be given a pseudonym and this will be used in the data analysis. They were also informed of their rights to withdraw their participations from the study at any time and there would be no

consequences from their withdrawals. They were all invited to join the project and were given a letter of request participation each which they signed immediately.

3.5 Data collection

The participative observations were completed within a period of four months from December 2016 till March 2017, once a month. The first observation day was attended by twelve women, nine women on the second observation day and five women on last two observation days. All participative observations were at the venue in Oslo, at noon, for 60 minutes. Each session included exercises that involved active movement of the extremities dynamically or statically in various body positions together with conversations either as they became relevant or by coincidence. Last but not least, the sessions included focus on teamwork and relaxation. All these were performed at a moderate pace in a training room.

Each completed observation was made with handwritten field notes in Norwegian that comprised details in words of what was being observed and heard, what bodily experience encountered during contact with the other participants, and reflections of incipient interpretation. These handwritten field notes were then converted to English and transferred to a computer written Word-file.

The first three interviews were completed on the third observation day and the final one in the following month. The conversation was completed individually in a quiet room just beside the training room, and it was performed in the Norwegian language. An interview guide with questions in Norwegian was used to guide the course of the conversation; the subject's personal background was noted and relevant issues concerning the movement group were also noted. The questions were formulated as open questions as recommended by Fangen (2010, p. 174). A few examples of the open questions were, "What do you experience when meeting the other women in the group?" "How would you describe your relationship with the therapist?" "Can you explain the reasons for your choice of clothing to attend the group?" Reconstructing of the questions needed to be done spontaneously; the reconstructed questions were in shorter versions, repetitive and led closely to the answers needed. Table 1 presents the interviewees with pseudonyms, with the necessary details that are relevant for later use in the discussions.

Table 1 List of interviewees with pseudonyms

Rosa	Iren	Zadia	Marie
29 years old	41 years old	45 years old	54 years old
Middle Eastern	Southern Asia	Northern Africa	Southern Asia
Same ethnicity spouse. 4 children.			
Arrived in 2010	Arrived in 1998	Arrived in 1998	Could not recall
Attended all 4 observation days	Attended all 4 Observation days	Attended 2 observation days	Attended 3 observation days
Able to converse in Norwegian	Able to converse in Norwegian	Difficulty to converse in Norwegian	Difficulty to converse in Norwegian

Other spontaneous conversations obtained during participative observation were also taken in as part of the data material for interview, but not presented in Table 1 as interviewee. All interviews were also noted by hand in Norwegian. They were later rewritten in English and transferred to a computer written Word-file.

3.6 Data analysis

Repetitive questioning, reading and organising the material are routines of qualitative data analysis. These processes enable the researcher to summarize the answers systematically, understandably and with relevance to the problem statement (Malterud, 2011, p. 91). There are many common features between systematic text condensation (Malterud, 2011, p. 96) and qualitative content analysis (Graneheim & Lundman, 2003, p. 106), and I am inspired by these techniques, but have chosen to illustrate the process of analyses using qualitative content analysis (Graneheim & Lundman, 2003). Table 2 shows segment of the process in data analysis.

Table 2 Process of data analyses

Meaning unit	Condensed meaning unit	Code (underlying meaning)	Subtheme	Theme
A list of words, statements and paragraphs of notes from observation and conversation, relating to the similar content and context.	A summary version of meaning unit. The essence of content and context is preserved.	To discover the data materials in condensed meaning unit from a different angle. Shared commonality of content.	The linkage of codes to domain that shares details of a subjective experience.	
"The first few women were dressed in their traditional costumes in which I would describe as layers of long colourful fabrics. They also had on their head covers, or known as hijab."	*-dressed in their traditional costumes -layers of long colourful fabrics - hijab*	*Participation with own clothing*	*Self decision making*	*Practical doing*

I find the above mentioned analysis techniques are suitable based on the amount of data material obtained. Its step by step guidance is understandable, guiding me to discover happenings in a systematic way and enabling me to gather sufficient information to answer the problem statements (Graneheim & Lundman, 2004, p. 106).

I have accumulated meaning unit extracted from field notes of observation and interview notes side by side, based on their similarities of content and context. Then, I coded them from a new angle, giving them new understanding of the core content and context. Last but not least, identify them into small themes (issues) before classifying them under a head theme.

For more details of data analysis, please see attached appendices 4 and 5; Field note day 1 and Analysis sheet –clothing.

3.7 Critical reflections over methodology

Reflexivity, transferability and reliability are the few guidelines that must be critically considered throughout the course of this research (Malterud, 2001, p. 483-484; Fangen, 2010, p. 251-252), in which its purposes are to explore the movement group for the immigrant women.

3.7.1 Reflexivity

Reflexivity is a commitment when one chooses to do a qualitative approach. One is advised to be alert and to be open of decisions made during the research, in order to defy the claim of only observing potential perspectives by interest (Malterud, 2001). Wilson (2015) added in the phenomenological research that one has to be cautious of one's own lived experience not to tarnish the subject's lived experience; one is also advised to be open to the line between preconceptions and interpretation. In this way the possibility that newly discovered knowledge will come to surface is feasibly widened.

I am rather concerned with my own preconceptions based on the guidelines. I have earlier presented my professional background in the first chapter. As for my personal background, I am an immigrant myself who came to Norway for 16 years ago at the age of 27, and I am an Asian Chinese woman originally from a South-Eastern Asia country which practises Islam as its official religion. I am categorized as a family immigrant, in which I have a Norwegian spouse. My journey to Norway was based on voluntary ground and carried none-traumatic experiences. Even so, my own experience has been challenging since day one. The simplest adjustments for the daily day to day living such as food, clothing, climate has required a great sense of coping, even more coping has been needed to meet the learning process of a new language and social anticipations. These processes have definitely made marks on my personal experiences in all aspects as bodily, psychologically and environmentally.

I have experienced the pros and cons of my preconceptions in different stages of the study. My personal background has made an impact when I met the women on the secondment day. I presented myself and the women promptly showed their interests in my background. I assumed that the above situations opened up a great deal of opportunity for this research; firstly, the women were willing to join the research at once after getting to know my background, secondly, the unsaid mutual understanding of having the same status as immigrant and lastly, to have the rather similar necessary readjustments to living in a new country. On the other hand, my professional knowledge of understanding of the women's health conditions and consequences of not striving for a functional recovery were rather overwhelmed. I was drawn to the urge of providing these women with substantial help.

I ought to be more aware of my role as a researcher in this project; I ought to be aware of the tendency or spontaneity to jump into conclusions based on earlier experiences. To keep these at bay, I choose to include my incipient interpretations as part of the data collected and use them in the later work of discussion. I have also consequently reminded myself to keep my interpretations open and focus on the problem statements. Moreover, I involve myself actively with discussion and reflection during supervision with my thesis supervisor, both individually and in group.

3.7.2 Transferability

Transferability is dependable on internal and external validity. Internal validity consists of sampling the appropriate materials that relate to the research questions/ problem statement and external validity is to contextualize the setting in which the findings can be implemented (Malterud, 2001, p. 484-485).

The research theme of movement group and immigrants has long been a great interest. However, the process of recruiting the appropriate subject and setting demanded time. The main reason is that there were only a few PPs that lead such group. When one was found, a round of survey was immediately initialized (see 3.3; Fangen, 2010, p. 52). Even though the discovery was by coincidence, it was clearly a relevant choice to the research theme both of the subjects and setting. The movement group is strictly for the immigrants and Oslo city has more immigrants than any other city in Norway. This form of sampling was an obvious purposive sampling due to the survey initialed beforehand (Malterud, 2011, p. 56; Fangen, 2010, p. 52). It was advised that the number of selected data items in qualitative method is not

as strict as in quantitative method. Other more important advices were encouraged; the subjects share certain similarities, enable to provide the information that is relevant to the research theme and most importantly, the prospect of transferring the research findings to the similar context in the society (Fangen, 2010, p. 54-57; Malterud, 2011, p. 59 & Johannessen et al., 2010).

On the other hand, there are a few factors in the data collection that are extremely crucial to the issue of validity. Firstly, the number of subjects observed is inconsistent due to unstable attendances, and also the decision made at third and fourth observation day for the sessions of interview. These might cause insufficiency of a particular subject observed from session to session, and also loss of relevant observation data. Secondly, the language mastery of the women required immediate modification of the interview, from open question to closed question. For example, “How do these exercises affect your disturbances?” to “Do you feel more or less pain when you stand up and move your arms at the same time?” The immediate modification of question was indirectly giving the women limited alternatives of answers, “yes/no/I don’t know/no comment”. In my opinion, there is a great loss of information that possibly could be obtained if the questions were to remain open. Thirdly, the different level of language mastery influenced also the level of mutual understanding, the purposes of the study and their personal interpretations of the situations they were placed in. The need to consider hiring an interpreter to overcome the language barrier has been clearly reflected during the course of data collection. The decision of not hiring an interpreter could probably be the cause of the issues above, but on the contrary the decision of hiring could lead to more challenges than anticipated both for the women and the researcher, as advised in Horntvedt (2015, p. 107) of the cumbersomeness and cost to hire interpreter. Last but not least, the handwritten field notes and interview notes were in Norwegian, and later on translated to English. This can cause either loss of underlying meanings in the original text or inaccurate translation from Norwegian to English.

Despite the above concerns and reflection process, I am still confident to producing a reliable research study. The criterion of reliability in a research study is that the findings of the data collection and analysis can be reproduced if the research is repeated by another researcher. In order to maintain the research’s reliability, one has to present clearly the procedures undertaken starting from the data collection to data analysis, not forgetting the findings of data analyses according to presented theoretical framework (Fangen, 2010, p. 250-252). One

way of presenting reliability in participative observation is that the researcher reproduces its field notes. Thus I choose to present two pieces of my analysis work as appendices to this thesis; Appendix 4, Field note Observation day 1 and Appendix 5, Analysis sheet –clothing.

4.0 FINDINGS

This chapter will present the findings of the participative observations and unstructured interviews. Three main findings emerged from the data analyses: content and context of the movement group, practical doing and continuity.

4.1 Content and context of the movement group

4.1.1 Activities, level of awareness, togetherness

In my conversations with the interviewees, they told me that their travel time to the training centre was between 10 to 15 minutes, either on foot or by local public transport. The travel time and mode of transport did not seem to be an issue.

I observed that the PP placed the women in a 16 square metres space with all necessary equipment nearby. The window blinds would be drawn down by one of the women. PP gave information and instructed the women in Norwegian language. “Do you understand what I just said?” (In Norwegian: “*forstår dere hva jeg sa?”*), she set her eye contact to everyone in the circle. PP would ask the women again if they received or understood what was said. The women would then refer to each other, to the one sitting closest to them for better explanation, in their native language. Then, they would answer the PP, “yes/no” or by head movement nodding/shaking it.

The exercises were arranged in the following sequences; individual, two by two, small group of 5, the whole group and individual again. The individual exercises were performed various positions; sitting on chairs, standing and lying on floor mats. While sitting, the women would use a spiky ball and roll it along their arms, legs and back repetitively. The movement was slow and easy to be followed up. While standing, the women would move their extremities in various combined movement; making circle movement with their feet, weight transferring from one leg to another, lifting their arms in various directions. The movement here started to increase in pace and the women seemed to show differences in their performance. Several movements seemed not optimal; when they extended their arms, they extended with flexed elbows. Their movement seemed to lacking agility and spontaneity. Most of the women also

kept constant eye contact, either at the PP or at the other women during instructions. They initialed movement not during instructions, but after close eye contact.

Lying on floor included exercises for muscles at stomach and spine region, in addition to relaxation. PP used “hands on” method occasionally to make aware of the women of these body regions.

The exercise of throw and catch balloon was performed in pairs. The small group exercise included dance to the music, throwing a soft foam ball to each other in a circle. The whole group exercise included a kind of “tug of war” routine where the woman each held on to a long rope, they were instructed to pull or push, to lift or to lower. These group exercises were performed at a moderate pace, there were differences in their performance and it caused a different feeling in the room. Some women moved faster in their limbs, some had to pick up the ball repeatedly from the floor, some had difficulty to coordinate the upper and lower limb, some managed to cooperate with their partners with stable flow, and there was either laughter or concentration in the air.

In paired exercise, these were paired; Rosa and Iren, Zadia and Marie. Rosa and Iren seemed to hold their balloon up in the air for rather a long time before they giggled and the balloon would fall on the floor. While Zadia and Marie managed to keep the balloon up in air in shorter time, and spent more time in picking up the balloon up from the floor. Each of them took a break in turn so that the one left with the activity had to look for another partner to continue with the activity. When any of them rejoined the ongoing activity, no one seemed to reject them, not the PP not the other partner in pair. But instead the activity was stopped for a process of rearrangement and continued on after the rearrangement was accomplished.

In group exercise, PP played the song Pata Pata, sung by a South African artist, Miriam Makeba. The women looked at each other and burst into mild laughs. They formed a circle and started to move to the rhythm of the music; their feet and hips, their spine and arms, there were happy faces. Their body movement seemed contraindicating to their aforementioned disturbances, the movement seemed accordingly to the rhythm of the music, pain free and filled with liveliness. They stood in a circle, inviting two by two in the circle to show their moves, and this continued on till the song was over. When it was over, they laughed and made small conversations with each other.

Besides the exercises, these women were accommodated with frequent short breaks of a few minutes. The women would use the short break to talk to each other, doing adjustments to their clothing, and a few strolled around waiting for the next exercise.

PP would also strike up a conversation during session; asking the women's body state at that moment and how a particular exercise was experienced, in addition to reminding them the breathing techniques. Relevant themes such as the cause of stress and its effect, use of crampons on icy road to prevent fall were also taken up. Again, the conversation between the PP and the women were repetitive, and the women were also actively referring to the one who was closest to them in the placement to confirm the content of conversation, in their known language or in Norwegian.

In our conversations, the interviewees were rather satisfied with the arrangement and exercises given. Rosa mentioned that the group being strictly for women is a plus and was pleased with all given exercises. While Iren could not comment on the exercises as she knew no other. However, she believed that the exercises given were directly focused to the physical disturbances faced by most of the women in the group; in the region of neck, shoulder and spine. She also preferred low paced exercises, especially the final session of relaxation.

On the other hand, Zadia enclosed more expressions of the content and context of the group, verbally and non-verbally. Pointing with one hand to her chest, Zadia expressed "I can feel it's tightening up here if the room is too dark". She looked down and paused a long moment. Her eyes seemed teary. Then, she added, "I like bright rooms". When I asked her of the issue of window blinds, she seemed not react much of to it. She was also showing concern of the exercises that could be strenuous and that the room could be too crowded and noisy. "When it's noisy and too many people in the room, I get headache..."

4.2 Practical doing

4.2.1 Participation at own premises

During participative observations, the irregular arrival time and attendance were obvious; a few women would arrive 15 minutes earlier and a few women would arrive 15 minutes later. Half an hour passed the actual time the group should initiate, one would finally get the final number of attendance. The first observation day had final number of 12 women, 9 women on the next and last two of 5 women.

During interview with Iren, she claimed that she does not like to be late, but she explained that there could be many things that would come in the way. That made it difficult to be punctual. She also presumed one of the reasons for the others being late was probably; the motivation for attending the session came later than anticipated. She added the motto “better late than not go”.

The third day of participative observation, the PP asked the women what they thought might be the probable reason for such a low attendance rate. The women answered almost simultaneously, “slippery!” It had been under zero temperature in Oslo the past few days and the other women did not want to experience slippery road condition and most importantly, to avoid fall. They chose to stay indoors.

During my conversation with Rosa, she persisted that PP should be stricter of the issue of punctuality. A sense of irritation cut through her voice. She continued, “...the women did not seem to bother even if the PP had repeatedly reminded them verbally and on written reminders...”

A few of my participative observations included one of the women would ask for permission to leave the session. After permission was acknowledged, the woman walked to the corner of the room and started her routines for her ritual of prayer. PP and the rest of the women seemed neither interrupted nor affected by this behaviour, but instead they continued on with their activities. After completion of her ritual for approximately 10 minutes, she joined the session again. PP rearranged the woman’s initial position and continued on.

Marie and Zadia took frequent non-accommodated short breaks during exercises, performed individually or in group, one at a time or simultaneously. It was a short break of a few minutes. When any of them or both of them joined the ongoing activity after the short break, the PP and the other women would not only immediately rearrange their own positions, they would also position Marie and Zadia to the ongoing activity.

During my conversation with Marie, she explained, “I have to take short break. I sit long time, I get pain. I go on the treadmill for little, and come back to the group, I am better then...”

My conversation with Zadia, Zadia explained “some of the exercises are strenuous...they give me more pain. I take break then by sitting down”

My conversation with Rosa, Rosa seemed agitated, “these women should try to do the exercises, if they want to rest they should do it at home, when they are here they should do the exercises, try their best”

During the second relaxation exercise, which was the final part of the session, I observed that two of the women did not perform the exercise. They tidied up the hall; they moved the chairs, they picked up spiky balls and balancing mats, and placed them in the equipment room. Another relaxation exercise, a few women who did not perform the exercise went to the changing room. The murmuring of their conversations inside the changing room could be heard in the hall.

4.2.2 Participation with own clothing

My participative observations noticed that there was clear costume segregation between these women; half of the group members attended session with loosened blouses and trousers in addition to their *hijab*, and one woman would put on a loosened T- shirt, fitted training pants and took off her *hijab*. The rest of the women would come with their traditional costumes; layers of fabrics of ankle length and hip length *hijab*.

Frequent adjustments of fabricated layers and *hijab* were noticeable, to facilitate to the criteria of particular exercise or to replace the costume to its original position.

My conversation with Rosa, who usually put on a loosened T-shirt and fitted training pants, she persisted again that PP should be stricter of customized clothing for the movement group. She was again, irritated that the other women did not take into consideration of PP’s recommendation. She described that the room would smell of unpleasant body odor and sweat.

Iren explained her choice of clothing during our conversation; loosened T-shirt, a pair of trousers and *hijab*. She added, “I have these clothes on because I don’t want to spend money on myself. I use the money on my children that needs obviously more than me” “I feel also these clothes that I have on me are ok, ok to move around with these in the group.” She presumed that the other women whom came with their traditional costumes would have the same explanation as hers, which was family priority and comfort. However, she did not deny that the reason could be based on the issue of religion too. “Whatever it is, it is ok. I accept

whatever they choose to put on to attend the group." "I don't intend to create any conflict here as I have enough problems of my own".

During my conversation with Zadia who had on rather similar clothing as Iren; loosened T-shirt, a pair of trousers and *hijab*. Zadia recalled herself stumbling upon the lengthy layered dresses that she used to put on before. "I don't want to fall again," "I use these now", as she pointed to her present clothing.

When Marie was confronted with her choice of clothing in our conversation; traditional lengthy blouse and trousers, in addition to *hijab*, she smiled and answered, "I want. I like."

During participative observation, one of the women who was not interviewed was asked of her choice of clothing. She had on layers of lengthy fabrics in addition to her lengthy *hijab*. She told me, "...it is cold here...brrrr," as she giggled and flipped up her layers of fabrics to show me what was underneath; it was a rather thick layer of wool and three layers of various thin fabrics.

4.3 Continuity

4.3.1 Room and time to treat, motivation and the therapist

During the conversations, the interviewees informed of their experience under the Norwegian Labour and Welfare Administration (NAV)'s administrative procedures.

Rosa told her story, "I came to Norway about 7 years ago. I have worked in the groceries store, kindergarten and in the governmental office." "My pain problem started after the birth of my youngest child..." "It started with pain in my legs, later all of my upper body, and I could feel lack of liveliness in my body." "It was like I have no strength and want to lie down and sleep all the time" "At the worst state of my health, I felt loss of muscle strength in my legs." She sought first individual physiotherapy and then, she joined the group last year. She quit the individual therapy recently and started to only focusing on this group. When she was asked of her pain disturbances each time after the group, she described them as "not worsened, not better". She also confirmed, "I like to be in the group. It was really nice to be able to meet other women".

Iren's story started with her working experience, "I used to work as a waitress." "I liked the job, but at the same time I experienced pain in my body" "I did not want to be bothered with

the pain in the beginning, I was hoping that the pain would eventually go away naturally" "But it did not, instead it got worse that I needed to get treatment". She underwent individual physiotherapy for a period of time, but had to quit because of her financial situation. That was when she started coming to the group. When she asked of her bodily experience after the group, she confirmed that she still experience similar pain. "I still want to come to the group because it has helped me to maintain my activity level" "I feel also happy during and after I have been at the group!"

During our conversation, Marie told me that she used to work as a cleaner before she became unemployed. When she was asked of the year she moved to Norway, she had difficulty to remembering the year, the same happened when I asked her of when she started joining the group. As we went on our conversation, she would suddenly recall the year that she came to Norway and the year she joined the group. "I have pain at my neck, shoulders and back..." she said as she pointed the body regions. "...and my doctor told me to come here" She has regular doctor appointment and seemed content with the arrangement. She added, "NAV is after me all the time so my doctor helps me." She expressed feeling tired after each group, but in a positive way as she said, "Tired but it's OK." She took also pleasure of meeting the other women in the group, as she phrased it, "I feel a little better after the group".

Zadia started her conversation by asking, "Is this conversation going to be sent to NAV?" I shook my head and was bewildered by the question. She nodded and continued to inform of her earlier working experiences. "I worked as a clerk in the government office and later as an assistant in the kindergarten." "I have hypertension, hypothyroidism and depression..." she looked down, and continued, "I have many medicines every day and it was stressful to follow the routines for the medication." Zadia has been followed up by three health professionals; NPMP individual with another PP, psychologist at a local district psychiatric hospital and the movement group. She expressed her gratitude for all the help that she has received, as she placed both her hands close to her chest. "I thank you to them..." "But I am still no good, I have pain, I am tired..." her eyes were almost teary; her voice was low and her upper body in a flexed position. Despite her situation not showing any improvement, she still insisted of continuing with the group. "I do exercise, I want to get well...", as she expressed repeatedly.

When the interviewees were asked of their views of the PP, their expressions seemed to collectively show great fondness. Their faces gave expressions of satisfaction and delight.

They smiled. “She is very kind” “She is like a good friend” “She cares for us and I care for her” were their words of expressions.

During participative observations, the PP would glance at the women who just walked into the training hall. The woman would nod to her in which she returned the same nod back to the woman. The PP remembered every woman’s name. She would address the woman’s name as she requested her to write down on the list of attendance. During activity and instructions, the PP would smile and encourage the women to get moving, to push away their worries by stroking from the shoulder to the hand and out in the air repeatedly and one arm at a time, to feel their feet, their legs, and their hips and so on. She would participate in the activities together with the women. During accommodated short breaks, the women would approach the PP for various assistances, from the complaints of body pain to practical help in contact with her doctor. The PP would take time to answer the women. When the group was over, the PP would tidy up the room and here, the women were also actively tidying up the room.

5.0 DISCUSSION

The problem statements of the study were as follows;

What are the characteristics of the movement group for immigrant women?

What encourages the women to attend and to be in the group?

The data analysis showed three central findings; content and context of the group, practical doing and continuity. In this section, I will discuss the findings in light of the literatures in chapter 1 and the theoretical frameworks laid out in chapter two.

5.1 The structured frames and its two-ways effects

The movement group was set up in a structured frame, in which it was located in a local based health care centre with proper training facilities. Since it was locally based, it was meant to be easily access by local participants. The average time of travel from their home to the centre has been confirmed to be approximately 15 minutes. The group was offered once a week, on the same day and same time, for 60 minutes. This group was arranged only for immigrant women and it was a low threshold service. The regularity of scheduled venue, time and duration, in addition to it being zero cost and of the same sex participants resonated with the study of Khan et al. (2012) where these implications were claimed to be promoting adults with psychological distress, to be more active. The structured frame also seemed to follow recommendations by WHO (2016), Ministries (2007) and MHCS (2005), in addition to Rongved's (2016) descriptions for motion practice.

Despite the above structured frame, punctuality was clearly a challenging issue, as the women tend to arrive later than scheduled time. The findings of interview showed contradictory behaviours, in which they did confirm the travel and time estimated to arrival seemed non problematic at all, yet they excused the delay by quote "better late than not go", unexpected situation that interfered leaving the house on time, to the uncontrollable climate change. Not only arrival time was an issue, the women seemed to accommodate their leaving time and attendance on their own. The findings seemed to be representing the women's orientation to time according to the activity of their present interest, instead of activity offered within the scheduled start and end clock time, in addition to its time duration (Galanti, 2015, p. 60). The

combination of the many issues raised not only question of more firmness needed for the frame, it also evoked question of if these hinder the women's course of convalescing. The fact that these women had actually followed up and been followed up in the group for a period of time still did not change their behaviour toward time perspective seems concerning.

Self decision making in this study or autonomy as aforementioned by Lindwall (cited by Lindwall and Asci, 2014, p. 97), is known to be essential factor when promoting mental health. The women made their decisions of their participations in the group. The decisions included; to attend or not to attend, to leave home at the appropriate time in order to be there at scheduled time or to leave home anytime so that I attend the group, time to leave the group. These decisions were made not only intentionally, but there were also other external circumstances that could be in the way such as call from school for a sick child or the woman actually felt under the weather that particular day. Any ways of the decision made, it was made intentionally and also based on the SOC; the woman was motivated to attend the group process with the state of her body functions, that she could anticipate the day's challenges bodily and mentally, and that she had faith in her state of body functions could manage the upcoming day's challenge, may it be the group or other obstacles to come. As I see it from perspective of mental health, the structured frame should be indirectly lessening the woman's instability in her SOC; no matter she is attending for the first time or has been several times. However, this appears to be an issue that needs more work to improve it.

These women arrived and sat down at the defined placement. This allowed direct vision of every one participating and eye contact in an appropriate distance. It gave the women the flexibility, or the space to vary their eye focus; they could consciously or unconsciously direct their vision to the therapist, to their own selves or to the others. Visibility has been claimed to allow imitation, in addition to reaffirming of own bodily experiences or movement in comparison with the others (Kjølstad, 2004, p. 49). The therapist had easy access to notice each woman's bodily movement and breathing patterns, and this seemed to allow corrugation when needed, either verbally or a combination of words and hands facilitation. The therapist gave exercise instructions in Norwegian, short sentenced and repeatedly. Her verbal corrugations were rather similar as the instructions and her touches were brisk. The defined placement is also a form practical arrangement as mentioned in the therapeutic alliance (Løvlie Schibbye, 2012), in which it accommodates mutual understanding of the

communication between the therapist and the woman individually, and among the women themselves.

From my professional perspective, the exercises given seemed to move about from the NPMP approach of supportive to readjustment (Gretland, 2007). The starting exercise seemed to encourage the women to awaken each of their extremities one by one, slowly establish contact and loosen up the tense. The exercises continued on with more coordination of the upper and lower body, they seemed to encourage the women to experience the ability of mobilization and stabilization simultaneously. When mobility and stability became more established, the content of exercise continued to expand, increasing pace with coordinated movements of extremities, individually or in cooperation with the other. The above seemed to confirm the scientific impression of psychophysiological and biological feedbacks presented in section 2.3 (cited by Lindwall & Asci, 2014, p. 97; Burton et al., 2004; Martinsen, 2004). The women proved their abilities to work themselves physically up to another level of intensity, accordingly to their own bodily resources; their breathing patterns changed, they smiled, they laughed, they became chattier. The atmosphere changed from quiet to a lively one, the women who were at beginning seemed serious were now acting playful. The combination of smile, laughter and playfulness, as I experience it in the common daily living, are expressions of enjoyment or fun. The fact that the women were actually doing the exercises based on their bodily resources and at the same time enjoyed the exercises seemed to resonate with the notion of intrinsic motivation, as I quote “Intrinsic motivation is the motivation to do something for its own sake in the absence of external (extrinsic) rewards. Often this involves fun, enjoyment and satisfaction such as recreational activities and hobbies” (Biddle & Mutrie, 2008, p. 78). Seeing the findings in combination with the above quote, I would like to believe that the exercise-participation helps to stimulate the women’s mental well-being and subsequently reliving physical wellness.

5.2 Being mentally and physically present

The structured frames derive the many emphasizes of intervention for mental well-being in chapter 1 and theoretical framework in chapter 2. Nonetheless, there are a few contrarieties that need to be critically discussed. These contrarieties involve the women’s level of awareness during activities, and the inconsistency of communication between the women and the therapist.

5.2.1 The coalescence of past and present body experience

The women's level of awareness was noticed especially during paired and grouped exercises. The observations obtained from the two rather outstanding sessions were the task of keeping the balloon in the air and the task of dancing to the African tune, Pata Pata. In the first activity named, several women seemed unable to focus and perform movement in an optimal pace and coordination, and accordingly to the partner's movement and pace. They had to repeatedly pick the balloon up from the floor and return their focus back to the partner, and to repeatedly initiate the bodily coordination for the task. All these actions that were observed caused delay in the activity pace and affected the quality of task performed. It also seemed to be demanding more body energy to facilitate one's bodily and psychologically need in order to continue with the cooperated task. Their lack of awareness seemed also to cause chaos, physically and environmentally.

Gretland (2007) mentioned the factors for sustaining calmness and grasping the experience was by applying specific focus, internally and externally. Martinsen (2008) reminded of the interplay between the brain, the body and the psychological aspects. The interplay seemed to be determining in this scenario of performance. I add Csikszentmihalyi's (2014) assertion of subjective experiences of thoughts, feelings and sensations as factors that affect one's level of awareness, or as he termed it consciousness. He specified that the input of information as the core for one's behavioural reaction of consciousness, and the channels of input were of both internal and external sources. Again, these inputs required one's energy to keep its consciousness in active state, may it be in the count of calories or essential psychological process. One way or another the term for one's awareness is explained, the bottom line seemed to distinguish the individual needs to integrate the internal and external stimulations in order to experience an optimal balance of the task performed. Unfortunately, the first observation seemed not to resonate with the given explanations, instead the women showed tendencies to separate their physical and mental state through their observed reactions.

On the other interpretation of this activity, NAV follow-up was taken up during conversations. The conversations noted a few expressions by the interviewees that seemed to reveal their insecurity and anxiety. The women also indicated non-accommodated breaks as an act of physical need, or it implicated the requirement of the task actually exceeded their capabilities to cope. As a health professional, it is quite common practice that one is contacted by NAV to get an update of patient's health state. NAV needs the updated information to

evaluate of the patient's ability to either acquire a job or to continually be provided of social welfare. Seeing these given circumstances of NAV and inability to cope with task, these women were obviously experiencing disturbances of their level of awareness; they not only used more energy to mobilize their extremities, they also need to insert extra effort to not be distracted by the reality of having an authority to constantly keeping an eye on them.

In the second named activity, there was an indescribable spontaneous shift of the women's level of awareness (Gretland, 2007). Their dance movement seemed to stage the idea of embodiment, the integration of body phenomenology, the magnificent cooperation of body image and schema (Gallagher, 2001). The minimalism of body disturbances and psychological distress seemed to exist here, as their body movements and mental presence seem to balance the effort needed, internally and externally. They seemed to move presently, but with the knowledge they had from the past; listening to a familiar tune from their earlier cultural influence, accordingly to the familiar body movements from their lived lives from the past (Råheim, 2003). Not only one of them who staged these familiarities, but the majority in the group. This precious moment was not only lived individually, but also in solidarity (Kjølstad, 2004).

So, does this mean that the women's level of awareness is not only dependent on the internal and external input of information, but it is also dependent of a known movement or as I would label it "bodily memory from their past"? In the framework of body phenomenology (Gretland, 2007; Duesund, 2008), it was stated that an individual's past experience is a contributor to how the individual handles the present situation. If the present situation is of unknown moments of the past, the body needs to be modified and learn new ways of being. Indirectly, the group content provided space for the women to explore new moving patterns and also to move habitually. As I place these scenarios into the aims for the NPMP treatment of supportive and readjustment, the habitual movement tends to provide supporting elements and the non-manageable task tends to challenge the women's ability to readjustment. The mixture of exercises given in the structured frames, as I presumed, will create a newly way of body movement over time, either their past movement will be integrated to the new one, or vice versa. The newly established movement, as I presumed again, will be exclusively owned by the women, individually and mutually in group. And most importantly, one's ability to acknowledge support and allow readjustment could help to prevent one to objectify its bodily disturbances, but instead subjectify (or make experience of) the disturbances through an

intentional task with the tolerable body schema and rational body image (Råheim, 2003; Gallagher, 2001). Thus, one's potential to well-being, physically and mentally, would also be encouraged.

5.2.2 The channels of verbal and non-verbal communication

The intercultural communication is challenged when there is a variation of language competency and a non-mutual understanding of biomedical practise (Thornquist, 2006; Horntvedt, 2015). These were illustrated by the following obtained observations;

i) The therapist gave instructions and information in Norwegian. She would repeat after herself.
ii) Several women chose not to complete the whole course of the activities incorporated in the group, they particularly excluded the relaxation exercise.

The therapist's experience of the women having difficulties to receive either instruction or information was likely to appear in her manners of constant repetition. Not only oral and written reminders needed, the therapist had also the need to allocate time from message conveyed, to message received and finally message being processed. One of the many anticipated capabilities of an experienced therapist was explicitly mentioned by Tvedten (2013), which was responsiveness. Implying this in the discussed context, I am assuming that responsiveness is a process of back and forth, between the therapist as a messenger and the women as receivers. The therapist and the women must find, as I am describing it as the cognitive meeting point; the message given must be easily processed by the receiver and the receiver must be able to respond as anticipated by the sender. Again, the shear movement of back and forth is probably caused by the necessity of affirming and reaffirming that message transported is accurately interpreted by both parties. As I see this happening in the study, I am agreeing with the therapist to spend more time for communication, this allocates not only room for confirmation, it also enable room for reflection and explanation.

The second observation of unwillingness to complete the relaxation exercise, as I presumed, was probably due to lacking understanding of the procedures. From my professional knowledge, relaxation in NPMP is usually performed in a supine position with closed eyes. The position allows whole body contact with the ground and the closed eyes excludes unnecessary stimulations from the external environment. The individual will then listen to the therapist's soothing voice to guide its attention to its physical state, from top till toe or vice

versa, in addition to making one aware of its breathing patterns. Personally, I have experienced this exercise to anticipate the individual's term understanding of the body parts, it also acquire high degree of understanding for the body being in the present state. My professional and personal knowledge coincided during the relaxation exercise, thus I experienced no difficulty to undergo the exercise. The interviewees who managed the exercise seemed to confirm my personal experience, by their expressions of contentment and satisfaction. Despite the unavailable reasoning of those who excluded the exercise, the situation still draw the need of additional measures in order to promote the women's engagement to the whole course, and most importantly for the women to increase their body awareness.

NPMP includes various approaches during therapy and one of them is massage. It is reminded that this measure should be intervened accordingly to the individual's permissible pace and space (Gretland, 2007). In Ekerholt and Bergland (2006), the effect of NPMP massage on patients who suffered psychosomatic or musculoskeletal disorders was studied. Massage was mentioned to be a treatment performed by the therapist's hands through touch and manipulation of the soft tissues of the body. One of the many results obtained was the ambiguity between pleasure and provocation, or as quoted from the study "Massage could be agreeable and relaxing, but could also open up for unpleasant feelings" (Ekerholt & Bergland, 2006, p. 139). In another study by Hiller, Delany and Guillemin (2015), touch was explained to be crucial form of function. It was used during assessment and treatment, and also to conceive the patient's biomedical perspective. The patients confirmed that the touch that they received during therapy was an acknowledgement of genuine care and trustworthiness for the therapist.

In the findings of this study, it was mentioned the therapist being "hands on" or applied touches during relaxation exercise. However, her touches were seen to be brisk. Before I go any further with the discussion, it is essential to bear in mind that this a low threshold mental health care service and the women joined the group of different channels of requisitions. The women have also various physical and mental disturbances. Based on the mentioned circumstances, the therapist has to be make proper assessment prior to initiating touches that are more firm with a longer stroke, or even a mild form of massage. On the other hand where circumstances are taken care of, the application of firmer touch with longer stroke, or a mild

massage will then presumably showing the results of aforementioned studies, one's physical and mental well-being.

To recite the above scenarios, there were obvious observations that could be used as indicators to invite changes, either by giving more support or challenge readjustment. No matter which methods are chosen, it will be implementing flexibility in the line of verbal and non-verbal communication, as recommended in NPMP approaches of form of contact and conversation (Gretland, 2007), in addition to the therapist's ability to improvise and be creative (Tvedten, 2013).

5.3 The manners of acceptance and collaboration

The women's self decision making concerns also of their participation with own clothing. The obtained findings showed their chosen attires influenced the exercises performed. In another perspective, it could symbolize the women's bodily expression of preserving control of their world and self perception.

A study was conducted in 2012 (Fougner & Horntvedt) where Mesendieck-physiotherapy bachelor students were interviewed of their experiences leading physical activity groups for Muslim women. Among the issues taken up by the students was the choice of training costumes by these women; "very loose fitting and with ankle length, showing no skin except faces and hands" (Fougner & Horntvedt, 2012, p. 21). They expressed the dressing code as hindrance for the women to perform their tasks in an optimal way, and at the same time they wanted desperately to respect the women's culture and religion. This caused silent acceptance, the acceptance in which no other way the situation could be tackled. As time went on, the women tend to discover the reasons for the proper clothing during physical activity and started to dress themselves accordingly. The students indicated that the time the women used to realise of the reasoning, to be an important factor in accommodating their modification process.

The fact that the students chose to respect the women's choice at the beginning and at the same time allowed them to experience physical activity in their chosen clothing was rather a brilliant move. The students chose not to enforce any stringent rule, but instead they waited and saw. Time has allowed the women to go through modification of their past experience in a tolerable pace, the pace that not only allowed them to absorb learning but also to implement the learning to their daily living (Gretland, 2007; Duesund, 2008; Galanti, 2015).

Seeing the context in the perspectives of self perseverance and control, the women in this study would have better overview of the group process when familiar conditions acted to console unexpected circumstances. I recalled my choice of attire to attend the group training in Norway for the first time; my familiar conditions did not fit with the Norwegian context. I experienced inappropriate consciousness over my attires than extending the consciousness over to the exercises provided. My consciousness was evidently split between my body schema and image; I was losing control of the situation. The next time I attended the group again, I readjusted my choice of clothing, to accommodate the norm of the group and the readjustment allowed me to gain my consciousness to an optimal performance of exercise. My personal experience is not fully consolidating with the women's firmness of their choices. However, it indicates how each individual preserves their control and self perception accordingly to their tolerable pace and space. Possibly, these women in the movement group need more time for readjustment in a newly placed situation. When the new situation is stabilized in which it is processed bodily and mentally as secured and acceptable, these women will then allow themselves to explore further readjustment. The readjustment will subsequently forward their SOC to another level (Antonovsky, 1996), where their attitudes towards coping mechanisms in tackling new situations will expand with the appropriate resources, mentally and physically.

This study has so far acknowledged many visible roles of the therapist; the therapist was accommodating and accepting the challenging situation, and at the same time saw the women's disturbances individually and in group, yet able to reward each and every one of them with equal treatment. In the context of therapist in a group therapy, the therapist's visible roles resonated with the specification of benign respect for each other, genuine sincerity and empathetic capabilities (Kjølstad, 2004; Nedrum, 2011). One must also be reminded of the aim for this group; to better the women's health awareness; to advocate them the connection between their psychological distresses to their physical disturbances, sense of presence and to relieve pain (see section 3.3). The therapeutic alliance between the therapist and the women has to acknowledge the aim as a common task; both parties need to contribute their effort to seeing results for the goal. The therapist had so far been the most committed party with extensive approaches to bring out the women's potential of well-being.

Nonetheless, the issue of a more stringent therapist was acknowledged by the interviewees when concerning participation at own premises and clothing. In addition to the participation

of relaxation exercise that was noticed to needing further implementation. These issues show indirectly the women's various level of commitment that needs to be nurtured in order to find the optimal balance for the wholly group process. Remember Tvedten's (2013) findings of therapist need to be aware of its reflections, able to be flexible and creative at improvising? Acknowledging so, the therapist needs to be more courageous to try out new rules. The new rules can be practically explained and set up as goals in the therapeutic alliance.

Take the interviewees' demand; the therapist can allocate a group session only to focus on communicating the issues with the women. An example of the focus can be paying attention to the women's versions of time orientation (Galanti, 2015) and to encourage them to come with solutions that can help them overcome their adaption to changes. This improvisation, not only lead to a mutually understood and progressed therapeutic alliance, it also potentially promote the women's sense of belonging to the group when their opinions are heard and taken seriously. Sense of belonging will then lead the path to having a social network, in a network where everyone is equally important (Sørensen et al., 2008). The same path has been claimed to have the potential of minimising psychological distress, in this case the women would definitely benefit from it.

Take the implementation needed for the relaxation exercise; in spite of the necessary assessment done prior to touch or massage approach (Hiller et al., 2015; Ekerholt & Bergland, 2006), the therapist should try out these approaches more frequently during session. As Tvedten's (2013) findings of flexibility, the therapist has the flexibility to continue or stop such approach when noticing the woman's reaction, either by observing the breathing pattern or directly asking the woman of their experiences. The therapist's flexible approaches also allow the women to experience, to actually experience at their own space and pace. These flexible approaches will eventually encourage the women's awareness, an awareness that will unite their movement and breathing patterns. Again, the same awareness will contribute to each intentional task performed automatically, instead of excessive focus on the real disturbances being in the way (Råheim, 2003; Gallagher, 2001).

5.4 The cycle of preserving well-being in a group

The literature reviews beforehand covered substantial areas of concern and intervention for the immigrants. Several studies showed the challenges of physical activity, psychological well-being and the intercultural communication among immigrants (Abebe et al., 2014;

Jenum & Birkeland, 2003; Kumar et al., 2008; Qureshi, 2005; Hansteen, 2005; Ahlberg & Dahl, 2005). More studies have also indicated the importance of physical activity for mental health (Stewart et al., 1994; Daley, 2014; Hannan et al., 2014; Gallegos-Carillo et al., 2013). And lastly, the studies mentioned by Khan et al. (2012) and cited by Daley (2014) came with implications to intervene these challenges. Unfortunately, they seemed to pinpoint on how to establish an intervention, whereby little was indicated for the factors to sustain patient's continuity of attendance and presence.

These women came together in the group despite their various background contexts; earlier lived experiences of countries and cultures, age and years in Norway. On the other hand, they seemed to come to the same present phase of life; being occupied by their health disturbances and the urge of accomplishing recovery. Placing these phenomenons in the framework of group therapy, one can see the factors like universality, to help another and hope are simply relevant (Kjølstad, 2004, p. 40-47). Being and belonging in the group allow the women to experience that she is not alone with health disturbances, instead they see that there are many others who are "in the same boat" as them. The recognition indirectly prevents isolation and encourages togetherness to overcome the obstacles. Being together with the other women also allow the woman to experience other's way of handling situation, to be utilizing one's own resources to live a functional life. Indirectly, the women are helping each other to obtain their hope for wellness, during the course of the group without much consciousness being verbalized (Kjølstad, 2014; Lindwall & Asci, 2014). In my professional and personal opinions, this must not be kept in low tone but instead should be highly spoken of as the motivator for what continuity in group participation could accomplish.

To be relying continuity of participation specifically to only one aspect at a time could seem both monotonous and detached. Continuity is an ongoing process that needs active actions from all aspects. In the light of the theoretical framework, the women's biological and physiological readjustment needed the allocation of time and room. The women's psychological aspect was seen to be potentially improved with the appropriate accommodations and experiences of being accepted as an individual. The women's sociological factor of being in the group not only was a bonus to their mental well-being, it was also contributing to a network the women appreciated. These benefits seem not realistic without the unconditional understanding and flexibility of the therapist. I somehow could hear the women whispering the quote of "What is important is not an Indian doctor, but a doctor

who cares" (Shapiro et al., 2002, p. 753), instead of their verbal expressions of fondness to the therapist.

Remember my initial curiosity of finding out of movement group when the participants are not composed of ethnic Norwegians, from the discussion chapter, I kind of realize that the participation and continuity is not a one man's work, but instead it's an ongoing process that needs constant attention and improvisation. Thus, it has little to say of the participants were to be ethnic Norwegians or immigrants. Most importantly is both the participants and the therapist are at the same phase of engagement and cooperation, and this sustains continuity.

6.0 SUMMARY

The purpose of the study was to explore the NPMP movement group for immigrants. The subjects for the study were specifically immigrant women in a local-based and low-threshold mental health care service, and the group was led by a NPMP therapist.

Based on the data analyses, three findings were presented; content and context of the movement group, practical doing and continuity. The content and context of the movement group focused mainly of the structured frames accommodated, exercises provided and the women's reactions. While the practical doing consisted of the women's self decision making concerning their situations and exercise attires. Lastly, continuity included the experiences of being in therapy, motivation and the therapeutic alliance. The findings led to discussion in which the whole practice of the movement group was focused. The discussion led to rather inspiring information relating to the problem statements.

The characteristics of the movement group can be seen from two perspectives; the structured frame of content and context, and the women's receptivity of the structured frame. The structured frame was maintained with similar arrangements at every session of the group such as the scheduled time and venue, arranged seating, sequence of exercises and it only offered to women. Despites the few issues concerned, this was showing a more encouraging effect to the women's well-being as it allowed the women to tolerate accordingly, based on their physical and mental resources. The women's receptivity indicated two manners of feedback, the coalescence of their past and present body experience, and also the channels of verbal and non-verbal communication. Again, these feedbacks had rather disparate qualities that brought out the question of embodiment or body disintegration, based on each woman's lived experiences and bodily disturbances. Thus, the women's receptivity could lead to either promising outcome to their recovery of well-being or the outcome will appear rather later than anticipated. Due to the insecurity of the overall outcomes, appropriate implementations need to be commenced. A few named suggestions were the incorporation of open reflective conversation, hand facilitation and to make aware of both parties' responsibilities to follow-up in the therapeutic alliance. Indubitably, these suggestions need the appropriate allocated time and space for the women to accept and engage.

The sustainability of the movement group can be represented by the manners of acceptance and collaboration, in the interaction among the women and in the patient-therapist relationship. The composition of the women showed homogeneity when concerning their health disturbances and hope for recovery. Despite the poor impact of their situations, their interaction in the group seemed to be energised by the experience of universality and solidarity, in addition to their unconscious ability to lend a hand to each other towards the same hope for recovery. Nevertheless, the relationship between the women and the therapist contributed to even better prospect for continuity. The therapist formed the base of stability with her presence at all time, in the content and context of the group. The therapist formed the base of trust with her unconditional attributes of being empathetic and genuine, in addition to her patience and benevolence for the women. The representations sustained the women's motivation to return to the group continuously, and the vice versa effect for the therapist to sustain her engagement to meet the women's hope for well-being.

On the other hand, the study also revealed that the task of sustaining continuity is not as simple as one could anticipate beforehand. It is an ongoing process and it does not involve only one aspect or one party. It is interplay of all aspects and parties that have been discussed. Seeing this task in the big picture, one can again refer to the theoretical framework; all aspects of psychophysiology and biology, psychology and sociology should be equally emphasized, and every party should be engaging their roles with sufficient dosage of participation and follow-up. The collaboration of the aspects and parties will subsequently present not only the initial aim for the movement group; it will also contribute to sustainability of the women's return.

6.1 Implications for mental health care service

This study unfortunately covered only a significantly small portion of the total immigrant population in Norway. Its transferability was earlier taken into consideration, see 3.7.2. Thus, it could cause disagreement if I conclude that the end results will be seen if other immigrants are to be placed in the same circumstances as in this study.

This study has, however, shown characteristics and sustaining factors for the movement group for immigrant women, for the same reasons I would believe that it has also given useful knowledge to how such intervention could lead to providing mental health care service for immigrant women. Most importantly, this form of mental health care service for immigrant

women seems pragmatically to be implemented by the respective health professionals and to be realistically accepted by immigrant women.

6.2 Further recommendations for research

Further studies need to be undertaken and I suggest these should consist of more observation days or observation of more such groups. In addition to more information could be obtained in various ways, an interview with the therapist in charge or by involving an interpreter during group session or the interviews with the immigrants. These suggestions will strengthen the validity of future studies; it will produce more details of each and everyone's experience of the group process and the compliance of transferability to the general immigrant population will be more likely distinguished.

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APPENDIX 1: APPROVAL FROM NORWEGIAN CENTRE FOR RESEARCH DATA

NSD

Marit Aalen
Institutt for sykepleie og helsefremmende arbeid Høgskolen i Oslo og Akershus
Postboks 4 St. Olavs plass
0130 OSLO

Vår dato: 17.10.2016 Vår ref: 50502 / 3 / BGH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 11.10.2016. Meldingen gjelder prosjektet:

50502	*Hvordan kan følelser og kroppsutrykk bearbeides i en bevegelsesruppe med sikte på forebygging av psykiske vansker?*
Behandlingsansvarlig	*Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*
Daglig ansvarlig	*Marit Aalen*
Student	*Nancie Siew Yee Luth-Hanssen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 30.06.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Belinda Gloppen Helle

Kontaktperson: Belinda Gloppen Helle tlf: 55 58 28 74

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

NSD – Norsk senter for forskningsdata AS Harald Hårfagres gate 29 Tel: +47-55 58 21 17 nsd@nsd.no Org.nr. 985 321 884
NSD – Norwegian Centre for Research Data NO-5007 Bergen, NORWAY Faks: +47-55 58 96 50 www.nsd.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 50502

FORMÅL
I følge informasjonsskrivet er prosjektets formål å forstå hvordan følelser kan ha sammenheng med kroppens bevegelser. Dette skal gjøres ved å observere et kroppsbevissthetskurs og dermed finne ut av sammenhengen mellom følelser og kroppsutrykk i en bevegelsesgruppe, som forebyggende psykisk helsearbeid.

UTVALG OG REKRUTTERING
Utvalget består av 8 deltagere på et kroppsbevissthetskurs. Deltagerne er kvinnelige innvandrere. Deltagerne skal rekrutteres gjennom leder for kurset. Personvernombudet legger til grunn at det ikke blir oppretter kontakt mellom kursets deltagere og studenten før de har ytret ønske om å delta i masterprosjektet. Vi forutsetter at frivillighet og konfidensialitet blir ivaretatt ved rekruttering, og vi minner om at frivillighet er særs problematisk når det er et avhengighetsforhold mellom den som rekrutterer og informant, som forholdet mellom behandler og bruker.

INFORMASJON OG SAMTYKKE
Utvalget (deltakerne på kurset) informeres skriftlig om prosjektet og samtykker til deltakelse. Revidert informasjonsskriv mottatt 16.10.2016 er godt utformet.

DATAINNSAMLING
Datamaterialet samles inn ved at studenten deltar på kroppsbevissthetskurset og filmer kurset.
Personvernombudet vurderer at bruk av videoopptak er nødvendig for prosjektets formål, som er å se på sammenhengen mellom kroppens bevegelser og følelser. Imidlertid legger vi til grunn at studenten bare er tilstede og bare filmer kursene dersom samtlige av kursdeltakerne har samtykket til deltagelse.

Videre består datamaterialet av informasjon om deltagernes fysiske- og psykiske helseplager. Studenten får innsyn i disse opplysningene gjennom lederen av kurset, men bare dersom utvalget samtykker til dette.

INFORMASJONSSIKKERHET
Personvernombudet legger til grunn at dere behandler alle data og personopplysninger i tråd med X sine retningslinjer for innsamling og videre behandling av personopplysninger. Ettersom det skal behandles sensitive personopplysninger, er det viktig at dere krypterer opplysningene tilstrekkelig.

PROSJEKTSLUTT OG ANONYMISERING
Forventet prosjektslutt er 30.06.2017. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som

f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lyd-/bilde- og videoopptak

Emne:	**Prosjektnr: 50502. Hvordan kan følelser og kroppsutr ykk bearbeides i en bevegelsesruppe med sikte på forebygging av psykiske vansker?**
Fra:	Belinda Helle <belinda.helle@nsd.no>
Dato:	Mandag 5. Desember 2016 13:11 CET
Til:	cue_lh@haugnett.no
CC:	jonas.debesay@hioa.no
Svar-til:	Belinda Helle <belinda.helle@nsd.no>

BEKREFTELSE PÅ ENDRING

Viser til endringsskjema registrert 30.11.2016

Vi har nå registrert at daglig ansvarlig er endret og at det nå skal gjennomføres observasjon uten videoopptak. Vi forutsetter at informasjonsskrivet oppdateres (jf. epostkorrespondanse med studenten 05.12.16) med at det inkluderes hvilke informasjon om deltakerne som skal hentes fra terapeuten.

Vi legger til grunn at alle deltakerne som er tilstede under observasjonen får informasjon og synes det er greit at studenten er tilstede. Det skal bare registreres personopplysninger om de som har samtykket til deltagelse i prosjektet.

Vi har ikke behandlet endringen om at det skal gjennomføres intervju med informantene. Som avtalt med studenten på epost skal intervjuguide/temaliste ettersendes med endringsmelding når denne er klar.

Personvernombudet forutsetter at prosjektopplegget for øvrig gjennomføres i tråd med det som tidligere er innmeldt, og personvernombudets tilbakemeldinger. Vi vil ta ny kontakt ved prosjektslutt.

Vennlig hilsen,
--
Belinda Gloppen Helle
Rådgiver | Adviser
Seksjon for personverntjenester | Data Protection Services
Tlf: (+47) 55 58 28 74

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data
Harald Hårfagres gate 29, NO-5007 Bergen
Tlf: (+47) 55 58 21 17
postmottak@nsd.no www.nsd.no

APPENDIX 2: LETTER OF PARTICIPATION AND CONSENT

Forespørsel om deltagelse i prosjektet

<< Bevegelsesgruppe for kvinner med innvandrerbakgrunn>>

Dette er et masterprosjekt der hensikten er å få kunnskap om bevegelsesgruppe for kvinner med innvandrerbakgrunn, der man observerer deltagerens kroppsutrykk og dets betydning i deres psykisk helse. Dette er også et masterprosjekt ved Høgskolen i Oslo og Akerhus og er en del av den avsluttende masteroppgaven i Master i psykisk helsearbeid for studenten, Nancie Luth-Hanssen.

Prosjektinnhold

Denne bevegelsesgruppen ledes av spesialist i psykomotorisk fysioterapi, X ved Y-sentral. Masterprosjektet er en liten del og over en liten periode av din deltagelse i denne bevegelsesgruppe. Din deltagelse i masterprosjektet er ikke en del av behandlingen som foregår i bevegelsesgruppen.

Du blir spurt om å delta i prosjektet fordi du deltar i denne gruppen, og fordi du er en kvinne med innvandrerbakgrunn. Du blir valgt ut som den aktuelle av X for prosjektet. De generelle informasjon om deg blir kort informert av X til studenten; nemlig din bakgrunn for henvisning og kontakt med denne gruppen, dine fysiske- og psykiske plager, din alder og familie/kulturbakgrunn. Studenten fører ikke disse informasjon som personopplysninger, men velger istedenfor å dele ut et kodert navn slik at du kan bli gjenkjent i forskningsanalysen.

Masterprosjektet er et kvalitativt studie der studenten skal benytte observasjon i gruppeprosess og ha kort samtale med noen deltagere om deres erfaring i denne prosessen. Disse planlagte aktiviteter skal gjennomføres noen ganger innen 4 måneders tid. Observasjonen og samtalen skal føres skriftlig på papir som feltnotat. Notatene skal beskrive både visuelle- og auditive hendelser som for eksempel, deltagernes kroppslige bevegelser, kroppslige kontakt med de andre deltagere og terapeuten.

Frivillig deltakelse og mulighet for å trekke ditt samtykke

Det er frivillig å delta i masterprosjektet.

Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Din uttrekkelse vil gi deg krav i å fjerne de skriftlige feltnotater som gjelder deg.

Dersom du ønsker ikke å delta, vil ikke det være noen påvirkning på din deltagelse i denne bevegelsesgruppen.

Dersom du har spørsmål til prosjektet eller ønsker å trekke deg under gjennomføringen av prosjektet, kan du kontakte veileder Jonas Debesay, 67236078, jonas.debesay@hioa.no eller student Nancie Luth-Hanssen, 90060923, cue_lh@haugnett.no.

Videre oppfølging om dine opplysninger

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med prosjektet. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Alle opplysningene vil bli behandlet uten navn og fødselsnummer.

Jonas Debesay og Nancie Luth-Hanssen har begge ansvar for den daglige driften av prosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli slettet når Masteroppgaven er godkjent som bestått ved Høgskolen i Oslo og Akershus, forhåpentligvis ut Juni 2017.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

Jeg er villig til å delta i prosjektet

JA	
NEI	

Sted og dato Deltagers navn

APPENDIX 3: INTERVIEW GUIDE

INTERVJUGUIDE NORSK-ENGELSK

- Kan du si meg litt om din bakgrunn? (alder, land, sivilstatus, familieforhold, arbeid)

  Can you tell me about your background? (age, country of origin, family status, work status)

- Hva er det som gjør at du deltar i gruppen?

  What makes you join this group?

- Hvor lenge har du vært i gruppen?

  How long have you been in the group?

- Hvordan kommer du deg til treningslokalet, og hva synes du om lokalet? (lokalisering, utstyr og annet forhold som persienne)

  How do you commute to this training facility, and what do you think of the facility? (Location, equipments and etc)

- Hva synes du om opplegget til gruppen? (Om andre som kommer senere til timen, andre tar pauser i timen)

  What do you think of the arrangement in the group? (Others that arrive late, taking break during session)

- Hva liker du best av øvelsene/ hvilken del av øvelser synes du at du har best utbytte?

  What do you like best with the exercises/ which part of the exercises do you benefit most of?

- Hvordan opplever du dine bevegelser i timen? (tempo/ flyten/ samarbeid med de andre)

  How do you experience your body movement during session? (pace, flow, cooperation with the others)

- Hva gjør øvelser med dine plager?

  How do the exercises affect your disturbances?

- Hva opplever du når du treffer de andre i gruppen?

  What do you experience when meeting the other women in the group?

- Kan du kjenne forskjell i din kropp før og etter denne timen? Om ja, kan du beskrive dem?

Can you feel the difference in your body before and after the session? If yes, can you describe the differences?

- Hvordan vil du beskrive ditt forhold til terapeuten din?

  How would you describe your relationship with the therapist?

- Kan du si litt om valget for disse klærene til gruppen?

  Can you explain the reasons for your choice of clothing to attend the group?

- Er det på noen måte gruppen kan forbedres, om den skal introduseres til andre?

  Is there anything that the arrangement of the group can be modified/upgraded, if it is to be promoted to the other immigrants?

APPENDIX 4: FIELD NOTE OBSERVATION DAY 1

Table of colours representing meaning units in the data analysis

Colour	Meaning units for-
Grey	Arrangement
Turquoise	Attendance
Bright green	Participant's experience
Yellow	Clothing
Red	Participant, miscellaneous
Purple	Therapist
Bold + italic	Researcher's experience

The location of the observation was taken place in a training room in a local-based service centre. The training hall is constructed with changing rooms for male and females, and a small storage room. All rooms are fitted with proper lightings. Training equipments such as treadmills, rowing machines and stationary bicycles are also placed at the corner of the hall. There are long-glassed windows and a glassed door facing the sidewalk to the main road, and a full length mirror. Other necessary equipments such as stereo system and training mats are easily accessed.

The psychomotor physiotherapist (PP) placed the training mats on the floor, they were gathered into a 16 square metres space. The chairs were then placed at the outline of the mats. On the front of each chair, it was placed a balancing Airex pad and a small spiky massage ball. As she was doing the arrangement, a few women started to enter the training room. The time was about 10 minutes to the session was going to start. The first few women were dressed in their traditional costumes in which I would describe as layers of long colourful fabrics. They also had on their head covers, or known as *hijab*. They nodded when they saw me. As the time went on, they started to take place on each chair with no shoes on, and some of them have started rolling the spiky ball on their hands, their arms or their feet. One of the women made sure all blinds at the windows and door were down. They had small conversations with each other in a foreign language. 20 minutes passed and the women were still arriving. The therapist had eye contacts with them whom were sitting and working on the massage ball. At the same time, she managed to spare quick eye contacts to the women whom just arrived. 30 minutes went passed and it was taken a final count of women for the day's session; 12 women.

5 of the women wore various attires compared to the others. The 5 women, as I am giving them a pseudoynm each, were Rosa, Iren, Marie, Zadia and Hanna. Rosa had on a T shirt and a pair of long training pants, and only Rosa had no *hijab*. Zadia and Hanna had on hip-length blouses and black trousers. Iren and Marie wore their colourful traditional costumes, a long lengthy blouse and long pants. The rest of the women had on their typical Northern African

daily clothing as I earlier described as layers of fabrics and long head covers from the head to the hip. The Northern African women sat in a row at one side of the circle, while the others on the other.

Following were the exercises instructed by the therapist in the group;

a) Usage of the massage ball, in a sitting position: rolling it on different parts of the body such as hands, arms, shoulders, spine, thighs and feet.

The therapist sat on a chair just in front of the mirrored wall with her back straight, legs placed in abduction and feet grounded on the floor. She was facing the rest of the women who sat on their chairs in a circle. She spoke clearly despite the music in the background. She gave short instructions in Norwegian, repeatedly. Rosa, Iren and Marie who had their seats nearest to the therapist followed exactly of the instructions. Zadia fell in and out of the instructions, and Hanna managed to follow but in slow movement. Zadia's facial expression was rather different than the others, her eyelids showed slight droopiness, the same for the angle of her mouth. Her body movement were rather slow and careful. The therapist also explained in between instructions the reasons for one can experience pain in the body. Her eyes were looking at the members during instructions and explanations. The Northern Africans did as they were instructed; there were times they had to adjust their clothing to facilitate the exercise.

b) Usage of balloons, in a standing position: paired exercise, throwing to each other and keeping the balloons on air.

Rosa and Iren were hitting a balloon to each other. They hit every time, sending the balloon back and forth. Their movement was mostly at the arm level. Marie and Zadia had more movement as their balloon was bouncing up in the air and fell on the floor several times. They bended down as many times to pick the balloon from the floor. Zadia left the activity and sat slowly down on her chair. During her short break, she adjusted her veil with her hands several times. Marie was left alone. She looked for another to throw the balloon to. She did not find anyone that was available. She threw the balloon in the air on her own.

The therapist and Hanna were sharing a balloon. The therapist was moving all limbs in order to keep the balloon up; her movements took bigger space and seemed determined. It looked like Hanna had to keep up with the therapist as they were focused on the balloon. Zadia joined the activity after a short break. This time it was Marie whom left the activity and went to her chair for a break. Zadia kept the balloon in the air on her own, and at times with Hanna. Zadia and Marie took short breaks in between activity several times.

c) Coordinated movement of extremities to an upbeat song, in standing position.

The women were focused on the therapist as she moved her arms and legs in a coordinated way. Some of the women followed exactly like the therapist, while others tried to cope up with the requested movements. The therapist then made small bouncy

movement of the upper and lower body. The women followed her movement again. ***The women's movement seemed lacked of body agility and spontaneity.***

d) Usage of soft foam balls, in a standing position: throwing in a coordinated position

The members stood in a small circle and were given instruction by the therapist who they should pass the ball to consistently. ***This started rather chaotic***, which made them had to repeatedly pick the ball from the floor, and started the sequence all over again. A few of them broke into laughter when this happened. After a few rounds with trial and error, they finally managed the sequence consistently.

Zadia went to her seat again, and did the same as what she did in earlier activity. After a short break, she came back to the activity. It was then Marie's turn to go back to her seat for a break. Following the short break, she stood up and went to the treadmill. She started walked slowly on the treadmill. The therapist and the rest of the women continued with the activity.

e) "Tug a war" with a rope of multiple edges, in standing position.

Everyone was holding one edge of the rope and stood in a circle. They pulled the rope outwards and gathered it inwards in various positions of their arms, their movements looked synchronised. There was laughter in the air when they moved closer to each other, and small sounds of cheering were made.

APPENDIX 5: ANALYSIS SHEET - CLOTHING

Meaning unit		*Incipient interpretation*	Condensed meaning unit	Code	Sub theme	Theme
OBSERVATION	INTERVIEW					
CLOTHING **Day 1** - The first few women were dressed in their traditional costumes in which I would describe as layers of long colourful fabrics. They also had on their head covers, or known as *hijab*. - Rosa had on a T shirt and a pair of long training pants, and only Rosa had no *hijab*. - Iren and Marie wore their colourful traditional costumes; a long lengthy blouse, a pair of long pants and *hijabs*. The rest of the women had on their typical Northern African daily clothing as I earlier described as layers of fabrics and long head covers from the head to the hip. - The Northern Africans did as they were instructed; there were times they had to adjust their clothing to facilitate the exercise. - During her short break, she adjusted her veil with her hands several times. **Day 2** - During the instruction of rolling the ball on their feet or on their back, a few women had to adjust their layers of clothing in order to get better contact between their body and the ball. - A few of the women were occupied with adjusting their head covers and clothing in front of the mirror each quick break time.* **Day 3** - A new participant. She was dressed in layers of long fabrics and had headcover. She was a big woman, about 120-140kg. **Day 4** - Rather similar observations of clothing as earlier days.	**Rosa** -'I can take off my *hijab* because there is only women here in the group' -'I am angry that the others don't take PP's advice of using training costumes during group session.' -'The room stinks with the body odor and sweat!' 'PP is too kind. PP should be more strict of the costumes' -she had repeatedly taken up issues such as the training costume - but she explained that they did not seem to want to listen to her and still do things as they pleased. -'PP should be stricter of the rules in the group, especially with the training costumes...' **Iren** -'I have these clothes on because I don't want to spend money on myself. My children needs more than me' 'I feel these clothes are ok to move around with.' - She assumed that the others chose to use their traditional costumes for the same reasons as hers, but she did not deny that it could be for the religion too. She pinpointed that she accepts how the others chose to do things for themselves, as she has enough problems of her own that she does not intend to create more problems when she is in the group. **Marie** - When she was confronted for the choice of her clothing, she smiled and said, 'I want. I like.' **Zadia** -She had stumbled many times on her long dresses during session, she didn't want that to happen again.	*Too many layers of fabrics to be able to get close enough to their skin and muscle.* *Good to see that someone took off her hijab.* *Room air was a little congested, no possibility of opening the door/window.* *Out of curiosity, I asked one of them if she was not feeling warm after such intense activities. She replied, "Here Norway, it's cold" and showed me her layers of clothing; warm wool plus 3 other layers of thin fabrics. "In X, it's not like this"* *To place myself as the therapist for the group, would I let the issue of clothing just go or would I pester them to change?* *Could understand Iren's financial plight, we're of the same age and have children of the same age.* *Smile to Marie's reasoning for her choice of clothing. So simple and genuine answer.*	**Meaning unit from observation:** -Layers of fabrics, *hijab*, customised costume -Frequent adjustment of clothing during movements -Difficulty to perform movement **Meaning unit from interviews:** -Light movable clothing, without *hijab* -Hygienic issues, odour and sweat -Financial issue -Preference and comfort -Climate issue	Participation with own clothing	Self decision making	Practical doing