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## **A lonely life**

### **A qualitative study of immigrant women on long-term sick leave in Norway**

*Background:* This study focuses on the everyday life of immigrant women with chronic pain on long-term sick leave in Norway. Research has shown that rehabilitation of immigrant women with chronic pain might be challenging both due to their lack of linguistic competence, due to lack of sufficient confidence/trust in their employers and in health personnel and lack of knowledge/skills among health care personnel in meeting immigrants' special needs.

*Objective:* The objective of the study was to explore how immigrant women on long-term sick leave in Norway due to chronic pain experience their illness and their relationships at work and in the family.

*Design:* This article has a qualitative design, using participant observation and in-depth interviews.

*Methods:* Participant observations were carried out in an outpatient clinic and qualitative interviews were conducted after the rehabilitation period. A hermeneutic approach was used to understand the meaning of the narrated text. All the authors participated in the discussion of the findings, and consensus was obtained for each identified theme.

*Settings:* The research was conducted at an outpatient clinic at a rehabilitation hospital in the southern part of Norway. The clinic offers wide-ranging, specialized, multidisciplinary patient

evaluations that last between 24 and 48 hours, followed by advice and/or treatment either individually or in a group, i.e. in a rehabilitation course.

*Participants:* Participants (immigrant women) who had been referred to the outpatient clinic and to a rehabilitation course were recruited. Fourteen African and Asian women were observed in two rehabilitation courses, and eleven of them agreed to be interviewed once or twice (3).

*Results:* The interpretation revealed the following two main themes: 'Shut inside the home' and 'Rejected at the workplace'. Based on the women's experiences, a new understanding emerged of how being excluded or not feeling sufficiently needed, wanted or valued by colleagues, employers or even by family members rendered their daily lives humiliating and lonely.

*Conclusions:* The immigrant women on long-term sick leave live in triple jeopardy: being ill and being lonesome both at home and at the workplace. This can be described as a vicious circle where the humiliating domestic and workplace-rejection might reinforce both the women's experience of shame and avoidance of telling anybody about their illness/symptoms, which then results in more days on sick leave during which they are again isolated and lonesome. There is a need for more research on multidisciplinary rehabilitation approaches designed to cater for immigrants' special needs.

**Key Words:** Immigrants, Humiliation, Loneliness, Chronic Pain, Qualitative, Shame, Sick Leave, Women, Work.

## **Introduction**

In Europe, the proportion of immigrants in the total population has grown rapidly, from 7 % in 1990 to 10 % (72 million immigrants) in 2013 (UN, 2013). Furthermore, the immigrant

population in Scandinavia has been steadily increasing since the end of the 1960s, with nearly 50 % of the immigrants originating from Asia, Africa and Latin America (Pettersen and Østby, 2013). There are approximately half a million immigrants living in Norway, or 14,9 % of the total population, which is 5.156.000 persons (SSB, 2014). Thirty-one percent of the population of Oslo are immigrants or Norwegians born to immigrant parents (SSB, 2014). When people migrate and settle down in other nations, they encounter other cultures, people, ways of life, health services and environments that may influence their health either negatively or positively (Hultsjo and Hjelm, 2005, Nkulu Kalengayi et al., 2012, Ogunsiyi et al., 2012). Though the migrant population in Norway is young and 'the healthy migrant effect' (i.e. the health of immigrants just after migration is substantially better than that of comparable native-born people) might be applicable to a large majority, the strain of migration might still influence health conditions among this population (Helsedirektoratet, 2013).

Swedish studies reveal that immigrant women experienced discrimination in the labour market and were mainly employed as cleaners, home-helpers or nursery assistants (Akhavan et al., 2007, Akhavan et al., 2004). As a parallel, immigrants in Canada and Scandinavia, most of which are from low- and middle-income countries, often experience social exclusion and discrimination because of their race, language, religion and immigrant-status. They also have limited access to personal, social and community resources (Herz and Johansson, 2012, Hynie et al., 2011). In Norway, temporary employment is higher for migrant women than it is for the native women. It is not only one's level of education that determines entry into the labour market; one's fluency in Norwegian and duration of stay in Norway also play a significant role. The paradox is that immigrant women, despite their degrees and higher education,

cannot gain entrance into the labour market because of their poor language skills since their education is often not recognized in Norway (Tronstad, 2009).

Immigrant women experience hardships domestically as well. A Norwegian study about intimate partner violence (IPV) among Norwegian and immigrant women revealed that the immigrants were overrepresented (62,2 %) in the shelter population (Lund, 2014). In another study, immigrant women cited economical and practical reasons for not leaving or returning to a violent partner more often than ethnic Norwegian women (Bo Vatnar and Bjorkly, 2010).

The Oslo Immigrant Health Study (HUBRO) documented that the prevalence of self-reported musculoskeletal disorders among immigrant groups from Turkey, Iran, Pakistan, Sri Lanka and Vietnam was approximately three to eight times higher than for Norwegians. In addition, the proportion was higher among immigrant women than immigrant men, which underlines that immigrant women are a high-risk group for developing musculoskeletal disorders (Kumar, 2008). A study in Oslo confirmed that the high rate of disability pension use among immigrants from what the authors denoted as 'developing countries' is associated with work-related factors, such as manual/unskilled work characterized by physical hardship, long working hours and low wages (Claussen et al., 2009). According to Claussen (2008), musculoskeletal disorders and subsequent lack of employment leads to the individual being excluded from important social arenas. Hence, women on long-term sick leave miss out on the contact with colleagues and the benefits provided by that social arena (Claussen, 2008). In this study, we use the term 'chronic pain', which is defined by the International Association for the Study of Pain (IASP) as chronic if it persists beyond three months (IASP, 1994). To meet the need to rehabilitate people with chronic pain, a multidisciplinary intervention through systematic rehabilitation has been conducted since 2007. This was to help people on

long-term sick leave return to work, and was initiated and sponsored by the Norwegian health authorities (Aas Wågø, 2012).

Immigrants are at risk for health problems and discrimination, both of which hinder their ability to work or find work. This is particularly a problem for women, because they have less education, more linguistic challenges (SSB, 2010) and greater caring functions compared to immigrant men.

Though data on the health of immigrants in Norway has been generated, it continues to be fragmented. Moreover, immigrant women on long-term sick leave and their experiences of everyday life during their rehabilitation process are understudied.

### **Aim and Research Question**

The aim of this article was to explore how the immigrant women on long-term sick leave in Norway experienced their daily life, their own illness, their work and their family life. The research questions explored in this article are as follows: How do immigrant women on long-term sick leave in Norway due to musculoskeletal disorders experience illness and their relationships at work and in the family? Furthermore, how do they narrate these important issues concerning their lives?

### **Methods**

#### **Design**

The study was designed as a qualitative study based on observations and qualitative interviews with a hermeneutic approach to the analysis. According to the French philosopher Ricoeur (1981), the hermeneutic arc describes the analytic movement back and forth between parts of the text and a view of the whole during the process of interpretation. Furthermore, as Ricoeur indicated when explaining the text by extracting its objective content, we looked at

the meaning of the words by analysing the internal relations of the text. Moreover, we developed a deeper understanding of the text by taking into account our prior understanding regarding what we knew about the women and about the context of the interviews, which was informed by the field notes. In addition, our theoretical knowledge and our experiences as healthcare workers influenced the analysis.

### **Setting and sample characteristics**

The research was conducted at an outpatient clinic at a rehabilitation hospital in the southern part of Norway. The outpatient clinic includes patients with complex/chronic muscle disorders and possibly with mental health problems. The clinic offers wide-ranging, specialized, multidisciplinary patient evaluation that lasts between 24 and 48 hours, followed by advice and/or treatment either individually or in a group.

A total of 14 women were recruited and participated in our study. Prior to the commencement of the rehabilitation course, the women received verbal information about the study from the course leaders together with an information sheet from the researcher. At the same time, the course leaders asked for their consent to join the study. None of the fourteen participants withdrew during the participant observation period, which consisted of two groups comprised of eight women in the first group and six women in the second. However, in the first group, one of the participants dropped out of the rehabilitation programme three weeks before it ended; another declined to participate in the interview because she was in good health again and a third woman was not available to participate in the interview.

### **Description of the sample**

The sample included immigrant women aged 30 to 56 years. Eleven of them were on partial sick leave and three were on 100 % sick leave. The inclusion criteria were as follows: 1) adult

immigrant women from Asia and Africa on long-term sick leave that were able to speak Norwegian at a level that enabled them to exchange their experiences and to understand the teachings in the rehabilitation course about various topics related to coping with illness, sick leave and health; and 2) women referred by their general practitioner to a rehabilitation course at the outpatient clinic due to nonspecific chronic muscle and soft tissue pain.

The women came from low- or middle-income countries. Four were from Southern Asia, three from the Middle East, three from North Africa, two from Southeast Asia, one from East Africa and one from Central Asia. Three of the women were skilled workers and 11 were non-skilled workers. One of them had five years of primary school education, 11 had completed high school and two had university degrees. All the women had children. Of the 14 women, 11 were married; three of them were divorced and lived together with one or more of their children. All 14 participants had settled and lived in the eastern parts of Oslo, Norway for more than five years and they were acquainted to the Norwegian health care system.

### **Ethical considerations**

The project was approved by the Regional Committee for Medical Research Ethics (REK, nr. 2011/662a). The health care workers and the immigrant women were given written and verbal information about the study. Informed written consent was obtained from all participants. Participation was voluntary and confidentiality has been respected throughout the study. The anonymity of the women's identities has been ensured throughout the process and in all publications. The first author reiterated the purpose of the research to the participants and that they could withdraw from the study at any time. The immigrant women were informed that the digital data would be erased after the data analysis. In Norway, personnel from Health Services and Social Services closely follow up with women on paid sick leave; one of the government's goals is to help them return to the workforce as quickly as possible.

We also had an oral agreement about follow-up treatment with the health personnel at the outpatient clinic, if needed. In line with the Declaration of Helsinki, the interests of the participants have been ensured.

## **Data collection**

### *Participant observations*

The first author conducted participant observations during two rehabilitation courses, each of which was spread over 10 days during the course of 10 weeks each (totalling 45 hours). In accordance with Silverman (2011), the purpose of these observations was to gain a better understanding of how the women experienced their daily life, including how they experienced work, sick leave and the rehabilitation course. The participant observations provided insights into the unspoken elements embodied in gestures and physical movements in order to better understand the interface between the participants' spoken words and courses of events (Nielsen et al., 2006). The observations revolved around the women's activities, such as group discussions, participation in the clinical lessons, indoor gymnastics, relaxation techniques, practising elements of mindfulness and their walks to a nearby park. Carrying out participant observations over several weeks made it possible to get to know the women; to learn about their concerns, viewpoints and opinions and to develop rapport with them while observing what was going on (Emerson et al., 2011). The participant observation contributed to a wider understanding of the women's family background, their migrant history, their thoughts about health and sickness and their experiences with working life and sick leave. Furthermore, we learnt about their rehabilitation process regarding collaboration with different health personnel and diverse rehabilitation institutions. The fieldwork also gave us insight into the women's everyday lives, particularly in terms of their hard workdays. Furthermore, it also provided greater insight into the importance of religious activities, being close to their families and the challenges they faced as immigrants when they were unable to understanding



the social system. Additionally, it was interesting to observe the in-group interactions, the peer-group effect and how the women learnt from one another while exchanging ideas and experiences. The field notes were taken during group discussions and clinical teaching; hence, conversations could be cited more or less literally. The handwritten notes taken during the course sessions were transcribed into complete texts immediately after each session by the first author. Other indoor and outdoor activities were also described as precisely and detailed as possible after each session (Hammersley and Atkinson, 2007). Establishing an open and trusting relationship between the researcher and the informant is essential to obtain reliable data (Kelly, 2010, King and Horrocks, 2010, Kvale and Brinkmann, 2009).

### *Qualitative interviews*

One or two months after each rehabilitation course, qualitative interviews were conducted to provide us with insight into the women's experiences (Silverman, 2006) with work as well as their home situation, health and rehabilitation. The first author conducted in-depth semi-structured interviews with 11 of the 14 women. To ensure confidentiality and anonymity, we chose not to use an interpreter during the interviews. The women were not explicitly asked if they wanted an interpreter or not, but during the rehabilitation course many of them uttered that using an interpreter was outdated. Some of the women also said that they did not want to use an interpreter in health care settings because of the quite small linguistic groups in Oslo and the unpleasant feeling of being identified or unveiled. Furthermore, the first author became familiar with the women's ways of speaking Norwegian during the courses, and in that way learnt to understand their 'interlanguage'. Selinker (1972) coined the term 'interlanguage', which refers to the linguistic systems that an immigrant (L2) learner constructs as she progresses towards the target language (here Norwegian) (Myers-Scotton, 2006). To ensure a better understanding and in-depth analysis, three of the women who spoke Norwegian fluently and who had been on long-term sick leave for an extended period of time

were chosen as key-informants and were interviewed twice. In order to be part of the workforce in Norway, knowledge and fluency in Norwegian are a must. Therefore, a large majority of the subsample of working immigrant women will be fluent in Norwegian except for those with cleaning jobs.

In addition to speaking fluently, the key informants were talkative and were able to give rich descriptions of their everyday lives. They were also willing to do an extra interview, a willingness which the other informants did not clearly demonstrate. The interviews lasted between 35 and 110 minutes. Six of the interviews were conducted in the informants' homes and eight in the offices of the first author.

## **Data analysis**

### *Transcription of data*

The field notes were converted to text using verbatim quotations and descriptions (Silverman, 2006). The digitally recorded interviews were transcribed verbatim immediately after each interview by the first author.

### *Analysis*

We conducted a qualitative analysis of both participant observation and interview data. We started with a naïve reading, then a structural analysis and, finally, a critical interpretation. The first author read the data set several times in order to get what Ricoeur describes as 'a naïve grasping of the meaning' (Ricoeur, 1981, Ricoeur, 1976), which means to have an immediate, unreflected understanding of the text (Ricoeur, 1984). The first author conducted the main analysis, but all the authors participated in the discussion of the findings. To ensure the consistency of the analysis, the three co-authors read parts of the data set, and consensus was obtained for each identified theme.

A structural analysis was also conducted which involved identifying and formulating themes, which implies identifying the essence of the meanings that arise from different parts of the

text. Through the process of moving in the text from 'what is said' to 'what it means', units were formed as sub-themes and themes (Ricoeur, 1976, p.88). The themes reflect both explanation and understanding. The interpretation was validated by the first authors' pre-understanding, the literature review and the context of the study (Ricoeur et al., 2002). Reflecting on theoretical perspectives on loneliness, humiliation, rejection and shame afforded the first author some new insights into her own and the immigrant women's experiences with loneliness and rejection, which in turn informed new theoretical understandings. The first author's understanding was based on the synthesis of all the women's histories and the participant observations. The amount of data provided a more comprehensive understanding through the process of interpretation and, as Ricoeur (1981) denoted it, obtained 'appropriation of meaning'.

## **Findings**

Our analysis revealed one main finding 'A lonely life', and two related subthemes, 'Shut inside the home' and 'Rejected at the workplace'. The women's narratives illustrated their common experience of being isolated at home due to physical pain, depression, family uneasiness and exclusion at the workplace. Thus loneliness increased the burden as it was experienced continually either within the family or with colleagues. In our findings, besides rejection at the workplace, lonesomeness was related to the experience of being locked inside the home due to lack of a social network or the lack of possibilities to live in another place or country. At the same time, the women dealt with the experiences of powerlessness and longing for the extended social network in their country of birth. Failing to master a new language also made them powerless, dejected and shut out from the neighborhood and collegial communities. Not being understood because of their invisible illness or their cultural and linguistic differences implied a lonesome life.

Hereafter, when quotations from the field notes have been provided to illustrate the themes, 'O' indicates that the quote has originated from an observation period, while 'I' indicates the quote has originated from an interview.

### **Shut inside the home**

Worries about their health and the long-term sick leave, resulted in the women experiencing the monotony of *'just sitting [alone] at home thinking'* (W2-I), which reinforced the difficulties in getting to know their Norwegian neighbours. Additionally, they had lost their most important network, i.e. their extended families, friends and acquaintances that lived in their country of birth. Furthermore, this isolation at home led to the women forgetting how to use the Norwegian language and thus further fortified the feeling of seclusion and shame. Speaking Norwegian was also of vital importance to them when they had to express their inner feelings and thoughts to their psychologist. One of them expressed this as follows:

*'Because I don't speak to anybody, [when] I'm at home, so I forget and forget [the language]'*(W9-I).

She also told that she felt shameful when unable to find the right Norwegian words at the rehabilitation course or in other social settings when unable to remember all the concepts and ways of speaking in Norwegian she had learnt some years ago. Another woman described her isolated situation as a single mother of two preschool children. She only had infrequent contact with native Norwegians, which reduced her opportunities for requisite language practice. She expressed this as follows:

*'Now language decides for me'* (W4-I).

She further explained that her proficiency in Norwegian was not good enough for her to get a job where she could earn a sufficient amount of money.

Homesickness was evident from conversations among the participants during participant observation. One of them expressed that she missed her extended family, neighbourhood network and even her former spouse in her country of birth because they would have assisted her in caring for her children; she does not receive such support in Norway.

The women's depression and physical pain led to the feeling of being exhausted and subsequently a desire to withdraw from others. During both the observation periods and in the interviews, some of the informants reported sleep disturbances, nightmares, homesickness, pain in many parts of their body and a wish to hide away from others. One woman explained as follows:

*'...I have been depressed, I was sad and it was not ok. I didn't want to meet people; I wanted to be alone, just lying under the covers. This is how the days went by for a year' (W5-I).*

She was one of several women who told about depressive feelings, which made them stay indoors. In a number of cases, the women felt shut inside the house because of social circumstances, such as living together with husbands who were distressed, alcoholic or disabled. They described the need to rest at home on their days off. However, to be 'locked in' with husbands needing attention for a longer period was often unbearable. One woman, who was married to an alcoholic, reflected as follows:

*'Cause I notice that I can't be at home... because then it's going to be hard to live. If I was 100 % disabled, then I would go crazy... No, I don't think that would work' (W7-I).*

This woman's extensive pain problems and consequently her great need for recuperation in her own flat was impeded because her marriage was marked by shame caused by her husband being drunk all the time. Furthermore, the situation at home was humiliating and

characterized by what she referred to as '*sadness, arguing and unrest*' (W7-I). From this perspective, the workplace seemed to be utterly important.

In addition, many husbands withdrew from social activities and some could not even visit their country of origin and their families because of their refugee status. However, for one couple despite being able to visit their native country, the isolation continued as the spouse rarely wanted to travel with his wife. She said:

*'I become crazy' from just being at home and I want to get out and meet other people'* (W8-I).

Interpretation of the fieldnotes revealed that intimate partner violence was another theme the informants were concerned with, both at the outpatient clinic and in the interviews. One woman described the shameful situation and her pent-up feelings from being maltreated by her husband at home. She reflected upon how she had endured being beaten for a long time:

*'Yes, I remember that he beat me. My face turned blue and I went to work the next day. My employer saw my face and asked 'Is it your husband who beats you?' I said yes. 'Do you need help, like calling the police?' I said no, don't need help, I endure it. But after so many years of being beaten I don't know how much longer I will continue to tolerate it'* (W1-I).

This story illuminates the life of being alone, shut inside, being beaten, quarrelling and feeling like a captive that was forced to continue her daily life with him. At the rehabilitation course, she told the other participants that,

*'Before I cried a lot, but now I can't cry any longer'* (W1-O).

Observations revealed both astonishment and support from the rest of the group after W1 had told about a quarrel, in which she was beaten and strangled. One of the women rose up, walked around the room and said loudly:

*“Will you accept that your husband beats you? We are in 2011”* (W6-O), while some of the other women were nodding. Other social circumstances that made the participants feel shut inside the home included the lonesomeness that arose from taking on responsibility for the home and their family, including economic matters. They experienced this as a burden because they felt obliged to send money to their relatives in the homeland. One woman shared how ashamed she was when she was admitted to a rehabilitation stay because she did not have money for a coat, a sweatshirt and cigarettes. She had to borrow money from the staff, which illustrates her social isolation. She was given some money from a fellow patient, but then she felt like a beggar.

### **Rejected at the workplace**

The findings also revealed how the informants experienced rejection at the workplace, both from workmates and managers. The informants' colleagues had inadequate understanding of diseases and pain. Both in the interviews and during participant observations, the women expressed that they experienced attitudes like trivializing, moralizing, condemnation and indifference from their workmates. Invisible symptoms, such as headaches, pain in different parts of the body, dizziness and sadness made it difficult both for the women to explain the difficulties they faced and for their colleagues to understand. Hesitation in expressing themselves or only giving limited information resulted in the experience of being excluded and rejected. One woman spoke about how she would have to explain everything in order for others to properly understand her:

*'Nobody has the time to listen to my afflictions, I think nobody bothers... it's hard.*

*You get very lonely'* (W7-I).

Another informant was afraid of the shameful and humiliating situation of being exposed to her colleagues' gossip if she told them too much. She preferred not to tell her workmates

about her health complaints because she had experienced indifference and lack of understanding in the past. Continuous staffing problems at the workplace made her reach the following conclusion:

*'I don't think I can get a job in the kindergarten suited to my health. They do what they can... So I feel like a burden, to be honest' (W11-I).*

Another woman who was on 50 % sick leave felt bad after a colleague indicated that she could not do as good a job as those working fulltime. Therefore, when she was at work she gave herself extra cleaning duties and activities with the children. She observed as follows:

*'I have a bad conscience if not, cause in my head it says all the time that I work too little. But when I'm at work, I do everything... as if I work 100 % or every day' (W8-I).*

She wanted everything in her department to be clean and tidy and for the children to be happy so that the parents could be satisfied and understand that there is a difference between when she is at work and when she is not. In this way she did not have to feel ashamed about not doing her job well enough. Another woman, who is a primary school teacher, missed the feeling of belonging to one specific team of teachers. She felt like a stranger. She also felt alone at lunchtime. The staff room was equipped with chairs that caused her to experience pain in her neck and shoulders if she sat down, and so instead she chose a more comfortable sofa, which was placed a bit away from the chairs. While her colleagues smiled, talked and were generally friendly, they only greeted her superficially when passing. She described the situation as lonely, humiliating and shameful:

*'Nobody bothers to come and sit beside me' (W7-I).*

Even their employers lacked sufficient knowledge of painful chronic diseases and hardly made efforts to include these women into the work community or help make the workplace suited for their needs. One woman described how she felt rejected and humiliated by her boss when she asked for suitable work tasks at the primary school:



*'One day he [the boss] told me that maybe I should start thinking about changing primary schools if I couldn't work here. Then I got very disappointed I thought to myself 'I have worked here for many years and I have never had any problems with teachers or pupils or with the job. I have been punctual and worked as much as I could all the time, and this is what I get in return' (W7-I).*

Another example was a woman who even after explaining to her boss about work tasks that provoked pain, she was still assigned heavy duties and unsuitable work. Therefore, she felt that she was poorly and unfairly treated:

*'... no consideration was given to how I could carry out my tasks. I didn't get any help from the management or colleagues. They never even took that into consideration' (W3-I).*

Another woman did not feel respected and was offended and humiliated by a report written after a meeting with her personnel manager, her boss in the kindergarten together with her physician. The informant quoted the following lines from the report, which was written by the personnel manager:

*'She cannot sit while squatting, she cannot roll prams, she cannot carry a rucksack... colleagues are weary, and colleagues have taken her responsibility". However, when I'm at work, then I do all these tasks. I got so sick; I was deeply hurt when these things were said about me' (W8-I).*

The day after she got the report, she wrote a letter with help from her daughter in which she told the personnel manager that she disagreed. She explained that when she is at work, she rolls twin prams for walks, carries rucksacks and sits on the floor while singing with the children. She concluded that her boss must have misunderstood, which was confirmed in the second interview when the personnel manager admitted that she had understood the situation

incorrectly. This informant had the resources she needed to stand up against the employer, which was not always the case for all the immigrant women.

Fear of losing their jobs because of health problems led to exclusion for some of the informants. At the outpatient clinic, some of the women were observed to assume and fear that they would be dismissed if they were sick for a long period of time, and therefore they took the shortest possible sick-leaves. They forced themselves to go to work and some of them overworked themselves in spite of the pain from the heavy physical labour. Not receiving an employment contract might also have reinforced the fear of suddenly being without a job and being stuck at home. Some of the women also told about the shame of being on sick leave including not being able to go to work like all their neighbours and the feeling of being different and undignified. One woman explained (both to the other participants in the rehabilitation course and the first author in the interview) that she actually lost her job in connection with a long-term sick leave. For many years, she had had temporary positions in a nursing home. The year before she got sick, her employer incidentally offered her a part-time education to become an enrolled nurse. However, lack of permanent employment along with the long-term sick leave excluded her both from the nursing home and from pursuing her studies, and nobody had prepared her for this kind of humiliating risk.

## **Discussion**

Our findings show that immigrant women in Norway live a lonesome life and feel shut inside their homes because of pain, depression, health concerns, language problems and/or social circumstances. The informants in our study could not prioritize their need for rest and recuperation in their homes because of high demands in caring for their families, taking on economic responsibilities and dealing with violent or sick spouses. Additionally, the women were excluded at the workplace, where they were met with lack of understanding regarding

their health situation and lack of willingness to make workplace adjustments and include them in the work community.

### **Loneliness and shame due to humiliation in domestic life**

Some of our informants preferred to stay at home, rather than seeking help from a physician/other health personnel or even reaching out to their social network. While this might be interpreted as their inability to recognize or understand their own situation, it might also be understood that they did not perceive depression as a medical condition and, furthermore, did not believe that doctors could help them (Bhugra, 2005). The women's reduced trust in others is similar with the finding of previous research (Ponizovsky and Ritsner, 2004) that found a relationship between self-reported loneliness, psychological distress and lack of social support among immigrants. Loss of friends' support might lead to reduced trust in one's ability to be self-sufficient and autonomous, which again can result in lower self-confidence and the diminishment of trust in others (Ponizovsky and Ritsner, 2004). This supports our findings and might contribute to understanding why our informants felt shut inside the home.

Our findings suggest that living alone without a partner was a vital stressor for some of the women, even if they were partly on sick leave. Valenta (2008), who found that being an isolated immigrant single mother excluded from the workforce has negative consequences for economic prosperity and leads to discontent with social life and social identities, supports this finding. The women, bearing the responsibility of the family economy alone, experienced shame and humiliation, as they did not have the same possibilities as others in the community. According to Hartling et al. (2004), shame is experienced as a failure to realise one's ideas, and is recognized as a strong, lasting experience that affects the whole self. Shame can also be seen as a powerful factor that can disrupt connections, resulting in loneliness and profound isolation (Hartling et al., 2004). Such experiences were recognizable among our informants.

Killeen has developed a loneliness continuum which ranges from alienation to connectedness. He labels the characteristics of alienation as powerlessness, rootlessness and social and self-isolation, which are similar to our findings (Killeen, 1998). Because of the distressing and undignified experiences of living with a violent or sick partner, the women in our study often wished for an escape from the unbearable situation, but felt they were bound by both economic and cultural obligations. In situations when a home has turned into a strenuous place, it is no longer a place to relax or be safe; the humiliation women experience is even more evident in such situations (Klein, 1991). Klein also points out that in families where one of the members is alcoholic, the rest of the family members are often locked into destructive denial because they feel degraded as a family and fear further humiliation. The women in our sample seemed to experience shame regarding their alcoholic or violent partners. As Klein observed, people who feel shame tend to believe that they brought their experience upon themselves (self-blame). This is different from our findings because the women did not seem to blame themselves for the difficulties in their domestic sphere, but instead seemed to see themselves more like victims in an unescapable situation.

The findings suggest that feelings of lonesomeness and homesickness were reinforced by communication difficulties. This is similar to Nawyn et al.'s findings from a North-American setting that reported on refugees' experience of being unheard when they spoke because their speech was unintelligible (Nawyn et al., 2012). The ignorance our informants experienced when doing their best to speak Norwegian might have fortified their experience of shame. Even though they had scattered contact with neighbours and practiced Norwegian at their workplaces, they were embarrassed about the way they expressed themselves in Norwegian, which became a barrier for daring to speak in new contexts. This is comparable to a study with elderly African immigrants in Oslo, who experienced poor language proficiency as a barrier to civic engagement (Gele and Harslof, 2012). According to Killeen (1998), loneliness

indicates a lack of options, which was the case for our informants who felt unable to choose friends or to have contact with their former networks. This can be related to previous studies in Australia with immigrants from different countries (Ogunsiji et al., 2012, Watt and Badger, 2009); namely, when not feeling accepted in the new location the respondents' feelings of homesickness increased.

### **Lonely, rejected and humiliated in working life**

An obvious sign of being alone at the workplace is expressed in the following statement from an immigrant woman 'Nobody wants to sit beside me'. The feelings of exclusion and loneliness are also documented by the fact that very few of the workmates took the time or were willing to listen in order to gain insight into the women's suffering. The women chose not to speak of their suffering because of their fear of gossip in accordance with the 'humiliation dynamics'; when confronted with the feeling of humiliation, people develop a desire to avoid it as it makes them even more vulnerable (Klein, 1991). Concurrently, we can see this as shame, which according to Chase and Walker (2013), is co-constructed – combining an internal judgement of one's own abilities and an anticipated assessment of how one will be judged by others (Chase and Walker, 2013). Furthermore, pain, an invisible illness, increases the demands on the women in expressing their situation in a manner that enables colleagues to understand how difficult it is for them and offer to assist with coping strategies that can alleviate their suffering. Hartling developed a humiliation inventory scale, and one of the items is to be 'treated as invisible' (Hartling and Luchetta, 1999). This can be described as a vicious circle where the humiliating rejection at the workplace might reinforce both the women's experience of shame and their avoidance of telling anybody about their illness/symptoms, which then results in more days on sick leave during which they are again isolated and lonesome.

The findings suggest that the employer's lack of understanding and knowledge about the women's health concerns made the women feel rejected and disrespected, and some even experienced it as ethnic discrimination. According to Klein (1991), discrimination is part of the humiliation dynamic.

Most of our informants did obtain employment, even if not all of them were 100 % content with their positions. This is different from an Australian study, which showed that African immigrant women did not get jobs according to their qualifications and were discriminated against based on their countries of origin, both of which impact their psychological and emotional health (Ogunsiji et al., 2012). A theme which was relevant for the majority of our informants was their lack of confidence in getting a new job (despite the fact that the unemployment rate in Oslo was quite low, 4,1 %, at the time of the interviews) (Statistisk årbok, 2012) because they had been unable to pursue a higher education. Insecurity about losing their job forced the women to work despite illness. A heavy conscience might be attributed to shame if they believed that they failed to live up to their self-ideals (Klein, 1991). Furthermore, Chase and Walker (2013) argued that the shame of poverty in England was connected to prevailing 'truths' current in the British public opinion; e.g. poverty is seen as a direct result of people not working. Fear of indignity is implicit in the fear of poverty and of being dismissed, which contributed to the fact that some of the immigrant women in Norway forced themselves to go to work or took short sick leaves even when they were in pain and felt sick. This is consistent with literature which documents that fear of losing one's job can affect job attendance and causes employees to be more careful about their present work situation (Carneiro et al., 2010). As a parallel, in the Swedish labour market the proportion of female immigrants who had short-term employment, low-status jobs, part-time and/or inferior salaries was higher than for native women, which indicated a higher level of insecurity for female immigrants (Akhavan et al., 2007, Valenta, 2008).

Despite having jobs, for some of the women who work for example as cleaners, the work tasks did not involve social contact, and therefore it was not easy to practise the Norwegian language. For some of the immigrant women in Norway, family conflicts, coupled with unemployment, lack of respect and discrimination at work led to anxiety and depression. Difficulties in making friends with indigenous people are not resolved however, by weak and superficial relations with colleagues (Valenta, 2008). Weiss underlined that one of the provisions offered by social relationships, for example, with one's co-workers, is reassurance of one's worth by providing a sense of competence and being valued (Weiss, 1974); many of our informants did not have such relationships. Valenta (2008) upholds though that being employed might give immigrants higher social status and improve interactions with indigenous locals due to growing self-confidence and a positive self-image.

Some of our informants had challenging care-giving tasks, a lack of physical resources and a limited social network. As for our informants, as underlined by Killeen (1998) and Syed et al.(2006) some factors might have contributed to a feeling of powerlessness, such as increasing demands, the inability to influence work, poverty, lack of social support and lack of resources needed for example, to speak the language fluently. Furthermore, Klein (1991) defined humiliation as the experience of being degraded, put down or belittled for who one is rather than for what one does. Additionally, the immigrant women in Norway experienced indignity that poisoned relations between individuals and groups; according to Klein (1991), such indignity is the foremost weapon in the harassment of women, coloured people and other stigmatized groups.

Inability to apply for part-time education, as promised to one of the informants in the present study, is in accordance with Akhavan et al. (2007). He points out that the immigrant women in his study got fewer opportunities to upgrade their skills in order to enhance professional knowledge, well-being and motivation, all of which can result in an increased number of

opportunities for career and psychosocial development. A part-time education could have been an effective approach to rehabilitation (Aas Wågø, 2012) for one of our informants, but instead she was excluded from the workforce - and thus the possibilities for a part-time education - leaving her alone in insecurity and humiliation.

### **Limitations and strengths**

Although immigrants are a heterogeneous group, similarities, rather than differences in culture, are evident from our findings. Even if the women came from different countries/continents, research has shown that people with a minority background have much in common and meet with many of the same challenges in their host country (Hanssen, 2010). According to Hanssen (2010), immigrants often meet with nurses or other healthcare workers who do not understand their collectivistic orientation and their tendency to be passive and value beneficence and interdependence over autonomy. Furthermore, many of the immigrant women in Norway lived with holistic family traditions and were low-paid workers, e.g. cleaners, grocery staff and kindergarten assistants. The setting for participant observation was the outpatient clinic. More extended observations at the informants' workplaces, for instance, could have provided important additional insight. After an overall assessment of the work, employment and sickness among immigrant women in Norway, we chose not to use an interpreter, even if it might have produced some bias in the findings (Squires, 2009). According to Squires, researcher-participant language barriers might have been a limitation of our study that could have affected the analysis and interpretation of the results. We also reflected on the relative power of languages; in other words, the participants did not fluently speak the dominant language in the country (Norwegian), and were thus unable to give voice to all thoughts, opinions and feelings (Temple and Young, 2004). In retrospect, we learnt that



in one or two of the interviews, interpretation could have resulted in more in-depth information from the informants because their language skills varied significantly. Additionally, parts of the interview excerpts may seem taciturn due to language deficiencies. We could have further increased our understanding if we had continued to interview all the informants twice, but that was not an option because of the participants' reluctance. One of the strengths of the study is the use of different methods that widened the information base. The interdisciplinary composition of the authors was an advantage in being able to analyse and assess the findings.

## **Conclusion**

The findings of this Norwegian study indicate that the immigrant women on long-term sick leave due to chronic pain experience many hardships in their daily life, both at home and at the workplace. This became apparent through the descriptions of low self-worth, shame, lonesomeness, rejections from spouses and neighbours and their own confinement because of painful bodies and distressed minds. Furthermore, the lack of consideration from the work environment, and the experience of worthlessness, shame and what might be ethnic discrimination, might explain some of the suffering the informants referred to. One can understand the informants' daily life as humiliating when being excluded from written job-contracts or not feeling sufficiently needed, wanted or valued by colleagues, employers or even family members. The immigrant women on long-term sick leave in Norway live in triple jeopardy: being ill and being lonesome both at home and at the workplace. This can be described as a vicious circle where the humiliating domestic and workplace-rejection might reinforce both the women's experience of shame and avoidance of telling anybody about their illness/symptoms, which then results in more days on sick leave during which they are again isolated and lonesome. Our findings of loneliness and discrimination among immigrant

women from Asia and Africa living in Norway could be extrapolated to other groups, and possibly also for men. Musculoskeletal disease has low status among health personnel compared to for instance cardiovascular disease. However, our findings might relate chronic muscle pain to broader lifestyle perspectives, thus drawing greater attention from health care personnel.

### **Implications for practice and further research**

This study provides new insights into immigrant women on long-term sick leave in Norway and their struggles with daily life at home and at the workplace. There is a need for health personnel in rehabilitation clinics and health service staff to include mapping for early identification of loneliness, emotional distress and discrimination in this population. This will in turn highlight these hidden issues for health personnel, thereby making it easier for them to perform culturally appropriate multidisciplinary rehabilitation. There is also a need to disseminate the knowledge of immigrant women's hardship to employers in the labour market. More research is needed to illustrate how immigrant women and men experience their workplaces in terms of inclusion/exclusion, discrimination, humiliation and lonesomeness. Furthermore, research is needed to identify effective coping mechanisms and how health care professionals could contribute to identifying and dealing with these issues at their early stages of the illness.

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