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

Abstract

Purpose: The purpose of this study was to explore if and how immigrant women suffering from chronic pain experience and maintain their dignity, during rehabilitation.

*Methods***:** The study was designed as a field study, with participant observation and in-depth interviews. Participant observations were carried out during a rehabilitation course for 14 immigrant women on an outpatient clinic at a rehabilitation hospital in southern Norway. In-depth interviews were performed after the rehabilitation period. Hermeneutic analysis was applied to interpret the data.

Results: Findings show that the immigrant women experienced dignity by being seen, respected and believed by family-members, healthcare personnel and other patients at the outpatient clinic. Moreover, they maintained their dignity through a sense of their own value, integrity, religious faith and hope for the future.

Conclusion: The immigrant women maintained and protected their dignity by finding strength, pride and self-worth in their religion and through their family-members' affection. Taking responsibility for themselves and others and experiencing fellowship and equality with other women, they enhanced their dignity during their rehabilitation process. The caring attitudes and behaviour of some healthcare personnel promoted patient dignity. They also gained hope and dignity by experiencing goodness, cultural competence and sensitivity from healthcare personnel.

Keywords: Chronic Pain, Dignity, Immigrants, Qualitative, Rehabilitation, Sick Leave, Work.

Introduction

The purpose of this study was to explore if and how immigrant women suffering from chronic pain experience and maintain their dignity, during rehabilitation. In the beginning of 2016, about 850,000 immigrants resided in Norway, or 16 % of the total population. Thirty-three per cent of Oslo residents are immigrants or Norwegians born to immigrant parents [1]. Immigrants are here defined as persons born abroad of two foreign-born parents, who at some point have emigrated from a low/middle income country to Norway. A higher proportion of immigrant women have musculoskeletal disorders than immigrant men [2]. A survey from 2006 in Europe showed that 15-19 % of the adult population suffers from chronic pain [3], whereas the literature shows that the prevalence of chronic pain is higher among immigrants in Europe than the native European population [4, 5]. Compared to native Europeans and to immigrant men, immigrant women are generally suffering from chronic pain with higher levels of pain anxiety and pain intensity [6, 7], they take more sick leave [8, 9] and experience to lack control over their pain [10]. Moreover, many immigrants demonstrate low expectations for rehabilitation programs, as they find the concept of self-training and empowerment problematic [11], and they often perceive pain as a barrier to initiating and maintaining physical activity [12].

The fact of being on long-term sick leave or in the phase of work reintegration, might influence the experience of indignity due to feelings of exclusion [13] and experiences of social stigmatization [14]. Several studies have revealed that immigrant women when compared to men, face a double or triple oppression due to nationality, class and gender [15-

17]. Studies have also shown that immigrant women sometimes suffer indignity at their workplaces [18-20] at times in their homes [21] and sometimes in their contact with the public health system [22].

The fact that immigrant women experience indignity in health care, give emphasis to the importance of cultural competence, defined as "…attitudes, knowledge and skills necessary for providing quality care to diverse populations" [23]. Dignity preservation is a part of caring for vulnerable human beings [24] and maintenance of dignity is believed to be a central value in healthcare [25].

According to Nordenfelt (2004) [26], dignity is comprised of "dignity of identity", which implies integrity and the subject's self-image that are linked to our history, our future and our relations to others. The three other notions of Nordenfelt's human dignity are "merit", "moral stature" and "Menschenwürde" (a universal human dignity). Dignity of "merit" refers to an individual's role, rank and position in society, and is associated to concepts of rights and respect. Whereas dignity of "moral stature" refers to a sense of self-respect and moral identity, in addition to a dignified character and a dignified conduct, as well as having a moral standard [26]. In this regard, Lindström et al. [27] underscore the importance of self-worth and being in harmony with oneself as essential to dignity. Moreover, Chochinov et al. found that the presence of an available and helpful community of friends and family enhanced patients' dignity [28]. Shotton and Seedhouse (1998), who suggest that dignity is like a brick wall that can be rebuilt, for example, by learning how to master one's disability, by meeting others who suffer or by reassessing one's priorities [29], underline dignity seen in a mutuality perspective. Furthermore, Chochinov [30] claims that spiritual comfort has a dignity-sustaining effect. If patients can gain strength from a rich spiritual life, achieved by a connection to a spiritual or religious practice or community, it may contribute to the preservation of dignity [30].

In nursing, research on dignity has mainly focused on the contexts of elderly people, dementia care and nursing homes, end-of-life care and care in hospital settings. Some studies about dignity have also focused on patients with chronic rheumatic diseases, multiple sclerosis and head injuries in their course of rehabilitation [31-33]. Studies show that dignity-enhancing care—characterised by empathy, compassion, understanding and interest—is of decisive importance for vulnerable patients to experience and maintain their dignity during rehabilitation. A small number of qualitative American studies have focused on immigrants' experiences of dignity. These studies have examined populations such as undocumented immigrants (persons without papers for legal residence in the country) with chronic illness in California [34], mentally ill Chinese immigrants in New York [35] and immigrant women with mental illness and HIV risk in New York [36]. These studies have shown how immigrants risk jeopardising their social and moral standing and how they should be supported in making decisions regarding mental disclosure related to exploring their personal and familiar dignity. The aforementioned studies found that some immigrants were provided dignity and respect through positive labels, whereas others needed to be recognised as worthy human beings with legitimate medical needs [34-36]. However, we have found only a few studies that describe immigrant women's experiences of dignity and how it might be maintained during the rehabilitation process.

The research question~~s~~ was as follows: How do immigrant women on long-term sick leave in Norway experience, understand and preserve their dignity during the rehabilitation process?

Methods

The study was designed as a field study. A hermeneutical approach was used to explore the participants' experiences of dignity. Data was collected through a combination of participant observations during two rehabilitation courses and qualitative interviews after the courses.

Study setting and participants

Study participants suffering from chronic muscle pain were recruited from an outpatient clinic at a rehabilitation hospital in southern Norway. Fourteen immigrant women (aged 30–56 years) participated, of whom 11 were on partial sick leave and three were on full sick leave. The outpatient clinic offers a rehabilitation course for immigrant women on long-term sick leave within 52 weeks or if they receive other benefits when the sickness absence period is ended. A physiotherapist and a social worker led the rehabilitation course, using a psychoeducational program, built on cognitive therapy [37, 38]. This included teaching about stress-coping strategies with the aim of reducing pain, tiredness, anxiety and depression.

Written information and an invitation to participate were sent to the women from health professionals at the outpatient clinic. Oral information was given individually from health professionals and from the researcher (the first author of this article) [20]. The inclusion criteria were as follows: 1) adult immigrant women from Asia, Africa and the Middle East on long-term sick leave, 2) women who were capable of speaking Norwegian fairly fluently so that they could discuss their experiences and be able to take part in the rehabilitation course without a translator and 3) women who had been referred by their general practitioner to a rehabilitation course at the outpatient clinic. None of the 14 participants dropped out of the participant-observation period throughout the two rehabilitation courses, which involved two groups comprising eight women in the initial group and six women in the next. However, one of the participants in the first group dropped out of the course three weeks before it ended, another woman declined to take part in the interview because she was no longer on sick leave, and a third woman was not accessible for an interview [20].

The immigrant women originated from low or middle-income counties: one from East Africa, one from Central Asia, two from Southeast Asia, three from North Africa, three from the Middle East and four from Southern Asia. Three were trained employees and 11 were non-skilled employees. Two had academic degrees, 11 had graduated from high school, and one had finished five years of primary school. All the participants had children. Eleven of the women were married, and three were divorced and resided with one or more of their children. All of the participants had lived in Norway for more than five years (table 1), and they were familiar with the Norwegian healthcare system [20].

Table 1: Demographics

Code	**Age**	**Continent**	**Single mother Hood**	**Number of children**	**Employment**	**Length of residency in Norway**
W1	40-45	South east Asia		2	Handcraft	More than 10 years
W2	35-39	Central Asia		4	Assistant in kindergarten	6-10 years
W3	30-35	South Asia		1	Assistant in kindergarten	More than 10 years
W4	35-39	East Africa	X	2	Cleaner	6-10 years
W5	50-55	Middle East	X	7	Grocery store assistant	More than 10 years
W6	50-55	South east Asia		2	Technician	More than 10 years
W7	50-55	South Asia		2	Primary school teacher	More than 10 years
W8	40-45	North Africa		4	Assistant in kindergarten	More than 10 years
W9	45-49	Middle East	X	2	Nursing assistant	6-10 years
W10	55-59	South Asia		4	Assistant in kindergarten	More than 10 years
W11	35-39	North Africa		2	Assistant in kindergarten	More than 10 years
W12	45-49	South Asia		2	Assistant in kindergarten	More than 10 years

W13	40-45	Middle East		1	State enrolled nurse	6-10 years
W14	35-39	North Africa		2	Assistant in kindergarten	More than 10 years

Data collection

The data collection was based on two methods and performed by the first author. She conducted a field study with participant observation during two rehabilitation courses that lasted for ten days each during the course of ten weeks each, for a total of 45 hours [20]. Qualitative interviews were then conducted with the selected sample.

Participant observation

In line with the work of Silverman, the intention of the participant observation was to gain an understanding of how the women experienced their daily lives, employment, sick leave and the rehabilitation course [39]. The immigrant women were observed in diverse situations during the course, which consisted of taking part in group discussions and lessons, practicing indoor workouts and during walks in a public garden [20]. The participant observations made it possible to be acquainted with the women, to learn about their concerns and their viewpoints and to develop a rapport with them [40].

In order to cite conversations more or less exactly, field notes were taken during group conversations and lessons. Other indoor and outdoor activities were also described as accurately as possible directly after each session [41]. Creating an open and confident connection between the researcher and the participants was important for gaining reliable data, and it was crucial in acquiring the women's trust and willingness to be interviewed later [20].

Qualitative interviews

Four to eight weeks after each rehabilitation course, qualitative interviews were performed to gather information about the women's experiences [42]. In-depth, semi-structured interviews

were conducted with 11 of the 14 women. The interviews with eight of the women who spoke Norwegian proficiently or at a beginner level (not fluently) was not demanding for the interviewer to understand, as she had become acquainted with the participants and their way of speaking during the rehabilitation course.

To ensure an in-depth insight into the lives of the women and to have the richest possible data set, the first author carefully chose three of the women who spoke Norwegian fluently and who had been on long-term sick leave for a long period of time to be key informants. They were interviewed twice [20], the second interviews were performed 2-5 months after the first interview.

Moreover, the key informants were conversational and were able to give rich descriptions of their daily lives. The interviews started with an open-ended question about their everyday experiences after the rehabilitation course. An interview guide was used, which built on themes from prior research on immigrant health, working life and/or dignity and a preliminary analysis of the field notes. The interviews lasted between 35 and 110 minutes, for an average of 70 minutes [21].

Data analysis

Analysis and interpretation of the empirical material were performed using a hermeneutic approach to the text [43]. The handwritten field notes were, in accordance with Silverman [42] converted to text using verbatim quotes and descriptions. The first author transcribed the digitally recorded interviews verbatim immediately after each interview. We combined the interview data and the observation notes in the analysis by initiating the analysis with the aim of getting a sense of the whole text [20]. Therefore, the first author read the empirical material a number of times in order to achieve what Ricoeur refers to as “a naïve grasping of the meaning” [44]. This approach permits the first author to establish an immediate understanding of the text without considerable reflection on its meaning. The first author then prepared a

structural analysis that involved categorising and enunciating themes and conducted the main analysis. She developed a deeper understanding of the interview text by taking into account her prior understanding regarding what she knew about the women and about the context of the interviews, which were informed by the field notes. The co-authors contributed to the discussion of the analysis and the findings. To ensure the trustworthiness of the analysis, the co-authors also read parts of the empirical material and approved each identified theme [20]. The pre-understanding of the first author was limited to her Western background experience, while the background of the second author is Asiatic, which contributed to a thorough comprehension during the phase of analysis. Since all the participants were women and came from low income countries, they were expected to be more vulnerable to stigma and discrimination [45-47]. This was taken into consideration during the analysis.

Research ethics

The study was approved by the Regional Committee for Medical Research Ethics (REK, nr. 2011/662a). The participants gave their written, informed consent prior to the field study. The professionals in the courses got verbal and written information about the project, and they gave their informed consent to participate in the study. Both the participants and the professionals could withdraw at any time. Participation was voluntary, and we have respected confidentiality throughout the study. In order to protect the privacy of the immigrant women, their anonymity has been ensured. Women who were somewhat fluent in Norwegian were chosen; therefore, we decided not to use an interpreter during the interviews in order to ensure proximity in the interview situation. A verbal agreement about additional treatment with the healthcare personnel at the outpatient clinic was made, if required. In line with the Helsinki Declaration, we have protected the interests of the participants [20].

Findings

The hermeneutic interpretation revealed three main themes: 1) “having and protecting value and integrity”, 2) “being seen, respected and believed” and 3) “having faith and hope”. Despite their experiences of suffering and humiliation, we found that these women also felt that they had value in their everyday lives and in their contact with healthcare personnel.

Having and protecting value and integrity

The informants were asked if they had any thoughts about the concept of dignity. A South Asian woman associated it with value:

If you are something, then you have value ... you are valuable to others and … someone appreciates you (W7-I).

During the rehabilitation course and in the interviews another South Asian woman referred to her parents, husband and relatives in a very positive manner, despite the fact that she had a long-standing conflict with her stepfather and his family. They would not accept her choice of husband when she chose to marry the man she loved. In this difficult situation, she thought about the idea of dignity:

Dignity is what I mean to others … or what my value is. That’s what I think (W3-I).

Although her distant relatives talked about her in a negative way, she felt valued by her close family and by herself.

Furthermore, when another woman was asked what she did to preserve her dignity, she replied that she sent money to her sisters in her homeland, and explained:

I am a decent person, I think; I do good for others, and I try as best I can to do my job and take on responsibilities and everything. However, people do not appreciate it (W7-I).

This participant protected her rank or position, even with few resources and despite the fact that she was not appreciated, which may have been a way to maintain her value.

Another woman who had been depressed and pain afflicted for about a year struggled to avoid showing her children her weakness and bad health:

Although I am sick, I am strong ... I don't show them my weakness. I cannot stand that they are worried, but life is like that, and life is not perfect. Everything goes up and down, and we must be strong (W5-I).

She did not want her children to be worried; she wanted them to be strong when they faced problems. She explained that this was a way to let herself and her children be recognized for their value, instead of being looked down upon or pitied.

This woman had also been some weeks at a rehabilitation clinic, where she did efforts in socialising with and trying to encourage the other clients. Thus, she came out of her own loneliness and depression and stated:

At the rehabilitation clinic … I found myself again (W5-I).

By this, she meant that the restoring of her health made her stable and secure and made her feel that she could trust in herself. In addition, she emphasised the encouragement from discovering her ability to use her own resources to offer emotional support to others and cheer them up. In this way, she felt valuable.

Another woman experienced her ability to protect herself by learning to disagree or to say "no" to people.

This woman mentioned the ability to say "no" as one of the most important value-fortifying aspects she had learnt during the course, which strengthened her integrity. At the rehabilitation course a woman confirmed this new insight when telling:

Now, my husband also does housework, it is not only me…and I told my colleagues that I cannot do the heavy tasks because of my pain problems, and they agreed (W12-O).

Another woman was concerned with not being false:

Somehow, you must take me as a valuable person ... I do not want to do something extra that is not a part of me, so that I should prove a false personality; I will not. I just have to be the way I am. If someone thinks that I am valuable, then it is fine, but if not then it's up to them (W3-I).

She described her value as stemming from who she is, regardless of what others might think, and she avoided compromises, which could imply dishonesty. According to these findings, the women demonstrated strong integrity while striving to maintain their sense of personal worth.

Being seen, respected and believed

A woman from North Africa gave the following statement about the healthcare personnel at the outpatient clinic:

I think they are very clever; they treat everyone equally, but differently according to what disease you have. I thought they were very understanding ... I felt very valuable and respected … They believed in me (W11-I).

This woman was surprised that the healthcare personnel treated her with sensitivity, competence, empathy, respect and understanding. In the interviews and during participant observation other women had similar experiences; they stated that the healthcare personnel at the outpatient clinic "*are good listeners*", "*give good advice*", *"have enough time",* "*are dedicated*", "*motivating and enthusiastic*" and "*try all possibilities*".

When the interviewer and one woman spoke about dignity, she said the following about the support she had received at the outpatient clinic:

There, [outpatient clinic] I've got a lot of help; they have been open to discussing everything, and I have a sense of being heard, too ... got good guidance and counselling. It can be everything, it's my

private life and health and stuff… But the health personnel, you feel like they care about me ... it's like someone is thinking of you so much (W3-I).

She experienced being heard and seen by skilled healthcare personnel who showed that they cared for her. Moreover, during the rehabilitation course, one woman understood that the other participants had the same problems as her, which gave her courage to find a way out of the despair and difficulties in her life:

When I started the course, I saw that several [of the other participants] had almost the same problems, and then my brain began to work better. I saw more light [rather than darkness], and I thought that I would find solutions (W5-I).

In the women's fellowship, it seemed that she was heard, seen, understood and believed among equals, among women with the same struggles and similar backgrounds. This was evident during the observation period, as the field notes describes that a woman (W5) changed her attitude from the first course day:

Giving voice to a negative focus on her body and her life situation…, and then turning to be quite positive, optimistic and hopeful the last course day, saying that she… felt joy and positive thoughts…, you gave me hope (W5-O).

Another woman felt that the treatment from the doctors in her homeland in Central Asia was much better than in Norway. She said that it was painful for her when the Norwegian general practitioner looked at his watch. On the other hand, the doctor in her homeland did not even think about the time. This provided a large contrast; she felt more seen, respected and believed in her homeland.

Having faith and hope

In one of the sessions of the rehabilitation course, one Southeast Asian woman described her difficult life and her expectations for the future:

If I die, I'd rather be a flower. I don't think flowers have so much pain (W1-O).

This woman had lived under rather mortifying conditions, with intimate partner violence. However, her faith in reincarnation as a flower gave her meaning and hope for a better condition in her next life. She believed that flowers do not suffer; instead, they are valued for their beauty, whereas indignity may increase the suffering. A woman from the Middle East emphasised that she got her strength and self-worth from her religion, which prevented her from succumbing to despair:

I pray, I trust my religion, believe strongly and therefore I live now, and I survived a tough life. My background is not easy, but still I am strong, smiling and dancing. It comes from Allah, from God, from the Quran. I read a lot from the Quran; I pray a lot. Always I talk to Allah, I cry and everything, and afterwards I feel confident and relaxed, and I can breathe (W5-I).

Furthermore, because she trusted her faith so intensely, she could both have confidence in herself and have hope for the future. Another woman from Southern Asia mentioned silent breaks at work in the kindergarten, during which she prayed to Allah:

I also pray there. Often when I pause, I pray. Everyone has a right to do it. I think it is much better to take a break, to be completely calm and pray (W10-I).

In this way, she recuperated and felt peaceful for the rest of the workday, both mentally and spiritually, and thereby protected her dignity. She also prayed, turning towards Mecca during our breaks at the rehabilitation group meetings. One of the women from the same continent had five years of university education, but was not yet approved in Norway, so she worked as

an assistant in a kindergarten. She explained that even if she attended to various qualification courses, the rules for authorization frequently changed so that she eventually resigned. She was unsure if she would ever get an authorisation, and it seemed that the only way she could accept and live with that was through her religious faith:

If I cannot work in my profession, then it's just my fate (W3-I).

She explained that in this way, she could accept her degrading situation. She alternated between the hope that she would eventually get an authorisation and despair that it would not happen. Another woman reflected on the fact that none of her family members, workmates or friends valued her input, engagement or help. She felt hurt and taken for granted. However, her religious faith in destiny enabled her to maintain her own sense of value, despite the fact that she felt offended by her social network. By accepting the will of God, she was able to uphold her worth as a person.

Discussion

The findings presented through the three themes— "having and protecting value and integrity", "being seen, respected and believed", and "faith and hope"—set the stage for a discussion about *dignity,* both *absolute dignity* and *relative dignity*. In the following section, we discuss our findings in relation to an overall theme, which we have called "maintaining dignity". This theme includes dignity that is obtained through strength and pride, within caring relationships and through spirituality and hope.

Maintaining dignity through strength and pride

The immigrant women experienced their value as being maintained by their loved ones, which is part of the relative dignity enhancement underlined by Lebech, who points out that by experiencing love and friendship, the individual can learn to respond to the equally

fundamental value of others [48]. Other evident values for the immigrant women included getting strength and self-worth from their religion, being loved by family-members and accepting themselves. In this regard, Fisher and Tronto underline that even where women become dependent on their workplaces, their role in their families give them status, power [49] and thereby strength and pride.

It seemed to be of decisive importance for the immigrant women to maintain the positive qualities of the doctors' treatment and behaviour in their native countries, and in this way to be connected with their "historical selves". Lindström et al. uphold that "in being, the person strives for balance and harmony; in becoming, the human becomes whole on a deeper level of integration" [27]. In this way, the participants also experienced what Edlund [50] refers to as absolute dignity, which implies human worth, freedom and responsibility. Furthermore, Eriksson claims that health entails striving towards a realisation of one's potential [51] that is determined by one's needs and desires; in other words, the will to find meaning. For our participants, experiencing an improved health-situation in their former home-settings was an essential source of relative dignity. On the other hand, some of the women expressed hopefulness by using their potential and resources in the new Norwegian setting. This was manifested in economically supporting relatives still living in their homelands, being strong despite sickness, being honest and respecting and encouraging others. The pride of being economically independent, and being able to support distant relatives, can be seen in relation to a study with Chinese immigrant women who gained more power in the family decision-making process due to their ability to contribute to family income [16]. This can also be related to when one's dignity is compromised, it can be restored through moral deeds [50]. Moreover, Edlund underlines that inner dignity is described as esteem, pride, position and rank, and is part of the relative dignity [50]. For some of these women, this meant taking responsibility for their relatives and colleagues.

Maintaining dignity within caring relationships

At the outpatient clinic, the participants met others living in situations similar to theirs. Being seen, respected and believed by other immigrant women gave them reciprocal comprehension. In this way, the women experienced dignity-enhancement. In this regard, Baillie found that dignity was enhanced among patients in a hospital setting, in which they could have contact with fellow patients in similar circumstances [52]. We can therefore tentatively state that the relative dignity of the immigrant women was fortified through fellowship with other women. Furthermore, Fisher and Tronto, point out that the sisterhood ideal, in the form of support groups provide a resource and experiences of equality for women who, to a great degree, are living in the household context [49]. Moreover, the fact that the rehabilitation course was arranged for immigrants only, implied that the counselling and the teaching was specifically tailored to immigrants who are not fluent in Norwegian. This is in accordance with Premji (2015), who found that lack of proficiency in English (in Canada) made immigrants hindered by interpersonal and structural barriers in their process of returning to work during rehabilitation [53]. At the outpatient clinic, the immigrant women felt respected and believed, and they felt that the healthcare personnel responded to them with competence, empathy and respect. Moreover, their integrity was strengthened, which thereby protected their absolute dignity. This is in accordance with the findings of Nordenfelt [26] who claims that the integrity of the subject's body, mind and self-image is tied to their sense of dignity of identity, and it is the result of other people's acts. Accordingly, it is apparent that the caring attitudes and behaviour of the healthcare personnel were dignity-enhancing for the immigrant women.

Moreover, the healthcare personnel seemed to convey an attitude of personal involvement and understanding, with an adequate amount of time for each woman. In this regard, Gastmans is concerned with the vulnerability of the human being when maintaining, protecting and promoting his or her dignity. He underlines the importance of responsibility and competence

as two ethical attitudes that are needed to connect with vulnerable patients [24]. Our informants characterised the healthcare personnel at the outpatient clinic as responsible, implying that the immigrant women could trust them, and they were also viewed as having cultural sensitivity and competence. This finding indicates that when the healthcare personnel at the outpatient clinic demonstrated responsibility and competence, the immigrant women felt that their dignity was fortified. This is in line with Tronto (1998), who claims that responsibility to meet an identified need and competence to understand the complexity of the caring process are the moral dimension of caregiving [54]. Moreover, cultural sensitivity and competence are, according to Papadopoulos (2006) seen as having the important qualities as trust, respect, empathy and communication skills [55], which the health care personnel at the outpatient clinic seemed to hold.

In terms of investment of time, some women felt that doctors in their homeland seemed not to be concerned with how much time they spent with each patient. This was also the case for the healthcare personnel at the outpatient clinic, who were able to communicate that they were not in a hurry neither in their consultations nor during the rehabilitation course. According to Niemeier et al., many immigrants find it important that the general practitioner take time to get to know them and their family to develop confidence and trust [56]. From a more philosophical point of view, Nurminen states that lack of time is “non-time”, leading to the absence of time for fellowship, and time flaw appears as loneliness [57]. Nurminen maintains that the opposite is a caring relationship that will make the patient whole, and thereby contribute to the patient’s dignity [57]. When the immigrant women drew attention to health personnel in their homelands and in Norway, who had enough of time to care for them, it was an important way to experience relative dignity.

Maintaining dignity through spirituality and hope

This study shows that the immigrant women found support for their absolute dignity in their faith in God through daily prayers, reading Holy Scriptures and believing in reincarnation. Experiencing a religious life is in line with findings of Lindström et al. [27], who maintain that the human being seeks to experience hope and faith in some form of God, to find meaning and thereby experience absolute dignity. This was also the case for our participants; they described their religious faith as a strong force that carried them through life, in spite of all their troubles. In this regard, a German effect study in medical rehabilitation about treatment outcomes among immigrants from Turkey and a former Yugoslavian country, showed that cultural and religious needs were not sufficiently addressed by the health care providers [58]. By this, we can determine that health workers should consider immigrants' religious needs when offering rehabilitation programs.

Hope—for better conditions, for future good health and for finding ways out of their struggles—is an important source of energy for immigrant women on long-term sick leave. This is in line with Chochinov [30] who asserts that a dignity-conserving perspective must be hopeful and offer sustained meaning or purpose. When our participants experienced being filled with hope, both in contact with doctors in their homeland and with healthcare personnel at the outpatient clinic, this can be seen in relation to what Arman and Rehnsfeldt [59] describe as "seeing the whole human being … and respecting his or her needs and wishes". The authors conclude that when patients are offered hope by experiencing goodness, this has the power to open patients up to development and growth, and it helps maintain their dignity [59].

For some of the women, faith in destiny helped them to accept their situation and thereby maintain their absolute dignity. This is in accordance with Chochinov's description of

acceptance as the ability to accommodate to changing life circumstances or to be at peace with what is happening to oneself, which is a dignity-sustaining capacity [30]. Mustering hope for one's fate in daily life was also important for the immigrant women in our study. Furthermore, Frankl upholds that the way we accept our fate and our suffering gives us the opportunity to add deeper meaning to our life. In this way, we may remain fearless, unselfish and dignified [60]. On the other hand, this could also be perceived as a barrier for the rehabilitation process, as faith in destiny both could be seen as a demonstration of resilience, but also a hinder for further rehabilitation. Shanthakumari et al. (2014) do however underline that for people accepting their fate as Gods' will, also see it as a hope to find solutions [61], and according to Theron et al. (2012), acceptance might lead the believer to a process of searching new pathways to well-being when some conditions are beyond control [62]. This is in accordance with Lohne (2008) who underlines that during a rehabilitation process the patients' hopes give strength and motivation to carry on, to look forward and creativity to find new solutions [63].

Strengths and limitations

One limitation of this study was that not all of the participants spoke Norwegian perfectly fluently, which means that some of the interviews were not as rich as they could have been. Interviews conducted in the women's homes, made participant observations possible in the women's home environment. None of the interviews was however conducted at their workplaces; accordingly, important additional insight was not feasible to get from these contexts. Although the immigrant women in this study came from different continents and cultures, research has shown that minorities have mutual experiences and encounter many of the same trials in their new countries [64]. Our participants represent a divergent group, but similarities in culture, rather than differences, are apparent from our study. One of the strengths of the study was the use of diverse methods of participant observations and

qualitative interviews, which extended the information base. The multidisciplinary composition of the authors was an advantage in being able to analyse and assess the findings.

Conclusion

This study has shown that the immigrant women maintained and protected their dignity — both relative and absolute—continuously and in diverse ways. Additionally, the women found strength, pride and self-worth in their religion, through their family-members' affection and through self-esteem, all of which fortified their sense of absolute dignity. Moreover, when they took responsibility for themselves, their relatives, close family and colleagues and, their relative dignity was fortified. Additionally, when they experienced fellowship and equality with other patients at the outpatient clinic, the caring attitudes and behaviour of some healthcare personnel also promoted patient dignity. Despite all the informant's suffering and indignity, they also gained hope by experiencing goodness, cultural competence and sensitivity from healthcare personnel, which helped the women to progress in their understanding of life and enhanced their dignity. As a final conclusive remark, we can determine that the mentioned dignity fortifying experiences of the immigrant women are universally human. Consequently, many of the findings are relevant for other immigrant women from low/middle income countries receiving rehabilitation. Nevertheless, further research is needed into the dignity of immigrant patients throughout their trajectory within different rehabilitation phases.

Implications for rehabilitation

- This study shows that the family role is more important for the immigrant women than the role as an employee, although financial independence and being able to help relatives financially also were central.

- Fellowship and equality with other patients, together with a rehabilitation programme, which is facilitated for different language levels, were understood as important factors for an effective recovery.
- Enough time to get to know the patients and cultural competence seems to be central components for the health care personnel to give efficient help to immigrants in rehabilitation.

- Immigrants from low/middle-income countries appear to apply their religiousness as a resource in their lives to a greater extent than native Norwegians do, and should be taken into consideration when planning and implementing rehabilitation programmes for immigrants.

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