

# Wellbeing through Group Exercise: Immigrant Women's Experiences of a Low-Threshold Training Program

## Introduction

Global migration has slowly increased in recent decades. In 2017 there were 258 million people residing in a country that was not their country of birth (IOM 2018) and in Norway 17.8 per cent of the population of five million are migrants (SSB 2019). Studies show that immigrants are at a higher risk of experiencing health issues, including mental health problems (Ahmad et al., 2005, Rechel et al., 2013, Bas-Sarmiento et al., 2017, Semedo et al., 2019). A number of reviews (Afari et al., 2014, Rohlof et al., 2014, Bustamante et al., 2018, Lanzara et al., 2019) furthermore report a high prevalence of psychological distress and psychosomatic complaints among immigrants, women being more vulnerable to mental health problems. In Norway there is a higher prevalence of mental health problems among immigrants aged 30-60 years old than in the adult Norwegian group and the population in general (Debesay et al., 2019, Abebe et al., 2017). Immigrant women also show a higher risk of mental health problems than men, women aged 59/60 showing higher levels of psychological distress than younger women (Hjellset et al., 2011). They also face more social integration challenges due to language difficulties and different understandings of women's role in the family, which causes psychological stress (Delara, 2016, O'mahony and Clark, 2018, Urindwanayo, 2018). Immigrant women may, as a result of cultural differences, face challenges in conveying their health problems. Health care providers in turn can experience difficulties in assessing and diagnosing patients and providing appropriate treatment options (Straiton et al., 2015). Immigrant women also report higher levels of musculoskeletal disorders than men, significant risk factors being an inactive lifestyle and obesity. Strategies

to prevent such risks and enhance migrant women's well-being are therefore required (Ahmad et al., 2005, WHO, 2017).

The World Health Organisation (WHO) promotes physical activity as a source of physical and mental wellbeing (WHO, 2018). The Norwegian government, in response to WHO's recommendation on physical activity, established the 'Action plan on physical activity 2005-2008' (Ministries, 2007). The plan encourages more active ways of living in all areas and recognises the need for easy access to low threshold activities. It also recommends the provision of community based services to assist social participation and recovery from mental health problems (Elstad and Eide, 2017). Reports show that mental health service provisions are required that are culturally appropriate and accessible by migrants (Kale and Hjelde, 2017). Norwegian Psychomotor physiotherapy (NPMP) is a treatment that helps reduce musculoskeletal disorders and mental distress. The treatment is an embedded mind and body awareness therapy which is usually applied to patients with widespread and long-lasting musculoskeletal pain and/or psychosomatic disorders (Dragesund and Kvåle, 2016). It is a biopsychosocial model that can help reduce mental stress and has an effect on health-related quality of life, pain, coping, self-esteem, and social rapport (Bergland et al., 2018).

The treatment can be given individually or in a group. The context in which the physical exercise intervention occurs is also an important key to better mental health. Ways to encourage adults with psychological distress to be more physically active include choice of location, cost of the activity, the availability of single sex groups, sessions on the same days and at the same time, supervised activity and activity that involves non-competitive measurement (Hoffman and Gabel, 2015, Bastug, 2018). Group exercise can provide other extensive benefits. This includes interaction with others, social integration, the opportunity to expand one's social acquaintances (Daley, 2014) and to share experiences and feelings

(Semedo et al., 2019) facilitated through women-only programs and cultural tailoring of interventions (Marinescu et al., 2013, Berggren et al., 2017).

The objective of this study is to explore immigrant women's participation in a psycho motor training group and to identify what motivates and affects their attendance and wellbeing. We discuss what sustains their participation in the group and the accommodations that can be made to increase participation. This study contributes to a better understanding and the promotion of the physical and mental health of immigrants.

### **Cultural Diversity and Body Awareness Exercise**

The tension between the traditional Western biomedical model and the alternative biopsychosocial model of disease is reflected in cultural differences in the way mental health and illness is perceived (Gopalkrishnan, 2018). The focus on pain not only as a physiologic but also a psychological phenomenon is, however, increasing, this broader understanding of the complex interaction of mind and body resulting in new approaches to pain treatment. Those with a non-Western background seem to be more familiar with this new field of counselling than with the traditional 'talking therapies' (as Gopalkrishnan (2018) and Lemon & Wagner (2013) refer to them) when addressing multicultural issues and client-centred body-mind therapies. A focus on the interrelated relationship between body and mind that is embedded in the biopsychosocial model of disease in group-based psychomotor physiotherapy, may therefore act as an incentive to immigrant women to enrol, this focus being on bringing consciousness into one's experience of one's body, rather than talking about painful events (Gopalkrishnan, 2018).

The components of biopsychosocial models are; a focus on body experience at a cognitive and emotional level, the facilitation of emotional reactions, and the link between movement and emotion. Treatment approaches such as massage, the form of interaction, positions and

movements, activities and conversation must be thoroughly thought through to avoid confusion and to promote self-development and participation (Bunkan, 2001, Gretland, 2007). Individually targeted interventions in a group setting are embedded in this framework (Probst, 2017). It is furthermore advised that treatment is conducted at a pace and in an environment compatible with the individual's perception of what is permissible (Gretland, 2007). Life experience events in the past have an impact on body awareness capabilities (Galanti, 2014). The body will, however, 'automatically' find a way to perform or tackle the situation adequately where the present situation involves many features that are relived or are in common with past experiences. An unknown situation will require the body to process learning mechanisms and then modify the previous terms of handling. It however becomes difficult to participate in new events where the features of this exceed one's bodily capabilities (Gretland, 2007, Duesund, 2008).

A key foundation of NPMP is 'therapeutic alliance' (Dragesund and Øien, 2018). A successful alliance is one of mutual responsibility and mutual understanding of the relationship established between the therapist and the patient, its goal, progression and other practical arrangements. The therapist's way of being tends to determine the patient's comprehension of their role in the therapy context. An outspoken therapist takes a lot of space in the relationship. A therapist therefore who holds back, allows the patient to present their stories and a 'laid back' therapist opens up a spacious therapy context. It is therefore important that the therapist is aware of these ways of being and of how choice of way of being can influence meaningful therapy for the patient (Schibbye, 2012). The recommended foci in group exercises are the degree of closeness, various stimulations of the sensorimotor system and emancipation (Gretland, 2007).

The amount of mental distress immigrant women endure makes it necessary to investigate alternative ways that might contribute to their wellbeing. To the best of our knowledge, only limited research has been conducted into psychomotor body training groups for immigrant women with musculoskeletal disorders and mental distress and no guidelines for this exist.

## **Methods**

Our study is informed by phenomenology. This approach aims to explore the subjective meaning of a person's experiences in everyday life (Wilson, 2015). This fits well with the study's purpose of exploring immigrant women's perceptions of group activity and wellbeing.

### ***Recruitment and setting***

A Facebook-group announcement requesting the participation of psychomotor physiotherapists (PP) in a study of activity groups led to contact being established with a PP and through the PP, access to a movement group in a local-based mental health care service. The movement group is a low-threshold service that offers activities that aim to better women's health awareness, including the connection between their psychological distresses and their physical disturbances and pain alleviation. The women enrolled in the group found out about it through the centre's awareness plan, through a doctor recommendation or through the sharing of knowledge between compatriots. The most common health issues faced by the women are body pain and feelings of reduced vitality. Each session was attended on average by 10 women. The women are from Middle Eastern countries and from Eastern and Northern Africa. Their ages range between 30 to 60 years. Most are married and have young or adult children. The sessions were held once a week, at noon, and lasted 60 minutes.

The training hall in which the group sessions are held has separate male and female changing rooms and a small storage room. Training equipment such as treadmills, rowing machines and stationary bicycles are in the corner of the hall. There are long-glass windows and a glassed door that faces the sidewalk along the main road. There also is a full length mirror. Other equipment such as a sound system and training mats are easily accessed.

### ***Data collection***

Data was collected using participatory observation and interview methods. Participatory observation provides direct access to the research material. The data collected using this method can furthermore be re-interpreted by the researcher, so providing a degree of flexibility. The data collected using this approach records what the subject says or does in a setting that is not structured by the researcher. The setting is the subject's habitual environment. Participatory observation therefore collects data on participants' actions.

Interviews, however, provide access to their self-reasoning (Fangen, 2010). The participative observations were conducted by the first author once a month between December 2016 and March 2017.

The observations were recorded in the training room in Oslo, each observation lasting 60 minutes. The number of women who attended varied. There were 9 attendees on the first, twelve on the second and five on the last two observation days. The activities of each session included active movement, dance and conversation. The sessions also focussed on teamwork among the women and relaxation. All the activities were carried out at a moderate pace in the training room.

One-on-one interviews were conducted with four of the participants (see table 1). The first three interviews were held on the third observation day, the last one month later. The

interviews were held in a quiet room beside the training room and lasted between 30 and 45 minutes. An interview guide with open ended questions was used. Examples of the questions include: What was attending the training program like for you? How do you feel about meeting the other women in the group? How would you describe your relationship with the therapist?

**Table 1 List of one-on-one interviews**

<b>Rosa</b>	<b>Iren</b>	<b>Zadia</b>	<b>Marie</b>
29 years old	41 years old	45 years old	54 years old
Middle East	Southern Asia	North Africa	South Asia
Same ethnicity spouse. 4 children.			
7 years in Norway	12 years in Norway	11 years in Norway	Could not recall
Attended all 4 observation days	Attended all 4 observation days	Attended 2 observation days	Attended 3 observation days

***Data analysis***

Field notes and transcribed interviews were analysed using qualitative content analysis. The transcripts were read several times to get an overview of the data and identify preliminary patterns. Meaning units were extracted from observation field notes and interview transcripts. These were then assessed based on content and context similarities (Graneheim and Lundman, 2004). This evaluation process resulted in the following codes and themes: 1) Content and context of the movement group, 2) participation on their own terms, 3) participation wearing own clothing and 4) past experiences and the exercise group.

### ***Ethical considerations***

The study was approved by Norwegian Centre for Research Data (NSD) (project number 50502). The women were informed of the purpose of the study and the process. They were also informed about confidentiality and their right to withdraw from the study at any time without consequences. The participants provided their written consent to participate in the project. All names are replaced with pseudonyms

### **Results**

#### ***Content and Context of the Movement Group***

The room in which the women exercised has a floor area of around 16 square metres. All the equipment required in the sessions was close by. The session was structured into the following sequences; individual exercises, two by two, small group of 5, the whole group and then individual exercises again. The individual exercises were performed from a number of positions such as sitting on a chair and standing or lying on floor mats. The women, while sitting, repetitively rolled a spiky ball along their arms, legs and back. The movement was slow and easy to follow. The women, while standing, moved their extremities in different ways; a circular movement of the feet, transferring weight from one leg to another, lifting arms in different directions. The speed of the movements gradually increased. The women, however, responded in different ways to this, carrying out the movements at their own pace and in their own way.

The exercise in which a balloon is thrown and caught was performed in pairs. Small group exercises included dancing to music and throwing a soft foam ball to each other in a circle.



The whole group exercise included a kind of ‘tug of war’. Each participant held on to a long rope and was instructed to pull, push, lift or lower the rope. Group exercises were performed at a moderate pace, the ways the women performed the exercises differing. Some women moved their limbs more quickly, some had to retrieve the ball repeatedly from the floor and others had difficulty coordinating upper and lower limbs. Some cooperated well with their partners and achieved a stable rhythm. In the air there was either laughter or concentration.

The PP also wanted to strike up a conversation with the women during the session. The PP asked the women about their body state at that moment and how they were experiencing a particular exercise. The PP also reminded them about breathing techniques. The women, through their conversation with the PP, could help each other make sense of and confirm to each other the content of the conversation, in their own language or in Norwegian.

The women appeared to be satisfied with the arrangement and the exercises. Rosa, a 29 year old Middle Eastern attendee, mentioned that a positive aspect was that the group was only for women. She was also pleased with the exercises. Iren praised the exercises and said they were focused on the physical disturbances faced by most of the women in the group, disturbances in the neck, shoulder and spine. She liked the slow paced exercises best, particularly the final relaxation. The women, overall, were comfortable with the pace and the focus of the activities. The activities seemed to motivate them and give them a sense of wellbeing.

### ***Participation on Their Own Terms***

Irregular attendance was a recurrent issue. Some of the women would often arrive 15 or 20 minutes late, and attendance was variable, one day 12 women, the next 9 and then 5. Iren, a 41 year old South Asian woman, said she did not like to be late, but that many things would

get in the way and make it difficult for her to be there on time. She, however, added that it was better to be late than not show up at all.

The women, when asked once by the PP why attendance was low, almost simultaneously shouted “slippery!” Temperatures at that time had been below zero in Oslo, and they wanted to avoid falling and injuring themselves. They therefore stayed indoors.

One of the women asked for permission to be excused from the group during a session. She, once granted permission, walked to the corner of the room and began her prayer ritual. The PP and the rest of the women appeared to not be affected by this and continued uninterrupted with the exercise. The woman, after having completed her 10 minute ritual, re-joined the session. The PP rearranged the group so that the woman could return to her original position and continue with the session.

Two group members, Marie a 54 year old South Asian woman and Zadia a 45 year old from North Africa, took frequent short breaks of a few minutes during the exercises they performed on their own. Marie explained; “I have to take short breaks. I sit long time and get pain. I go on the treadmill for little, and come back to the group, I then feel better”. Zadia’s reasons for taking a break were similar; “Some of the exercises are strenuous... I take break by sitting down”. When they re-joined the group, the PP and the other women immediately rearranged their positions to make space for them. There seemed to be a common understanding and mutual respect for the diversity in the group.

### ***Participation with Own Clothing***

The clothes the women wore during the session varied. Half of the women started the session wearing a loose blouse and trousers and a hijab or headscarf. One woman put on a loose T-

shirt and fitted training pants and took off her hijab. The rest of the women wore traditional costumes; layers of ankle length fabrics and a hip length hijab.

The frequent adjustment of fabric layers and hijabs, either to allow particular exercise moves or to return the costume to its original position, was noticeable. Rosa, a 29 year Middle Eastern attendee who usually wore a loose T-shirt and fitted training pants, told the PP repeatedly to be stricter on requiring suitable clothing for the sessions.

Iren, who wore a loose T-shirt and trousers and a hijab, explained, “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 believed that the women who wore traditional costumes had the same priorities as she had, which were family and comfort.

Zadia wore clothes similar to those worn by Iren, a loose T-shirt and trousers and a hijab. She recalled that she had tripped on the lengthy layered clothing in a previous session. “I don’t want to fall again,” “I use these now”, pointing to her clothes.

Marie was asked about her choice of clothing, a traditional lengthy blouse and trousers, and a hijab. She smiled and answered, “I want it. I like this.” Another woman who wore layers of lengthy fabrics and a lengthy hijab said, in our informal conversations, that she was freezing. She laughed and raised her dress to show me what was underneath; a thick layer of wool and three layers of various thin fabrics.

### ***Past Experiences and the Exercise Group***

Rosa told about the onset of her physical pain in the interview: “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 first tried individual physiotherapy and then joined the group last year. She recently stopped individual therapy to focus solely on the group. When she was asked about her pain disturbances at the end of each session, she described them as being “not worsened, not better”. She also said, “I like to be in the group. It was really nice to be able to meet other women”.

Iren’s story started with her work 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 had individual physiotherapy for a period of time, but had to stop because she could no longer afford it. That was when she started coming to the group. When asked about her bodily experience after a session, she said the pain was unchanged but that: “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!”

Marie told me in a conversation that she used to work as a cleaner before becoming unemployed. When I asked here when she moved to Norway, she had difficulty remembering the year. She also had difficulty remembering when she joined the group. She, however, later in the conversation remembered the year she came to Norway and the year she joined the group. “I have pain at my neck, shoulders and back...” she said pointing to these body regions. “...and my doctor told me to come here” She has a regular doctor appointment and seemed content with the arrangement. ...She said she felt tired after each session, but in a positive way, “Tired but it’s OK.” She took also pleasure in meeting the other women in the group, saying “I feel a little better after the group”.

Zadia also had a story to tell about her diagnosis and medications “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 was being followed up by three health professionals - a PP for individual NPMP treatment, a psychologist at a local district psychiatric hospital and the PP at the movement group. She expressed her gratitude for all the help that she had received. She said, placing both 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 very quiet. She however insisted of continuing in the group: “I do exercise, I want to get well...,” she expressed repeatedly.

The interviewed women, when asked of their views on the PP, appeared to express a collective great fondness. Their faces showed expressions of satisfaction and delight. They smiled and said “She is very kind”, “She is like a good friend” and “She cares for us and I care for her.”

## **Discussion**

The objective of this study was to explore immigrant women’s participation in a movement group and identify what motivates and impacts their attendance and wellbeing. One of the major observations during the study was movement group setup. The regularity, time and duration of the sessions and the group being only women is in line with the study of Khan et al. (2013). They conclude that this setup has implications for promoting adults with psychological distress to become more active. Punctuality was, however and despite the structured framework of the activities, a challenging issue. Some of the women arrived late. Travel time was not a problem. The women explained that their lateness was due to an unexpected situation that prevented them leaving the house on time. They also mentioned the weather conditions of the Nordic winter as a reason for their lateness. This is consistent with

another study (Berggren et al., 2017) in which the wintertime in Minnesota is reported as being an attendance barrier for Somali women. They ascribe snow as one of the reasons for their low level of participation in physical activity. There are, according to Price and Hooven (2018), no well-developed strategies for teaching and learning body awareness and for achieving access to internal body sensation. There was, however, an indescribable spontaneous shift in the women's level of awareness during their performance of some of the exercises. Performance of the NPMP exercises, based on verbal and visual guided attention, may have created a kind of uncertainty that was reflected in the need for supportive eye contact with the instructor and group participants. Defining exercise instruction as an external stimuli may, however, impede an awareness of internal body sensations (Mehling et al., 2009). Dance movements, which are contextualized in the cultural roots and principles of education of the participants, however seem to represent something very different (Young (Young and Sternod, 2011). Dancing for women of different cultural backgrounds is therefore more clearly associated with the biopsychosocial model. Other body awareness therapies are unfamiliar and must be learned. Their dance movements seemed to stage the idea of embodiment, the integration of body phenomenology, the magnificent cooperation of body image and schema (Gretland, 2007, Gallagher, 2001). Body disturbances and psychological distress seemed to be reduced, and their body movements and mental presence seem to balance the effort needed, internally and externally. They moved in the present, but with the knowledge they had acquired from past bodily experiences. This was achieved through playing familiar tunes from their earlier cultural influences and accompanying familiar body movements from their lived lives (Råheim, 2003). Dance, according to Ibe-Lamberts et al. (2018), also promotes positive perceptions among transnational Africans. Dance represents their cultural identity and they therefore perceive that "dancing is part of who they are" (Ibe-Lamberts et al., 2018 :260). Most of the women in the group in this present study, seem to

experience these familiarities. This valuable moment was not only lived individually and in isolation, but also in solidarity with the movement group (Kjølstad, 2004). Dancing as an expressive activity, performed together with group participants, seems to engage cultural and collective resources that promote a feeling of interpersonal connection and solidarity. The phenomenon can be described as a dance/movement therapy approach to fostering resilience and recovery (Harris, 2007). Expressive dance and movement are, as a therapeutic approach, used to help re-connect to the core self (Pylvänäinen, 2008). Much of the women's exercise experiences, even though at a very low intensity level, seem to have some of the characteristics described here and might contribute to their wellbeing.

In the body phenomenology approach, an individual's past experience is a contributor to how the individual handles the present situation. If the present situation contains unknown moments of the past, then the body needs to be modified and learn new ways of being (Gretland, 2007, Duesund, 2008). The group context therefore indirectly provided space for the women to explore new moving patterns and to move habitually. Habitual movement tends, in light of the NPMP treatment of support and readjustment, to provide supporting elements. Non-manageable tasks tend to challenge the women's ability to readjust. The mixture of exercises given in the structured frames might create a new way of doing body movements over time, either by the past movement being integrated into the new one, or vice versa. Successively, the newly established movement will be exclusively owned by the women individually and mutually by interacting with the group. Most importantly, the ability to acknowledge support and allow readjustment could help prevent bodily disturbances being objectified, and instead subjectify (or make experience of) the disturbances through an intentional task, through this acquiring a rational body image (Råheim, 2003, Gallagher, 2001). The potential to achieve well-being, both physically and mentally, is also encouraged.

The channels of verbal and non-verbal communication are salient during the immigrant women's exercise activities. This is partly due to the challenges of intercultural communication. Language competency and a non-mutual understanding of biomedical practise varied in the group (Horntvedt, 2015). This is illustrated by the therapist repeatedly giving the same instructions and information in Norwegian. A number of the women also chose not to complete course of activities. They withdrew from the relaxation exercise in particular. The therapist's constant repetition of instructions or information is likely to be due to the therapist's experience of the women having difficulty receiving this. The repetition of oral and written reminders was not sufficient. The therapist had to also pause and give time to message conveyance, message receipt and finally message processing. One of the many anticipated capabilities of an experienced therapist is responsiveness. Responsiveness is a process of back and forth, between the therapist as a messenger and the women as receivers (Tvedten, 2013). The therapist and the women seem, however, to find a cognitive meeting point. The message given must be easily processed by the receiver and the receiver must be able to respond to the message. A back and forth movement in their communication was due to the necessity of affirming and reaffirming that the message was accurately interpreted by both parties.

Research suggest that patients from minority ethnic groups shows that their positive experiences in communicating within healthcare (Rocque and Leanza, 2015, Schinkel et al., 2016) are associated with professionals' relational skills. This includes giving time to talk to and listen to the patient, being supportive, open minded and non-judgemental. The patients appreciate an approach that takes into account their individual opinions and their values from their cultural context. There is also evidence that clearly links clinician-patient communication to patient satisfaction, adherence and health outcomes. A study of



intercultural doctor-patient interaction by Paternotte et al.(2017) reports that patients with different cultural backgrounds emphasize the physician's overall communication capability, such as the ability to listen and engage in a dialogue. The feeling of being treated as a unique person and not as a disease was also frequently mentioned. A language barrier was considered to be the most important hindrance of good communication. This, however, emerged as being less important where they had managed to establish a relationship. The authors emphasize the marginal distinction between intercultural communication and person-centred communication in a close relationship. A similar reciprocity is reflected in the right to decide themselves what clothes they wear and a sense of freedom of movement and well-being during group training. Muslim women's clothes are associated with Islam and Muslim women are used to encountering institutionalized prejudices through racist attitudes, an experience that affects their mental health (Gopalkrishnan, 2018). This resonates well with the women in the low threshold activity group. There seemed to be an alliance with the PP based on mutual respect and a shared objective of the wellbeing of the women. This allowed both the setting and the exercises to be flexible and inclusive (Berggren et al., 2017).

Acceptance of the women's preferences during exercises paved the way for better collaboration. This includes the clothes they wore when participating in the sessions. The findings show the clothes they chose to wear influenced the exercises performed. This could, from another perspective, symbolize the women's bodily expression of preserving control of their world and self-perception. A study conducted in 2012 (Fougner and Horntvedt, 2012) interviewed physiotherapy bachelor students on their experiences of leading physical activity groups for Muslim women. The training clothes chosen by these women was one of the issues taken up by the students; "very loose fitting and ankle length, showing no skin except faces and hands" (Fougner and Horntvedt, 2012 :21). The students express that dress code is a

hindrance to the women performing the exercises in an optimal way. The students also, at the same time, wanted to respect the women's culture and religion. This caused silent acceptance, an acceptance based on their being no other way to tackle the situation. As time went by, the women tended to discover the reasons for suitable clothing during physical activity and started to dress in suitable clothes. The students indicated that the time that it took for the women to realise the reasoning behind this was an important factor in accommodating their modification process.

The students choosing to respect the women's choice at the start and at the same time allowing them to experience physical activity in the clothing they chose to wear, was an astute decision. The students chose to not enforce any stringent rules. They instead waited and watched. This gave the women time to go through the modification of their past experience at a pace they could tolerate. This pace not only allowed them to absorb learning, but also to implement the learning into their daily living (Gretland, 2007, Duesund, 2008, Galanti, 2014).

The therapist's flexible approaches also allowed the women to experience at their own pace and in their own space. These flexible approaches eventually encouraged the women's awareness, an awareness that unites their movement and breathing patterns. This awareness also contributes to each intentional task being performed automatically, instead of an excessive focus on the real disturbances as being in the way (Råheim, 2003, Gallagher, 2001)

These women came together in the group despite their different background contexts.

Differences included earlier lived experiences of countries and cultures, their age and number of years in Norway. They, however, seemed to come to the same present phase of life, of being occupied with their health disturbances and the desire to achieve recovery. One can see factors such as universality, helping another and hope as being relevant when placing the phenomenon in the framework of group therapy (Kjølstad, 2004). Review studies (Derr, 2016,

Semedo et al., 2019) have shown that social support is particularly important for immigrants. The women in the study group, through being part of and belonging to the group, were given the opportunity to experience that they are not alone with their health disturbances. They instead see that there are many others who are “in the same boat” as they are. This recognition indirectly prevents isolation and encourages togetherness to overcome obstacles. Being with the other women also allows the women to experience how others handle the situation and utilize their own resources to live a functional life. The women, during the group course, indirectly help each other to achieve their hope of wellness without much consciousness being verbalized (Kjølstad, 2004, Lindwall and Ascii, 2014).

The women’s biological and physiological readjustment needed time and space. The women’s psychological aspect also was seen to be improved with appropriate accommodations and the experience of being accepted as an individual. Taking part in the group also contributed to a network, which the women appreciated. These benefits do not seem to be realistic without the unconditional understanding and flexibility of the therapist. Limited empirical research has been conducted into the role of culture in empathy (Atkins et al., 2016). Atkins et al. claim, however, that culture shapes empathic responses to physical and social pain. An important prerequisite is therefore that the physiotherapist has the cultural and intercultural competence to recognize and take into account the cultural aspect of clinical reasoning for group participants from different cultures (Gard et al., 2019).

## **Conclusion**

Physical exercise enhances mental wellbeing. Low threshold physical programs should be considered for immigrant women to give them the opportunity to experience wellbeing and social participation. Such exercise must be adapted to the women’s own pace and their cultural preferences for group exercise. This type of culturally sensitive training program can

make a valuable contribution to wider strategies to empower and include immigrant women in society.

### **Disclosure statement**

No potential conflict of interest was reported by the authors.

### **REFERENCES**

- Abebe, D. S., Lien, L. & Elstad, J. I. 2017. Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: a nation-wide register study in Norway. *Social psychiatry and psychiatric epidemiology*, 52, 679.
- Afari, M. N., Ahumada, J. S., Wright, G. L., Mostoufi, G. S., Golnari, G. G., Reis, G. V. & Cuneo, G. J. 2014. Psychological Trauma and Functional Somatic Syndromes: A Systematic Review and Meta-Analysis. *Psychosomatic Medicine*, 76, 2-11.
- Ahmad, F., Shik, A., Vanza, R., Cheung, A. M., George, U. & Stewart, D. E. 2005. Voices of South Asian Women: Immigration and Mental Health. *Women & Health*, 40, 113-130.
- Atkins, D., Uskul, A. K., Cooper, N. R. & Desteno, D. 2016. Culture Shapes Empathic Responses to Physical and Social Pain. *Emotion*, 16, 587-601.
- Bas-Sarmiento, P., Saucedo-Moreno, M. J., Fernández-Gutiérrez, M. & Poza-Méndez, M. 2017. Mental Health in Immigrants Versus Native Population: A Systematic Review of the Literature. *Archives of Psychiatric Nursing*, 31, 111-121.
- Bastug, G. 2018. Examination of Body Composition, Flexibility, Balance, and Concentration Related to Dance Exercise *Asian Journal of Education and Training*, 4, 210-215, 2018.
- Berggren, K., Gerardi, M. & Mueller, L. 2017. Berggren, Kimberly; Gerardi, Meghan; and Mueller, Laura. (2017). The Impact of a Community based Exercise Program on Somali Immigrants Residing in Subsidized Housing in Minnesota. Available: [https://sophia.stkate.edu/dpt\\_papers/59](https://sophia.stkate.edu/dpt_papers/59)
- Bergland, A., Olsen, C. F. & Ekerholt, K. 2018. The effect of psychomotor physical therapy on health-related quality of life, pain, coping, self-esteem, and social support. *Physiotherapy Research International*, 23, n/a-n/a.
- Bunkan, B. H. 2001. Psykomotorisk fysioterapi - prinsipper og retningslinjer. *Tidsskrift for Den norske legeforening*, 121, 2845-2848.
- Bustamante, L., Cerqueira, R., Leclerc, E. & Brietzke, E. 2018. Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. *Rev. Bras. Psiquiatr.*, 40, 220-225.
- Daley, A. 2014. Depression and anxiety. . In: CLOW, A. & EDMUNDS, S. (eds.) *Physical activity and mental health*. Australia: Human Kinetics.
- Debesay, J., Arora, S. & Bergland, A. 2019. 4. Migrants' Consumption of Healthcare Services in Norway: Inclusionary and Exclusionary Structures and Practices. *Inclusive Consumption*.
- Delara, M. 2016. Social Determinants of Immigrant Women's Mental Health. *Advances in Public Health*, 2016.
- Derr, A. S. 2016. Mental Health Service Use Among Immigrants in the United States: A Systematic Review. *Psychiatric Services*, 67, 265-274.
- Dragesund, T. & Kvåle, A. 2016. Study protocol for Norwegian Psychomotor Physiotherapy versus Cognitive Patient Education in combination with active individualized physiotherapy in patients with long-lasting musculoskeletal pain – a randomized controlled trial. 17.

- Dragesund, T. & Øien, A. M. 2018. Demanding treatment processes in Norwegian psychomotor physiotherapy: From the physiotherapists' perspectives. *Physiotherapy Theory and Practice*, 1-10.
- Duesund, L. 2008. Embodied learning in movement. In: SCHILHAB, T. S. S., JUELSKJÆR, M. & MOSER, T. (eds.) *Learning bodies*. Copenhagen: Danish University of Education Press.
- Elstad, T. A. & Eide, A. H. 2017. Social participation and recovery orientation in a "low threshold" community mental health service: An ethnographic study.
- Fangen, K. 2010. *Deltagende observasjon*, Bergen, Fagbokforl.
- Fougner, M. & Horntvedt, T. 2012. Perceptions of Norwegian physiotherapy students: Cultural diversity in practice. *Physiotherapy Theory and Practice*, 28, 18-25.
- Galanti, G.-A. 2014. *Caring for Patients from Different Cultures*, University of Pennsylvania Press, Inc.
- Gallagher, S. 2001. Dimensions of embodiment: body image and body schema in medical contexts. In: TOOMBS, S. K. (ed.) *Handbook of Phenomenology and Medicine*. Dordrecht: Springer Netherlands : Imprint: Springer.
- Gard, G., Nyboe, L. & Gyllensten, A. L. 2019. Clinical reasoning and clinical use of basic body awareness therapy in physiotherapy – a qualitative study? *European Journal of Physiotherapy*, 1-7.
- Gopalkrishnan, N. 2018. Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in public health*, 6, 179-179.
- Graneheim, U. H. & Lundman, B. 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105-112.
- Gretland, A. 2007. *Den relasjonelle kroppen : fysioterapi i psykisk helsearbeid*, Bergen, Fagbokforl.
- Harris, D. A. 2007. Dance/movement therapy approaches to fostering resilience and recovery among African adolescent torture survivors. *Torture : quarterly journal on rehabilitation of torture victims and prevention of torture*, 17, 134.
- Hjellset, V. T., Ihlebaek, C. M., Bjorge, B., Eriksen, H. R. & Hostmark, A. T. 2011. Health-Related Quality of Life, Subjective Health Complaints, Psychological Distress and Coping in Pakistani Immigrant Women With and Without the Metabolic Syndrome : The InnvaDiab-DEPLAN Study on Pakistani Immigrant Women Living in Oslo, Norway. *J Immigr Minor Health*, 13, 732-41.
- Hoffman, J. & Gabel, C. P. 2015. The origins of Western mind–body exercise methods. *Physical Therapy Reviews*, 20, 315-324.
- Horntvedt, T. 2015. *Interkulturelt helsearbeid*, Drammen, Vett & viten.
- Ibe-Lamberts, K., Tshiswaka, D., Onyenekwu, I., Schwingel, A. & Iwelunmor, J. 2018. Dance and Hometown Associations are Promising Strategies to Improve Physical Activity Participation Among US Nigerian Transnational Immigrants. *Journal of Racial and Ethnic Health Disparities*, 5, 253-260.
- Kale, E. & Hjelde, K. H. 2017. Mental health challenges of immigrants in Norway : a literature review. Oslo: NAKMI, Nasjonalt kompetansesenter for migrasjons- og minoritetshelse.
- Khan, A., Brown, W. J. & Burton, N. W. 2013. What physical activity contexts do adults with psychological distress prefer? *Journal of Science and Medicine in Sport*, 16, 417-421.
- Kjølstad, H. 2004. *Gruppeterapi*, Oslo, Gyldendal akademisk.
- Lanzara, R., Scipioni, M. & Conti, C. 2019. A Clinical-Psychological Perspective on Somatization Among Immigrants: A Systematic Review. *Frontiers in Psychology*, 9.
- Lemon, J. C. & Wagner, B. 2013. Exploring the Mind-Body Connection: Therapeutic Practices and Techniques *Ideas and Research You Can Use: Vistas*.
- Lindwall, M. & Asci, H. A. 2014. Physical activity and self-esteem. In: CLOW, A. & EDMUNDS, S. (eds.) *Physical activity and mental health*. Australia: Human Kinetics.
- Marinescu, L., Sharify, D., Krieger, J., Saelens, B., Calleja, J. & Aden, A. 2013. Be Active Together: Supporting Physical Activity in Public Housing Communities Through Women-Only Programs. *Progress in Community Health Partnerships*, 7, 57-66.

- Mehling, W. E., Gopisetty, V., Daubenmier, J., Price, C. J., Hecht, F. M. & Stewart, A. 2009. Body Awareness: Construct and Self-Report Measures. *PLOS ONE*, 4, e5614.
- Ministries 2007. The action plan on physical activity 2005-2009. Working together for physical activity. . Oslo: Government Administration Services.
- O'mahony, J. & Clark, N. 2018. Immigrant Women and Mental Health Care: Findings from an Environmental Scan. *Issues in Mental Health Nursing*, 39, 1-11.
- Paternotte, E., Van Dulmen, S., Bank, L., Seeleman, C., Scherpbier, A. & Scheele, F. 2017. Intercultural communication through the eyes of patients: experiences and preferences. *International Journal of Medical Education*, 8, 170-175.
- Price, C. J. & Hooven, C. 2018. Interoceptive Awareness Skills for Emotion Regulation: Theory and Approach of Mindful Awareness in Body-Oriented Therapy (MABT). *Frontiers in Psychology*, 9.
- Pylvänäinen, P. 2008. A dance/movement therapy group as a community outreach for intercultural women in Tokyo. *Body, Movement and Dance in Psychotherapy*, 3, 31-44.
- Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P. & Mckee, M. 2013. Migration and health in an increasingly diverse Europe. *The Lancet*, 381, 1235-1245.
- Rocque, R. & Leanza, Y. 2015. A Systematic Review of Patients' Experiences in Communicating with Primary Care Physicians: Intercultural Encounters and a Balance between Vulnerability and Integrity. *PloS one*, 10, e0139577-e0139577.
- Rohlof, H., Knipscheer, J. & Kleber, R. 2014. Somatization in traumatized refugees : A review of the literature. *Social Psychiatry and Psychiatric Epidemiology*, 49, 1793-7954.
- Råheim, M. 2003. Kroppsfenomenologi ; innsikt relevant for klinisk praksis. *Fysioterapeuter*, 70, 14-18.
- Schibbye, A.-L. L. 2012. *Relasjoner : et dialektisk perspektiv på eksistensiell og psykodynamisk psykoterapi*, Oslo, Universitetsforl.
- Schinkel, S., Schouten, B. C., Street, R. L., Van Den Putte, B. & Van Weert, J. C. M. 2016. Enhancing Health Communication Outcomes Among Ethnic Minority Patients: The Effects of the Match Between Participation Preferences and Perceptions and Doctor–Patient Concordance. *Journal of Health Communication*, 21, 1251-1259.
- Semedo, B., Stålnacke, B.-M. & Stenberg, G. 2019. A qualitative study among women immigrants from Somalia – experiences from primary health care multimodal pain rehabilitation in Sweden. *European Journal of Physiotherapy*, 1-9.
- Straiton, M. L., Powell, K., Reneflot, A. & Diaz, E. 2015. Managing Mental Health Problems Among Immigrant Women Attending Primary Health Care Services. *Health Care for Women International*, 37, 1-22.
- Tvedten, N. 2013. Practice makes perfect - Significance of experience as a knowledge source in physical therapists motion practice. *Övelse gör mester - Erfaringens betydning som kunnskapskilde i fysioterapeuters bevegelsespraksis*, 80.
- Urindwanayo, D. 2018. Immigrant Women's Mental Health in Canada in the Antenatal and Postpartum Period. *Canadian Journal of Nursing Research*, 50, 155-162.
- Who 2017. Promoting the Health of Refugees and Migrants: Draft framework of priorities and guiding principles to promote the health of refugees and migrants. WHO Secretariat.
- Who 2018. Physical Activity. Fact Sheet. World Health Organization.
- Wilson, A. 2015. A guide to phenomenological research.(Report). 29, 38.
- Young, S. & Sternod, B. M. 2011. Practicing Culturally Responsive Pedagogy in Physical Education. *Journal of Modern Education Review*, 1 1-9.