Student: Annette Owusu Bringaker

Public health nurses' experiences with mental health promotion to adolescent immigrants in schools

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FORFATTER:

Annette Owusu Bringaker

VEILEDER:

Berit Misund Dahl

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All of you made it possible.

KAPPA

Sammendrag:

Bakgrunn

Helsesykepleiere spiller en viktig rolle i å fremme den psykiske helsen til ungdom, inkludert innvandrerungdom. Noen få studier har sett på innvandrerungdom og psykisk helse, eller helsesykepleiere og psykisk helse. Det ser ut til å være en mangel på studier som undersøker helsesykepleieres erfaring med å fremme den psykiske helsen til innvandrerungdom.

Mål

Studien utforsket helsesykepleieres erfaringer med psykisk helsefremmende arbeid overfor innvandrerungdom på ungdomsskole og videregående skole.

Metode

En utforskende kvalitativ studie med en hermeneutisk tilnærming ble utført med tre fokusgrupper. Tretten helsesykepleiere deltok. Hver fokusgruppe hadde minst fire deltakere, fra tre kommuner på Vestlandet. Dataene ble samlet inn ved hjelp av fokusgruppeintervjuer og analysert ved hjelp av refleksiv tematisk analyse. Det var viktig for forskeren, en helsesykepleier som er førstegenerasjons innvandrer, å reflektere over sin forforståelse.

Funn

Tre temaer ble avdekket: i) Strebe etter å forstå innvandrerungdoms psykiske helse ii) ulike strategier for å fremme psykisk helse iii) opplevde barrierer for å fremme psykisk helse.

Konklusjon

Mens eksisterende studier antyder at innvandrerungdom sjelden søker hjelp, avdekker funnene at det snarere ser ut til å være en forsinkelse i innvandrerungdoms hjelpesøken på grunn av språktilegnelse og tillit, noe som tar tid å utvikle. Studien bidrar til kunnskap om strategier som kan styrke helsesykepleiere sin rolle som støttespillere for innvandrerungdom på skolen. Videre avdekker studien utfordringer helsesykepleiere kan møte i sitt arbeid, samt behovet for å informere relevante politiske nivåer om helsesykepleiers psykisk helsefremmende arbeid overfor innvandrerungdom.

Nøkkelord

Innvandrerungdom, psykisk helse, psykisk helsefremming, norsk, helsesykepleier, skole

ABSTRACT

Background

Public health nurses play an important role in promoting mental health to adolescents including the immigrants in school. However, a few studies have looked at either adolescent immigrants and mental health, or public health nurses and mental health. There seems to be a lack of studies combining both, to examine the public health nurse experience in promoting mental health to adolescent immigrants.

Aim

The study explored public health nurses' experiences with mental health promotion for adolescent immigrants in lower secondary and high school.

Method

An exploratory qualitative study taking a hermeneutic approach was conducted using three focus groups of thirteen public health nurses, with at least four per group from three municipalities in Western Norway. The data was collected using focus group interviews and analyzed using a reflexive thematic analysis. It was important for the researcher, a public health nurse, and a first-generation immigrant, to reflect on her pre-understanding.

Findings

Three themes emerged: i) Striving to understand adolescent immigrants` mental health, ii) Different strategies for promoting mental health, and iii) Perceived barriers to promoting mental health.

Conclusion

While existing studies suggest that adolescent immigrants rarely seek help, the findings reveal that there seems to be rather a delay in seeking help due to language acquisition and trust, which takes time to develop. The study contributes to knowledge about strategies that can strengthen PHNs' role as supporters for immigrant adolescents at school, uncover challenges PHNs may encounter, and inform relevant policies on public health nurses` mental health promotion work towards adolescent immigrants.

Keywords

Adolescent immigrants, mental health, mental health promotion, Norway, public health nurse, school.

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1. INTRODUCTION

1.1 My personal and professional motivation for the topic

I am strongly interested in the public health nurses' (PHNs) experience with mental health promotion to adolescent immigrants in school for personal and professional reasons. First, I came to Norway as a youth immigrant and faced many challenges. I had a family who was not integrated into Norwegian society but had a network of good people who motivated and supported me in achieving my goals. Then, I released how it is to have someone who genuinely cares for you and wants to help you.

Second, my experience as a public health school nurse has led me to think about this subgroup that experiences changes as adolescents and as immigrants. I have always wondered why they seem to face difficulties expressing their feelings and emotions and putting words in their feelings. I have seen some doing well in school and are happy, but others struggle. I understand that to help the adolescent immigrant, I must be interested in what they say, the history behind the person in front of me, and curiosity about their culture and social surroundings. I want to help adolescent immigrants feel that PHNs care and are there to help, support and be available for them through the challenges they might face.

Before writing this master's thesis, I participated in a project on mental health among adolescent immigrants. I became curious to know if PHNs experienced that the guidelines met the adolescent immigrants' mental health expectations or if there was a need to adjust them. This motivated me to seek the experiences of PHNs working with this group. Nevertheless, PHNs' experiences working with these adolescent immigrants can help us understand their needs and inform mental health promotion interventions for this group.

1.2 Background

Good mental health allows us to realise our abilities, cope with normal stresses of life, work productively, and make a meaningful contribution to society, but the opposite results in mental health problems. Globally, mental health problems pose a severe challenge to attaining the United Nations' sustainable development goal (SDG) number 3: Good health and Well-being. The Norwegian Directorate of Health (2018) report identifies that mental health problems can affect people of any age and demographic group but varies depending on their

life situation. Further, the report highlights that their effect on vulnerable groups, such as immigrants and young people, worsens other challenges, and as a result, they are left behind.

The challenges mentioned above take an intersectionality effect exacerbated by the conditions and circumstance vulnerable group facer. Thus, immigrants, especially adolescents, are likely to face more mental health challenges than the majority population (Abebe et al., 2014; Attanapola, 2013; Debesay et al., 2019; Ekeberg & Abebe, 2021; Kale et al., 2018; Linney et al., 2020). Adolescents are young people above the age of ten and below the age of twenty (Helsenorge, 2021), who are discovering themselves in a changing world as their bodies change and are under pressure the need for self-determination to self-actualise and belong, and they need to balance expectations that come with their age, such as going to school (Helsenorge, 2021; Helsedirektoratet, 2023; Suren et al., 2019; The Norwegian Directorate of Health, 2018). Similarly, the definition of immigrants includes both "1st generation" (born abroad by non-Norwegian parents) and "2nd generation" (born in Norway, both parents 1st generation immigrants to Norway." (Abebe et al., 2017 p681).

In general, adolescents, due to their psychological, social and physical transition, are likely to experience mood swings and one form of anxiety or another due to perceived uncertainty and the sense that events are uncontrollable, unpredictable, and therefore, unfavourable, and its severe conditions can result in depression (Helsenorge, 2021; Helsedirektoratet, 2023; Suren et al., 2019; The Norwegian Directorate of Health, 2018). While emotional challenges may affect adolescents' mental health regardless of background, immigrants face unique challenges (Dangmann, 2022; Harker, 2001; Qin et al., 2008). This may be to do with their perception of the host society. For first generation adolescent immigrants may be new to a school setting, which may also affect their schooling and socialisation, and are in constant comparison with themselves and others. Also, the challenges of language acquisition can result in stress which further increases their vulnerability to other psychological challenges. Thus, the intersection of their unique circumstances as immigrants (The Norwegian Directorate of Health, 2018) and adolescent transitions can positively or negatively affect their mental health. These health outcomes are likely to double up in adolescent immigrants compared to most adolescents.

In Norway, the recent Ungdata.no report (Bakken, 2022) shows that the number of youths, including adolescents reporting mental health problems has increased. Although the report does not explicitly state the state of adolescent immigrants, it points out that traditionally risk-prone and vulnerable groups "are not still more vulnerable than others, but to an even great

extent than before." There are also concerns that they rarely seek help with their health (Suren et al., 2019). Second, adolescent immigrants are likely to experience life differently from most adolescents (Dangmann, 2022).

In response to these challenges, mental health promotion has been given priority in Norway, and the government, consistent with the aspirations of the WHO (2019), has acknowledged the right of everyone, including immigrants and adolescents, to good mental health (Helsedirektoratet, 2023). Accordingly, the Norwegian Directorate of Health (2018) guidelines state that mental health should be holistic, focusing on factors that promote it and those that hinder it. If adolescents are given support tailored to their specific needs and unique circumstances, such as adolescent immigrants, they will likely develop and maintain positive health effects.

There is a recognition that PHNs play an essential role in mental health (e.g., Dahl & Clancy, 2015; Helsedirektoratet, 2023; Jørgensen et al., 2020) promotion to everyone, including young people in schools. Thus, the nursing guidelines emphasise this role since school nurses provide various health and welfare services to schools (Helsedirektoratet, 2023). Therefore, the PHNs' interactions and experiences in their everyday practices, exposure, and experience give them knowledge and the opportunity to promote mental health among adolescents, including immigrants. Accordingly, this study argues that PHNs can influence whether school-going adolescent immigrants experience mental health positively or negatively. Specifically, the study focuses on school-going adolescent immigrants between 13 and 19 years.

1.3 Previous research in the field

The literature on immigrants and mental health is vast (e.g., Abebe et al., 2014; Abebe & Phil, 2010; Attanapola, 2013; Dangmann, 2022; Debesay et al., 2019; Kale et al., 2018; Ekeberg & Abebe, 2021). Some studies suggest that immigrants, compared to the native population, are more susceptible and vulnerable to mental health problems, a phenomenon known as the negative or exhaustive migrant effect (Abebe et al., 2014; Debesay et al., 2019; Attanapola, 2013). On the contrary, other studies limited to Hispanics and South Asians in the US and UK, respectively, suggest that immigrants might experience healthy effects (Abebe & Phil, 2010). Arguably, these studies suggest that the experiences and mental health outcomes vary depending on the reasons for migration and post-migration experiences (Kale et al., 2018).

However, several literature reviews (e.g., Abebe et al., 2014; Abebe & Phil, 2010; Attanapola, 2013) show that a few studies have focused on adolescent immigrants and produced inconclusive findings. Also, most of these studies, except for a few (e.g., Bjørnsen et al., 2019), have focused more on the negative aspects and neglected the positive aspects of mental health problems. While this holds, these studies remain isolated from another strand of studies on the role of nurses in the provision of health services, including mental health (e.g., Dina & Pajalic, 2014; Jørgensen et al., 2020). At the same time, studies on the role of nurses in mental health have not explicitly looked at adolescent immigrants. The result is a lack of understanding of PHNs' experience with mental health promotion to adolescent immigrants, affecting interventions aimed at this population sub-group.

1.4 Purpose of the study

The study explored public health nurses' experiences with mental health promotion for adolescent immigrants in lower secondary and high school. The study can contribute to knowledge about strategies that can strengthen PHNs' role as supporters for immigrant adolescents at school, uncover challenges PHNs may encounter in their work, and inform relevant policies on mental health promotion work towards adolescent immigrants.

1.5 Problem statement

The research question was: What are the public health nurses' experiences with mental health promotion for adolescent immigrants in schools?

2. THEORETICAL FRAMEWORK

To increase the understanding of PHNs` experiences of adolescent immigrants and mental health promotion, theory on salutogenesis and mental health and migration theories are included.

2.1 Salutogenesis and mental health

Antonovsky (1979; 20

22) developed the salutogenesis theory for health in general and later expanded it to the context of mental health. Its central argument is that one's sense of coherence helps to mobilize resources within their biological, social, cultural, and historical dispositions to cope

with stressors and manage tension, determining the extent of one's health and well-being. In particular, the WHO (2019) has defined mental health as a state of wellbeing that allows individuals to realise their potential or abilities, cope with the everyday stresses of life and can contribute to society. The definition departs from the traditional pathogenesis approach, where health is perceived as the absence of diseases, to a salutogenesis approach, which includes positive aspects such as capabilities and happiness (Antonovsky, 2022; Bauer et al., 2020; e.g., Keyes, 2014; Lindström & Eriksson, 2010; Mjøsund et al., 2018; Mjøsund & Eriksson, 2021; World Health Organization, 2019). Thus, following salutogenesis, mental health has been defined as a state of well-being that includes positive feelings or emotional wellbeing, positive functioning, psychological wellbeing, and social well-being, where one flourishes, and the opposite or negative aspects where one languishes. In the context of adolescent immigrants, their life situation can contribute to stressors and provide mental health resources. It depends on their ability to mobilize resources from the social system, including family and school PHNs. Therefore, understanding mental health from a salutogenesis perspective helps us look at adolescent immigrants to understand their mental health and how to promote it given their unique development needs as adolescents and their experiences as immigrants.

2.2 Mental health and Migration theories

The literature on mental health and immigrants provides theoretical perspectives that take at least three strands: the negative migration or exhausted migrant theory, theories on acculturation, and the intersectionality theory (Attanapola, 2013). The negative migration or immigrant disadvantage theory argues that migration's unfavourable circumstances and conditions contribute to mental health (Berry, 2006). Arguably, the same is even more pronounced for refugees due to their triple burden of trauma, uprooting, and resettlement (Kim et al., 2021; Dangmann, 2022) and insufficient help. More so, non-Western immigrants are likely to be more vulnerable than their Western counterparts, and it is worse for dark-skinned immigrants(Attanapola, 2013).

In contrast, the acculturation theories (Abu-Kaf et al., 2021; Szapocznik et al., 1978) suggest that immigrants can enjoy similar health benefits and well-being if they adapt to their host societies, or the opposite if they do not but depends on cultural aspects such as ethnicity, religion, and language. At the same time, the acculturation theories in the context of migrants suggest that cultural factors such as ethnicity, religion and language influence patterns of

seeking help and coping in individuals' perception of health and mental health and that PHNs need to be culturally competent and trained to engender trust between them and migrants (Dangmann, 2022; Lecoq, 2020; Næss, 2019).

In complement to the acculturation theory, the intersectionality theory (e.g., Cole, 2009; Crenshaw, 1989) can be used to explain challenges faced by immigrants as an intersection of several factors that include social, political, economic, and even gender dimensions. These factors also include navigating the complexity of the health systems that make immigrants more vulnerable than native populations to mental health challenges, may affect their integration and access to services, consequently affecting their mental health, and, if addressed, can result in positive health outcomes. Overall, the intersectionality theory suggests that interventions aimed at promoting mental health to immigrants need to pay balanced attention to these factors. Between them, the first three theories of the negative migration or exhausted migrant theory, acculturation and intersectionality explain that immigrants are likely to experience mental health challenges (Attanapola, 2013). But they differ in that the last two theories offer a middle of the road perspective, which suggests that the opposite can happen depending on the post migration experience.

While these first three theories explain that immigrants are likely to experience mental health challenges, another theory, the healthy migrant effect (e.g., Abebe et al., 2017; Abebe & Phil, 2010; Chen et al., 1996), also termed the immigrant paradox, suggests the opposite, where they experience positive aspects of mental health. The explanation is that immigrants depending on their reasons for migration may experience a better life that maintains or improves their mental health. For instance, if they came from worse to better conditions and those moving from one country to another because of jobs or education may experience better mental health. Arguably, these negative or positive effects and their consequences on mental health are likely to double up in adolescent youth (Aronowitz, 1984).

3. METHODOLOGY AND METHODS

The study had a qualitative design. In essence, a qualitative study seeks to explain a phenomenon based on the experiences of individuals or groups and how they make meaning of their environment (Creswell & Creswell, 2017). For instance, in nursing research, Malterud et al. (2017, p309) argue that qualitative studies ". explain how patients experience care, how practitioners think or how the complex relations between the healthcare system and the outside world are working." However, qualitative studies are not a single approach but take

several directions depending on the specific philosophical stand, research design, and data collection and analysis.

The study took a hermeneutics instead of a phenomenological position. While phenomenology focuses on human experiences, hermeneutics interprets them using the participant's knowledge and competence (Malterud, 2016). Their common thread is, 'If you want to know how people understand their world and lives, why not talk to them?' (Kvale & Brinkmann, 2009, pxvii). Thus, nurses are not just observers but actively participate in attending to the health and well-being needs, including the mental health of particular 'others' from different cultural backgrounds, including immigrants (Bondas, 2013). In this way, the nurses' experience can help to understand better the adolescent immigrants' mental health and well-being.

The overall understanding is that reality or our understanding of the world is subjective (Creswell & Creswell, 2017) making the study qualitative. Thus, it can be understood from people's or groups' experiences, feelings, and perceptions or meanings about the world around them. Therefore, it can be described using words and stories as opposed to numbers of statistics. Malterud et al. (2017, p309) argue that qualitative studies "explain how patients experience care, how practitioners think or how the complex relations between the healthcare system and the outside world are working."

3.1 Design

According to Creswell and Creswell (2017), a research design is a plan of action for getting data about the subject of interest. The study took an exploratory research design using focus groups. An exploratory research design is ideal where a phenomenon has not been researched (Malterud et al., 2017). A Focus group refers to an approach where a group or all participants are interviewed together, taking the form of a workshop or session (Malterud et al., 2017; Thagaard, 2009).

3.2 Participants

Thirteen PHNs from three municipalities in Western Norway were chosen, of which twelve were qualified PHNs. One participant was registered as a nurse but working as a PHN for immigrant adolescents. Initially a PHN had bee targetted as part of the focus group but

withdrew from the interviews. Therefore, the researcher had to ask this colleague who works as a PHN to join as a backup plan. Three focus group interviews were performed. Each focus group had at least four participants. An overview of the participant is given in Table 1.

Table 1: Sample characteristics (*n* =13)

Focus group	**Participant**	**Sex**	**Workplace**	**Years of experience**
1	H1	Female	Lower secondary school	4
	H2	Female	High school	5
	H3	Female	Lower secondary	16
	H4	Female	High school	5
2	H5	Female	Lower secondary/High school	4
	H6	Female	Lower secondary	3
	H7	Female	Lower secondary	27
	H8	Female	Lower secondary	20
	H9	Female	Lower secondary	7
3	H10	Female	Lower secondary	5
	H11	Female	Lower secondary	2 1/2
	H12	Female	Lower secondary	9
	H13	Female	High school	5

The participants were not randomly chosen but purposively selected, involving snowballing (e.g., Creswell & Creswell, 2017) and an inclusion criterion (e.g., Dahl & Clancy, 2015). Purposive sampling involves a researcher making some judgement or choice to find participants who are likely to be knowledgeable on the subject of interest. An inclusion criterion considers people with qualifications and knowledge about the phenomenon under investigation. The criterion for inclusion was PHNs working in school health services with a minimum of one year of experience. The other nurse was included because of her experience with working with adolescent immigrants in schools.

Similarly, snowballing involves identifying participants by going through a gate keeper or someone who can help identify them based on their position or knowledge about the phenomenon (Creswell & Creswell, 2017). The recruitment of the participants involved the researcher sending an email to the head of school nursing services in the commune or

municipality, who helped identify and contact individuals who suited the inclusion criterion. The researcher sent information about the study to the leader of the school health services. The leader initially contacted the PHNs, and the researcher then contacted those who agreed to participate directly. The snowballing approach was beneficial because most participants automatically agreed to the interviews, except for one potential participant who withdrew. A possible explanation is that going through a gatekeeper such as a leader helps build trust, especially given the sensitivity of investigating a phenomenon such as adolescent immigrants.

3.3 Data collection

In this study, semi-structured interviews were conducted with three focus groups. In general, the advantage of semi-structured interviews is that they allow the researcher to explore the issue under study, explain and clarify interview questions, they can be modified and very flexible and give access to multiple viewpoints or perspectives (Creswell & Creswell, 2017). However, semi-structured interviews have disadvantages that includes being time consuming, need skepticism, subject to interviewer bias, inconvenient for participants, required training, and can result in difficulty coding or processing the large amounts of data.

More specifically, the advantage of focus groups is their non-governing interview style, which emphasizes that participants speak freely and present many different views on the topic (Johannessen et al., 2020; Kvale & Brinkmann, 2009; Malterud et al., 2017). The approach is ideal as it allows the public health nurses to exchange experiences and help explore the strategies, they use to meet adolescent immigrants' mental health and well-being needs. While there are advantages to using focus groups, their dynamics can prevent sharing sensitive matters (Malterud et al., 2017). Malterud et al. (2017) recommend that focus groups be homogeneous to create a shared experience base for the conversation. The researcher moderated the focus group but took a passive role. The focus groups were asked similar open-ended questions which had appropriate follow-up questions to seek clarity and stimulate the discussion. Thus, to invoke the experiences of PHNs', the following questions were asked: based on your work with you in secondary school, how would you describe the adolescent immigrants' mental health? What do you think affects adolescent immigrants' mental health, and how? What do you do as a public health nurse to promote mental health among young immigrants? Typical follow up questions seeking clarity from the participants included, why did you say so? What happened after and what did you do? At the end of the interviews the researcher asked the participants whether they had anything else to share to make sure that nothing was left and also that they were satisfied that they had given all the information that

was necessary. The interviews were tape-recorded and transcribed verbatim. The interviews lasted from 60 to 90 minutes.

3.4 Data analysis

Data analysis employed the thematic analysis following the six-step approach by Clarke and Braun (2017). There are three types of thematic analysis, inductive, deductive and abductive (Creswell & Creswell, 2017). An inductive approach generates data driven themes, working back and forth between themes and data to establish a comprehensive set of themes. In contrast, in a deductive approach, the researcher will compare the generated themes to the literature. An abductive approach combines the two. This study used an inductive thematic analysis and as mentioned following the steps by Clarke and Braun (2017).

The first phase involved the researcher immersing herself in the data and reading it several times. During this stage the researcher did not only re-read the transcripts but also went back to the audio recording to be sure that they died no miss anything. Also, the researcher kept their research questions in mind and kept on asking what does the data tell. In the second phase, the data was coded to extract relevant information to the research question. The coding involved identifying recurring words and phrases, and also meanings but the words or what the participants said. The codes were written as comments on the margin of the transcripts for each of the focus group. In the end all the codes were collated for each focus group separately.

In the third phase, a search for patterns identified similarities and differences among the coded data. During this stage, all the codes from the separate interviews were put together against each other using Microsoft word. The researcher reviewed the process during this phase to check what the patterns suggest. In the fourth phase, the emerging patterns were assigned into themes. Initially, the researcher identified four main and twelve sub-themes with at least four subthemes per theme.

The fifth phase involved naming, defining, and aligning the themes. During this stage, the researcher relooked at the emerging themes and sub-themes. Three sub-themes (four) were combined to form one sub-theme and another two to form one. Two themes also created one. Finally, three main themes and eight subthemes emerged. One theme had two subthemes, and the rest had three subthemes each.

In the last and sixth stage, the themes are discussed in a narrative or story in line with the existing literature. The process involved checking which finds confirm the literature and

which ones contradict it, as well as what could be revelatory or insightful information. Two researchers have contributed to the analyzing phase and critically assessed the analyzing steps.

3.5 Pre-understanding

In qualitative studies, one never thrives on total facts or accuracy nor eliminates what is considered 'bias' (Malterud et al., 2016). Instead, the 'bias' could be based on pre-understanding, which forms part of intersubjectivity (Alvesson & Sandberg, 2022). Instead of being taken as a challenge in that it influences the interpretation of the text (Thagaard, 2009), it must be considered a central part of the research process and value to the study (Malterud et al., 2017; Maxwell et al., 2020). Thus, by making the pre-understanding explicit, the reader understands the conditions on which the knowledge is based, which is helpful for the findings' credibility and transferability (Leiros, 2019). In this study, the researcher is an immigrant and a PHN. Therefore, she reflects on her pre-understanding and uses it as an advantage to understand and interpret the PHNs experiences.

3.6 Study ethics

Research often has issues and ethical dilemmas (Polit & Beck, 2020). Most importantly, the researcher has to be honest and transparent about the research and not harm participants in any way. The National Social Science Data Services (NSD) approved the study, and the reference number is 343128. It followed the guidelines laid by the National Committee for Research Ethics in the Social Sciences and the Humanities (NESH) (2022). Potential participants received a letter seeking their informed consent. The letter explained what the reason was about and the interview process. During the interview, permission was sought to record the participants. Also, assurance was given that the information would be treated confidentially. Also, the participants were informed that their names will not be identified or attributed to the comments but will be anonymised and the researcher would use codes such as H1 to H13. Further, the participants were informed that participation was voluntary, that they had the right to withdraw before or at any stage of the research, and that doing so has no consequences. One participant withdrew from the study and I had to replace her with a colleague who is a nurse with experience working with adolescent immigrants in schools but is not a qualified PHN. In the previous section, I recorded and was transparent with the profile of who were the participants. Data management followed a strict protocol, was stored in a

secure place and was only accessible to the researcher and supervisor. I used an audio recorder and the digital recording application called "Nettskjema". Nettskjema is an application managed by the University of Stavanger which stores the data in an encrypted form on a secure computer server of the University of Stavanger. I deleted the recording on the manual audio recording immediately after uploading the file in ``Nettskjema". The data will automatically be deleted after a certain period (University in Stavanger, 2023).

4. FINDINGS

The analysis revealed three related main themes: i) Striving to understand adolescent immigrants` mental health, ii) Different strategies for promoting mental health, and iii) Barriers to public health nurses` promotion of mental health. These themes are presented in bolded italics and supported by subthemes.

**'Striving to understand adolescent immigrants` mental health aspects'** has three subthemes. First, the *PHNs observed that adolescent immigrants` mental health includes both negative and positive aspects*. On one hand, they reported that some adolescent immigrants 'struggle' and, experienced "sadness or grief, loss or trauma". On the other hand, they also reported that 'they flourish… and Blossom' and described them as "happy and grateful". Based on this, the PHNs emphasized the need to balance the negative and positive aspects.

Secondly, the *PHNs observed that the understanding of mental health differs between adolescent immigrants and most adolescents*. They observed that it does not exist in some cultures, nor do people talk about their feelings. One of the PHNs (H1) commented, "Some have almost zero experience in talking about mental health." In other cultures, the PHNs observed, as commented by H9, "Mental health, they associate it with 'madhouses' - serious things" and carried stigma and shame. As a result, adolescent immigrants shy away from seeking help.

Thirdly, *PHNs identified factors affecting the mental health of adolescent immigrants* to at least three aspects*:* cultural dilemmas, pre- and post-migration experiences, and family support. The PHNs observed that the adolescent immigrants lived in one culture at home and came out to live in a Norwegian culture and school and used metaphors such as 'stuck between two cultures' and 'falling between 2 chairs". Also, the PHNs identified pre- and post-migration experiences as another factor and described them using the metaphors 'luggage' and 'baggage', and that they differed between individuals. Lastly, the PHNs identified that

with family support “both boys and girls enjoy being with the family”, and the opposite put “pressure on them to do well at school.”

‘Different strategies for promoting mental health, has two subthemes. Firstly, *PHNs perceived adolescent immigrants as a resource* for promoting their mental health. Thus, despite their circumstances, PHNs observed that adolescent immigrants have a coping ability to turn these into resources for mental health. As one PHN (H12) said: “If they can see themselves as a resource in Norwegian society, I have a language that the Norwegians do not have. There is an understanding that the Norwegians do not have.” The PHNs commented that they needed to reinforce these positive aspects. They also suggested bringing adolescent immigrants together can help build their self-acceptance.

Further, the PHNs observed that adolescent immigrants’ health-seeking behavior involved testing them with physical symptoms to see if it was safe to open up. One of the PHNs (H1) said it is “a quality that they develop, keeping their cards close to their chest until they become safe”. The PHNs caution that instead of concluding that adolescent immigrants rarely seek help, they observed that it was delayed due to language acquisition and trust challenges. They suggested a need for follow-up after the eighth grade and using alternative words since the term mental health may not exist in some cultures.

Secondly, *PHNs perceived themselves as a tool* for promoting adolescent immigrants’ mental health. First, at the individual level, the PHNs stated that they should be empathetic and culturally sensitive as illustrated by H13, ‘wear cultural glasses. The PHNs also emphasized the need to confront prejudices and not ‘forget that adolescent immigrants are normal people ‘who can also fall in love’. Innovation was also seen as one of the activities PHNs can do to help adolescent immigrants. The need to build a relationship with parents was highlighted as a strategy to develop trust. PHN (H6) emphasized, “When parents get to know us, they can tell their children to go to the health nurse.” Also, the PHNs identified collaboration with other professionals, such as cultural competence specialists and teachers as necessary. Lastly, the PHNs identified that the eighth-grade introductory module and cross-cultural programs like Flexid were critical at the school level. However, they felt this was not enough, but suggested that they must be activists on behalf of adolescent immigrants to advocate for policies tailored to the needs of adolescent immigrants.

‘Barriers to PHNs promotion of mental health’ emerged from three subthemes. Firstly, the PHNs reported that *the background and experiences of adolescent immigrants* include

adolescent immigrants' cultural beliefs may be at odds with the host society. One PHN (H1) commented, "I think they have a different culture at home and when they go to school." PHN (H6) also commented mental health attracted stigma and "Shame is another topic." The PHNs observed that adolescent immigrants might lack awareness and information about mental health. At the same time, they may lack trust. One of the PHNs (H1) reported, **"**The trust the parents have in the health service is transferred to the children. It can stop the help we can give or promote it."

Secondly, language acquisition as a significant challenge by the PHNs in mental health promotion. They reported that adolescent immigrants struggle to communicate their mental health or feelings because they sometimes lack the host society's language. The PHNs stated an interpreter does not adequately explain one's mental health, as communication involves body language. One PHN (H1) commented, "So, I think the language barrier makes some people not want to seek help."

Thirdly, PHNs perspectives and practices as barriers to promoting mental health to adolescent immigrants. The PHNs reported that their knowledge of mental health could be a barrier when applied to adolescent immigrants. They reflected on their assumptions and beliefs and identified the tendency to look for trauma or negative aspects of mental health in some groups of immigrants. One PHN (H6) cautioned, "Own prejudices; we look for trauma in those from (…) war-torn countries." Furthermore, the PHNs observed the official time allocated as a barrier and one of them remarked, "I wish I had time."

5. DISCUSSION

In Norway, PHNs are essential in promoting mental health in schools where they interact with adolescents, including immigrants (Bjørnsen et al., 2019; Dahl & Clancy, 2015). Based on the interaction and experience of the PHNs, the findings reveal their understanding is consistent with salutogenesis (e.g., Antonovsky, 2022) adolescent immigrants' mental health has positive and negative aspects, like most adolescents. These findings caution against focusing only on the negative and overlooking the positive aspects of adolescent immigrants' mental health.

However, the findings reveal that understanding of mental health, especially the meaning of mental health by adolescent immigrants differs from most adolescents. Thus, consistent with studies by Linney et al. (2020) and Kim et al. (2021), PHNs observe that the term 'mental health' does not exist in some cultures, and in others, it attracts negative labels and has a stigma. They also observed consistent with the literature (e.g., Harker, 2001; Bjørnsen et al., 2019; Debesay et al., 2019; Ekeberg & Abebe, 2021) that adolescent immigrants have unique experiences and circumstances, including pre and post-migration experiences, cultural dilemma and family support different from the majority adolescents. This affects their mental health, making them either vulnerable or resilient. Also, the studies show, consistent with Qin et al. (2008), that cultural and family aspects can result in social control, leading to adverse mental health outcomes.

The findings show that the barriers to promoting mental health to adolescent immigrants included their background and circumstances, language acquisition challenges, and the practices and perceptions of PHNs, such as prejudices and the official time they allocated to adolescent immigrants. Thus, consistent with studies such as Kim et al. (2021) and Linney et al. (Linney et al., 2020), the findings show that cultural beliefs may result in a lack of knowledge about mental health and stigma that discourages adolescent immigrants from seeking help. Similarly, adolescent immigrants' and their parents' experience may lack trust in the health system. However, in contradiction to Debesay et al. (2019), who suggest that adolescent immigrants rarely seek help, the findings show that it is delayed due to language acquisition and trust, which takes time to develop.

Considering this understanding of adolescent immigrants' mental health and barriers to their mental health, the findings show that there are strategies. The findings are consistent with salutogenesis ((e.g., Antonovsky, 2022)) that adolescent immigrants can be a resource for promoting their mental health. There is a need to reinforce positive aspects such as their coping ability, cultural pride, and value of diversity. Equally, the findings suggest that the PHNs themselves are tools for promoting mental health to adolescent immigrants but, consistent with Lecoq (2020), must be empathetic and culturally sensitive, and competent.

Furthermore, the findings, as supported by Anttila et al. (2020), and Dina and Pajalic (2014,) suggest that PHNs should build relationships with parents to earn trust which is transferred to the children and collaborate with other support professionals. According to Næss (2019), trust

determines whether adolescent immigrants seek help from health service providers. The findings equally highlight the importance of school and cross-cultural programs. However, the PHNs felt that more needed to be done which is consistent with Debesay et al. (2019), and that the emphasis on equal services was inadequate, and they could play an active role in lobbying for better policies.

6. METHODOLOGICAL CONSIDERATIONS

Schwandt et al. (2007) identify transferability, credibility, dependability, and confirmability as essential aspects of research quality. According to Dahl and Clancy (2015), a researcher must ensure the trustworthiness of qualitative studies and an authentic and critical approach with honorable intentions. The findings are not transferable or generalizable except in similar contexts. One of the reasons is that the participants were gathered from one country in Norway, which may interfere with the transferability. The credibility of the findings was ensured through a thorough literature review to prove that what we find relates to the phenomenon of interest. The process of thematic analysis following the approach by Clarke and Braun (2017) and to be two researchers helped to ensure dependability and avoid the researcher's bias.

Similarly, the confirmability of the findings was ensured through two researchers contributing to the analysis and using my pre-understanding as an immigrant and PHN. The participant came from different municipalities of different sizes and helped strengthen the credibility and confirmability of the findings. The same applies to the nurse working as a PHN, who may reflect on the actual experiences. This variety of participants and focus groups contributed to a richer data variation. My pre-understanding based on my experience when I came to Norway as an adolescent immigrant and working as a PHN also helped improve the study's trustworthiness.

I will also reflect on the research process. However, the recruitment process of participants was not easy. I had to gather four to five participants from different places for a fixed date and time. It was deliberate to look for municipalities of various sizes, as this could affect the availability of resources. There was a back-and-forth of e-mails, and one municipality withdrew. It also took time for the school health service leader to send the letters to potential participants. One of the PHNs participants withdrew, and I included a PHN who is a colleague. I included the colleague because she has experience with adolescent immigrants. This may or may not affect the interview, but I could not find another replacement at short

notice. I also experienced a participant who was not vocal, and a little quieter than the others, which can happen in focus group interviews. I was privileged to see their body language and facial expressions, which were also helpful in the discussion. I used a colored sheet so that some interview responses could be handwritten to encourage participation from those who did not speak much.

7. IMPLICATIONS FOR PRACTICE AND FUTURE RESEARCH

The findings suggest that PHNs have an important role to play in promoting mental health to adolescent immigrants. But to earn trust, PHNs must be empathetic and culturally sensitive. Moreso, PHNs need to build relationships with parents, whose trust is transferred to adolescent immigrants, and encourage them to seek help. Also, collaboration with other professionals is essential as they complement the work of PHNs. Furthermore, in the specific context of countries like Norway, emphasis on equality of service is not enough as adolescent immigrants face a unique challenge. Since adolescent immigrants delay seeking help, the PHNs need follow-up programs in higher grades and more time beyond their officially allocated time Furthermore, they could play a role in lobbying and sensitizing policymakers on the need to be responsive to the unique needs of adolescent immigrants. However, the study is limited in that it uses a small sample and is based on one research setting of three municipalities in Norway and is not generalizable outside this context. Further research could consider a larger sample. Also, while the findings suggest that adolescent immigrants' seeking help are delayed, it cannot ascertain whether this improves with time. Therefore, future research could consider longitudinal studies to look at whether and how it changes.

8. CONCLUSION

The thesis explored the PHNs' experience with mental health promotion to adolescent immigrants in schools. Accordingly, the findings on the PHNs' understanding of adolescent immigrants' mental health, their perceived barriers, and strategies for mental promotion are consistent with the literature. However, contrary to the existing literature which argues that adolescent immigrants rarely seek help, the findings show that help-seeking is instead delayed as adolescent immigrants' health-seeking behavior improves over time due to language acquisition and the development of trust. These findings have implications for practice, and policy and provide opportunities for future research. For practice, these findings help inform PHNs on what they can do to help adolescent immigrants. They also challenge PHN to seek

to understand issues facing adolescent immigrants and to develop and implement interventions responsive to their needs. The finding also challenges me as an immigrant who came to Norway as an adolescent immigrant to understand and reflect on issues that I took for granted but affected me so that I can help others in a similar situation as an insider-outsider, being both a PHN and an immigrant. Equally, the findings provide intelligent and valuable insights for policymakers to consider interventions that go beyond the principle of equality of service and are responsive to the needs of adolescent immigrants.

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ARTICLE

Public health nurses' experiences with mental health promotion to adolescent immigrants in schools

Det helsevitenskapelige fakultet

Master i helsesykepleie

Article

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Abstract

Background

In countries like Norway, public health nurses interact with adolescent immigrants in schools and play an essential role in promoting their mental health. Exploring public health nurses' experiences with adolescent immigrants in school health services can help develop knowledge and insights into how public health nurses promote mental health for this group of adolescents.

Aim

To explore the PHNs' experiences with mental health promotion to adolescent immigrants in schools.

Methods

A qualitative study was conducted using a hermeneutic approach, with three focus groups to collect data. Each focus group had 4-5 public health nurses (*n*:13) purposively chosen through snowballing and criterion sampling. A thematic analysis was applied to the data to identify and explain the emerging patterns.

Findings

Three themes were developed: i) Striving to understand adolescent immigrants` mental health, ii) Different strategies for promoting mental health, and iii) Barriers to public health nurses` promotion of mental health.

Conclusion

Adolescent immigrants sought help when having mental health issues, however, there seems to be a delay due to language acquisition and trust, which takes time to develop. Therefore, if public health nurses want to be effective at mental health promotion to adolescent immigrants, they ought to be empathetic and culturally sensitive and

collaborate with parents and other professionals, implement follow-up programs, and strive to influence policy.

Keywords

Adolescent immigrants, mental health promotion, public health nurses, Norway, school

Introduction

Mental health is an important topic and has received a lot of attention in several countries, including Norway, in line with the United Nations' sustainable development goal number 3: Good Health and Well-being (1–4). Arguably, less attention and action on this matter may result in the opposite and leads to, or worsen, the existing mental health problems. These problems can affect people of any age and any demographic group in any society and manifest variably from person to person, depending on people`s life situation (5).

In comparison to the majority population in a host society, mental health problems are likely to be worse for immigrants due to their experiences and circumstances (6–9), particularly adolescent immigrants. Therefore, promoting mental health among adolescent immigrants is vital to ensure that no one is left behind. While this is ideal, a worrying trend, in general, is the adolescents' health-seeking behavior where they rarely seek help or are discouraged due to peer pressure (10). As such, public health nurses, especially in the context of Norway play an important role in mental health promotion to this subpopulation group as they interact with them in schools (4,11).

There are a few studies on adolescent immigrants focusing on their mental health (7, 12). These studies have focused mostly on negative aspects and neglected the positive side of mental health. Furthermore, the studies remain isolated from another strand of studies on the role of public health nurses (PHNs) in promoting mental health (13). Hence, there is a lack of studies on the PHNs` experience with mental health promotion for adolescent immigrants in schools.

Background

PHNs play an important role in health provision, and in Norway, PHNs serve target groups such as adolescents (4,11), including immigrants, with mental health promotion, in school health services. However, this requires appropriate professional and cultural competence as well as collaboration with other stakeholders (7,11,14,15). PHNs` experience with supporting adolescent immigrants, can provide valuable information to inform interventions aimed at mental health promotion to this group. Mental health and migration theories (16), and salutogenesis and mental health theories (17) can provide useful lenses to understand PHNs` work with adolescent immigrants and guide the study.

Mental health and Migration Theories

Mental health is a state of well-being that includes positive feelings or emotional well-being, and positive functioning which includes psychological and social well-being, where one flourishes, and the opposite or negative aspects where one languishes (17–19). While this applies to anyone, immigrants can experience positive or negative mental health effects (7,16, 20) and both are likely to manifest more in adolescent immigrants. First, as immigrants, it depends on their pre- and post-migration experience, their coping ability, and whether they successfully integrate or not. Second, being adolescents means they are undergoing a process of self-discovery and changes in their physical, psychological, emotional, and social well-being which may lead to positive or negative health aspects. Thus, whether they flourish or languish (19) in their mental health, adolescent immigrants are likely to double up or face a double bind (21) on their mental health effects.

Salutogenesis and mental health

The salutogenic theory by Antonovsky (17) allows us to understand that adolescent immigrants' mental health whether positive or negative aspects depends on an individual's life situation, a sense of coherence (SOC), and the ability to mobilize generalized resistance resources (GRR) from inside themselves and from their social system, to cope with stressors, manage tension and build resilience. However, adolescent immigrants may lack information or view mental health with a 'crazy' label (22, 23). Therefore, mental health promotion by PHNs to adolescent immigrants can help them with the much-needed resources and strategies to build a sense of coherence (10,24,25).

Aim

The aim was to explore public health nurses' experiences with mental health promotion to adolescent immigrants in lower secondary school and high school. The study pursued to answer the following research question: What are the public health nurses' experiences with mental health promotion for adolescent immigrants in schools?

Method

Design

This study had a qualitative design with a hermeneutic approach. It was exploratory, which is suitable when very little is known about a phenomenon (26). In this case, we knew little about the PHNs' experiences with mental health promotion to adolescent immigrants in schools. Hermeneutics is appropriate because the study used human experiences, where the participant's knowledge and competencies were interpreted (27).

Sample

A purposive sampling, involving snowballing and an inclusion criterion, was used to select 13 PHNs in three municipalities in Western Norway (Table 1). First, we emailed the leaders of school nursing services in the municipalities to help identify individuals fitting the inclusion criterion, which was to have a minimum of one year of experience as a PHN in school health services working with adolescent immigrants. The PHNs in school health services than established direct contact with the researcher.

Table 1: Sample characteristics (*n* =13)

Focus group	**Participant**	**Sex**	**Workplace**	**Years of experience**
1	H1	Female	Lower secondary school	4
	H2	Female	High school	5
	H3	Female	Lower secondary	16
	H4	Female	High school	5
2	H5	Female	Lower secondary/High school	4
	H6	Female	Lower secondary	3
	H7	Female	Lower secondary	27
	H8	Female	Lower secondary	20
	H9	Female	Lower secondary	7
3	H10	Female	Lower secondary	5
	H11	Female	Lower secondary	2 1/2
	H12	Female	Lower secondary	9
	H13	Female	High school	5

Data collection

Data were collected through 3 semi-structured focus group interviews during the winter of 2022. The advantage of focus groups is that they allow participants to speak freely and present many different views on the topic (26). However, group interviews can prevent participants from opening up. Malterud et al. (26) recommend that focus groups be homogeneous to create a shared experience. The researcher moderated the focus groups. The interview guide was not rigidly applied. The PHNs` experiences were evoked by asking questions: based on your work with you in secondary school, how would you describe the adolescent immigrants' mental health? What do you think affects adolescent immigrants' mental health, and how? What do you do as a public health nurse to promote mental health among young immigrants? The interviews were paced with discussions and writing responses to some questions, which were shared with the other participants. This encouraged everyone to participate and stimulated the discussions. The focus group interviews lasted from 60 to 90 minutes. The interviews were recorded and transcribed verbatim.

Data analysis

A thematic analysis was applied to the data following the six-phase approach by Clarke and Braun (28). We first familiarized and immersed ourselves by listening to the interviews and re-reading transcribed data. We coded the data for each group interview. We then searched for patterns, including similarities and differences among the coded data, and in the next phase assigned the emerging patterns into themes. These two stages involved writing comments on each transcript and collating them into a table, and then bringing together the tables for all the transcripts to identify the differences and

similarities between them. Initially, we identified four main themes and 12 subthemes. We relooked again at the themes and subthemes and finally developed three main themes and eight subthemes. Finally, the themes were discussed in line with the literature.

Findings

The analysis revealed three related themes: i) Striving to understand adolescent immigrants` mental health aspects, ii) Different strategies for promoting mental health, and iii) Barriers to PHNs` promotion of mental health. Table 2 presents these themes and their sub-themes.

Table 2: Themes and Sub-themes

Sub-themes	Themes
PHNs experienced that adolescent immigrants' mental health includes both negative and positive aspects	Striving to understand adolescent immigrants` mental health aspects
PHNs observed that the understanding of mental health differs between adolescent immigrants and most adolescents.	
PHNs identified factors affecting the mental health of adolescent immigrants	
PHNs perceived adolescent immigrants as a resource	Different strategies for promoting mental health
PHNs perceived themselves as a tool	
The background and experiences of adolescent immigrants	Barriers to PHNs` promotion of mental health
Language acquisition as a significant challenge	

Theme 1: Striving to understand adolescent immigrants` mental health aspects

The theme 'Striving to understand adolescent immigrants` mental health aspects was formed from 3 subthemes, as illustrated in Table 2. *The PHNs experienced that adolescent immigrants' mental health includes both negative and positive aspects*. One of the PHNs (H4) highlighted, "We must not only talk about the dilemmas (meaning negative aspects), but we also have to talk about in a way that there is a lot of positive." Accordingly, the PHNs used the following words to describe negative aspects: 'sadness or grief', 'loss' (H1), 'trauma', 'loneliness', and 'anxiety'. In contrast, the positive aspects were described as 'flourish and blossom' (H3), and 'happy and grateful' (H11).

The PHNs observed that understanding of mental health differs between adolescent immigrants and most adolescents. Thus, the PHNs commented that the term 'mental health' does not exist in some cultures, and they do not have the experience of talking about it. They observed that in others, as illustrated by H9, "They associate it with 'madhouses', carries stigma and shame. According to the PHNs, the result is that adolescent immigrants shy away from expressing their mental health or seeking help.

PHNs identified factors affecting the mental health of adolescent immigrants, including at least three aspects: culture, pre- and post-migration experiences, and family support. They described adolescent immigrants as characterized by a cultural dilemma with metaphors such as ', falling between 2 chairs" (H3) 'they live in one culture at home and come out and live in Norwegian culture' (H11), and 'swiping' between cultures. The PHNs also identified that the mental health of adolescent immigrants depends on their

pre- and post-migration experiences which vary from person to person. They used metaphors such as ‘luggage’, ' baggage’, and ‘backpack’ to describe these experiences. One of the PHNs (H11) said,

> There are quite a few differences between the students, how long they have been in Norway, where they come from, what background and experience they have with them, and whether they have experienced trauma or are migrant workers.

Lastly, the PHNs identified that family support also matters. Two of the PHNs (H1 and H12) respectively gave contrasting remarks where “Both boys and girls, they enjoy being with the family” or “pressure them to do well at school.” Also, the PHNs observed that families might use culture as social control, which leads to a comparison between adolescent immigrants (treatment of boys versus girls) and most adolescent youths on what they can and cannot do, affecting their mental health.

Theme 2: Different strategies for promoting mental health

The following two subthemes formed the theme ‘Different strategies for promoting mental health’. Firstly, *PHNs perceived adolescent immigrants as a resource* for promoting their mental health. The PHNs observed that despite their challenges, adolescent immigrants have a coping ability and can turn their circumstances and experiences into resources for promoting mental health. As one PHN (H12) said:

> I think if they can see themselves as a resource in Norwegian society, I have a language that the Norwegians do not have, and there is an understanding that the Norwegians do not have.

The PHNs commented that they needed to reinforce these positive aspects to encourage adolescent immigrants to open up. Also, since the term mental health may not exist in some cultures, they suggested using alternative ways such as talking about feelings and

thoughts. They also suggested bringing adolescent immigrants together so that they can learn from each other and build their self-worth.

Second, *PHNs perceived themselves as a tool* for promoting adolescent immigrants' mental health, emphasizing that this works at the individual, relationship, school, and policy levels. At the individual level, the PHNs stated that they should be genuinely interested and want to know adolescent immigrants. As H13 illustrated, they should wear 'cultural glasses and use 'magnifying glasses' to 'dig deep' to understand adolescent immigrants' health-seeking behavior. They observed that adolescent immigrants tested them with physical symptoms such as looking for bandages to see if it was safe to open. One of the PHNs (H1) said it is "a quality that they develop, keeping their cards close to their chest until they become safe". PHNs agreed that instead of concluding that adolescent immigrants rarely seek help, they had observed that it was delayed due to language acquisition and trust which improved over time. They suggested that they should give adolescent immigrants more time, be accessible and follow up in higher grades.

The PHNs also emphasized the need to confront their prejudices and understand that adolescent immigrants are individuals. One of them (H8) drew laughter from other PHNs after cautioning that, at times, they forget that adolescent immigrants are normal or ordinary young people 'who can also fall in love'. She narrated that a boy from a war-torn country surprised them by talking about heartbreak instead of trauma. Innovation and creativity were also seen as crucial as one PHNs (H1) mentioned that she created a free-minute activity called 'breathing room' to help adolescent immigrants to integrate.

At the level of relationships, PHNs highlighted that it was essential to build a relationship with parents. They argued that it is a valuable strategy to build trust as parents influence their children's health-seeking behaviour. One of the PHNs (H6) highlighted the following:

> When parents get to know us, they can tell their children: "Go to the health nurse" Then we have created trust in the adults. Having a relationship with our parents is so important to us.

Similarly, the PHNs identified collaboration with other professionals, such as cultural competence specialists, teachers, environmental teams, and priests, as vital, who unlike them, are perceived to be non-intrusive and do not carry the ‘mad house label’.

Lastly, at the school and policy level, PHNs identified that the eighth-grade introductory health module and cross-cultural programs like Flexid were critical to meet the mental health needs of adolescent immigrants. However, they felt and cautioned that more needed to be done at the policy level as the emphasis on equal services was inadequate. One PHN (H6) said they “should be activists on behalf of the youth, especially immigrant youth”, and play a pivotal role in lobbying and advocating for policies tailored to the needs of adolescent immigrants.

Theme 3: Barriers to PHNs` promotion of mental health

The theme Barriers to PHNs` promotion of mental health was developed from three sub-themes as illustrated in Table 2. *The Background and experiences of adolescent immigrants* include cultural beliefs at odds with the host society. The PHNs reported that while adolescent immigrants are encouraged to open up about their mental health at

school, and home, it may be a taboo, carrying a stigma and perceived to bring shame to the family. One PHN (H1) commented, “I think they have a different culture at home, and when they go to school, they have a different culture at school, so they are in two worlds.”

The PHNs also expressed that another aspect of adolescent immigrants’ background is the lack of awareness and information about mental health. One of the PHNs (H6) commented, “They are not aware that they have a mental health problem and are not open to getting help.” The PHNs added that the experience of adolescent immigrants *or* their parents could affect their trust. One of the PHNs (H1) reported, “The trust the parents have in the health service is transferred to the children. It can stop the help we give or promote it (referring to mental health).”

The PHNs identified *language acquisition as a significant challenge* to promoting mental health among adolescent immigrants. They reported that although they used interpreters, this was not good enough. As one PHN (H1) said, “When they learn to speak for themselves and use an interpreter is one thing, but learning to put feelings into words themselves is another.”

PHNs perspectives and practices as barriers, to promoting mental health to adolescent immigrants. The PHNs reported that their knowledge of mental health can be a barrier when applied to adolescent immigrants. One PHN experienced that the term mental health attracted a ‘madhouse label’. The PHNs highlighted that their assumptions, beliefs, and practices including officially allocated time are potential barriers. One of them (H6) cautioned, “Own prejudices; we look for trauma in those from (…) war-torn countries.” Another PHNs (H3) remarked, “I wish I had time.

Discussion

The PHNs play an important role in promoting health including mental health, and in countries like Finland and Norway, they carry out their work in public places such as schools, where they also interact with adolescent immigrants (11–13). The findings reveal that based on this experience the PHNs understanding of adolescent immigrants' mental health is that just like most adolescents it has positive and negative aspects. The findings are consistent with the concept of salutogenic, which describes mental health as having both positive and negative aspects where depending on their state one can either flourish or languish(4,17–19). The findings caution against a tendency to focus only on the negative aspects and overlook the positive side of adolescent immigrants' mental health.

However, the findings also reveal that the PHNs have observed that the meaning and understanding of mental health differs between adolescent immigrants and adolescents from the majority population. Specifically, the findings show that PHNs observe that in some cultures, the term mental health does not exist and in others, it attracts negative labels of the 'madhouse', and has a stigma. These findings are consistent with studies by Linney et al on Somali immigrants in the UK (22) and Kim et al on Burmese refugees in the US (23). They both observed that there was no word for mental health, no one talk about it and it attracted stigma.

While the findings show that the understanding of PHNs is that adolescent immigrants like the majority of adolescents experience positive and negative mental health aspects, they also observe consistent with the literature (12,20,22) that this group has unique experiences and circumstances can make them either more vulnerable or resilient to

mental health challenges. For example, Ekeberg and Abebe (6) report that post-traumatic disorders are likely to be higher among refugees. The PHNs observed that adolescent immigrants face a cultural dilemma where they may struggle to adjust to two dissimilar cultures resulting in adverse outcomes but can also flourish if they manage and are resilient. The latter has been confirmed by Harker (8) who finds that adolescent immigrants are associated with positive psychological well-being. Similarly, the nature of their pre and post-migration experience and family support can affect adolescent immigrants ' mental health. Also, cultural and family aspects can result in social control which may also affect their mental health. This is supported by Qin et al (9) in their study on Chinese American adolescents where they argue and find that family context can exert pressure on adolescent immigrants leading to adverse mental health effects.

The findings also show that PHNs identified language acquisition to be a major barrier to adolescent immigrants' mental health promotion. Accordingly, it affects adolescent immigrants' health-seeking behavior and seems to delay them from seeking help. These findings seem to contradict existing studies such as Debesay et al (20), which suggest that adolescent immigrants rarely seek help. In addition, the findings consistent with studies such as Kim et al (23) and Linney et al (22) show that cultural beliefs may result in a lack of knowledge about mental health and stigma that discourages adolescent immigrants from seeking help. Similarly, the adolescent immigrants' and their parents' experience with the health system or other public services may result in a lack of trust. Further, the findings show that other barriers included the PHN's perspectives and practices such as prejudices and the official time they allocated to adolescent immigrants.

To address factors that affect adolescent immigrants' mental health and barriers to its promotion, the findings show that the PHNs perceive adolescent immigrants as a resource for promoting their mental health. Thus, their coping ability, cultural pride, and value of diversity were seen as positive aspects that must be reinforced. Equally, the findings suggest that PHNs themselves are tools for promoting mental health to adolescent immigrants if they are empathetic and culturally sensitive. Lecoq (14) emphasizes the importance of transcultural competence among health professionals when providing health services to people with an immigrant background.

The findings also suggest that PHNs should build relationships with parents to earn their trust, which is transferred to the children and encourages them to seek help. Trust is acknowledged by Næss (15) who argues that it can determine whether adolescent immigrants seek help or not from health service providers. Similarly, the findings suggest that collaboration with other professionals is vital. Anttila (13), and Dina and Pajalic (25) emphasize the need for cooperation with stakeholders, parents, and other specialist support services. Lastly, the findings highlight the importance of school and cross-cultural programs. However, the findings show that PHNs felt that more needed to be done at the policy level and cautioned consistently with Debesay et al (20) that the emphasis on equal services was inadequate. They felt that they could play an important role to lobby and advocate for policies tailored to the needs of adolescent immigrants.

Conclusion

The study explored the PHNs' experiences with mental health promotion to adolescent immigrants in schools. Accordingly, the findings on the PHNs' understanding of adolescent immigrants' mental health, their perceived barriers, and strategies for mental promotion are consistent with the literature. However, they reveal new insights. While

there is a perception that adolescent immigrants rarely seek help, the findings reveal the contrary that it is delayed as adolescent immigrants' health-seeking behavior improves over time due to language acquisition and the development of trust. Therefore, the PHNs need more time and follow-up programs in higher grades to effectively promote mental health among adolescent immigrants. But to earn trust, PHNs must be empathetic and culturally sensitive. At the same time, PHNs need to build relationships with parents and collaborate with other professionals. Furthermore, they could play a role to lobby for policies that are sensitive to the unique needs of adolescent immigrants.

Methodological considerations

According to Dahl and Clancy (11), there is a need to ensure the trustworthiness of qualitative studies but also with an authentic and critical approach with honorable intentions. However, in qualitative studies, one never thrives on total facts or accuracy nor eliminates what is considered 'bias' (29). Bias could be based on pre-understanding (30). Instead of being a challenge (31), one of our research team member's pre-understanding and experience as a PHN working in schools was valuable to the study (26) and helped ensure credibility and transferability (32). Furthermore, the teamwork ensured that the analysis of one researcher was checked with the other to help with interpretation to strengthen confirmability. The findings cannot be generalized but can be transferable to similar contexts.

Ethics

The research was approved by authorities and the reference number is 343128. We followed the guidelines of the National Committee for Research Ethics in the Social Sciences and the Humanities (NESH) (33). Potential participants received an invitation

letter and consent form. We emphasize that their participation was voluntary, and they could withdraw at any time. All participants signed a consent form and consented to be recorded during the interviews. We also followed strict data management, anonymized the participant's identity, and treated sensitive information with confidentiality.

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Appendix 1: Interview guide in Norwegian

Intervjuguide for fokusgruppe

Helsesykepleieres erfaring med psykisk helsefremmende arbeid til innvandrerungdom

Fokusgruppe spørsmål:
Hvor lenge har du jobbet som helsesykepleier?
Hvor lenger har du jobbet som helsesykepleier i skolehelsetjenesten?
Arbeider du på ungdomsskole eller på videregående skole?

1. Hvordan vil du beskrive arbeidet ditt med ungdommer på ungdomsskole/videregående skole?
   - Hvilke tjenester gir du til dem?
   - Hva er din forståelse med tanke på deres behov?
   - Er det spesielle observasjon du har gjort?

2. Basert på arbeidet ditt med innvandrerungdommer på skolen, hvordan vil du beskrive det?

3. Hvordan vil du beskrive deres psykiske helse?
   - Hva er dine observasjoner i forhold til psykisk helse?
   - Kan du hjelpe oss med noen eksempler uten å nevne noen navn?

4. Hva tenker du påvirker innvandrerungdoms psykiske helse og hvordan?
   - Kan du fortelle om et møte med en ungdom?

5. Hvordan samhandler de med deg som helsesykepleier på skolen?
   - Hvis de søker hjelp, hvilken type hjelp søker de?
   - Hvis de ikke søker hjelp, hva tror du er grunnen?

6. Hvordan tror du innvandrerungdom kan hjelpe seg selv med tanke på god psykisk helse?

7. Hva gjør du for å fremme psykisk helse bland innvandrerungdom?

- Hvem tenker du kan også støtte disse innvandrerungdommene?

8. Om du skulle tenke på et verktøy eller hjelp du trenger som helsesykepleier på skolen for å fremme innvandrerungdoms psykiske helse, hva skulle det være?

9. Er det noe annet du vil tilføye?

English translation

Interview guide for focus group

Health nurses' experience with mental health promotion work for immigrant youth

How long have you worked as a public health nurse?

How long have you worked as a health nurse in the school health service?

Do you work at a secondary school or an upper secondary school?

1. How would you describe your work with young people at secondary school/secondary school?

• What services do you provide to them?

• What is your understanding of their needs?

• Is there a particular observation you have made?

2. Based on your work with immigrant youth at school, how would you describe it?

3. How would you describe their mental health?

• What are your observations in relation to mental health?

• Can you help us with some examples without naming any names?

4. What do you think affects immigrant youth's mental health and how?

• Can you tell me about a meeting with a young person?

5. How do they interact with you as a health nurse at the school?

• If they seek help, what type of help do they seek?

• If they do not seek help, what do you think is the reason?

6. How do you think immigrant youth can help themselves with regard to good mental health?

7. What are you doing to promote mental health among immigrant youth?

• Who do you think can also support these immigrant youth?

8. If you were to think of a tool or help you need as a school health nurse to promote immigrant youth's mental health, what would it be?

9. Is there anything else you would like to add?

Appendix 2: Letter to the head of department

Universitetet
i Stavanger

Brev til avdelingsleder ved helsestasjons- og skolehelsetjenesten i kommunen

Dette er en forespørsel om hjelp til å identifisere helsesykepleiere i skolehelsetjenesten som vil delta i et forskningsprosjekt om psykisk helsefremmende arbeid til innvandrerungdom. Med innvandrerungdom menes her en person som ikke er født av norske foreldre, og ikke er født i Norge, men har selv innvandret til Norge.

Jeg heter Annette, er ansatt som helsesykepleier ved skolehelsetjenesten i Stavanger kommune, og har erfaring med å jobbe med innvandrerungdom. Jeg er nå student ved masterutdanningen i helsesykepleie, UIS.

Jeg ønsker å intervjue 4 til 5 helsesykepleiere som jobber i skolehelsetjenesten. De må ha minst to års erfaring med å jobbe med innvandrerungdom, og ønske å delta i masterprosjektet mitt.

Formålet er å utforske helsesykepleiers erfaring med psykisk helsefremmende arbeid til innvandrer-ungdom på skolen.

Jeg har følgende forskningsspørsmål: Hvordan erfarer helsesykepleier et psykisk helsefremmende arbeidet til innvandrerungdom. Data skal samles inn ved hjelp av

fokusgruppeintervju i form av spørsmål fra meg som intervjuer og en diskusjon mellom deltakerne.

Du kan hjelpe meg med å sende ut vedlagte brev, og be aktuelle helsesykepleiere om å ta direkte kontakt med meg hvis de er interessert i forskningsprosjektet. Vedlagte brev forklarer hva prosjektet er, deltakerprosessen, og frivillighet ved å delta i prosjektet.

English translation

Letter to the head of the department at the health center and school health service in the municipality

This is a request for help to identify health nurses in the school health service who will participate in a research project on mental health promotion work for immigrant youth. Immigrant youth is meant here a person who was not born to Norwegian parents, and was not born in Norway, but has himself immigrated to Norway.

My name is Annette, I am employed as a health nurse at the school health service in Stavanger municipality and have experience working with immigrant youth. I am now a student in the master's degree in health nursing, at UIS.

I would like to interview 4 to 5 health nurses who work in the school health service. They must have at least two years experience working with immigrant youth and want to participate in my master's project.

The purpose is to explore public health nurses' experiences with mental health promotion for adolescent immigrants in lower secondary and high school.

I have the following research question: What is the public health nurse's experience with mental health promotion for adolescent immigrants in schools? Data will be collected using focus group interviews in the form of questions from me as the interviewer and a discussion between the participants.

You can help me by sending out the attached letter and asking relevant health nurses to contact me directly if they are interested in the research project. The attached letter explains what the project is, the participant process, and volunteering by participating in the project.

Appendix 3: Invitation letter to the individual participant in Norwegian

Vil du delta i forskningsprosjektet

- ***Helsesykepleiers erfaring med psykisk helsefremmende arbeid til innvandrerungdom?***

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske helsesykepleiers erfaringer med psykisk helsefremmende arbeid til innvandrerungdommer 13-19 år. Med innvandrerungdom menes her en person som ikke er født av norske foreldre, og ikke er født i Norge, men har selv innvandret til Norge. I dette skrivet gir vi deg informasjon om målet for prosjektet og hva deltakelse vil innebære for deg.

- ***Formål***

Forskningsprosjektet er en masteroppgave. Formålet er å utvikle kunnskap og innsikt om hvordan helsesykepleier arbeider for å fremme psykisk helse hos innvandrerungdom. Målet er også å bidra til å avdekke utfordringer helsesykepleier har i møte med ungdommene, og å styrke helsesykepleiers rolle som en støtte for innvandrerungdommen. Eksisterende studier som har undersøkt innvandrere og psykisk helse, har fokusert mindre på innvandrerungdommer og viet mindre oppmerksomhet på

helsesykepleier, spesielt helsesykepleier i skolehelsetjenesten, sin opplevelse av psykisk helsefremmende arbeid til innvandrerungdom.

Motivasjonen for studien er at siden helsesykepleier jobber med innvandrerungdommer, vil forståelsen av deres erfaringer med dem kunne gi innsikt og kunnskap som kan bidra til at innvandrerungdoms behov blir møtt. Forskningsspørsmålet er: Hvordan erfarer helsesykepleier det psykisk helsefremmende arbeidet til innvandrerungdom.

Hvem er ansvarlig for forskningsprosjektet?
Universitet i Stavanger, helsevitenskapelige fakultet er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?
Jeg er helsesykepleier og er ansatt i skolehelsetjenesten. Jeg har erfaring fra å jobbe med innvandrerungdom. Forskningsdesignet vil bestå av tre fokusgrupper, hver med fire helsesykepleiere, og fra tre ulike kommuner. Kriteriene for deltakelse er utdannet helsesykepleier og minst to års erfaring med å jobbe med innvandrerungdom i skolehelsetjenesten.

Jeg har fått kontaktinformasjonen fra din leder.

Hva innebærer det for deg å delta?

Dataene vil bli samlet inn ved hjelp av fokusgruppeintervju. Fokusgruppeintervju er forskjellig fra individuelle ansikt til ansikt intervju, da forskeren stiller spørsmål til gruppen, og intervjuet har et gruppediskusjonsformat. Forskeren vil også ta notater ved hjelp av notatbok, og intervjuene blir tatt opp på lydbånd. Fokusgruppeintervjuet vil ta omtrent 2 timer. Det vil være to som skal gjennomføre intervjuet.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og dataene vil kun være tilgjengelig for masterstudent og veileder i samsvar med personvernregelverket.

Vi vil ikke innhente personlige data eller bruke navnet ditt. Samtykkeskjemaene vil bli oppbevart på et sikkert sted. Alle deltakere vil bli identifisert ved hjelp av kode som A1, B1 and C1 for tre respektive fokusgrupper. Kodene lagres på egen navneliste atskilt fra øvrige data. Datamaterialet vil bli lagret på en forskningsserver, innelåst og kryptert. Deltakeren vil ikke kunne bli gjenkjent i en eventuell publikasjon.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes?

Prosjektet vil etter planen avsluttes 31.12.2023. Lydopptak og alt skriftlig materiale slettes ved prosjektslutt.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke. På oppdrag fra Universitet i Stavanger har Personverntjenester vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

- Universitet i Stavanger ved Det helsevitenskapelig fakultet. Kontaktperson og veileder for prosjektet er Annette Owusu Bringaker, ao.bringaker@uis.no, og Berit Misund Dahl, berit.m.dahl@uis.no

Hvis du har spørsmål knyttet til Personverntjenester sin vurdering av prosjektet, kan du ta kontakt med: Rolf Jeger Vatten, personvernombudd@uis.no

- Personverntjenester på epost (personverntjenester@sikt.no) eller på telefon: 53 21 15 00.

Med vennlig hilsen

Prosjektansvarlig og veileder	Masterstudent
Førsteamanuensis Berit Misund Dahl	Annette Bringaker

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet ***Helsesykepleiers erfaring med psykisk helsefremmende arbeid til innvandrerungdom***, og har fått anledning til å stille spørsmål. Jeg samtykker til:

☐ å delta i fokusgruppe *intervju*

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

---

(Signert av prosjektdeltaker, dato)

English translation

Invitation letter to the individual participant

Do you want to participate in the research project

"Public health nurses' experiences with mental health promotion to adolescent immigrants in schools"

This is a request to ask for your consent to participate in a research project where the purpose is to explore public health nurses' experiences with mental health promotion for adolescent immigrants in lower secondary and high school. In this letter, we provide you with information about the goals of the project and what participation will mean for you.

Purpose

The research project is a master's thesis. The purpose is to explore public health nurses' experiences with mental health promotion for adolescent immigrants in lower secondary and high school. Existing studies have examined minorities such as immigrants, youth, and mental health. However, these studies have focused less on adolescent immigrants and paid less attention to the experience of public health nurses, especially school nurses who provide mental health and wellbeing services to this subgroup. As a result, there is a lack of sufficient knowledge on the mental health and wellbeing of adolescent

immigrants and the role of nurses. The lack of such knowledge undermines the effective and equitable delivery of mental health services which works against the UN's goal number 3 for good health and wellbeing and the Norwegian health policy to ensure no one is left behind.

The motivation of the study is that since school nurse's work with adolescent migrants, understanding these nurses' experiences with them will give us insights and information that help meet their mental health and wellbeing needs. Specifically, it will answer the following question: What is the public health nurse's experience with mental health promotion for adolescent immigrants in schools?

The study will take a qualitative and hermeneutic approach where it seeks to understand the mental health and wellbeing of adolescent migrants by interpreting the nurses' experience in working with them.

Who is responsible for the research project?

The University of Stavanger, faculty of health and science

Why are you being asked to participate?

You are a school nurse sand your experience working with adolescent immigrants is important to help us understand their mental health and wellbeing, and needs. The research design will consist of three focus groups, each with four school nurses. You have been purposively selected using snowballing and criterion sampling.

The researcher will receive contact information from the school nurses' leader at the municipal office. The researcher will send an initial communication to the school nurse leader at the municipality will help identify the nurses who met the criterion for at least two years of work experience working with adolescents at schools. The researcher will directly communicate with the identified nurses to obtain their consent to participate in the study. The researcher will moderate the focus groups, collect and analyse the data.

What does it mean for you to participate?

The data will be collected using focus group interviews. A focus group differs from an individual face to face interview in that the researcher will give questions to the group, and the interview takes a group discussion format. The researcher will moderate the group to guide them and ask more questions. The researcher will also take notes using a notebook and flip charts and record the discussion using an audio tape. The focus group

interview will take about two hours, broken into three sessions with three breaks. There will be three focus groups, A, B and C.

Participation is voluntary

Participation in the project is voluntary. If you choose to participate, you can withdraw your consent at any time without giving any reason. All your personal data will then be deleted. There will be no negative consequences for you if you do not want to participate or later choose to withdraw.

Your privacy – how we store and use your information.

We will only use the information about you for the purposes we have discussed in this letter. We treat the information confidentially and in accordance with data protection regulations.

The data can only be accessed by the master's student, Annette Bringaker and their supervisor, Berit Misund Dahl.

We will not collect any personal data or use your name. All participants will be identified using codes such as A1, B1 and C1 for three respective focus groups. The participants will not be recognised in the publication.

What happens to your personal data when the research project ends?

The project is scheduled to end June 2023. No personal data will be collected except the signature on the consent form. The consent forms will be stored in a secure place. However, there will be audio recordings which will be deleted at the end of the project. The names of the participants will not be recognised, and anonymous names such as A1, B1 and C1 will be used for participants in the three respective focus groups.

After the end of the project, the data material will be destroyed.

The data can only be accessed by the master's student or researcher, and their supervisor.

The data collected will be stored until the master's thesis is approved for submission by the end of June 2023.

What gives us the right to process personal data about you?

We process information about you based on your consent. However, it this study the only personal information we have is your signature on the consent forms, and this is important for us to confirm that you have agreed to participate in the study, and that it is voluntary.

On behalf of Universitet i Stavanger, Privacy Services will assess that the processing of personal data in this project is in accordance with the privacy regulations.

Your rights

As long as you can be identified in the data material, you have the right to:

• access to what information we process about you, and to be provided with a copy of the information

• to have information about you corrected that is incorrect or misleading

• to have personal data about you deleted

• to lodge a complaint with the Norwegian Data Protection Authority about the processing of your personal data

If you have any questions about the trial or would like to know more about or exercise your rights, please contact: The University of Stavanger, Faculty of Health and Science.

The contact person and supervisor for the project is Annette Owusu Bringaker, Master Student at Universitet i Stavanger and Berit Misund Dahl, Professor at NTNU and our Data Protection Officer: Rolf Jeger Vatten, personvernombudd@uis.no

If you have any questions related to Privacy Services' assessment of the project, please contact:

• Privacy services by email (personverntjenester@sikt.no) or by phone: 53 21 15 00.

Best regards

Students/Supervisor

(Annette Bringaker/Berit Misund Dahl)

Declaration of consent

I have received and understood information about the project [insert title], and have been given the opportunity to ask questions. I agree to:

☐ to participate in focus group interviews]

I agree to my information being processed until the project is finished.

(Signed by project participant, date)

Appendix 4: Scandinavian Journal of Caring Sciences-Author guidelines

https://onlinelibrary.wiley.com/page/journal/14716712/homepage/forauthors.html

Sections

Submission and Peer Review Process

Article Types

After Acceptance

1. Submission and Peer Review Process

Please check to ensure that your proposed submission is in alignment with the Aims and Scope of this journal. Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at https://wiley.atyponrex.com/journal/SCS. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com

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Also, check out our resources for Preparing Your Article for general guidance about writing and preparing your manuscript.

Free Format submission

Scandinavian Journal of Caring Sciences now offers Free Format submission for a simplified and streamlined submission process.

Before you submit, you will need:

Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract (which does need to be correctly styled), introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. If the figures are not of sufficiently high quality your manuscript may be delayed. We also encourage you to include your figures within the main document to make it easier for editors and reviewers to read your manuscript. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.

An ORCID ID, freely available at https://orcid.org.

The title page of the manuscript, including:

Your co-author details, including affiliation and email address.

Statements relating to our ethics and integrity policies, which may include any of the following:

data availability statement

funding statement

conflict of interest disclosure

ethics approval statement

patient consent statement

permission to reproduce material from other sources

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To submit, login at https://wiley.atyponrex.com/journal/SCS and create a new submission. Follow the submission steps as required and submit the manuscript. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com

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The title page should contain:

A brief informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

A short running title of less than 40 characters;

The full names of the authors;

The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;

Acknowledgments;

Funding source (if applicable);

Conflicts of Interest (if there are none to declare, please state so).

Main Text File

Please ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on the separate title page. Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a Latex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the Latex Main Document should be uploaded as a “LaTeX Supplementary File.”

The main text file should be in [Word, PDF or LaTeX format] and include:

A short informative title containing the major key words. The title should not contain abbreviations;

Abstract

Up to seven keywords;

Main text:

References;

Tables (each table complete with title and footnotes);

Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);

Figures and Supporting Information

Figures, supporting information and appendices should be supplied as separate files. You should review the basic figure requirements for manuscripts for peer review, as well as the more detailed post-acceptance figure requirements. View Wiley's FAQs on supporting information.

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This journal uses Vancouver reference style and abbreviations of journal titles must conform to that of Index Medicus. Titles not listed should be written in full. References with titles in languages other than English must be translated. Review your reference style guidelines prior to submission.

Covering Letter

A covering letter must be submitted as part of the online submission process, stating on behalf of all the authors that the work has not been published and is not being considered for publication elsewhere. Please include any critical information, e.g. Conflict of interest statement, either via the submisison system or via the title page or main text.

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This journal operates under a double-blind peer review model. Except where otherwise stated, manuscripts are peer reviewed by at least two anonymous reviewers and an Associate Editor. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

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2. Article Types

Article Type

Description/Purpose

Word Limit

Abstract

Other Requirements

Original Article

Reports of original research, with methods, findings and conclusions.

5000 words maximum

(includes the abstract, text, author contributions, ethical approval and funding).

Figures, tables and references are excluded from the word count.

Structured Abstract: 300 words, formatted as:

Aims and objectives;

Methodological design and justification;

Ethical issues and approval;

Research methods, instruments and/or interventions; outcome measures; results; study limitations; conclusions.

- Authors should supply the relevant reporting checklist for their research

- 10 keywords or short phrases to identify the paper's subject, purpose and focus – used for SEO purposes, and to identify suitable reviewers.

Review Article

Overview of developments in fields or the current lines of thought. Synthesizes multiple sources of information and has references. Emphasis is more factual and less on opinion.

6000 words, excluding abstract and tables.

Structured Abstract: 300 words, formatted as:

Aims and objectives;

Methodological design and justification; Ethical issues and approval; Research methods, instruments and/or interventions; outcome measures; results; study limitations; conclusions.

- 10 keywords preceding the main text. Should include 'literature review'

- PRISMA checklist

Theoretical Article

Reports of original research, with methods, findings and conclusions.

5000 words, excluding abstract and tables.

Structured Abstract: 300 words.

Aims and objectives;

Methodological design and justification; Ethical issues and approval; Research methods, instruments and/or interventions; outcome measures; results; study limitations; conclusions.

- Must have a critical approach

- Must be focused on those receiving care

Methodological Article

Procedural method in the design and implementation of an experiment or study

5000 words, excluding abstract and tables

Structured Abstract: 300 words.

Aims and objectives;

Methodological design and justification; Ethical issues and approval; Research methods, instruments and/or interventions; outcome measures; results; study limitations; conclusions.

- Need to have a caring science approach

Short Communication

(Invitation only)

Brief observations and research reports in a concise format.

1500 words, excluding abstract and tables

No abstract

- Need to have a caring science approach

Letter to the Editor*

To raise a point of interest, discuss a difference of opinion or encourage participation

1,500 words, excluding abstract and tables

No abstract

- 5 or less references (more information see below)

* Letters to the Editor are reserved for:

Discussion about published papers

The Editorial Board reserves the right to accept or reject, edit, and condense letters for publication and to publish an author or editor response to letters.

If a Letter to the Editor is accepted for publication, the authors of the article you are writing about will have an opportunity to review their Letter and respond with a Letter to the Editor of their own in response if they wish. You will not be given another opportunity to respond to the author's response to you.

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Letters by article authors in response to Letters to the Editor disputing their articles are usually accepted for publication after the same type of review described above.

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We require that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Please include the name of the trial register and your clinical trial registration number at the end of your abstract. If your trial is not registered, or was registered retrospectively, please explain the reasons for this. Example databases include:

•http://www.anzctr.org.au

•http://www.clinicaltrials.gov

•http://isrctn.org

•http://www.trialregister.nl/trialreg/index.asp

•http://www.umin.ac.jp/ctr

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