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

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ABSTRACT

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 h, 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

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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.

What is already known about this topic?

- Immigrant women are discriminated in the labour market; they have more musculoskeletal disorders and are more on disability pension than Norwegian women.
- Being an isolated, immigrant single mother, excluded from the workforce has negative consequences for economic prosperity, leads to discontent with social life and social identities, and is predisposed to psychological distress, which also have negative influence on their children.
- Poor linguistic proficiency is a barrier to work opportunities, civic engagement and work attendance.

What this paper adds

- New insight into immigrant women's domestic and job-related burdens that contribute to their isolation, loneliness and humiliation.
- New insight into the immigrant women's experience of low self-worth, both regarding lack of language skills, dysfunctional husbands, besides not being able to work as much as they themselves and their surroundings expected of them.
- Contributes to a better understanding of immigrant women's situation and gives insight for both health care professionals and employers such that they can develop strategies to deal with difficult situations at the clinics and work places.

1. 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 5156,000 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; Ogunsiji 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, 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 (Hertz 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 Bjørkly, 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