PARVIN POOREMAMALI
CULTURE, OCCUPATION
AND OCCUPATIONAL THERAPY IN A MENTAL HEALTH CARE CONTEXT

The challenge of meeting the needs of Middle Eastern immigrants
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The challenge of meeting the needs of Middle Eastern immigrants

Malmö University, 2012
Faculty of Health and Society
In memory of my father Shafi, my mother Robabeh, my brother Ata and my Naneh.
I dedicate this book to my beloved niece, Rojina
Most of the time
I am clear focused all around
I can keep both feet on the ground
I can follow the path
I can read the sign
Stay right with it when the road unwinds
I can handle whatever
I stumble upon

Most of time my head is on straight
Most of time I’m strong enough not to hate
I don’t build up illusion until it makes me sick
I am not afraid of confusion no matter how thick
I can smile in the face of mankind
Most of the time

Most of the time I am halfway content
Most of the time I know exactly where it went
I don’t cheat on myself
I don’t run and hide
Hide from the feelings that are buried inside
I don’t comprise and I don’t pretended
Most of the time
Most of the time

Bob Dylan
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The purpose of the thesis was to explore the cultural views of reality embedded in experiences and perceptions of occupational therapy made by Middle Eastern clients with mental health disorders and their occupational therapists. The challenges of diversity related to occupational well-being in the field of occupation-based rehabilitation among Middle Eastern clients were also addressed. A qualitative approach was used throughout the thesis. A grounded theory was used for studies I, II and IV and a narrative analysis was applied for study III. In study I, eleven clients who received occupational therapy were interviewed and the elements that shaped their experiences and perceptions with occupational therapists were investigated. The result demonstrated that the clients’ desire for an alliance with the therapists encompassed the realities and truths embedded in their values and preferences and that the belief systems of their collectivistic world-views often clashed with those of the therapists. Study II included interviews with eight occupational therapists and investigated their experiences and perceptions of working with Middle Eastern clients. The result showed that cultural, societal, and professional dilemmas influenced feelings and thoughts, in turn influencing both motivation for seeking cultural knowledge and the choice of adequate strategies for creating a therapeutic relationship. Study III was a case study with a narrative approach, aiming to illustrate how an occupational therapy intervention can highlight the role of culture and address bicultural identification in a young adult immigrant woman with mental health problem. The study demonstrated how a culturally adapted
intervention model could help the client go through a transition from an interdependent to a more independent self and achieve better skills in dealing with cultural discrepancies in different situations. Study IV examined perceived occupational well-being among ten participants with psychiatric disabilities who received occupation-based rehabilitation. The results showed the participants’ ambivalence between striving for empowerment and wanting support and revealed the realities and truths embedded in both collectivistic and individualistic world-views, in turn influencing the ways the participants viewed themselves in relation to empowerment, support and occupational well-being. The results of this thesis provide new insight into the complexity of the phenomena of culture and mental health and may be used in developing culturally adjusted interventions, not only within the areas of occupational therapy and occupation-based rehabilitation but in mental health care in general.
LIST OF PUBLICATIONS

This thesis is based on the following studies referred to by their Roman numerals:


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INTRODUCTION

Immigration and globalization have transformed Sweden into a multicultural society (Baarnhielm, Ekblad, Ekberg, & Ginsburg, 2005). As persons relocate and resettle, irrespective of whether this takes place through processes of immigration or refugee resettlement, the cultural and physical landscape of cities and towns change (Dyck, 2000). Sweden has been characterized as a country that has developed from a homogenous nation to become a multicultural society Ekblad (2003), with a rapid growth of persons with a Middle Eastern origin in the last few decades (Hammarstedt & Shukur, 2007; Taloyan, Johansson, Johansson, Sundquist, & Koctürk, 2006). Eighteen per cent of the Swedish population of 9 million consists of individuals with a foreign origin (Statistic Sweden, 2009). The number of second-generation immigrants amounts to more than 800,000 individuals (Hammarstedt & Ekberg, 2004). Since 1975 the composition of annual immigration has changed from being mostly labor force immigrants from Europe to refugees and asylum-seekers from outside Europe and “tied movers” (relatives of previously admitted immigrants). As a consequence, immigration to Sweden over the past 30 years has consisted mainly of those seeking asylum and family reunions (Baarnhielm et al., 2005). Increased cultural diversity encompasses many challenges for the mental health care system (Baarnhielm et al., 2005). This leads to a growing demand for knowledge of the health situation among immigrants and the factors that determine their health status (Hedlund, Lange, & Hammar, 2007). Research reveals that ethnic minorities in Sweden are currently experiencing major men-
tal health problems and immigrants from non-European countries suffer more from mental health problems than the Swedish population (Baarnhielm et al., 2005; Bayard-Burfield, Sundquist, & Johansson, 2000; Sundquist, 1994; Tinghög, Hemmingsson, & Lundberg, 2007). There are also significant differences in the usage and quality of mental health services and immigrants often have poorer access to health care than Swedish-born citizens (Baarnhielm et al., 2005; Merlo, 2008; Zolkowska, Cantor-Graae, & McNeil, 2001).

There are indications that there may be an under-utilization of mental health care among some immigrant groups (Baarnhielm et al., 2005). Several causes have been identified as risk factors for mental illness, including low levels of social support, attachment and social integration (Ghazinour, Richter, & Eisemann, 2004) and socioeconomic risk factors (Tinghög et al., 2007). Other hazards are resettlement stress such as social and economic strain, alienation, violence and threats in Sweden, discrimination, loss of status and managing life in a new environment (Ghazinour et al., 2004; Hjern, Wicks, & Dalman, 2004; Leão, Sundquist, Johansson, Johansson, & Sundquist, 2005). Leao (2005) maintains that there are greater risks for being hospitalized for psychotic disorders and other psychiatric disorders among second generation immigrants in Sweden compared to native Swedes. It has also been shown that second generation immigrants have a higher suicide rate (Hjern & Allebeck, 2002).

Increasing multiculturalism, however, represents both a challenge and an opportunity for professionals in psychiatric care to expand their knowledge base. Still, to the best of our knowledge, little seems to be known about how staff in mental health settings respond to cultural issues and try to provide good services for their immigrant clients. Occupational therapy, with its focus on everyday life, is an area where clients’ and the staff’s varying cultural beliefs are highlighted. Fundamental to the practice of occupational therapy is the conceptualization of the human as an occupational being (Wilcock, 2006; Yerxa, 2000). Occupational therapy is about supporting clients in coping with different fields of everyday occupation, such as work, home maintenance, leisure and self-care
Few studies in occupational therapy have focused on the increasing cultural diversity and on the interaction between mental health care providers and different cultural groups in Sweden. Focusing on occupational therapy as an arena for immigrant clients’ meeting with psychiatry may shed light on cultural issues in mental health care in Sweden.

**Culture and diversity**

Philosophical doctrines of relativism and universalism in relation to cultural diversity

In the 1980s, a strong universalistic voice emerged in anthropology which presupposed the existence of a common rationality/morality from which diversity emerges in response to different natural contexts and as a result of different historical developments (Heintz, 2009). The scientific debate between supporters of universalism (positivism) and supporters of cultural relativism (constructivism) was crystallized in the 1960s and in the 1970s in the communication between philosophers and anthropologists over the question of rationality (Heintz, 2009; Nye, 2005).

Universalists focus on similarities and shared characteristics of mankind and cultures and their view of human beings is based on the idea that humans share certain basic qualities and needs (Nye, 2005). Therefore all humans also share the same rights (Mayer, 1995). The basic assumption in the universalistic approach is that cultural differences are insignificant compared with the shared similarities between human beings. Thus, this approach views human rights as universal and therefore will apply them in the same way regardless of context. Although the human rights discourse has been prevailing in the Western intellectual tradition since the eighteenth century, the idea of human rights can be traced in many philosophical and religious traditions (Ife, 2007). For instance, the world’s oldest and first document of human rights was engraved on the famous Cyrus Cylinder, written and confirmed by the Persian emperor Cyrus (538 BC). That document is also known to be the first human rights document that established freedom for
different ethnic groups within society, regardless of race, class or gender (Balci, 2008). The universalist approach has been subjected to criticism as it assumes that human rights are part of a Western worldview and reflects discourses which are predominantly Western, modernist and individualist (Ife, 2007). According to Safi (2003), universalism ignores the essential role played by culture and can suffer from normative blindness and also have a negative impact on native cultures. The moral and the pragmatic are two important foundations of a universalistic approach. The moral argument emphasizes that fundamental law and principles should be universally applied to all human beings, while the pragmatic argument emphasizes that certain values work better and promote development and wealth, and therefore should be universally applied.

In brief, the idea of absolute universal knowledge has led to the imposition of Western values and ideology on other cultural groups, and has also allowed a cultural bias which jeopardizes objectivity in science (Ife, 2007). According to Nye (2005), this focus on similarities can lead to dissociation and denial of differences.

Cultural relativists, in contrast, focus on differences and the variability of culture and human behavior. From a relativistic perspective, the surrounding cultural environment determines what humans are. In fact, this view is congruent with a postmodern, social constructivist stance (Ife, 2007; Iwama, 2006). Cultural relativist rejects the idea that any culture holds a set of absolute standards by which all other cultures can be judged (Ferraro & Andreatta, 2009). Cultural relativists argue that human rights are culturally relative and mean different things in different contexts. However, the criticism is that this approach can lead to reluctance to intervene with human rights violations because of fear of disrespecting other cultures (Ife, 2007). Baghramian (2004) described three assumptions in the argument for cultural relativism: (1) the descriptive assumption based on empirical observations, which claims that there exists a multiplicity of incongruence and incompatible worldviews and value systems, (2) the epistemic assumption, which proposes that there is no single criterion or reliable method for adjudicating between contrasting world-views and (3), the normative assumption, which promotes tolerance and respect for other
worldviews and argues against imposing own views on others. In brief, unlike universalism which emphasizes that truth is universal, cultural relativists believe that truth is relative to each individual within his or her socio-cultural environment (Hocking et al., 2008; Iwama, 2006). The cultural context is thus critical to an understanding of a person’s values, beliefs and practices (Baghramian, 2004; Ferraro & Andreatta, 2009; Ife, 2007; Nye, 2005).

The issue of a relativistic or a universalistic perspective within occupational therapy is thus clearly of relevance to clinical practice. Understanding the strengths and weaknesses of these contrasting positions can strengthen occupational therapy practice models and help occupational therapists to avoid clinical biases and misapplication of treatment models across cultures. In addition, researchers have recently started to examine the issue of culture in occupational therapy (Iwama, 2006; Nelson, 2007). Some authors of occupational therapy literature have begun to question the universality of the theories in use and emphasize the importance of acknowledging differences in cultural values and worldviews (Hocking & Whiteford, 1995; Iwama, 2006; Watson, 2006). As Hocking et al (2008) and Iwama (2006) argue, both occupational therapy practice and science are influenced by Western tradition based on a positivistic rationale which emphasizes individualism, agency, action, and the celebration of the self. In fact, the epistemological assumption of positivism (that there is a similar reality underlying occupation in all of these cultures) uses an etic approach to research across cultures ((Hocking et al., 2008). By using an etic approach, such researchers value systematic and scientific explanations developed through rigorous and carefully considered methods (Hocking et al., 2008). However, the question remains on how well research findings from positivist methods go beyond the barriers of cross-cultural understanding to describe similarities and differences in cultural groups in terms of occupation and their therapeutic applications (Hocking et al., 2008).

The potential danger of a universalistic stance for clinicians is thus that models and methods of practice will be misapplied across cultures. For example, applying Western values of separation and autonomy that focus on motivating clients to attain great-
er independence from the family may in certain contexts be irrelevant. This can also lead to failures among occupational therapists with regard to recognizing differences among clients. This, in turn, can lead to lack of empathy, misunderstanding and misapplication of treatment models across cultures (Bourke-Taylor & Hudson, 2005; Fitzgerald, Beltran, Pennock, Williamson, & Mullavey-O’Byrne, 1997; Iwama, 2004; Iwama, 2006; Watson, 2006).

The complementary philosophical perspectives of relativism and universalism provide the framework for multiculturalism for this thesis. This thesis attempts to view events, phenomena and behaviors as both being culturally specific, and thus unique to a particular culture, and as having universal features that are shared across cultures. The multicultural perspective is particularly appropriate in this thesis because it provides a conceptual framework that recognizes diversity, but, at the same time, opens up for building bridges of shared cultural values and value systems.

**Multiculturalism**

The concept of culture has been defined in a variety of ways by anthropologists, political scientists, sociologists, and psychologists. According to Kluckhohn (1951), “Culture consists in patterned ways of thinking, feeling and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values” (p. 86). Multiculturalism has emerged as a social, political, economic, educational, and cultural movement during the last two decades. Multiculturalism is the term refers to the situation in a society where the diverse groups are encouraged to keep up their ethnic uniqueness and to participate in the daily life of the mainstream society (Sam, 2006). The basic principle of a culture-centered outlook is to take into account both the culture specific attributes which differentiate and the culture-general traits which unite and provide a balancing and broad context (Pedersen, 1999). Multiculturalism combines the theories of universalism and relativism by explaining...
behavior in terms of both those culturally learned perspectives which are unique and those which provide a common ground across cultures. A multicultural perspective emphasizes both similarities and differences at the same time (Pedersen, 2004). According to Ward and Leong (2006), integrations at individual and group levels cannot be realized without the acceptance of multiculturalism. It is thus the key to positive intercultural relations and may underpin the steps toward increasing globalization. There are several assumptions inherent in multiculturalism which have been identified by researchers: (1) multiculturalism accepts the existence of multiple worldview, (2) it embodies social constructionism, meaning that persons construct their worlds’ thought processes, (3) is contextual in that behavior can only be understood within the context of its episode, (4) offers a ‘both/and’ rather than an ‘either/or’ view of the world, and (5) multiculturalism extols a relational view that allows for realities and truths beyond the Western scientific tradition (Sue, 1998).

The relevance of multiculturalism for occupational therapy has recently grown with increased globalization of the profession and its practice in international projects in human rights (World Federation of Occupational Therapists, 2006)*.

*The World Federation of Occupational Therapists (WFOT) position paper on human rights in relation to human occupation include the following principles:
People have the right to participate in a range of occupations that enable them to flourish, fulfill their potential and experience satisfaction in a way that is consistent with their culture and beliefs.
People have the right to be supported to participate in occupation and, through engaging in occupation, to be included and valued as members of their family, community and society.
People have the right to choose for themselves: to be free of pressure, force, or coercion; in participating in occupations that may threaten safety, survival or health and those occupations that are dehumanizing, degrading or illegal.
The right to occupation encompasses civic, educative, productive, social, creative, spiritual and restorative occupations. The expression of the human right to occupation will take different forms in different places, because occupations are shaped by their cultural, societal and geographical context.
At a societal level, the human right to occupation is underpinned by the valuing of each person’s diverse contribution to the valued and meaningful occupations of the society, and is ensured by equitable access to participation in occupation, regardless of differences. Abuses of the right to occupation may take the form of economic, social or physical exclusion, through attitudinal or physical barriers, or through control of access to necessary knowledge, skills, resources, or venues where occupation takes place.
Acculturation

Multicultural identity and acculturation are closely intertwined with biculturalism. Acculturation is a bi-dimensional, multidomain process in which a person deals with issues related to two cultural orientations that is identification and involvement with the culture of origin and in the mainstream dominant culture. The negotiation of these two central issues results in four distinct acculturation positions: assimilation (involvement and identification with the dominant culture only), integration/biculturalism (involvement and identification with both cultures), separation (involvement and identification with ethnic culture only), or marginalization (lack of involvement and identification with either culture) (Berry, 1980; Berry & Sam, 1997; Berry, 2005; Berry, 2006). Acculturation may differ among immigrants due to a variety of factors, such as socioeconomic background, age at migration, gender, the length of residence in the host country and religion (Al-Krenawi & Graham, 2000). As a result, in providing occupational therapy and other mental health care services to Middle Eastern immigrants in Sweden, it is essential to consider their level of acculturation and its effect on occupational life and well-being. A growing body of research supports the argument that acculturation, health and well-being are intertwined (Roccas, Horenczyk, & Schwartz, 2000; Yoon, Lee, & Goh, 2008; Zheng, Sang, & Wang, 2004). However, the degree to which an individual accommodates the dominant culture may depend on the acculturative strategy that a person adopts in response to the new demands. The process of acculturation involves not only external adjustment to the new society but also having to resolve issues regarding personal identity. Thus, acculturating individuals are exposed to new life circumstances that contribute to acculturative stress which, in turn, affect their mental and psychological well-being (Berry, 2006; Yasuda & Duan, 2002). A research project showed that through migration, the study participants encountered a cultural reality and a system of meaning that were differently constructed compared to their original cultural context. In order to function in the new situation they had to understand the new system of meanings and find,
choose, and construct meanings for their actions (Chirkov, 2009). As Chirkov (2009) argued, acculturation involves a deliberate, reflective, and comparative cognitive activity of comprehending, and meanings concerning the world, others and self that exist in one’s culture of origin and those one has discovered in the new cultural community. One important way for an acculturating individual to become socialized into the new country’s culture is through the process of internalization, through which previously external regulations or values transform into internal values (Chirkov, Ryan, Kim, & Kaplan, 2003; Ryan & Deci, 2005).

**Collectivistic versus individualistic worldview**

The concepts of individualism versus collectivism have been used in all fields of the social and behavioral science and humanities. The roots of individualism in the Western world have been traced in the history of idea, in political and economic history, and in psychology (Kagitcibasi, 1997; Kagitcibasi, 2005). Individualism has often been used synonymously with liberalism and, in contrast, collectivism with authoritarianism (Triandis, 1995). Individualism has been the hallmark of European social history, especially since the 16\textsuperscript{th} century. According to Triandis (1995), individualism and collectivism often exist together within every individual and in the world. As a child, one starts life in a collectivistic context by being attached to one’s family. However, a process of detachment from the collective (family) then occurs differently due to the cultural contexts. For example, in collectivist cultures this detachment is minimal and in individualistic cultures people are more detached from their collectives and often become autonomous earlier in their life span (Triandis, 1993; Triandis, 1995). The same author (1995) argued that individualism and collectivism are context related. A person may thus be very individualistic at work and still collectivistic in the extended family. Triandis (1995) summarized differences between collectivism and individualism along four universal dimensions: (1) the definition of the self is interdependent in collectivism
and independent in individualism; (2) personal and communal goals are intimately united in collectivism but not allied in individualism; (3) cognitions that focus on norms, obligations and duties channel most social behaviors in collectivist culture, whereas attitudes, personal needs and rights guide individuals’ social behaviors in individualistic cultures; (4) there is an emphasis on relationships even when they are detrimental in collectivistic cultures, but in the individualistic cultures people rationally consider the beneficial and non-beneficial sides of keeping a relationship (Gerstein, Rountree, & Ordonez, 2007; Triandis, 1995). Moreover, Kluckhohn and Strodtbeck (1961) developed a theory that was based on three basic assumption: (1) “there is a limited number of common human problems for which all individuals must at all times find some solution, (2) while there is variability in solutions of all problems, it is neither limitless nor random but is definitely variable within a range of possible solutions, and (3) all alternatives of all solutions are present in all societies at all times but are differently preferred” (p. 10). In addition, they suggested five basic types of problems to be solved by every society, namely how humans are related with the natural environment in terms of mastery, submission or harmony; the nature of human beings as good, evil or a mixture; temporal aspects of human life in terms of past, present and future; the modality of human activity in terms of doing to achieve, of being and of being-in-becoming to grow; and finally human relationships with others in terms of hierarchy or equality (Kluckhohn & Strodtbeck, 1961). Four value orientations of this framework (the nature of a human being is excluded) that are outlined in Table 1 may have relevance for this thesis, the human-to-nature relationship, the temporal focus of human life, the human occupation, and human-to-human relationship. Kluckhohn and Strodtbeck argued that people differ in their views and attitudes and how they perceive relationships to nature, time, activity, and relationships with others. The theory developed by Kluckhohn and Strodtbeck (1961) has been broadly used and has stimulated several studies around the world (Hill, 2002). According to Rudman and Dennhardt, (2008), the value orientation framework is particularly useful for occupational therapists and occupational scientists because it fo-
cuses particularly on the relationship between occupation, identity and self expression. For example, participation in occupation might be founded on *being* and *being-in-becoming* cultural values, which emphasize occupations connected with all aspects of the self as an integrated whole, or on *doing* cultural values, which emphasize activities connected with accomplishment, achievement and outcome (Rudman & Dennhardt, 2008).

The concept of self

The disposition of self has been one of the crucial concerns of both Eastern and Western philosophers. Philosophical, religious, and cultural self-images are reconstructed and reinterpreted in many different ways, and in order to understand how certain self-images are constructed, interpreted and lived one must grasp the dynamics between historical, cultural and social contexts (Allen, 1997). The human life is a process of socio-cultural engagement by which a biological being transforms into a social individual – a person with a self and a set of context-contingent identities (Markus & Hamedani, 2010). As people interact with their environments, they are constantly in the process of making meaning and reflecting these meanings in their actions (Bruner, 1994; Markus & Kitayama, 1994; Markus & Hamedani, 2010). However, culture and the self are profoundly intertwined with each other, and, hence, the meanings people create about themselves are mediated through their participation in socio-cultural interaction (Chirkov, 2007; Chirkov, 2009).
Table 1: Adaptation of Kluckhohn and Strodtbeck’s (1961) framework for describing cultural value variations within collectivistic and individualistic worldview

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Collectivism</th>
<th>Individualism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Human-to-nature relationship</strong></td>
<td>- Events are predetermined and pre-ordinated by external forces (God, fate, genetics, etc.).&lt;br&gt;- Human being should be active rather than passive participants in the world and at the same time the ultimate outcome of their efforts lie with Allah (God).&lt;br&gt;- Seeing mental disabilities in the context of fate, “tagdir/kismet.”</td>
<td>- Mastery over nature&lt;br&gt;- Control over environment&lt;br&gt;- Active self-assertion in order to master, and change the events to attain personal goals.</td>
</tr>
<tr>
<td>What is the relation of humans to nature?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Temporal focus of human life</strong></td>
<td>- Past-oriented culture.&lt;br&gt;- Highlighting history and tradition.&lt;br&gt;- Present-oriented culture, less concerned with things that happened in the past. Tend to see the future as unpredictable.</td>
<td>- Future oriented.&lt;br&gt;- Anticipating the future.&lt;br&gt;- Goal-setting toward future.</td>
</tr>
<tr>
<td>What is the temporal focus of humans?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Human occupation</strong></td>
<td>- Being and being –in-becoming oriented culture.&lt;br&gt;- Occupations that enable rising all aspect of self as an integrated self&lt;br&gt;- Occupations that enable development of inner self .&lt;br&gt;- Self-reliance entails not being a burden on the in-group.&lt;br&gt;- Competition is among in-group, not among individual.</td>
<td>- Doing-oriented culture (goals, accomplishments and achievements).&lt;br&gt;- Value competition and achievement.&lt;br&gt;- It is individual who achieve.&lt;br&gt;- Personal competition.</td>
</tr>
<tr>
<td>What mode of occupation is to be used for self-expression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Human-to-human relationship</strong></td>
<td>- Group-oriented.&lt;br&gt;- Interdependent self-construal&lt;br&gt;- Social relations with unequal power between leaders and followers.&lt;br&gt;- Intensive in-groups relationship and social relationship more enduring and involuntary and obligatory.&lt;br&gt;- Social support, resources and security in in-group.&lt;br&gt;- Respect and dignity and honor.&lt;br&gt;- Shame and other mechanisms of social control.</td>
<td>- Self-oriented&lt;br&gt;- Independent self-construal, individuals’ autonomy and self-reliance.&lt;br&gt;- Social relations tend to be more temporary and voluntary. Few obligations to in-group and having individual right.&lt;br&gt;- Less social support,or security in in-group.</td>
</tr>
<tr>
<td>What is the relation of human to human?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The human life is a process of socio-cultural engagement by which a biological being transforms into a social individual – a person with a self and a set of context-contingent identities (Markus & Hamedani, 2010). As people interact with their environments, they are constantly in the process of making meaning and reflecting these meanings in their actions (Bruner, 1994; Markus & Kitayama, 1994; Markus & Hamedani, 2010). However, culture and the self are profoundly intertwined with each other, and, hence, the meanings people create about themselves are mediated through their participation in socio-cultural interaction (Chirkov, 2007; Chirkov, 2009).

Independent and interdependent views of self

The idea of an independent self is founded on an individualistic worldview and a belief in individual primacy where the self is considered unique and autonomous. Behavior is interpreted through one’s own thoughts, feelings and actions rather than those of others, and more private, internal aspects of the self are emphasized, expressed as distinctive, personal attributes. Self-worth is measured by personal achievement, and the individual is believed to be in control of his or her own destiny. Important behaviors include: individual creativity, self-expression, recognition of personal attributes, and promotion of personal goals (Markus & Kitayama, 1991). Furthermore, individual goals are given superiority and the individual is viewed as a unique, autonomous being. The self is made meaningful primarily through a set of internal attributes, such as goals, desires, abilities, talents and personality traits. The highest priority is assigned to actualizing one’s individual potential and fulfilling one’s roles (Ringel, 2005; Rudman & Dennhardt, 2008). According to Markus and Kityama (1995) the individualistic cultural value system highlights self-reliance, autonomous, independent self-construal and individual achievement. In direct contrast to the individualistic worldview, the collectivistic worldview assigns priority to the interdependent view of self, grounded in the belief that social units (i.e., family, group, community) are considered first, rather than the individual ones. Valued behaviors in-
clude: belonging and fusing in, staying in one’s place, engaging in proper behavior, and promoting the goals of the group. The interdependent orientation focuses on relationships rather than on the individual and it values tradition, the status quo, hierarchical structures, and loyalty, all as means of maintaining group harmony (Awaad, 2003; Dwairy, 2006; Kitayama et al., 1995; Markus & Kitayama, 1991; Sue, 2005). To maintain harmony, the members’ subjective boundaries are controlled by tightly structured hierarchies, and behaviors expected among in-group members are based on trust, generosity, mutual respect and support (Dwairy, 2006; Raeff, 2006; Triandis, 1995). Thus collectivist cultures view situational factors, such as norms, roles and obligations, as major determinants of behavior and emphasize values which promote the welfare of their in-group (Hofstede & Bond, 1984; Kitayama et al., 1995; Triandis, 1995). According to Iwama (2006), the positioning of the self coincides with whether the past, present or future impacts the most on one’s world view. All three contribute to a context for the assembly and performance of human occupation in non-Western settings.

Several crucial questions and conceptually important issues have recently been raised in occupational therapy about the nature and role of autonomy in the behavior of persons from different cultures (Iwama, 2004; Iwama, 2006; Kondo, 2004). It is well acknowledged that occupational therapy as a profession represents Western “white” values, such as independence and the notion of a balance between work, leisure and self-care for a healthy life, which may be of less importance to persons of other cultures (Dyck, 2000). Understanding cultural orientation and people’s worldviews thus helps therapists understand their clients’ behaviors and provides insights into what motivates them (Watson, 2006). In Western occupational therapy, where independence and autonomy are highly valued Kielhofner (2007), the concept of self is fundamentally different from how it is framed in other cultures (Kitayama et al., 1995). Nye (2005) argued that Western individualized treatment models, which focus on autonomy and empowerment of the autonomous individual, may be inappropriate for work with clients from cultures with collectivist values, institu-
tions, and cultural practices. In such cultures, community-based models of practice, where cultural differences in the meaning and enactment of community are recognized, may be more culturally congruent. People’s views of the self thus differ in accordance with their cultural value systems.

The Middle Eastern cultures

The Middle East is a region spanning south-west Asia, south-east Europe and north-east Africa and has its own systems and traditions concerning ethics, religion, and politics. The history of the Middle East dates back to ancient times as well the historical origins of three of the world’s major religions–Judaism, Christianity, and Islam. The use of the term the Middle East first arose in the early years around the Persian Gulf, and in fact was a logical intermediate definition for the area between the Mediterranean, the Near East, and the Far East. During the Second World War, the Middle East was gradually extended westwards with the tides of war. A military province stretching from Iran to Tripolitania was created and named the Middle East (Fisher & Ochsenwald, 1997).

Although persons from the Middle East differ ethnically and in their characteristics from country to country, they do share core similarities in thought systems, lifestyles, values, customs, norms and behaviors (Lipson & Meleis, 1983; Meleis & Sorrell, 1981). They comprise a heterogeneous group, diverse in socioeconomic statuses, languages, religious practices, cultural values, beliefs, and acculturation levels. The prevailing social system is one in which the interests of the group and the wider society are placed above the interest of the individual, who has little autonomy. The family is seen as the most important social unit, with a strong patriarchal structure and hierarchy based on age, gender and status. The family is a strong source of role identity for everyone and there are obligatory forms of behavior towards other family members. Gender relations are clearly defined and an early segregation of the sexes is common (Awaad, 2003). Persons from the Middle East often resist seeking help from psychiatrists due to the stigma associated with mental illness. Care is mainly rooted in the Islamic context and
tradition in which the family is obligated to take care of and help each other. Consequently, help-seeking behavior is closely associated with resorting to religious and traditional folk remedies and self-help through involving in religious activities such as fasting, repentance and regular recitation of the Koran (Okasha, 1999). The traditional culture encourages interdependence, rather than independence. There are different explanations of illnesses, e.g. supernatural causes (such as God and the evil), social causes (evil eye and stress), natural causes (changes in weather and a dirty environment), and hereditary causes (Al-Krenawi & Graham, 2000; El-Islam, 2008; Lipson & Meleis, 1983; Meleis & Sorrell, 1981; Van den Brink, 2003; Yosef, 2008).

**Occupation**

As stated above, and as proposed in occupational therapy research, culture has great implications for people’s views on occupation, such as their acknowledgment and choice of valued occupational roles and behaviors (Burke, 2003). This section will delineate occupation as a construct in order to highlight that further.

**What is occupation?**

Occupation includes the entire range of “human activity whether physical, mental or social, obligatory or chosen, biological or socio-cultural in origin, or, according to cultural mores, described as either work, play, or rest” (Wilcock, 2005a, p.150). Individuals have an occupational nature and that contributes to their personal sense of identity and fulfils many functions for their survival and health (Christiansen & Baum, 2005; Creek, 2008; Hasselkus, 2002; Wilcock, 2006). Occupations are often classified as self-care, productivity/work and play/leisure, which are enacted by individuals within physical and social environments (Creek, 2008). Individuals perceive and interpret their occupations in different ways. The meaning ascribed to occupation is specific to each person and influenced by many factors, including culture. Hence, occupations need to be understood in terms of individuals’ personal meanings (Finlay, 2004; Watson, 2006). Hvalsøe and Josephsson (2003) ar-
gue that occupational interpretation is not only shaped by intrinsic feelings but is also affected and formed by external influences such as the social environment and culture. According to Persson et al (2001) there is a close link between the meaningfulness of occupation and the values occupations may bring, which consist of three dimensions: concrete value, symbolic value, and self-rewarding value.

**Occupation as a cultural construct**

The concept of culture is complex (Black & Wells, 2007) because it permeates every aspect of daily life and the way in which the individual perceives his or her world (Dodd, 1997; Lu, Lim, & Mezzich, 1995; Reed & Sanderson, 1999). The occupational human engages in daily life through the development of a range of skills, which remain true to the cultural rules that classify their relevant occupations conceptually (Yerxa, 2000). Culture thus has an important role in occupation and occupational performance (World Federation of Occupational Therapists., 2006). It shapes our entire way of living and impacts on human development (Black & Wells, 2007; Fitzgerald et al., 1997), forms the basis of context-situated occupation (Iwama, 2006) and lies behind a dynamic and complex interplay of shared interpretations that represent and shape the individual and collective lives of persons (Iwama, 2006). Culture is also important in relation to the concept of occupational identity, which is the result of engagement in occupations that provide a sense of accomplishment and allow one to realize one’s potentials. Being as both human occupation and identity are thought to play significant roles in human life, it is crucial to take culture into account when generating knowledge about these basic human expressions (Rudman & Dennhardt, 2008). Kielhofner (2007) identified occupational identity as a multiple sense of who one is and wishes to become as an occupational being. One’s “volition, habituation, and experience as a lived body are all integrated into occupational identity” (p. 106). Accordingly, occupational identity is grounded in one’s sense of capacity, effectiveness and competence in doing things through ongoing occupational participation.
This implies a universal set of values of occupation and identity, which can apply to all persons in all cultures. In Kielhofner’s view, all humans everywhere seek competence, mastery and control, self expression, and freedom. However, what he described as the “goods” for an individual might not be valid for those who belong to cultures that value the collective, prioritize the good of the family and the group over the individual, and value service and sacrifice over individual freedom, choice, and autonomy (Rudman & Dennhardt, 2008). According to Yerxa (2000) occupation is a universal phenomenon at the highest level, but it may be experienced in unique ways at a cultural level. There is thus a need to understand how differences and similarities in culture affect the occupational human.

**Culture and its role in occupational therapy**

Occupational therapy is the clinical context of this thesis. From the perspective of social construction and critical social science, knowledge construction is largely influenced by social, cultural and political factors. The way in which knowledge about occupation is constructed in turn influences how occupational therapists shape services and pose research questions (Rudman & Dennhardt, 2008). Iwama (2006) maintained that culture forms the basis of a “context-situated examination of occupation” (p. 19). Philosophical assumptions about the nature of the world, persons, occupation and health determine how occupational therapists view their professional field, goals and methods of intervention (Creek, 2008). Occupation is the core concept of occupational therapy and represents a demanding challenge to the profession due to its profound cultural dimensions, which persuade occupational therapists to go beyond medically defined problems of the individual (Iwama, 2006). Occupational therapy was born from the need to provide treatment for individuals, who suffered from severe mental problems and were unable to participate in everyday activities, and lacked the ability to structure and organize their day (Burke, 2003). While the role and influence of culture on occupation and occupational therapy is increasingly being acknowledged, relatively
few studies critically regard the profession of occupational therapy and its core concept of occupation as a cultural construction (Iwama, 2004), and there is also little critical reflection on the cultural underpinnings of central occupational concepts (Rudman & Dennhardt, 2008).

Given the social realities of a changing world, providing appropriate care to a diverse client population is a challenge for occupational therapists (Black & Wells, 2007; Kirsh, Trentham, & Cole, 2006). Furthermore, “culture represents a social process by which our shared experiences and interpretations of truth (and therefore our values and valuing of objects and phenomena around us) support ascription and associations of meaning within occupational therapy” (Iwama, p.20). This gives rise to the need for a critical examination of the cultural values embedded in the views of occupation, health and well-being expressed in current occupational therapy models, as well as in explanations of the relationship between humans and their environments and the contextual meanings of doing (Iwama, 2006). At present, occupational therapy is obviously focusing on diversity and recognizing and valuing cultural differences to an increasing extent. The current emphasis in occupational therapy practice on cultural competence involves awareness of and knowledge about such differences and how the clients’ beliefs and values affect the way in which they view health, their own illness, their belief in recovery, and their understanding of both their own role and the occupational therapist’s role (Black & Wells, 2007). Knowledge regarding occupation-based concepts is currently being developed internationally (Rudman & Dennhardt, 2008), and until recently there has been a lack of critical and fundamental discussion about whether humans truly are reflective occupational beings, as well as about the suitability of occupational therapy knowledge, theory and practice (Iwama, 2006). The use of occupation, as an integral aspect of treatment, is concerned with how individuals function in their work, leisure, domestic life and personal care in their everyday lives and how internal and external factors influence the behavior of a person (Bourke-Taylor & Hudson, 2005; Finlay, 2004), the value which individuals assign to what they do (Bejerholm & Eklund, 2006;
Hasselkus & Rosa, 1997; Hasselkus, 2002; Hvalsøe & Josephsson, 2003; Johnson, 1996; Law, 2002; Persson et al., 2001) and how occupation and actions can be used to influence health and well-being (Finlay, 2004; Wilcock, 1999). As a result, reconceptualizing occupation in different social and cultural contexts enables the therapist to take into account the significance of culture (Iwama, 2006).

Recently researchers have, however, posed questions on whether existing models, concepts and assessments in occupational therapy fit within different cultural contexts, and whether there is any universal occupational therapy knowledge and practice (Black & Wells, 2007; Hocking et al., 2008; Iwama, 2004; Iwama, 2006; Rudman & Dennhardt, 2008; Watson, 2006). As Black and Wells (2007) argue, occupational therapy can no longer only provide services in clinics, nor can it ignore the wider contextual issues which are of concern to their clients. This requires basic knowledge of how clients’ cultural beliefs influence their lives. In addition, Iwama (2006) argues that much of the occupational therapy literature on diversity focuses more on differences at the behavioral level rather than on differences at the subtle and complex level of the meanings, ideals and values. Knowledge about such complex differences among individuals at both the behavioral and the symbolic level is, however, most relevant (Iwama, 2006). To be effective, occupational therapists must reflect on the unique requirements of the populations which they serve and the epistemologies which lie behind those requirements (Iwama, 2006; Watson, 2006). Watson (2006) recognizes that the occupational therapists’ professional essence is connected to the “power and positive potential of occupation to transform people’s lives and functioning” (p. 151). This necessitates examining how culture is influencing the conceptual development of occupational identity (Rudman & Dennhardt, 2008). Culture may thus lead to differences in the valuation of the meaning of behavior, and if that happens in therapy there is a risk of miscommunication as a result (Rudman & Dennhardt, 2008). Thus in order for occupational therapy services to remain relevant, effective and meaningful for all persons, there is a need to reconceptualise occupations in different social and cultural contexts.
(Iwama, 2004; Iwama, 2006; Yang, Shek, Tsunaka, & Lim, 2006). However, matters of culture are not only about diversity but also about the creation of knowledge, theories, structures and contents of occupational therapy practice (Iwama, 2006), as well as awareness of the appropriateness and universality of such theoretical knowledge (Watson, 2006).

Cultural diversity and occupational well-being

Well-being is a holistic concept that attends to several personal dimensions in terms of physical, mental, social, includes a strong subjective element (e.g., harmony, pleasure), and is associated with many situations (e.g., occupation, relationships) (Wilcock, 2005a; Wilcock, 2005b). One of the significant issues in the study of well-being is whether individuals in different cultures have different conceptions of well-being as well as whether the predictors of these differences (Diener, 2009) are important for understanding what represents well-being for different individuals. According to Hasselkus (2002), a person’s ability to engage in life’s daily occupations is a key ingredient for well-being. An occupation focus on health and well-being suggests a consideration and exploration of occupation by focusing on what and how it can improve physical, mental, social, spiritual, and environmental well-being (Wilcock, 2006). In order to promote well-being, occupations must provide meaning and purpose, self-esteem, motivation and socialization (Ekelman, 2012). However, as Iwama (2004) and Rudman and Dennhardt (2008) claimed, the tenet of the occupational paradigm that occupation is a basic human need of central importance to health and well-being, seen as fundamental in Western occupational therapy, may not have relevance in other cultures. According to Wilcock (2006), engaging in occupation provides self-actualization and self-evaluation and grounds the senses of competency and moral worth. This assumption, however, reveals a universalistic view and the notion of growing through occupation towards the highest level of personal development, self-esteem and self-actualization (Rudman & Dennhardt, 2008). In other words, within this perspective well-being is interpreted as a realization and ful-
fillment of natural and absolute human potentialities that are inconsistent with many other cultures, which may assume people’s well-being as being dependent on their adjustment to the values and norms of their culture (Chirkov, 2007). Researchers have previously argued that the degree of cultural internalization has a significant effect on a person’s well-being (Chirkov et al., 2003; Downie et al., 2007). Iwama (2006) questioned the view that well-being overlaps with a state where the self is able to control his or her situation, and argued that phenomena like independence, autonomy and self-determinism are important mainly within a Western context.

Given the background as presented above, the intersection of culture, occupation and psychiatric disability, in occupational therapy and other psychiatric care contexts, is complex and might be difficult to negotiate. The increasing multiculturalism represents both a challenge and an opportunity for professionals in psychiatric care to expand their knowledge base. To the best of our knowledge, little seems to be known about how such an intersection impacts on the provision of mental health services among immigrant clients and how they perceive their situation as the receivers of care. The cultural aspects related to occupation, psychiatric disability, occupational well-being and occupational rehabilitation thus need to be further understood and the present thesis addresses the cultural perspective of Middle Eastern immigrants with psychiatric disabilities as they encounter the majority culture.
AIM OF THESIS

This thesis addresses cultural diversity in the context of clients’ meeting with occupation-based interventions in mental health care services, focusing on clients with a Middle Eastern origin to exemplify a scenario when there is likelihood that collectivistic cultural values meet with universalistic types of values.

The overall aims of the thesis were to explore the experiences and perceptions of occupational therapy made by Middle Eastern clients with psychiatric disorders and their occupational therapists, and to explore occupational well-being in the field of occupation-based rehabilitation among clients of a Middle Eastern origin.

Specific Aims

Study I
The aim of Study I was to explore the elements that shape the experiences and perceptions of occupational therapy among clients of Middle Eastern origin receiving psychiatric treatment.

Study II
The aim of Study II was to explore the experiences and perceptions of occupational therapists working in psychiatric care with immigrant clients with a Middle Eastern background.
Study III

The aim of Study III was to illustrate how an occupational therapy intervention can address bicultural identification in a young adult immigrant woman with mental health problems.

Study IV

The aim of Study IV was to examine the meaning and experiences of occupational well-being among Middle Eastern immigrants with psychiatric disabilities participating in occupation-based rehabilitation.
MATERIAL AND METHODS

Study design

This thesis consists of four qualitative studies. According to Creswell (Creswell, 2009), “the plan or proposal to conduct research, involves the intersection of philosophical worldview, strategies of investigation, and specific methods” (p. 5). The philosophical underpinning of the thesis’ study design was based on a constructivist paradigm. The constructivist stand claims that truth is relative and depends on human construction of multiple subjective meanings of their experiences of the world they live (Creswell, 2009). The second element of the study design was the selection of the methodological strategies for the studies. According to Creswell strategies of investigation are types of qualitative, quantitative, and mixed methods designs that make available detailed technique for procedures in a research design. A qualitative methodology based on Grounded Theory (Strauss & Corbin, 1998) and a descriptive case study (Yin, 2003) was useful in exploring, understanding and describing the phenomena under study, especially since little was previously known about them. Qualitative inquiry is a form of interpretive investigation in which the researchers make an interpretation of what they perceive, hear, and understand about people’ lives, lived experiences, behaviors, emotions, and feelings that are difficult to extract or learn about through more conventional research methods (Creswell, 2009; Strauss & Corbin, 1998). According to Pickering (2008) experience is central to cultural studies and qualitative inquiry thus seems relevant for this thesis. Therefore,
qualitative researchers are interested in understanding what those interpretations are at a particular point in time and in a particular context (Merriam, 2002).

A Grounded Theory approach, as formulated by Strauss and Corbin (1998), is used in Studies I, II and IV. The purpose of Grounded Theory studies is to explore how complex phenomena occur and to understand the meanings associated with experiences. A researcher does not begin a project with a preconceived theory in mind. He/she begins instead with an area of study and allows the theory to emerge from the data (Strauss & Corbin, 1998). The rationale for using Grounded Theory was to generate a tentative theoretical structure which reflects the full complexity and variability of cultural phenomena of human action, and to discover the inter-relationships among conditions, actions and consequences in the multicultural encounter. The methodological strategy used in Study III was based on case study methodology (Merriam, 1998; Yin, 2003) with a narrative approach in order to present a complex explanation of an experience within its context (Yin, 2009). A case study is an empirical inquiry which investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and the context are not clearly evident (Yin, 2003). According to Merriam (Merriam, 1998), “the case study offers a means of investigating complex social units consisting of multiple variables of potential importance in understanding the phenomenon” (p. 41). Case studies allow the researcher to achieve high levels of conceptual validity and to identify the indicators that are difficult to measure in cultural contexts (George & Bennett, 2005). The third component of the study design was about specific methods such as the form of data collection, procedure, analysis and interpretation (Creswell, 2009). The specific methods in Studies I, II and IV were based on Grounded Theory while in Study III a narrative method was used.

**Study contexts**

Four types of settings were used in the four studies of the thesis; outpatient psychiatric clinics, a psychiatric rehabilitation unit, day
centers and municipality-run psychosocial projects. These were located in different municipalities in the south of Sweden. Studies I and II were performed at outpatient clinics and Study III at a psychiatric rehabilitation unit. The outpatient services, where the participants in Studies I and II were recruited, offered a variety of treatments for clients with different kinds of psychiatric diagnoses. The treatments included medication, supportive counseling, psychotherapy, occupational therapy, cognitive therapy, some other types of behavioral therapy and psychiatric rehabilitation (limited). The context for Study III was a psychiatric rehabilitation unit which was part of a psychiatric department. The unit aimed at providing psychiatric rehabilitation to clients with psychiatric disabilities and improving their abilities to function and perform daily life tasks and engage in occupations related to education, work and leisure. All these settings were staffed with mental health care teams, including a psychiatrist, a social worker, nurses, a psychologist, an occupational therapist and a physiotherapist. Study IV was conducted at day centers and municipality-run psychosocial projects. The day centers offered a variety of work-like opportunities for clients with psychiatric disabilities, including a café, a bicycle repair shop, photocopiering, assembly work, carpentry, sewing and weaving. The centers aimed at helping the clients break their isolation, providing support and structure to their everyday lives and when possible preparing them for work-oriented rehabilitation. The municipality-run psychosocial projects provided occupation-based rehabilitation for unemployed clients with less severe but long-term illness and with long-term income support from the social services or the Social Insurance Office. These centers offered vocational opportunities of a preparatory nature and included assessment of work ability, provision of motivational activities and job training. These psychosocial projects were run by the municipalities in collaboration with the Employment Service.

*The term psychiatric disability is generally used to indicate the foremost condition of the participants in Study III and Study IV in this thesis. The definition of psychiatric disability comprises having current difficulties in performing occupations in important life area due to a mental illness that are presumed to continue for a long period of time (Official Report of Swedish Government (2006:5), 2006).
Selection procedures and participants

Study I

Occupational therapists working in mental health care services were used as mediators in recruiting patients for the study. The inclusion criteria were being a patient of Middle Eastern origin, having lived in Sweden for at least three years and having received occupational therapy within the mental health care services for at least three months during that three-year period. Theoretical sampling was used in order to maximise the opportunities of determining how a category varies in terms of properties and dimensions (Strauss & Corbin, 1998). The author thus procured some background information on each client from his/her therapist. Twenty-two clients fitted the inclusion criteria and agreed to participate. The clients who agreed to participate in the study were contacted by the author and informed of the possible contact and interview procedure over the following three months. In the initial stage, appointments were made with two clients, one a man who had difficulty speaking Swedish. The other was a woman born in Sweden who had long-term contact with occupational therapists and other mental health care providers. When the initial data was analyzed, particular topics came up that facilitated the choice of further participants. Theoretical sampling continued until the point of saturation and when no new ideas emerged from the initial analyses (Strauss & Corbin, 1998). This process continued until an appropriate number of informants and amount of data had been collected in order to be able to fully explore the participants’ perceptions and experiences of their encounter with occupational therapy. The final sample consisted of 11 clients (five males and six females) of whom nine were born in the Middle East (Iran, Iraq, Afghanistan, Turkey, Lebanon, and Palestine) and two were born in Sweden. All participants described themselves as Muslims. The age range was between 22 and 67, the clients had lived in Sweden more than five years at the time of interview, and spoke several languages at home, e.g. Arabic, Farsi, Pashto, and Turkish. Two clients had moved to Sweden when they were less than 10 years old. The ma-
The majority of participants could speak Swedish fluently or semi-fluently. Three participants (two female, one male) had completed university education; three clients had either no education or only primary school education and five clients had completed or semi-completed high school. Three participants (one highly educated female, two males) had work experience from their home countries. At the time of the data collection, one participant was employed, one client took part in occupational training, five participants were at training centers, and four participants were retired (three of these had a disability pension).

Study II

The participants were chosen among occupational therapists, who currently worked with immigrant clients in psychiatric care in an urban area in southern Sweden. The author contacted all the occupational therapists working (nineteen) in the psychiatric services in this area by telephone. This was done in order to explain the purpose of the study and the criteria for recruiting the participants. Confidentiality was assured for those who agreed to participate, and the principle of informed consent was applied. At this stage, appointments were made with two therapists, one older one with long work experience and one younger with shorter experience of working with immigrant clients from the Middle East. The author explained to the rest of the presumptive participants that any further contact would be made during the next three months. After interviewing two therapists and analyzing the data, the next participants were selected according to the draft codes and the new questions and ideas that successively emerged during the preliminary analysis of each new interview. The size of the study sample was not determined beforehand, but saturation was attained when the data from the eighth participant had been analyzed. The majority of the participants were female therapists with ages ranging from the mid-thirties to the mid sixties and with more than two years of working experience with immigrant clients. Two therapists were themselves immigrants, originating from Eastern Europe, but had been living in Sweden for more than twenty years and had a Swe-
dish occupational therapy qualification. All the participants were working at outpatient units with patients who had a psychosis diagnosis, or were forensic psychiatry patients. One of the participants had a Master’s degree in occupational therapy, while the others had a Bachelor or diploma degree.

Study III

The participant was a twenty two year old woman of Turkish origin who had been born in Sweden and had her first psychotic breakdown at the age of thirteen years. She received occupational therapy at a psychiatric rehabilitation unit, at the age of twenty years when she was hospitalized due to a relapse that occurred when she was moved to another city and began studies tailored for adults with psychiatric disabilities. When the client was discharged, she was offered outpatient occupational therapy. She was sick-listed and had a passive lifestyle without structure or routines and lacked the motivation and volition to perform the roles and occupations required for the course of an independent daily life. The data collection occurred when the author was working as an occupational therapist in a rehabilitation unit in the psychiatric department of the local mental health services.

Study IV

A sample of Middle Eastern immigrants with psychiatric disabilities was recruited from the occupation-based rehabilitation centers. The staff at these centers was used as mediators in recruiting participants for the study. After collecting and comparing some background information on each participant at the centers, eligible participants were identified according to the principle of theoretical sampling. Appointments were made with the participants in order to explain the purpose of the study. Confidentiality was assured for those who agreed to participate and the principle of informed consent was applied. The inclusion criteria were being a Middle Easterner, having lived in Sweden for at least three years and receiving occupation-based rehabilitation at the time of interview. The size of the sample was not decided in advance, but after ana-
lyzing the first interview, the preliminary codes and categories guided selection of the next participants in accordance with Grounded Theory (Strauss & Corbin, 1998). Saturation was achieved when the data from the tenth participant had been analyzed. The final sample included six males and four females, born in different countries in the Middle East (Iraq, Afghanistan, Lebanon, Israel, Kurdistan and Palestine). Eight participants described themselves as Muslims and two as Jews. The age range was between 35 and 60 years. The participants had lived in Sweden for more than four years at the time of interview, and spoke several languages at home, e.g. Arabic, Pashto and Farsi. Four participants had lived in Sweden for more than twenty years. Eight participants could speak Swedish fluently or semi-fluently. The majority of the participants were on long-term sick leave, had temporary disability pension or were dependent on social benefits. According to the participants’ self-reported diagnoses, three had psychoses and seven had long-term depression. All the participants had ongoing contacts with the psychiatric outpatient services and other mental health care services.

Data collection

Interviews, Studies I, II, IV

No specific questions were pre-formulated for the Grounded Theory based interviewing in Studies I, II and IV, but the interviews touched upon certain themes which allowed the participants to explain their own views, thoughts, perceptions, feelings and experiences. The interview styles for these studies were based on qualitative interviewing technique, which applied an open-ended outline and flexible framework around topics and inquiries. Following the recommendations of Strauss and Corbin (1998), initial questions were launched more broadly and then gradually became more specific and more focused during the interview process, with a following up of the participants’ answers (Figure 2). A starting point for all interviews was thus an invitation to all respondents to talk about their perceptions, experiences and views of reality in their
own way. The interviews, which lasted 1-2 hours, were all recorded and transcribed verbatim by the author of this thesis. Three interviews in Study I and two in Study IV were conducted in Farsi and were translated into Swedish by the author, together with the transcription. The author of this thesis and one of the co-authors of Paper IV listened to the Swedish interviews to ensure agreement between the interviews and the transcripts. The corresponding procedure was performed by the author and a translator regarding the interviews made in Farsi.

Examples of broad and specific questions for grounded theory interviews

<table>
<thead>
<tr>
<th>Study I</th>
<th>Study II</th>
<th>Study IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Broad question</strong>&lt;br&gt;- Can you describe how you perceive your relationship with your occupational therapist?</td>
<td><strong>Broad question</strong>&lt;br&gt;- Could you describe your experiences from working with immigrant clients with different cultural backgrounds?</td>
<td><strong>Broad question</strong>&lt;br&gt;- Can you explain how you perceive what you do in this center?</td>
</tr>
<tr>
<td><strong>Specific questions</strong>&lt;br&gt;- Can you describe what you expect of your therapist? Can you explain this perception?</td>
<td><strong>Specific question</strong>&lt;br&gt;Tell me how you work with client expectations and motivation, and with problem solving.</td>
<td><strong>Specific questions</strong>&lt;br&gt;- Can you describe conditions that facilitate or inhibit your possibilities to develop abilities and improve your work situation? - Can you explain how participating here influences your health?</td>
</tr>
</tbody>
</table>

Figure 2. Broad and specific questions in Studies I, II, IV

**Narrative data, Study III**

In Figure 3, the narrative data used for Study III is outlined, including notes taken during the course of therapy, clinical documents such as assessments and intervention plans, a reflective therapist diary about different events during the therapy, and paintings made by the client, either spontaneously or as an element in the
therapy. The data related to the first part of the course of occupational therapy mainly focused on storytelling and on the client’s past and present life experiences, including the stories of her identity, illness, treatment, occupation and family story and involving the issues of migration and acculturation. The data included the therapist’s field notes about communication, conversations with and observations of the client and her family in the clinical as well as the home and outdoor settings. Furthermore, the client’s pictures which she had painted during her psychotic episodes before the therapy in question formed part of the data. The field notes, which concerned the latter part of the therapy, concentrated on the present and thoughts about the future and the focus of those data gradually shifted from the activities that were important in the client’s life to conversations about herself and her identity. Furthermore, six new paintings which the client painted in the course of the therapy were part of the data. All information was continuously recorded in accordance with the Swedish regulations on medical records. In addition, the therapist continuously wrote down field notes of discussions about the paintings, as well as a number of metaphoric proverbs that were important to the client.
Figure 3. The data used for the Study III

Methods for analyzing the data

Grounded Theory

According to Grounded Theory (Strauss & Corbin, 1998), data collection and analysis occur concurrently. It means an iterative cycle of induction and deduction, consisting of the collection of data and constant comparison between results and new findings in order to further guide the data collection. Accordingly, the analysis started with the first interview, which led to the next interview, and a constant interplay between the researcher and the data took place. One problem that arose during the process of each study was how to maintain a balance between objectivity and sensitivity. According to Strauss and Corbin (1998), objectivity is necessary to obtain in order to make an impartial and accurate interpretation of events. On the other hand, sensitivity is seen as a necessity to com-
prehend nuances and meanings in data and to establish the connections between concepts and placing them in context. The researcher thus attempted to have an empathetic approach in all the studies and be open and listen actively to the participants. Some analytic tools proposed in Grounded Theory were used to facilitate analysis, such as the flip-flop techniques for comparison, systematic comparison of phenomena and waving the red flag (Strauss & Corbin, 1998). “Through a ‘flip-flop technique’ a concept was turned ‘inside out’ or ‘upside down’ to obtain a different perspective on the vent, object, or action /interaction” (Strauss & Corbin, 1998. p 94). Moreover, an episode in the data may, through systematic comparison, be set against other events reflected in the data, and this comparison may be further strengthened by contrasting the data with the literature (Strauss & Corbin, 1998). A systematic comparison could generate additional attention to properties and dimensions in the data that might otherwise be ignored. Finally, waving the red flag was used to identify the researcher’s own or the respondents’ biases, assumptions or beliefs in order to prevent them from intruding into the analysis (Strauss & Corbin, 1998). These three techniques helped the researcher to handle all the raw data and consider alternative meanings of the phenomena.

The analysis started by open coding, in which the interview transcripts were read line-by-line and similar events, happenings, and objects were grouped under a common heading (Strauss & Corbin, 1998). Through two basic analytic procedures, that is, making comparisons and asking questions to the data, the researcher could conceptualize and categorize data. Data were broken down into separate incidents, ideas, events and topics, which were afterwards bestowed with a name. In the continued comparative analysis the researcher sought for phenomena that shared common characteristics and assembled them under the same name or code. Certain concepts were then grouped under categories and each category was developed in terms of its explicit properties and dimensions. According to Strauss and Corbin (1998), researchers contextualize a phenomenon, through axial coding, by seeking for answers to questions like why, how, where, when and what is the result of. The second stage of data analysis was axial coding, i.e.
the process of relating categories to sub-categories by examining each phenomenon in terms of its properties, dimensions and causal conditions. A coding paradigm, as suggested by Strauss and Corbin (1998), was thus used to sort out and organize the emerging connections between and within categories and sub-categories. In this paradigm, each concept was depicted in terms of a phenomenological description, conditions behind the phenomenon, its context, its actions/interactions and the consequences of the action (Figure 4).

![Diagram](https://example.com/diagram.png)

Figure 4. The coding paradigm adopted in the thesis, in accordance with propositions by Strauss and Corbin (Strauss & Corbin, 1998).

The process of integrating and refining the theory occurred in the final stage of the data analysis, the selective coding. In the selective coding process, a core category was constructed upon the foundation of the previous open and axial coding efforts (Brown, Stevens, Troiano, & Schneider, 2002). According to Strauss and Corbin (1998), a central or core category should have the “analytic power to pull the other categories together to form an explanatory whole and should be able to account for considerable variation with the categories” (p. 146). Within this analysis process, the the-
oretical saturation was reached, which means that no new properties, dimensions, or relationships emerged during the analysis. In addition to coding, a major tool in the data analysis was the use of memos that provided a history of the data analysis and helped the researcher to develop the theory. The memos functioned as support for analytical ideas and elevated data to a conceptual rather than descriptive level. Constant comparisons between collected data, codes, and categories helped the researcher shed light on ideas that became part of the tentative theory.

**Narrative method**

The collection of data occurred during a period of more than two years of the therapy in Study III but the analysis was performed four years later. The process of narrative analysis is a synthesizing of the data rather than a separation of it into its constituent parts (Polkinghorne, 1995). Whereas a paradigmatic type of analysis was employed for Studies I, II and IV, with the aim of discovering commonalities that existed across the stories and developing concepts from the data, the analysis in Study III aimed at configuring the data elements into a story that united and provided meanings to the data (Polkinghorne, 2005). An important analytical task was thus the development of a coherent story on the basis of the different data sources, and a story was at the same time the desired outcome of the study. Thus, all of the data in Study III needed to be integrated and interpreted into a story. The researcher thus applied a threefold analytical tool in order to compose different elements into a story and relate events and actions to one another by configuring them as contributors to a plot. The first step concerned getting close to the participant’s story by reading and re-reading all data thoroughly in order to gain an insight into the data and make sense of the underlying meanings. The second step was to provide criteria for the selection of events to be included in the story. Polkinghorne’s adaptation of Dollard’s criteria (Polkinghorne, 1995, p.16-17) was used in order to make a detailed examination of significant life events and experiences that were told by the participant. These criteria included, (1) The contextual features, in-
cluding the cultural context that gave specific meanings to events, 
(2) The central character’s embodied nature, including factors that 
may influence his or her personal goals and actions, (3) The signifi-
cance of other people in affecting the actions and goals of the cen-
tral character, (4) The choices and actions of the character and his 
or her movements towards an outcome and the interaction be-
tween the central character and the setting, (5) The historical con-
tinuity and previous experiences, (6) The bounded temporal peri-
od, e.g. the beginning, the middle and the end, and (7) The provi-
sion of a plot that configure data elements into a meaningful ex-
planation of the character’s responses and actions. As 
(Polkinghorne) emphasizes, a story requires the data elements to be 
arranged chronologically.

The third step concerned the core story creation and the ex-
amination of plots. At this step, the author configured the data el-
ements into a coherent story. In a story, events and actions are 
drawn together into an organized whole by means of a plot. A plot 
is a type of conceptual scheme by which a contextual meaning of 
individual events can be displayed (Polkinghorne, 1995. p.7). The 
researcher moved back and forwards, to and from the original 
notes and texts, to recheck and validate meanings. The product at 
this point was a series of preliminary plots. The major events or ac-
tions described in the data that were in accordance with the emerg-
ing plot as well as pertinent to its development were seen as sub-
plots. In this case, the plot established a segment of happenings, 
events and actions, ordered in time and to which all elements of the 
participant’s life could be linked. The temporal range which 
marked the beginning and end of the story was clarified. Then, the 
causality behind happenings, events and actions was identified in 
such a way that it gave meaning to and made sense of the data.

**Ethical consideration**

All studies in this thesis were approved by the Regional Ethical Re-
view Board in Lund, Sweden, and were guided by the ethical prin-
ciple of informed consent and voluntary participation. The partici-
pants were informed about the study in question in great detail be-
fore they were asked to take part. Aims of the studies, together with details about the data collection process were explained. The participants were also informed that they could withdraw from the study at any time. Issues pertaining to the nature and purpose of the research, the procedures, voluntariness, the expected benefits, the potential risks for stress and discomfort, the confidentiality or anonymity of the participant and whom to contact, were highlighted both orally and in writing. In this way confidentiality was assured, and the principle of informed consent was applied. All clients signed a consent letter before starting the interview. All the data collected were made anonymous by replacing the participant’s name with a code in Studies I, II and IV and by using a fictive name and altering some details in Study III. A concern pertaining to the theoretical sampling was how to ethically handle those of the presumptive participants who had agreed to participate but were not interviewed because saturation was reached. This issue was dealt with by the researcher meeting each client to explain the situation. Furthermore, the case study included detailed descriptions of the client’s life world, which warrants some ethical reflections. The client’s approval of the study was obtained both at the time of therapy and when the study was made. That was to ensure that she did not look differently upon her previous consent four years later when this study was conducted. Furthermore, in order to safeguard the client’s identity some details such as type of and location for activities and the client’s name were disguised. The involvement of family members in the therapy inferred a significant dilemma in terms of the client’s right to autonomy and protection of her privacy. Thus, involving the family in the therapy was an act of balancing bicultural aspects, and for each decision the ethical implications were carefully considered.
RESULT

Desire for a sense of union with the therapist (Study I)

The investigation of the Middle Eastern immigrant clients’ experiences of mental health occupational therapy in Study I led to the core category desiring a union. An important phenomenon, namely mahram affinity, was articulated by the participants. Mahram affinity seemed to have a mediating role and to regulate the ethical aspects of connecting to, interacting with and relying on the health care providers. The first category in Study I, desiring relationship, was shaped by a narrative about compassion, authentic respect and transparency. The therapists’ ability to listen with the heart and respond compassionately by giving care and support and sharing their joy and pain was highly valued. Furthermore, being unconditionally accepted without fear of rejection was a desire that was shown to diminish self-concealment for some respondents. The therapists’ ability to be transparent, concrete and present without hiding behind a professional façade was valued by the respondents. The second category, desiring affiliation, was composed of a narrative about two components, namely sameness with the therapists.

* In Islamic sharia legal terminology, a mahram is an unmarriageable kin with whom sexual intercourse would be considered incestuous, a punishable taboo. In Islamic normative tradition sharia has classified opposite-sex relationships within two categories: Lawful mahram and unlawful na-mahram and has developed rules for how men and women may associate in daily life. However, mahram is a deeply established belief system based on tradition, and customs that consciously or unknowingly employ a criterion of moral truth into many aspects of ethical and social norms. Despite the fact that mahram is not shaped as a common law or statute in the Middle East’s health care system but it has an enormous consequence on ethical codes of behaviors in the many aspects of the medical health care system (Ask, 2005; Rashidian, 2005; Yasmeen, 2001).
and the therapists’ proficiency. Language deprivation was mentioned as an essential obstacle to entering each other’s worlds in the therapeutic situation. Differences in cultural backgrounds, life experiences and diversity were also mentioned as the sources of a feeling of insecurity and discomfort. As a result, a sense of being more comfortable and safe in therapy when the therapist had a similar background was articulated. On the other hand, the quality of the therapeutic relationship and the therapist’s skills, honesty, charisma and sincerity were considered even more vital in building the sense of affiliation between them and their therapists. The third category, desiring affirmation, was about the perceived tension, challenge and resistance in the therapeutic situation caused by discrepancy in cultural worldviews and value orientation between the participants and the therapists. Desiring affirmation, involved two components, namely, making sense of one’s lifeworld and inner tranquility. The participants wanted their therapists to value their former occupational identity and to understand their deep sorrow about the loss of occupational identity, self esteem and dignity that they had in their home countries. They highlighted having a culturally cognizant therapist, who could help them in a deeply holistic approach, where the focus would not be only on occupation and occupational performance, but also on balancing the inner “self” and getting peace in the body-mind-spirit wholeness.

The challenges of the multicultural therapeutic journey (Study II)

In Study II the analysis led to a core category termed the challenge of a multicultural therapeutic journey – a journey on a winding road. That was composed of the therapists’ narratives about a variety of complications, consequences and challenges that obstructed or facilitated their clinical work. Three categories were discerned within this core category, namely dilemmas in clinical practice, feelings and thoughts, and building a cultural bridge. These categories in turn comprised subcategories and components. The first category, dilemmas in clinical practice, included three subcategories; “cultural dilemmas”, “societal dilemmas” and “professional di-
lemmas”. Cultural dilemmas were seen as rooted in differences in cultural worldviews and value systems, particularly regarding issues such as personal autonomy, mental illness and dysfunction, communication, occupation, gender roles, and family. It seemed that the therapists’ views of independence, mental illness and disability often clashed with those of their clients. For example, shame and stigma attached to mental illness, a focus on somatic complaints and reluctance to engage in occupation due to being ill were more common and acceptable among their Middle East clients. The therapists also experienced a challenge in terms of clear differences between them and their clients in communication, values, attitudes toward occupations, utilization of time, and ideals concerning occupational balance and occupational engagement. Furthermore, cultural expectations regarding gender complicated the therapeutic relationship and was especially challenging when the therapist was a woman and the client a man. Family was the last cultural dilemma mentioned by the therapists as the source for conflicts, particularly around young clients. For example, the strong family attachment was indicated as an obstacle to especially young clients’ engagement in the occupational therapy goal of independence. The therapists also mentioned societal dilemmas, like stigmatization and discrimination by society, poverty, lack of work-related occupations and adequate resources, as hindrances for the therapists to carry out an effective intervention. Professional dilemmas in clinical practice were composed of narratives about a lack of culturally adjusted models and instruments that generated difficulty in providing an effective service. The second category, the therapists’ feelings and thoughts, was a result of how they were affected by the cultural, societal and professional dilemmas, but also of their motivation for seeking cultural knowledge and their choice of strategies in which the multicultural therapeutic relationship could develop. Furthermore, by becoming culturally competent and using culturally adapted techniques the therapists could build a multicultural relationship, which formed the third category. As the findings demonstrated, developing such strategies could reduce their uncertainty and anxiety. In addition, they also became aware
of their own cultural biases. The result indicated that culturally responsive occupational therapy needs to be further developed.

A bicultural personal growth (Study III)

The analysis in Study III led to a core plot denoted; *a bicultural personal growth*, comprising seven sub-plots, which in chronological order were: the invisible self, the ill self, the caged self, the confused self, the fearful self, the released self, and the integrated self. The invisible self was composed of the client’s narrative about her step-by-step engagement in the therapy process and her life story. In this sub-plot, the client viewed herself as an inseparable part of the family and her relatives. A variety of professionals from the mental health care services and other authorities formed part of her life in an irregular manner that created frustration, exhaustion and confusion. She became increasingly withdrawn and felt that she was invisible and that nobody cared for or noticed her. The second sub-plot, the ill self, illustrated the client’s narratives about her illness, which she saw as created and controlled firstly by God and secondly by the medicine. Her ill self meant days of “doing nothing” and of having no interests, little family involvement, and no involvement in work or studies. While the ill self prevailed, she was still able to identify fashion, painting, and domestic activities as interests, although she did not currently pursue these hobbies in any meaningful way. The third sub-plot was about the caged self, which was composed of the client’s narrative about her feelings of loneliness and abandonment in daily life. While the caged self prevailed, the focus of the therapy was on increasing her motivation to explore some occupation-related solutions that might help her to cope with the stress of symptoms and distract her from destructive thoughts. She began to realize that by doing activities she could influence her recovery, because when engaged in activities her hallucinations were less prominent. The fourth sub-plot revealed the confused self, in which the client’s narrative revealed a transformation from a passive, helpless jailbird to a released, although confused, being. A culturally based intervention plan aimed at stimulating her and involving her in a process of personal growth linked
with two cultures was applied. The fifth sub-plot illustrated a fearful self to which the client showed considerable ambivalence. On the one hand she demonstrated more courage to express herself and a desire for a changing life with personal growth towards “some independence”. On the other hand, she talked about her fear of being unable to live independently of the family. Involving her family actively in her process of personal growth was thus essential in order for her to overcome her anxiety and fear. The narrative about the sixth sub-plot was about a released self that configured a bicultural personal growth in which the client was increasingly able to maintain a balance between independency and interdependency. The sub-plot about the released self also revealed a connection between being involved in different activities and having less destructive hallucinations. The motivation for being independent and active gradually increased during the course of the therapy, but peaked in the last sub-plot, about the integrated self. This also meant the end of the therapy, where the client mentioned that she dreamt about leaving her parents and living by herself in her own apartment. An apartment was arranged and a stepwise transition plan in consultation with her mother and siblings was developed in which the family members had different functions until the client’s situation became stable.

**Being empowered by getting support – a paradoxical pathway to occupational well-being (Study IV)**

Study IV identified *being empowered by getting support – a paradoxical pathway to occupational well-being* as the core category describing a variety of factors that facilitated or inhibited the participants’ attempts and abilities to deal with the many difficulties related to finding a safe and relevant place and occupational stability in the host society. Three categories were discerned within this core category, namely *striving for control, grasping meaning in occupation, and striving for self-respect*. These categories also covered some subcategories. Striving for control was composed of the participants’ narratives about the demands they met, which were often beyond their abilities and exceeded their level of control. This
made it difficult for them to make decisions for a changing life. By being both an immigrant and mentally ill the participants faced double hindrances that increased their state of powerlessness and restricted their ability to take responsibility for their own lives. Therefore, they expressed a desire for empathetic and directive support to keep up their motivation. The participants who had opportunities to make decisions and be involved more actively in the process of occupational rehabilitation showed more satisfaction and happiness. Being placed in vocational training as a time-limited solution decreased their motivation for changing their lives and influenced negatively on their overall control over life. A sense of alienation and powerlessness was expressed because they perceived that their opinions, thoughts, and plans had not been heard and they had not been involved in making decisions about their occupational lives. Grasping the meaning in occupation was the second category, illustrating the participants’ searches and challenges to find meaning in what they were doing at the centers. The participants at the day centers described a stronger sense of meaning in their occupations than the participants at the municipality-run psychosocial projects did. A majority of the participants at the municipality-run psychosocial projects centers showed a lack of meaning in relation to their occupations because of a mismatch between the occupation offered and their values, interests and purposes. That mismatch in turn influenced their active engagement negatively. A lack of belonging was expressed more by those in the municipality-run psychosocial projects centers. It seemed that the short-term and temporary placements in different municipality-run psychosocial projects centers disrupted the clients’ efforts to build a sense of belonging in the workplace. Striving for self-respect was the third category, composed of the participants’ narratives about occupational identity, self-continuity and being part of society. Some female participants who had been without work for many years were not basically motivated for any occupation outside the home but they gradually became motivated and engaged in the new tasks and could take in the values, meanings and benefits the occupations could bring. Feelings of shame, guilt and stigma and of losing face because of being incapable of accomplishing their cultural and tra-
ditional breadwinner duties were expressed by the men. All participants tried to find a connection between the present and their past occupational practice. Being given support in order to develop empowerment was mentioned as essential for them in striving to maintain control over the work conditions that formed their future. Their hopes and aspirations for their future could not be realized if they felt ignored and neglected by the system. Those participants who received social benefits showed lower aspirations and weaker beliefs in a changing life. They frequently emphasized how disabled they were by talking about a variety of psychosomatic symptoms that impeded their occupational abilities. They accepted being dependent on the social services and saw no reasons for having other ambitions regarding their future. In contrast, some other participants, who expressed high degrees of motivation and aspiration, emphasized certain occupational goals they wanted to attain. They also demonstrated strong beliefs in the future and more positive feelings in comparison to those who were poorly motivated and felt enforced to perform their occupations. However, according to the majority of the participants, being empowered and supported was spoken of as being essential, which not only strengthened their capacity for developing work skills but also their possibilities for community integration. The majority of the participants perceived, however, that they did not receive adequate support and claimed that they did not know how to enter into community life.
DISCUSSION

The purpose of the discussion section is to elaborate some of the core elements in the results of Studies I-IV about the nature of cultural value variations. Indeed, differences in collectivistic and individualistic cultures were evident in Studies I and II and gave rise to further questions on whether inclusion of cultural dimensions in the ordinary models of occupational therapy could contribute to cultural integration. In an attempt to further understanding cultural dynamics, a specific case study (Study III) was carried out that highlighted the importance of cultural responsive therapy as a facilitator in the regulation and integration of cultural variations. Study III gave rise to further questions about which factors promote the process of cultural integration. Thus, in Study IV, a specific focus was placed on the meaning and experiences of occupational well-being in occupation-based rehabilitation contexts. The findings of each study revealed how cultural value variations shaped the participants’ experiences and perceptions between two cultures.

The Middle Eastern clients’ and the occupational therapists’ conceptualizations of realities and truths in dealing with issues in a therapeutic situations in outpatient care

The findings indicated that the clients of Middle Eastern origin (Study I) and the occupational therapists (Study II) showed how they developed their own conceptualizations of realities and truths embedded in their values, preferences, and belief systems based on the Middle Eastern and Swedish cultural worldviews. In Study I, the participants’ experiences and perceptions of cultural differences
with their therapist were mostly embedded in their cultural orientation based on their collectivistic worldview. For example, clients and the therapists differed greatly in their perceptions of occupation and its meaning and necessity for health, as well as occupational behavior and choice. The clients in Study I seemed to favor correspondence, coherence, consistency, harmony, social integration, and balance into a body–mind–spirit unity. On the other hand, the therapists in Study II seemed to favor self-sufficiency, personal autonomy, problem-solving, and self-esteem. The discrepancies also occurred when the therapists expected the clients to be able to do things and be effective and productive while the clients wanted to find meaning through spiritual activities. Moreover, the findings in Study II indicated clearly that the therapists held an individualistic worldview, emphasizing the individual’s autonomy and responsibility, in contrast to that of their clients, who held a more collectivist view, as demonstrated by close involvement of family members in the clients’ lives. According to Triandis (1995) and Iwama (2006), the culture in which individuals are raised influences the way individuals are socialized in terms of individualistic and collectivistic worldviews. It seemed that the therapists’ ideal of independence in daily occupations clashed with that of the clients, for example in terms of the desire to be cared for. However, in explaining how cultural value orientations might influence the participants’ views and experiences of realities and truth in Studies I and II, the theoretical framework suggested by Kluckhohn and Strodtbeck (1961) was applied as a helpful analysis tool. As depicted in Table 1, the common human problems attributed to the value orientations involve components related to human-to-nature relationship, temporal focus of human life, the human-to-human relationship and the human occupation. Many of the findings in Studies I and II shared an explanation on cultural variations embedded in individualism and collectivism as values in line with cultural value orientation according to Kluckhohn and Strodtbeck (1961). For example, in Study I, the participants’ view of human-to-nature relationship indicated that human beings should be active rather than passive participants in the world, but at the same time they realized that the ultimate outcome of their struggles is determined
by Allah (God). In other words, they viewed their mental disabilities in the context of fate, “tagdir/kismet”. The proclivity toward subjugation orientation is found in the following quotation: “I think medicine cures me, but first I try praying to Allah [God] and the prophets and if I don’t become better I read the Koran and ask Allah again to help me and if this has not helped, I go to the doctor. The Swedish therapist does not understand my thinking and beliefs by going to mosque and praying I try to find a balance and meaning of life that moves me forward…”. In contrast, the therapists in Study II believed in autonomy, mastery, control over daily life and that each human can influence and change the events in their lives and control mental illness and disability, which clashed with the beliefs of the clients. As a result the therapists encouraged active self-assertion to the clients in order to master and change their lives and to attain personal goals. In addition, in line with Kluckhohn and Strodbeck, the participants’ temporal orientations differed between Study I and Study II. Kluckhohn and Strodbeck’s main point is that not all individuals interpret the world in the same way. In fact, the clients in Study I emphasized continuity between past and present, which explains a temporal focus on life in collectivistic value orientations. The future is unpredictable and uncontrollable in such a temporal orientation and might impede their motivations in collaborating with the therapists toward a future goal. However, in Study II, the occupational therapists’ individualist values are indicated in the following quotation: “I cannot accept the fact that time is not used for self-development”.

The conceptualization of the human-occupation relationship and occupational identity also showed variations between Study I and Study II. For example, in Study II, the therapists criticized the clients’ views of mental illness, which collided with their views about reluctance to engage in occupations due to the presence of mental illness. In the following quotation the therapist stated: “Mental illness is for most immigrant clients connected to disability and a disruption of role performance. Swedish clients usually say that they must keep on doing something…”. In individualistic cultures, individuals are encouraged to accomplish things and become individually responsible (Kitayama & Uchida, 2005;
Kitayama, Duffy, & Uchida, 2007; Markus & Kitayama, 1991; Markus & Kitayama, 2003). However, the therapists’ ideal of independence in daily occupations, mastering one’s own life and engaging in remunerative occupation clashed with some of the ideals of the clients, for example, the desire to be cared for. A “doing” perspective was predominant among the therapists in Study II, as revealed by statements such as “do something”, “getting balance”, “moving on”, or “changing your life”. The “doing” orientation was also frequently expressed by the therapists when they highlighted that work could motivate an individual to change, because it could offer dignity, self-respect, self-efficacy, and a clear sense of identity. As a result, the clients’ unwillingness and lack of enthusiasm to engage in the occupational therapy process was generally seen as a challenge. In contrast, the tendency towards “being” and “being-in-becoming” was common among the clients, as expressed by one participant in Study I: “My therapist said that I must have balance with sleep and rest and work… But, she fails to understand that reading the Koran gives me pleasure, balance, and a feeling of well-being…”. The Middle East clients thus showed a “being” orientation about “what they are” having greater meaning than “what they do” in contrast to the “doing” orientation.

Furthermore, the findings covered a range of issues concerned with the nature of human-to-human relationships and boundaries between people, for example, the extent of being independent and interdependent. In Study I, the participants’ conceptualizations of relationship were based in part on the collective and social relationships. Through identifying with the in-group, the participants attempted to find meanings, goals and a shared life world. According to Zunker (2011), Triandis (1995) and Hofstede (1994) the major individual function, in collectivistic cultures, focuses on the welfare of the family and the group and on building group solidarity. But in Study II, the therapists highlighted uniqueness, autonomous being and independent self-construction. Consequently, conflicts occurred when the families hindered the occupational therapy goal of independence, as shown in the following quotation: “Often the mother tries to control her son or daughter who is sick… this is a hindrance for us in carrying out a pro-
gramme to promote an independent life”. Furthermore, the findings indicated how the clients’ and the therapists’ cultural values impacted their conceptions of therapeutic relationships, expectations and desires and generated challenges for both the therapists and their clients, as described in the following quotation from the therapist: “Most immigrant clients are not always able to make decisions…. Often their parents, especially the fathers, are against this” and “I always ask them what they want and not to care about what others would want… it is your life”.

One of the most important findings regarding human-to-human relationships in Study I was that the clients were searching for a state of union with the therapist in its prototypical form, expressed in groups of persons who are either blood relatives or have a mahram connection. In fact, the clients’ belief in the mahram affinity might contribute to a sense of being united with the therapist in a natural trusting relationship. According to Husain (2007), the wisdom behind having a category of relatives known as mahrams is related to the pattern of organization and relational functions within the family systems of Muslims, which are composed of interwoven multi-generational family member relationships. In other words, within such interdependence and broad in-group family systems in the Middle East cultures (Dwairy, 2006), mahram affinity regulates many ethical rules of connecting with and interacting with others as their siblings in the group. The concept of mahram generates a moral, ethical and social order in which one feels protected, safe, and secure in his/her environment among the relatives who fall into the category of being mahrams (Husain, 2007). As the findings in Study I revealed, the belief in the mahram affinity contributed to a sense of being united with the therapist. Consequently, the concept of mahram may contribute to a natural trusting relationship with a therapist. However, the clients seemed, on the other hand, to place the therapist in a familial context which may cause confusion for the therapist in his or her professional role. In addition, this may also generate more challenges for the therapist to look beyond the boundaries of his/her own cultural interpretation of encounter and treatment. Placing the therapist as
mahram in a familial context might thus be confusing and frustrating for both parties because the clients consequently try to make sense of being friends or family with the therapist, which may affect the establishment of adequate boundaries.

A transition from an interdependent to an independent and integrated bicultural self in psychiatric rehabilitation

The findings in Study III illustrated how the client went through a transition from being an interdependent to being a more independent and integrated bicultural self. As the client recalled her story about her experiences, the past events, delusions, and hallucinations were reconstructed in a way that became more visible and comprehensible. The findings showed how the client was gradually able to depict her bicultural problems in her paintings in the therapeutic sessions. In fact, through paintings, metaphoric proverbs and creative activities she was able to internalize different experiences and slowly transform and externalize them in relation to the therapist, the activities, and the external world in general. As the findings indicated, the client’s cultural value orientations in line with Kluckhohn and Strodtbeck (1961), tended to prevail within the collectivistic culture in the initial stage of the therapy. For example, she believed that her illness was created by God as a punishment and therefore her ill self had no interest in being involved in a process of change. Moreover, the client’s conceptualization of human-to-human relationships consisted of a strong, interpersonal relationship with the family based on group ties, where interpersonal relationships, loyalty, interdependence, duties, respect, and obligations are prominent. This result confirmed that in previous research by Kagitcibasi (1996) and Kagitcibasi (2003). In other words, the client viewed her self as not being separate from others and thus showed a strong tendency to seek connectedness and interdependence with others, such as her parents. From the onset the therapist therefore tried to generate a mahram relationship (Ask, 2005; Rashidian, 2005; Yasmeen, 2001) with the family members, by involving and including them in the client’s therapy. However, during the course of the therapy, the client went through a stepwise
transition from an interdependent to a more independent and integrated bicultural self. The process of cultural integration was promoted through a bicultural growth journey in which she could discover and compare value variations in both cultures, develop competence and skills and develop connectedness with society and gradually undergo a transition towards an independent life. In fact, the more the client became independent, the more she developed and expressed her own preferences, thoughts, feelings, desires, dreams, and capacities and somehow found sense in her own uniqueness. The findings in the present study are consistent with those of Chirkov, Ryan, Kim and Kaplan (2003) and Downie et al. (2007), in maintaining that the degree of cultural internalization increases the clients’ bicultural competency and ability to successfully interact in the new host culture, thus also influencing the clients’ well-being.

A paradoxical path of empowerment along a continuum from collectivism to individualism in occupation-based rehabilitation

The participants in Study IV showed a clear tendency to oscillate between collectivistic and individualistic cultural orientations when striving for occupational well-being. Their narratives revealed that they wanted to be empowered to gain control, meaning and self-respect, revealing needs for autonomy, motivation, power, choice and decision-making. On the other hand, they expressed a desire to receive emotional, practical and functional support in order to manage occupational demands. These findings of accepting new norms from the host society, while simultaneously valuing the norms of the original culture differ from Study I, which generally found that the old norms prevailed. Many of the findings in Study IV reflected an integration of cultural variations embedded in individualism and collectivism in terms of the descriptions proposed by Kluckhohn and Stordtbeck (1961). For example, the participants’ view on the human-to-nature orientation seemed to highlight human beings as active and as part of the environments, as humans, who should strive to achieve control and mastery of undesired
events rather than be passive bystanders. As the findings indicated, the cultural dimensions were more or less intertwined and the participants expressed, for example, desires for control, motivation, choice and decision-making. Another example of the participants’ variation in views concerned the temporal focus of human life Kluckhohn and Stordtbeck (1960). The participants referred to the continuity between the past, present and future, and an orientation towards the future was especially expressed in aspiring towards and believing in the future and the mentioning of occupational goals. Moreover, the participants’ conceptualization of occupation and occupational identity also showed a tendency of integration between collectivist and individualist cultural variations. The participants wanted to be empowered, for example, to be in control of occupational demands and become individually responsible. According to Kityama, Duffy and Uchida (2007), Kitayama and Uchida (2005), and Markus and Kitayama (2003), much value is placed on individual accomplishment, self-actualization, autonomy and independence in individualistic cultures. In fact, the participants’ ideal of mastering, changing and having control over their own lives and occupations and engaging in remunerative occupation and grasping for meaning in the occupations revealed a developing integration between being, being-in-becoming and doing orientations. For example, they maintained that work could motivate them to change their lives, because it could offer dignity, self-respect, self-efficacy, and a clear sense of identity. A desire to receive support was frequently expressed and may be seen as a reflection of the human-to-human relational orientation proposed by Kluckhohn and Stordtbeck. For example, the participants’ conceptualizations of relationship were based in part on the collective and social relationships that give meaning in life through support, social order, respect, security, obedience and wisdom within an ingroup (Schwartz, 2008). However, the findings also indicated an ambivalent state concerning directive support and non-directive support. On one hand, the participants in Study IV expected more directive support and less responsibility for decisions about goals and tasks. On the other hand a desire for non-directive support was expressed in being involved in the process of making decisions
and choices regarding occupations. According to Dwairy (2006), individuals in a collectivistic social system are dependent on their families for their survival, which thus entails needing to be obedient in order to gain vital collective support. It can be argued that Study IV provided findings both in agreement with and in contrast to the universality of the need of autonomy and control. On one hand, the typical individualistic elements of empowerment, such as autonomy, control, and decision-making, were found to increase the participants’ occupational well-being. On the other hand, typical collectivistic empowerment such as emotional, practical and social support, caring and respect had a significant role in the participants’ occupational well-being. Inarguably, the participants’ expressions of needs for support in maintaining more harmony, safety and continuity might need to be taken into account in the occupation-based rehabilitation services, particularly since such services focus on the provision of empowerment, as shown by Tjörnstrand, Bejerholm, and Eklund (2011). As the findings of Study IV showed, those participants who felt positive occupational well-being attended day centers that offered more constant and established support, which seemed to promote a sense of security, safety and continuity. It also seemed that the participants in Study IV were more able to manage demands concerning occupations in such places. Such positive experiences are in agreement with previous research (Tjörnstrand et al., 2011). In summary, the participants could, through the support given, develop an empowerment that effectively enabled the participants to have control, capture meaning of the occupation and gain self-respect, which in turn promoted their occupational well-being. As the findings showed, the support had not only enabled the participants to become empowered, but also to manage the process of integrating cultural values in relation to occupational needs, demands and well-being.

**Which factors promote ambivalence and cultural integration?**

The discussion of the overall findings in this thesis gives rise to the question, as expressed by Berry (1997), how clients, with a mental illness and a Middle Eastern background change and manage to
adapt different cultural value orientations to the new contexts, which are generated by the migration and acculturation. Before addressing this question in greater detail, a discussion about acculturation may be useful and might explain why integration of the cultural value orientations differs among the participants in the studies. Berry (1980) provided a classification of acculturation strategies, according to which immigrants may be strongly oriented to their host culture and only weakly oriented to their heritage culture (assimilation), strongly oriented to the heritage culture and only weakly oriented to the host culture (separation), weak orientation to both cultures (marginalization), and strongly oriented to both cultures (integration). Therefore, through a process of acculturation, a social connectedness might gradually take place with mainstream society, which presumably mediates in the process of integration between two cultures, as indicated in Studies III and IV. Furthermore, the participants’ ambivalence could also be explained as Chirkov (2009) does, maintaining that immigrants encounter different culturally constructed realities and different systems of meaning in the new situation, which might generate feelings of incompetence and a wish for support in order to be able to master discrepancies and regulate one’s behaviors. The overall findings raised questions about acculturation in relation to the integration of cultural value orientations that, in fact, would require further research studies. Acculturation as the essential aspect in cultural integration thus needs further inquiry.

The findings of Studies I-IV suggest a set of cultural value orientations that flow through the human-to-nature relationship, the temporal focus of human life, the view of human occupation and human-to-human relationship. These may be seen as paths through which the self can integrate collectivistic and individualistic values. Among the clients in Study I, the predominant cultural value orientation was collectivistic, whereas it was individualistic among the occupational therapist in Study II. In Study III and Study IV, the host culture seemed to become increasingly internalized among the participants and two cultural value orientations become integrated. For the participants in Study III and Study IV the cultural integration seemed to begin with the human-to-nature
path, by which the participants began to realize how to be active participants in order to find solutions to change things in their lives. As the participants integrated different individualistic elements in the human-to-nature path, they became more able to express a future-oriented temporal focus of human life. Viewed from this path, the participants still tended to see the future as unpredictable, but a tendency of goal-setting towards the future could be discerned, and beliefs in the future were expressed. The process continued in the human occupation path. Even though the participants preferred occupations that facilitated a development of the inner self, they also strove to accomplish and achieve their defined occupational goals, as indicated in Studies III and IV. The process continued in the human-to-human relationship path, where the participants attempted to find a balance between an interdependent and an independent self-construct. That struggle was particularly evident in Study III. Figure 5 illustrates how the aforementioned paths may serve as a basis for transforming purely collectivistic and individualistic cultural values into cultural integration. The Figure also highlights four mediating factors found in Studies III and IV, where cultural integration was part of the results, namely occupation, culturally sensitive intervention, bicultural self and empowerment by getting support. These factors might facilitate a process of cultural integration.
In summary, based on the overall findings in this thesis, culture is depicted as a dynamic phenomenon, which is in accordance with Dodd (1997) because it is seen as a product of group values, norms and experiences (Lopez & Guarnaccia, 2000). However, the attempt has not been to solidify culture into a set of generalized value orientations. On the contrary, the thesis demonstrated that culture is a dynamic and creative process, some features of which are changeable and some features of which are not changeable. The overall findings also demonstrated that the participants with a
Middle Eastern background, who originally encompassed collectivistic cultural values, could adjust to, change, or resist cultural values and influences.

Although this discussion focuses on cultural dilemmas and the findings from this thesis are based on narratives from mental health clients with a Middle Eastern origin, one cannot exclude that some of the findings had more to do with the participants’ mental health status than their ethnic origins. For example, the needs for support and continuity are probably universal and likely to be found among people who have to rely on help from others. This should be born in mind when interpreting the results, but it is beyond the scope of this thesis to go into the complex interplay between having an immigrant status and being mentally ill and the vulnerability it generates.

**Methodological consideration**

**Grounded Theory and its relevance for the research in Studies I, II and IV**

Grounded Theory was deemed to be a useful method because little was known about Middle Eastern immigrants with psychiatric disabilities. It was, moreover, considered to be the approach that was best suited for Studies I, II and IV. It emphasizes simultaneity and reflectivity (Strauss & Corbin, 1998), which allowed the author, with a constructivist view, to approach the studied phenomenon and view it as an insider. In fact, through Grounded Theory, the author could make sense of the multiple realities and truths in the data as well as view all phenomena in a larger social and cultural context. Comparative and iterative strategies allowed the author to become involved profoundly in the data and gain a complete picture of the whole setting. However, the research process raised a few concerns, one of which concerns the role of the researcher in the process and how she used and involved herself as an insider, with her theoretical knowledge, her life and professional experiences. The essence of the Grounded Theory is its inductive nature (Strauss & Corbin, 1998), which requires the researcher to move
from being an outsider and having a relatively neutral perspective towards becoming an insider. In that process the researcher’s experiences need to be bracketed (Creswell, 2009) so that preconceptions do not distort the analysis. In order to diminish the concern pertaining to neutrality and preconception, the three co-authors involved in the studies of this thesis were active in the analysis and in developing alternative interpretations of the data. Another concern was about theoretical sampling and saturation of the categories. By theoretical sampling, the author went back to the field to gather specific data to fill gaps between categories, and to discover variation within and between them (Charmaz & Mitchell, 2001). Theoretical sampling helped the author to saturate categories, which occurred when no new information or ideas were generated from the additional data. Saturation was a challenge in itself, however, and gave rise to many questions. The author was concerned with questions such as: Were the constructed categories, although saturated, actually the most effective ones? Might saturation lead to early narrowing of categories rather than to locating them in a wider context?

Another issue, particularly evident in Study I and in Study IV, was that the author could be seen as an insider in the field because of her ethnic background and being an immigrant from the Middle East and because of her professional status as an occupational therapist. Thus, a problem with the present study, in terms of trustworthiness, might be that the interviewer’s/author’s preconceived ideas and knowledge, related to her cultural background from the Middle East, might have jeopardized a neutral approach. The interviewer/author was, however, aware of this risk and has tried to counteract it by actively involving the three co-authors, all of whom are of Swedish origin, and by following the strategies proposed in the literature, but also by bracketing the researchers’ experiences. Such reflexivity works in close association with the iterative nature of Grounded Theory research and can bring predetermined beliefs into the dialogue (Brown et al., 2002). As Creswell (2009) and Lyons (2007) state, a researcher is an important part of the process of knowledge production and plays an important role in the interpretation of a data.
A problem with Study II, in terms of trustworthiness, could be that the occupational therapists may not have spoken openly about negative attitudes, feelings, and thoughts, because of the fact that the interviewer/author was herself an immigrant and also an occupational therapist and colleague. In order to attempt to counteract this, a relaxed atmosphere was established before each interview started. Another problem might be that the interviewer’s/first author’s preconceived ideas and knowledge, related to her migrant and cultural background and working experiences in psychiatric care, might have jeopardized a neutral approach. In order to counteract this issue, the two co-authors took an active part in the analysis process.

In an attempt to establish trustworthiness in Studies I, II and IV, credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985) were considered. Prolonged engagement with the participants or the context under study was sought in order to ascertain credibility. The author met the participants on several occasions to develop trust and involvement in the study. Furthermore, a rich description of the research methods and processes was carried out, so that readers could assess the transferability of the study to another context. The author also endeavored to create an audit trail by which the process of iterative data collection and analysis was clarified. All interviews were conducted close in time to each other, which limited the impact of unknown potential biases, such as historical effects and discontinuity in the data collection and reinforced the dependability. In addition, the researcher presented preliminary findings in seminars and discussion groups with critical coworkers. Finally, as in accordance with Lincoln and Guba, conformability was established by an audit trail, which included careful documentation of the raw data and memos.

One of the primary issues in performing Grounded Theory research among immigrants could be related to the etic (culturally universal) versus emic (culturally specific) perspectives (Black & Wells, 2007). In the case of research into cultural matters, the emic perspective refers to those dimensions of human functioning which are specific to a culture, while etic dimensions are those aspects of human functioning which are more universal across cultures.
(Uomoto & Wong, 2000). The author used an emic approach in order to obtain a holistic picture in constructing meanings of the realities and truth. This was considered appropriate since relatively little was known about the participants’ cultural views. Wicks and Whiteford (2006) assert that qualitative approaches offer an emic or insider’s perspective which is essential in understanding the constructions of meaning of an individual. At the same time, there was a risk that an emic perspective might diminish the degree of neutrality. In fact, as Black and Wells describe, the emic view provides the authors with a subjective experience but limits objectivity, while the etic view is further from the actual experience of the phenomena and may be more objective and less subjective. However, the cultural, ethnic and professional background of the author of the thesis could generate more of an emic viewpoint, which is a strength in terms of understanding others from the similar personal perspective. An emic approach was thus applied in all the studies in this thesis, but being as that could possibly jeopardize objectivity in the findings, an etic complementary strategy was also employed, mainly by exerting reflexivity and by including co-authors in analyses and discussions.

Narrative method and its relevance for Study III

According to Polkinghorne (1995), narrative analysis differs from thematic analysis in that it allows themes to emerge and concepts to develop from the stories rather than breaking down the data into categories. As a research methodology, narrative method was significant for understanding the uniqueness and complexities of the client’s experiences in Study III. Furthermore, narrative analysis provided a way by which the author could unite the client’s experiences into meaning. Understanding the content and the complexity of meanings in which narratives are produced is seen as crucial (Crossley, 2007). A problem with Study III was that the data collection occurred when the author was working as an occupational therapist in the outpatient rehabilitation setting where the participant was admitted. The author’s collaborative approach as an insider may have several advantages concerning the trust and confi-
dence in the therapist-client relationship. Although the cultural af-
affiliation between the therapist/author of this thesis and the client
and her family contributed to an early collaborative stance, this
type of insider approach might jeopardize professional boundaries,
distancing, and roles. Being aware of this problematical situation,
the therapist (still not a researcher at the time for the therapy)
wrote down the experiences, reflections, insights, and questions
and discussed these on a weekly basis with the multidisciplinary
team. Moreover, the insider approach may also have influenced the
analysis and interpretation of the previously collected data, which
were made four years later. The three co-authors were therefore
active in the analysis and in developing alternative interpretations
and in developing the plots into a holistic story. Conducting this
research such a long time after the therapy took place was also an
advantage because the researcher had achieved a distance that re-
duced the risk of a professional judgment taking precedence over
research findings. In order to satisfy demands for rigor, the authors
followed the criteria of credibility, transferability, dependability,
and confirmability as proposed by Lincoln and Guba (1985) and as
described above regarding Studies I, II and IV.

**Conclusions and clinical implications**

The conclusions from Studies I-IV and the implications for both
research and clinical practice they infer are summarized below.

- The cultural differences between the clients and the therapists
  regarding a desire for a union had their origin in the conflict of
  their respective collectivistic and individualistic worldviews.
  Having a therapist who could consider their values, preferences,
  worldviews, and belief systems was vital for the clients.
- One of the most important findings in this thesis was that the
  clients were searching for a state of union with the therapist in
  its prototypical form expressed in groups of persons who are
  either blood relatives or have a *mahram* connection.
- The concept of *mahram* may contribute to a natural trusting
  relationship with a therapist. However, it may place the thera-
pist in a familial context that may lead to the therapist being confused in his or her professional role.

- The cultural, societal, and professional dilemmas create complications and challenges and influence the therapists’ feelings and thoughts.
- The challenges in working with clients from a different culture motivated the occupational therapists to build cultural bridges by searching for cultural knowledge and choosing culturally adapted techniques.
- The multicultural therapeutic journey depicted by the occupational therapists indicated a need for revision and/or supplementation of the prevailing occupational therapy practice models, bringing consciousness of multiculturalism and opening up to new skills and attitudes and broadened views among occupational therapists.
- Alternate theoretical frameworks are needed that are more consistent with non-Western worldviews. Moreover, the occupational therapists expressed a strong demand for supervision from experienced colleagues and a greater cultural awareness among those who develop curricula for educational occupational therapy programme.
- The narrative method was a relevant tool for understanding the subtle meanings and values depicted in the painted pictures and metaphoric proverbs.
- The proverb metaphors and the paintings were important therapeutic tools in the case study for acquiring insight about the participant’s thoughts and feelings regarding her life. They made it possible to unveil the client’s deeper conceptions, grounded in her lifeworld experiences.
- Involving and including the family in the client’s therapy was an imperative task for the therapist and important for the therapy outcome. The family was used as an important ally in supporting the client to move towards bicultural personal growth and an independent life.
- Meaningful occupations in different contexts could enable the client to develop a sense of self and insight into her feelings.
The study of occupational well-being showed that individualism and collectivism co-existed in each person. Being in the area of tension that exists between two cultures influenced the views of empowerment and support, which in turn was essential for the participants’ occupational well-being.

The state of ambivalence revealed how, on the one hand, the typical individualistic elements of empowerment, such as autonomy, control, and decision-making, were desired by the participants. On the other hand, typical collectivistic elements of empowerment, such as emotional, practical and social support, caring and respect, had a significant role in their occupational well-being.

Implications for further research

Research needs to be carried out to determine the type of support system for Middle Eastern clients with psychiatric disabilities that will best facilitate integration between cultural value orientations and thereby facilitate social connectedness into mainstream society.

It may be relevant to conduct further research that focuses especially on the degree and nature of acculturation and how it affects minorities’ views of empowerment and well-being.

Mental illness in relation to culture cannot be fully understood through one lens. There is need for integrated perspectives, based on both qualitative and quantitative methodology, and research teams need to include ethnographic, observational, clinical, contextual and epidemiological methods when focusing on prevalence, causes, and mediating factors of mental illness.

There is an imperative need for research in clinical and community-based mental health services to assist decision-makers in recognizing the problem of acculturation, mental illness, and the mediating factors of well-being.

Potentially protective factors such as empowerment, social support and community-based rehabilitation should be investi-
gated. Research should also be linked to the development and improvement of cultural competence and training.

- Research needs investigating disparities in the usage and access of mental health services among immigrants.
- Occupational deprivation and alienation and social exclusion in relation to mental illness among immigrants need be investigated. Productive areas of research will thus be the investigation of the meaning of occupation, occupational identity, and well-being from an ethnic perspective.
- Gender may be an important issue in relation to occupation-based rehabilitation and recovery from mental illness. This was touched upon in Study IV but needs to be further investigated.

**Implications and recommendations for clinical practice**

- The occupational therapists and mental health care providers should view and respect the clients’ belief of *mahram* affinity as a possible obstacle or advantage for establishing a trustful therapeutic relationship. Thus, conducting a conversation and reflective dialogue about *mahram* affinity with the client may facilitate the building of a working consensus.
- Occupational therapists and other mental health care providers need to understand the meaning of culture and integrating culture into their daily clinical practice of decision-making, assessment, and intervention. Using cultural responsive assessments alongside their ordinary assessment is recommended. An assessment of a client’s life story is thus crucial in order to identify culturally appropriate interventions in light of the client’s life story.
- The client’s life story could include: migration story (pre-migration, under-migration, and after-migration), acculturation story (integration, assimilation, marginalization and separation), family story, illness story, occupational story, treatment story, support system story, identity story and help seeking story.
- The cultural value orientation taxonomy (Kluckhohn & Strodtbeck, 1961) could be a useful framework in assessing
cultural values related to the human-to-nature relationship, temporal focus of human life, the human-to-human relationship and human activity.,

- Clients with a foreign background, such as the Middle East, may express their needs and expectations in ways that differ from those of the mainstream culture. This requires careful attention and occupational therapists and other mental health care providers need to take a range of perhaps seemingly inconsistent matters and assumptions, both overt and implicit, into consideration.

- The occupation-based rehabilitation services, and the authorities that run those services, need to adopt a multicultural approach to reduce occupational alienation, social exclusion and marginalization among the clients.

- People from different cultures may define empowerment and support differently. Understanding the meaning of support within cultural contexts thus requires knowledge of the culture in which support is given and received.

- Mental health care providers are recommended to rethink regarding existing conceptual models, theories and frameworks and question whether they are suitable when working with immigrant clients. The questioning may motivate them to initiate a journey to gain cultural competence.

Svårigheter att anpassa sig till två kulturer är något som blir alltmer erkänt som en viktig klinisk fråga inom den psykiatriska


Av ovan beskrivna bakgrund framgår är samspelet mellan kultur, yrkesroll och psykisk ohälsa inom arbetsterapi och annan psykiatrisk vård komplext och kan vara svårt att balansera. Den ökade multikulturalismen utgör både en utmaning och en möjlighet för personal inom psykiatrisk vård till att utöka sin kunskapsbas. Enligt vad vi har kunnat konstatera är kunskapen begränsad när det gäller på vilket sätt det kulturella samspelet påverkar den psykiatriska vård och hur de själva uppfattar situationen som vårdmottagare. Det behövs således en bättre förståelse av de kulturella aspekter som är relaterade till aktivitet, psykisk ohälsa, välbefinnande. Föreliggande avhandling behandlar det kulturella perspektivet rörande invandrare från Mellanöstern med psykisk ohälsa och deras möte med psykiatrisk vård.
Det allmänna syftet för denna avhandling är att utforska betydelserna av kulturell mångfald så som den framgår i den erfarenhet och de upplevelser av arbetsterapi som klienter från Mellanöstern med psykisk sjukdom och/eller funktionsnedsättning och deras arbetsterapeuter har haft, samt att utforska mångfaldens utmaningar i förhållande till aktivitetsrelaterat välbefinnande hos klienter från Mellanöstern som deltar i arbetsinriktad rehabilitering. Syftet med delstudie I var att utforska de element som formar erfarenheter av och uppfattningar om arbetsterapi hos klienter från Mellanöstern som får psykiatrisk vård. Syftet med delstudie II var att utforska erfarenheter och uppfattningar hos de arbetsterapeuter som arbetar inom psykiatrin med klienter som är invandrare från Mellanöstern. Syftet med delstudie III var att illustrera hur en arbetsterapiinsats kan påverka utvecklandet av en bikulturell identitet hos en ung vuxen invandrad kvinna med psykiatriska problem. Syftet med delstudie IV var att utforska betydelsen och erfarenheter avseende aktivitetsrelaterat välbefinnande bland invandrare med psykisk ohälsa som har sitt ursprung i Mellanöstern och som deltar i arbetsinriktad rehabilitering.

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REFERENCES


Merlo, J. (2008). Distribution of mental illness and health care resources in Malmo, region Skåne In M. Östman (Ed.), *Migration and mental ill health* (pp. 45-95). Malmö: Holmberg.


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CULTURE, OCCUPATION AND OCCUPATIONAL THERAPY IN A MENTAL HEALTH CARE CONTEXT

The challenge of meeting the needs of Middle Eastern immigrants