

Adolescents' perspectives  
– on mental health, being at risk, and promoting initiatives

This thesis is dedicated  
to my mother and my father,  
Birgit and Lars

*För att nå nya kontinenter  
måste man våga lämna  
stranden ur sikte*

*Örebro Studies in Caring Sciences 21*



AGNETA TINNFÄLT

**Adolescents' perspectives**  
**– on mental health, being at risk, and promoting initiatives**

© Agneta Tinnfält, 2008

*Title:* Adolescents' perspectives – on mental health,  
being at risk, and promoting initiatives.

*Publisher:* Örebro University 2008  
[www.publications.oru.se](http://www.publications.oru.se)

*Editor:* Maria Alsbjer  
[maria.alsbjer@oru.se](mailto:maria.alsbjer@oru.se)

*Printer:* Intellecta DocuSys, V Frölunda 11/2008

ISSN 1652-1153  
ISBN 978-91-7668-639-3

Fotograf, omslagsfoto: Hans-Ove Nykvist

## ABSTRACT

Tinnfält, Agneta (2008). Adolescents' perspectives – on mental health, being at risk, and promoting initiatives. *Örebro Studies in Caring Sciences* 21. 107 pp.

Mental health is a major child public health issue in Sweden. The overall aims of this thesis are to explore girls' and boys' perspectives on mental health and on mental health-promoting initiatives, and to deepen the knowledge of disclosure and support for adolescents at risk of abuse and neglect. Four studies are included in the thesis, and a qualitative descriptive design was chosen. In three of the studies (Studies I, II, and III), adolescents in Sweden were interviewed individually or in focus-groups. In the fourth study (IV) officials and politicians in nine municipalities in Sweden were interviewed, and documents were analysed in a multiple-case-study design.

In study I the adolescents were asked about the mental health-promoting dialogue with the school nurse. The results reveal that what the adolescents found important were trustiness, attentiveness, respectfulness, authenticity, accessibility, and continuity. The adolescents also had certain views on what issues to talk about in the health dialogue; physical and psychological issues should be included. In Study II, the adolescents perceived "mental health" to be an emotional experience with positive and negative aspects of internal and relational feelings. Family, friends, and school were regarded as important determinants of mental health by the adolescents. Neither girls nor boys thought that there were any major differences in mental health between girls and boys, but did think they were subject to different expectations. In Study III the results show that adolescents with families with alcohol problems are unsure whether to disclose their home situation to an adult; the adolescents seem to make a risk assessment when looking for trustworthy adults. It is a disclosure process. Friends are confidants and supportive, and sometimes facilitators for contacting adults, when support from adults is needed. Study IV show that even small grants to municipalities for children-at-risk projects lead to more activities for these children and adolescents. But children or adolescents were not involved in the planning or decision-making of the activities.

The studies in this thesis show that most important thing for adolescents' mental health is the relation between adolescents and adults, foremost parents, and between adolescents and friends. In addition, gender and age, adolescents' perspectives and participation, and society's support, including the implementation of the UN Convention on the Rights of the Child, have an impact on adolescents' mental health, both for adolescents in general and for adolescents at risk of abuse and neglect. The results are viewed in relation to the bioecological model, to illustrate how all levels in society influence mental health among adolescents, on an individual and a population plane. The findings have implications for adults: to learn more about adolescents and puberty, and about the home situation for children and adolescents at risk of abuse and neglect; to listen to suggestions from children and adolescents; to include friends in support to adolescents at risk of abuse and neglect; and to include girls and boys in all matters concerning them.

Key words: Abuse and neglect, adolescent, bioecological model, child public health, children of alcoholics, Convention on the Rights of the Child, school health service, social work.

[agneta.tinnfalt@oru.se](mailto:agneta.tinnfalt@oru.se)



## ACKNOWLEDGMENTS

I would like to express my warm and sincere gratitude to everyone who has made this research project possible, and supported and inspired me. I would like to make special mention of a number of you.

First of all I would like to thank the adolescents who so willingly participated in the individual and focus-group interviews. It has been truly rewarding and fun to meet you all, and to have the opportunity to listen to your views. Without you, this thesis would not exist.

My thanks to the officials and politicians who participated in one of the studies, and who showed so much enthusiasm in your work for children and adolescents at risk of abuse and neglect. You gave me a reason to visit the southernmost, northernmost, and westernmost parts of Sweden. My thanks also go to all the school nurses, teachers, group leaders, and others who have helped me with all the practical issues concerning the interviews.

Most of all I want to express my gratitude to my head supervisor, Professor Charli Eriksson, and my assistant supervisor, Associate Professor Elinor Brunnberg. Charli, you have an extraordinary knowledge of Public Health Sciences, and I am so grateful that you have shared some of that knowledge with me. You have guided me through the work of this thesis, and have been very supportive of my ideas.

Elinor, you have a remarkable knowledge of Social Work, which I have had the opportunity to share. You have supported and challenged me, forced me to re-think my ideas, deepened them and made them clearer. You have also introduced me to scientific groups, for which I am very grateful. Charli and Elinor, you have both been very supportive and enthusiastic, and I am lucky to have had the two of you as my supervisors.

In one of my studies, Professor Margareta Ehnfors was my supervisor. You introduced me to research, and have been supportive and enthusiastic throughout my work. You added Nursing Science to the study, and I am very grateful for the three scientific fields that are included in my work with the thesis: Public Health, Nursing, and Social Work.

Two very good friends have helped me transcribe the interviews, Gunilla and Ulla. I am so happy to have your friendship, and your generous help with the transcriptions relieved me of a great burden.

My thanks to Curt Hagqvist, Karlstad University, who so kindly provided me with background materials.

Thanks to Everett Thiele, for careful revision of the English language in most of the materials, especially when I sent you the text shortly before the deadline.

To all my colleagues, past and present, and fellow doctoral students, past and present, I wish to send my gratitude for your support and rewarding discussions. Especially to the doctoral students closest to me – Karin, Camilla, Jonny, and Susanna (and all your babies...) – I am going to miss having you as fellow students, and I wish you all the best of luck in the future.

Last, but not least, I want to express my warmest gratitude and affection to my family. To my mother, Birgit, and my father, Lars – I am so grateful for your everlasting support, in all ways and always, and your belief in me. To Karin, Petter and Hampus, and Jonas – you are the joy of my life. To Stefan and Ingrid – for being a wonderful brother and sister-in-law, and believing in me. To Kjell – my love.

Finally, the work presented in this thesis was carried out at the School of Health and Medical Sciences at Örebro University. I am grateful for the support from Örebro University, and for grants from the Swedish Society of Nursing, Stiftelsen Solstickan Swedish Match and to Charli Eriksson from the Ministry of Health and Social Affairs.

## ORIGINAL PUBLICATIONS

The present thesis is based on the following four studies, which will be referred to by their Roman numerals:

- I Johansson<sup>1</sup>, A. & Ehnfors, M. (2006). Mental health-promoting dialogue of school nurses from the perspective of adolescent pupils. *Nordic Journal of Nursing Research and Clinical Studies*, 26(4), 10-13, 19.
- II Johansson<sup>2</sup>, A., Brunnberg, E., & Eriksson, C. (2007). Adolescent girls' and boys' perceptions of mental health. *Journal of Youth Studies*, 10(2), 183-202.
- III Tinnfält, A., Eriksson, C., & Brunnberg, E. Adolescent children of alcoholics' perspective on disclosure and support. Submitted.
- IV Tinnfält, A., Brunnberg, E., & Eriksson, C. Promoting initiatives for children at risk of abuse and neglect – impact of small governmental grants on municipalities' work. Submitted.

The articles are reprinted with the kind permission of the publishers.

---

<sup>1</sup> Change of name. Former surname Johansson, now Tinnfält.

<sup>2</sup> Change of name. Former surname Johansson, now Tinnfält.



## DEFINITIONS AND ABBREVIATIONS

Adolescent	Developing from childhood to maturity, growing up. A girl or a boy from puberty to adulthood; teen-age person (Webster's New World Dictionary, 1988). In this thesis: "adolescents" are 12-19 years of age.
Alcohol problems	"Alcohol use problems exist on a continuum of severity from occasional binge drinking to alcohol abuse or dependence. Alcohol abuse is described as continued drinking despite adverse effects on: health; family, work, or personal relationships; interpersonal problems; or alcohol-related legal problems" (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2008). In this thesis "alcohol problems" include differences in severity, but are mainly problems of greater seriousness.
At risk	At risk of abuse and neglect.
Child	In the UN Convention on the Rights of the Child "...a child means every human being below the age of eighteen years ..." (United Nations, 1989, article 1).
CRC	The United Nation Convention on the Rights of the Child (1989).
Determinants	Factors that can predict health or ill health. They may be risk or protective factors (SOU 2006:77).
HBSC	Health Behaviour in School Health. Surveys from WHO, in this thesis from 2001/2002 and 2005/2006.
Health promotion	"Health promotion is the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). "Health promotion strategies are not limited to a specific health problem, nor to a specific set of behaviours. WHO as a whole applies the principles of, and strategies for, health

promotion to a variety of population groups, risk factors, diseases, and in various settings. Health promotion, and the associated efforts put into education, community development, policy, legislation and regulation, are equally valid for prevention of communicable diseases, injury and violence, and mental problems, as they are for prevention of noncommunicable diseases.” (WHO, 2008).

Mental health	“... is used positively to indicate a state of psychological being, negatively to indicate its opposite (as in ‘mental health problems’) or euphemistically to indicate facilities used by, or imposed upon, people with health problems (as in ‘mental health services’) (Pilgrim, 2005).
Perspective	A specific point of view (Webster’s New World Dictionary, 1988).
Prevention	“In the health field, prevention is the process whereby specific activity is taken to prevent or reduce the possibility of a health problem or condition developing and to minimize any damage that may have resulted from the previous conditions” (Modeste, 1996).
Protective factor	Factors that modify the effect of a risk factor. The risk decreases when a protective factor is present (Lagerberg & Sundelin, 2000).
Risk factor	Social, mental, or physical conditions that can lead to developmental, behavioural, adaptational, or health problems (Lagerberg & Sundelin, 2000).
Resilience	“...to develop normally in spite of adverse life conditions” (Lindström, 2001, p. 10).
Young people	In this thesis: “young people” are up to 19 years old.

# TABLE OF CONTENTS

<b>INTRODUCTION .....</b>	<b>15</b>
CHILDREN’S RIGHTS .....	15
<i>The UN Convention on the Rights of the Child</i> .....	16
<i>Non-discrimination</i> .....	16
<i>The best interests of the child</i> .....	16
<i>Life, survival, and development</i> .....	17
<i>Participation</i> .....	17
<i>Child protection</i> .....	18
<b>BACKGROUND.....</b>	<b>19</b>
CHILD PUBLIC HEALTH .....	19
<i>Social inequalities and inequalities in health</i> .....	21
<i>Adolescence and gender</i> .....	22
ENVIRONMENT AND DEVELOPMENT OF YOUNG PEOPLE.....	23
<i>A bioecological model</i> .....	23
<i>Adolescent development</i> .....	26
LIVES AND HEALTH OF YOUNG PEOPLE .....	26
<i>Adolescents in general</i> .....	26
<i>Adolescents at risk</i> .....	28
MENTAL HEALTH AMONG GIRLS AND BOYS .....	29
<i>The concept of mental health</i> .....	29
<i>Mental health in adolescents in general</i> .....	30
<i>Mental health in adolescents at risk</i> .....	31
PROMOTING ADOLESCENTS’ MENTAL HEALTH .....	32
<i>School and school health services</i> .....	34
<i>The social services</i> .....	35
<i>Promoting mental health in adolescents in general</i> .....	36
<i>Promoting mental health in adolescents at risk</i> .....	37
RATIONALE .....	37
<b>AIMS.....</b>	<b>39</b>
<b>MATERIALS AND METHODS.....</b>	<b>41</b>
DESIGN .....	41
PARTICIPANTS .....	42
<i>Study I</i> .....	42
<i>Study II</i> .....	42
<i>Study III</i> .....	42
<i>Study IV</i> .....	42

DATA COLLECTION .....	43
<i>Study I</i> .....	44
<i>Study II</i> .....	44
<i>Study III</i> .....	45
<i>Study IV</i> .....	45
ANALYSIS .....	46
<i>Content analysis</i> .....	46
<i>Phenomenographical approach</i> .....	47
<i>Case study</i> .....	48
ETHICS IN THE STUDIES.....	48
<i>Study I</i> .....	48
<i>Study II</i> .....	49
<i>Study III</i> .....	49
<i>Study IV</i> .....	49
INTERVIEWING YOUNG PEOPLE.....	49
<b>SHORT SUMMARY AND MAIN RESULTS STUDY I-IV .....</b>	<b>53</b>
STUDY I.....	53
STUDY II.....	55
STUDY III .....	57
STUDY IV .....	59
<b>GENERAL DISCUSSION .....</b>	<b>61</b>
ASPECTS OF IMPORTANCE FOR ADOLESCENTS' MENTAL HEALTH.....	62
<i>Relationships between adolescents and adults</i> .....	62
<i>Friends</i> .....	65
<i>Gender and age</i> .....	67
<i>Adolescents' perspective and participation</i> .....	68
<i>Society's support</i> .....	70
METHODOLOGICAL CONSIDERATIONS .....	74
<i>Limitations and strengths</i> .....	74
<i>Reflections on ethics in interviewing young people</i> .....	76
<i>Assessing the trustworthiness of the findings</i> .....	77
IMPLICATIONS .....	78
FUTURE RESEARCH DIRECTIONS .....	80
<b>CONCLUSIONS.....</b>	<b>83</b>
<b>SAMMANFATTNING PÅ SVENSKA .....</b>	<b>85</b>
<b>REFERENCES .....</b>	<b>89</b>

## INTRODUCTION

When I worked as a school nurse in Swedish public schools during the 1980s and 1990s, I found that pupils more and more often came to talk to me about problems in their lives and feelings of unhappiness. Studies from the late 20<sup>th</sup> century and onwards (see e.g., Children's Ombudsman, 2005; SOU 2006:77; WHO, 2004) report high and growing levels of mental health problems among young people, and mental health is an important issue within child public health. Young people in Sweden are in very good health from an international perspective, but increasing numbers of schoolchildren have mental and psychosomatic symptoms (Hjern, 2006). A large group of children and adolescents who can develop mental health problems are children and adolescents at risk of abuse and neglect, among them those who have a parent with alcohol problems. Some of them visited my school health office.

One of the key articles in the UN Convention on the Rights of the Child (CRC) declares that children have the right to express their views in matters that affect them, and that these views should be given due weight (United Nations, 1989, article 12). The CRC was ratified in Sweden in 1990, and since then there have been discussions about children's rights, the best interests of the child and children's participation. Children's and adolescents' voices should be heard (Eriksson, 2000) and it is important that they are participants in research and that research is conducted for them and with them (Lewis, 2004). This thesis deals with how adolescents perceive mental health, and how adults can promote mental health and prevent mental health problems, for all children and adolescents, and in particular for those at risk of abuse and neglect. A point of departure for the thesis is that childhood is important in its own right. To listen to adolescents' voices and to try to understand adolescents' views is a central goal of this thesis.

### CHILDREN'S RIGHTS

Important for health are the human rights, among them the right to participation. The Swedish Parliament has set eleven public health targets for health, the first of which is participation (Swedish National Institute of Public Health, 2007). The CRC (United Nations, 1989) is a powerful tool for promoting children's rights, protection, and

health. The perspective of the child or the adolescent is important in terms of children's rights in research, in decision-making, and in daily life.

### **THE UN CONVENTION ON THE RIGHTS OF THE CHILD**

Children and adolescents are protected under the UN Convention on the Rights of the Child (CRC) from 1989. The convention is a framework for human rights for all children.

The Convention on the Rights of the Child sets out the rights that must be realized for children to develop their full potential, free from hunger and want, neglect and abuse. It reflects a new vision of the child. Children are neither the property of their parents nor are they helpless objects of charity. They are human beings and are the subject of their own rights. The Convention offers a vision of the child as an individual *and* as a member of a family and community, with rights and responsibilities appropriate to his or her age and stage of development. By recognizing children's rights in this way, the Convention firmly sets the focus on the whole child. (UNICEF, 2008).

The guiding principles of the CRC include non-discrimination (Article 2), the best interests of the child (Article 3), the right to life, survival, and development (Article 6), and the right to participate (Article 12) (United Nations, 1989). The convention declares the right to protection, care, and participation for all children. The right to protection is emphasized in Article 19. To realize the convention's ideas, the children's and adolescents' perspectives have to be known.

### **NON-DISCRIMINATION**

Children should not be discriminated because of the child's or his or her parents' origin or other status, according to Article 2. The Committee on the Rights of the Child has emphasized the importance of giving special attention to children who are vulnerable and disadvantaged (Hodgkin & Newell, 2002).

### **THE BEST INTERESTS OF THE CHILD**

One of the guiding principles of the CRC is declared in Article 3: the importance of the best interests of the child. The ratification of the convention has led to some changes in the Swedish legislation. When the Social Act, which regulates the social authorities' responsibility for all children's welfare, was altered, the CRC was incorporated into it

(SFS 2001:453). The opening chapter emphasizes that the best interests of the child shall guide the measures taken to support and protect children.

### **LIFE, SURVIVAL, AND DEVELOPMENT**

In Article 6, survival and development are declared fundamental principles. Survival and development are very important to the whole convention, and many of the articles refer to development. Protection from violence is, for example, crucial to maximizing survival and development (Hodgkin & Newell, 2002).

### **PARTICIPATION**

Article 12 of the CRC declares the right to participation and to express views freely. There is a positive shift towards children and adolescents participating in research (Lewis, 2004) and they are more and more often participants in social and public health research. One trend in social, psychological, and medical research since the CRC was ratified in most countries in the world is to regard children as “active beings” and “knowing subjects”, and to try to gain access to their standpoints by asking young people about their views, and listening seriously to what they say (Balén, Blyth, Calabretto, Fraser, Horrocks, & Manby, 2006; Brunnberg & Larsson Sjöberg 2006). Research should be conducted with young people (Fraser, 2004). Children’s and adolescents’ views may differ from what adults think children and adolescents think (see Balén *et al.*, 2006). Four knowledge domains in public health are proposed by Eriksson (2000): (i) the distribution of health, which concerns the variation in health development among different population groups; (ii) the causal web, which concerns the determinants; (iii) consequences, the impact of health on individuals and on society; and (iv) intervention methods for changing health determinants. He underlines the benefit of giving a voice to those whose voices are weak.

In addition to the contribution children and adolescents can make to understanding childhood, two more developments have taken place: the legislative support for the value of young people’s voices, and politicians having become interested in listening to what young people have to say (France, 2004). In the Swedish legislation, the Social Act, Article 12 of the CRC is clear (SFS 2001:453). The child must be kept informed, and his or her views taken into account as much as possible. The will of the young person must be taken into consideration in accordance with age and maturity (SFS 2001:453).

**CHILD PROTECTION**

In Article 19 of the CRC the protection and support of the child is emphasized. This includes identifying children who are maltreated. This goes beyond what is commonly called abuse, and calls for protection from all kinds of physical or mental violence, whether in the care of parents or others (Hodgkin & Newell, 2002).

# BACKGROUND

## CHILD PUBLIC HEALTH

Public health and children's health fuse into child public health. Public health is described as "the science and art of promoting health, preventing disease and prolonging life through the organised efforts of society" (Blair, Stewart-Brown, Waterston, & Crowther, 2003, p 109). For children, child public health can be described in almost the same way. It covers health and illness – factors that affect children's and adolescents' health, and how to promote their health and well-being (Blair, Stewart-Brown, Waterston, & Crowther, 2003). Köhler (1998, p. 254) described child public health as a field "... the tasks of which are to place the health of children, and their families in their full social, economic and political context". WHO (1986) stated that, "Health promotion is the process of enabling people to increase control over, and to improve, their health", which shifted the focus from individual disease prevention to the health actions and social determinants that keep people healthy (Barry, Patel, Jané-Llopis, Raeburn, & Mittelmark, 2007). WHO (2008) applies health promotion to a variety of population groups, risk factors, diseases, and settings. Thus, child public health includes knowledge about young people and the determinants of health, as well as interventions to promote young people's health.

Determinants of young people's health consist of risk factors and protective factors. Risk factors put children and adolescents at risk of developing health problems, and protective factors protect them (SOU 2006:77). Determinants of young people's health are closely linked to maternal and family health, environmental conditions, behavioural issues, and societal development (WHO, 2005). The Health Behaviour in School-aged Children (HBSC) study defines family, school, peers, and socioeconomic circumstances as the contextual factors related to young people's health (WHO, 2004). Indicators for assessing children's and adolescents' health have to take into account the different health aspects in young people's age groups, as health aspects are quite different between the infant and the adolescent. Rigby, Kohler, Blair, & Metchler (2003) recommend several indicators categorized into four main categories: demographic and socio-economic determinants of young people's health, health status and well-being, determinants, risk and protective factors, and child health systems and policy.

Risk factors are social, mental, or physical conditions that can lead to developmental, behavioural, adaptational, or health problems (Lagerberg & Sundelin, 2000). Recently biological markers have been found that indicate vulnerability for psychosocial adversity and depression. The interaction between heredity and environment is of great interest (Nilsson, Alm, Leppery, Orelund, Sjöberg, & Öhrvik, 2006). Rutter (2006) finds that the genetic claims are overstated, however. But there is evidence for genetic and environmental influences on mental health problems, and that they interact (Rutter, 2006). Risk factors for negative mental health in young people include neonatal illness, poverty, parents' abuse of alcohol, and violence at home (Werner & Johnson, 2004). Problems in the family have a great impact on mental health problems (see Hansson, 2007; Ståhlbrandt, 2008). Here, a child's temperament is important, as shown in longitudinal studies (Cederblad, 2003). Witnessing domestic violence is another risk factor. As of 2006, new legislation in Sweden regards children as victims when they have witnessed domestic violence. This is a part of the Social Act (SFS 2001:453). Many young people experience risk factors, but they sometimes become resilient by also experiencing protective factors.

Protective factors are factors that modify the effect of a risk factor. The risk decreases when a protective factor is present (Lagerberg & Sundelin, 2000). Protective factors for mental health that produce resiliency in children are factors within the children themselves, such as intelligence or a protecting personality (Werner & Johnson, 2004). Masten and Coatsworth (1998) add competence in life, which can control your behaviour, your emotions and your attention. Having relations with supportive adults is part of gaining competence in life, and a family is the most important support a young person can have (Pedersen, Alcón, Rodriguez, & Smith, 2004; United Nations, 1989; Werner & Johnson, 2004). In a longitudinal study from Kauai, Werner and Johnson (2004) analysed 32 year-olds who had grown up with parents with alcohol problems, and were regarded as resilient. A supportive relationship had been the most important means of gaining self-esteem and self-efficacy for these resilient adults. They had had at least one person who accepted them unconditionally. This person could be a non-alcoholic parent, a sibling, a grandmother, a teacher, or a spouse. They had assumed a responsible position in their families, for example, caring for younger siblings or managing the household. The resilient people had interesting hobbies and were in-

volved in activities outside the family. Major life events, such as education or meeting a supportive friend or a mate, were important to them (Werner & Johnson, 2004). Friends are crucial to the development of young people (Settortobulte & Gaspar de Matos, 2004). Rutter (1987) argues that the focus of resiliency is on changes in life trajectory, that key turning points in resilient people's lives can be managed in a more adaptive way. Three types of factors can be associated with resilience: self-esteem and confidence; self efficacy and the ability to adapt to changes; and having various coping strategies (Rutter, 1985). Adults who were abused in childhood, but had good experiences of relationships throughout life – in childhood, adolescence, and adulthood – demonstrated resiliency in a longitudinal study in UK. This was related to personality, relations to parents and friends, and adult love (Collishaw, Pickles, Messer, Rutter, Shearer, & Maughan, 2007). This demonstrates the necessity of a life-span perspective (Rutter, 2007). Lindström (2001, p. 10) concludes that resilience is “...to develop normally in spite of adverse life conditions”. Risk factors and protective factors are important to recognize in the work for child public health.

#### **SOCIAL INEQUALITIES AND INEQUALITIES IN HEALTH**

There are great gaps between the young people having the best social prerequisites and those who are not so well off. Social injustice affects people's lives in the way they live, become ill, and risk premature death. Social inequality appears between countries and within countries. Inequalities of health appear because of these inequalities in health systems and in social prerequisites concerning how people grow, live, work, and age (Commission on Social Determinants of Health, 2008). Socio-economic factors are determinants for young people's health, which also concerns access to health services (Rigby, Kohler, Blair, & Metchler, 2003). Social disadvantage is an important risk factor for health problems (Blair, Stewart-Brown, Waterston, & Crowther, 2003). Increasing gaps were found in the HBSC study from 2005/2006 regarding socioeconomic status, geographical location, race and ethnicity, age group, and gender. In addition disability can be included as an important dimension of social difference (Currie *et al.*, 2008). The HBSC surveys from 2001/2002 and 2005/2006 are cross-national studies on the well-being of young people in industrialized nations. In the 2001/2002 study, 35 countries from Europe, the US, and Canada participated, and in the 2005/2006 study 41 countries. Adolescents from less wealthy families more often reported fair or poor health and lower life satisfaction, but the relationship seems to be complex between

socioeconomic variables and adolescent health (Currie *et al.*, 2008). Academic orientation, what program adolescents chose in high school, was found to be a powerful way to identify adolescents at high risk of adverse health inequalities in a Swedish study. Students who chose a theoretical program were more likely to have better health and less health-damaging behaviour than students who chose a practical program (Hagqvist, 2006). Also in Great Britain academic orientation was found to be a tool for detecting health inequalities and adolescents at higher risk (Spencer, 2005). Social factors are important to consider in assessing health for children and adolescents.

However, there seems to be a decline in diverse health problems. In the US there was a decline in sexual and physical abuse substantiations 1990-2006, juvenile victimizations 1993-2005, teenage pregnancies, and teen suicide (Finkelhor, 2008). Börjesson (2008) concludes from a survey conducted by a public authority under the Ministry of Justice (BRÅ) that criminality rates among adolescents in Sweden are not rising, adolescents are not subjected to crime more often than adults, and rates of bullying are not rising. This report relies on self-reporting from adolescents. Finkelhor (2008) speculated on the causes of the decline, and suggested that economic improvements in society were one factor. Another positive factor could be increasing employment of social interventions, for example police and schools working with families. In addition increased prosecution and more psychopharmacology could play important roles.

#### **ADOLESCENCE AND GENDER**

Two related concepts are sex and gender. Sex is biological, with differences in chromosomes, hormones, the body, etc. Gender is culturally and socially constructed, where differences are regarded as changeable (Hammarström, Härenstam, & Östlin, 1996). Essentialism most often rests on biological arguments supporting differences between men and women, according to which each gender carries with it a set of physical, emotional, and psychological characteristics. The social constructionist perspective claims that gender is shaped by the society and the social system in which we live, and is a process which is learned in the culture (Ambjörnsson, 2003; Göthlund, 1997; Pattman & Kehily, 2004; Svaleryd, 2002). Girls become girls and boys become boys within a social system where everybody wants to be well liked and adapted to the social system. Girls and boys can only be understood in relation to each other (Karlsson, 2003). Cultural expectations of our emotional behaviour differ according to who we are: children,

women, men, professors, unemployed, sick, healthy, etc. (Engdahl, 2004). In school, there is much informal learning about gender – how to act as a girl or a boy (Pattman & Kehily, 2004). Often, there is a dichotomy between these two views: the essentialist and the social constructionist perspective (Pattman & Kehily, 2004). But the two views should probably be used together if we want to understand why there are differences in health between women and men (Hammarström, Härenstam, & Östlin, 1996).

In reports on adolescents' health, girls report more symptoms than boys. Girls in general report lower degrees of self-rated health and higher degrees of health complaints. The importance of gender in the research and practice of public health and health promotion is highlighted (Gabhainn, 2004). It is important to try to understand the differences between girls and boys. Four different explanations are offered in a governmental report. These are that girls might tend to report more symptoms, that girls more often express their feelings, that the differences are biological, or that they depend on the social gender construction (SOU 2006:77). According to the governmental report answers can probably be found in biology, but most often in the social gender construction.

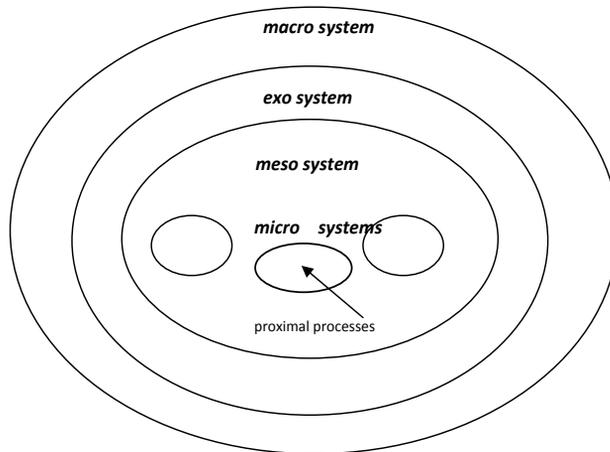
## **ENVIRONMENT AND DEVELOPMENT OF YOUNG PEOPLE**

### **A BIOECOLOGICAL MODEL**

In individual development, changes take place in the environment as time passes. A model which demonstrates development as an on-going process throughout life, which is affected by close relations and the environment is the bioecological model of Bronfenbrenner (1979, 2000). Individual development is seen as a process based not only on biological development, but also on the social systems at different levels embracing him or her throughout the course of life and across generations (Bronfenbrenner, 2000). The system is divided into four spheres: the micro, the meso, the exo, and the macro systems (fig.1). In the model the ecological environment is "... a nested arrangement of concentric structures, each contained within the next" (Bronfenbrenner (1979, p. 22). Recently Bronfenbrenner has added proximal processes to the bioecological model. These processes are the "primary engines of development" (Bronfenbrenner, 2000, p. 130). He gives examples of proximal processes such as ongoing behaviours like feeding or comforting an infant. Development is thus a process over time, both throughout the

life course, but also across generations, which shows the importance of historical continuity and change in affecting human development (Bronfenbrenner, 2000).

---



---

Figure 1. The bioecological model with the macro system, the exo system, the meso system, the micro systems, and the proximal processes (Bronfenbrenner, 1979, 2000).

In the micro systems, the individual is found together with friends, family and other close relations. This inner system contains activities, roles, and interpersonal relationships, which constitute the elements of the micro system. The elements occur in a setting. It is important how the individual perceives the situation. Activities are ongoing processes of behaviour, some carried out solely by the individual, some in interaction with other people. Roles are positions in society that are associated with certain activities and relationships. A role can influence the activities and relationships that the individual engages in, and might alter the trajectory of development. Interpersonal relationships consist of activities of two or more individuals, where the dyad is the most important relationship. The primary dyad exists for both participants even when they are not together; they are in each other's thoughts and they have strong feelings for each other. The most important dyad for the child is with his or her parents. Development is promoted when power is gradually shifted towards a balance of power between the participants in the dyad. If one of the participants changes concerning development,

this will affect the other one, which leads to reciprocal development of the individuals (Bronfenbrenner, 1979).

The meso system is the system that binds the micro systems together. Two or more settings in which the individual actively participates are involved. The individual can move into a new setting, and then the meso system is changed. An ecological transition occurs when the individual's role or the setting is altered. Development is promoted if the individual, before entering a new setting, has access to information, advice, and relevant experience. Most important is information given in one setting about another, meaning that intersetting knowledge is important. The individual is embedded in the meso system and parts of the overall systems (Bronfenbrenner, 1979).

In the exo system, the developing person is not involved personally, but he or she is affected by events happening in the setting. Bronfenbrenner gives an example for the case of a child, whose parents' places of work are included in the exo system. Local structures such as the local school system, the health care system, and the communication system are parts of the exo system. In the macro system we find laws, customs, and the culture where we live our lives. The macro system influences the other systems; for example, the school systems differ between countries, and the relations between family and school are not the same. The macro system also represents different cultures within a society; the system differs for sub-groups in the culture. Life-styles and belief systems differ between groups in the same society, which leads to an ecological environment that is specific for each group (Bronfenbrenner, 1979). An ecological fact is that everything takes place in context (Garbarino, 2008).

This ecology system is a tool for deeper understanding of the relations and cooperation between child, family, and society (Bronfenbrenner, 1979, 2000; Brunberg, 2001; Ceci, 2006; Lagerberg & Sundelin, 2000; Magnuson & Stattin, 2006). Bronfenbrenner extended the concept of the ecology of human development. The environments, from the family to economic and political structures, are viewed as part of the course of life from childhood to adulthood (Ceci, 2006). Magnusson & Stattin (2006) state that development for each individual and for his or her way of thinking, feeling, acting, and reacting depends on interaction with the environment. Many influences shape the developing child, within the child and in the environment. There is a process

of transaction between the surrounding environment and the individual (Aldgate, 2006).

### **ADOLESCENT DEVELOPMENT**

The development of the child is often described in terms of interactions between physical, emotional, cognitive, and psychosocial development. All young people progress systematically through different stages of development. These stages are broadly age-related, however there are great variations between individuals (Aldgate, 2006). The years between 12 and 18 are transitional; childhood comes to an end, and the development of an independent period in life starts. Puberty typically occurs during the period, new relationships arise, and friends become more important (von Tetzchner, 2001). An adolescent is developing from childhood to maturity – growing up (Webster's New World Dictionary, 1988). The development during adolescence includes "...autonomy and connection with others, rebellion and the development of independence, development of identity and distinction from and continuity with others" (Bailey, 2006, p. 208). Identity is about how the individual perceives her or his place in society. A large number of changes take place (von Tetzchner, 2001). Adolescence is often regarded as starting with the physical changes that occur in puberty. A range of emotional, physical, and social changes occur in adolescence, which is a natural developmental process (Bailey, 2006). Puberty is an important transition in life, and it means that the person takes a step into a new stage. Exactly when puberty starts in a girl or a boy is very individual, but the timing seems to play a role for their lives psychologically and socially (Skoog, 2008). The ecological perspective and the adolescent developmental perspective taken together suggest that traumatic experiences can affect development in a negative way. But they also suggest that change is possible, depending on the adolescent's life experiences before the traumatic experience, time and duration, and what happens afterwards (Aldgate, 2006).

## **LIVES AND HEALTH OF YOUNG PEOPLE**

### **ADOLESCENTS IN GENERAL**

Young people in Europe, the US, Canada, and Sweden are generally satisfied with their lives (Children's Ombudsman, 2005; Torsheim, Vålímáa, & Danielson, 2004). In the latest HBSC study from 2005/2006, among 15 year-olds in Sweden 79% of the girls and 89% of the boys reported high levels of life satisfaction. But in the older age group

the perceived health is less good than in the younger age group. The 11-year-olds in the study reported higher ratings for general health and overall life satisfaction, than the 15-year-olds of both genders (Currie *et al.*, 2008). Young people in Sweden are the most happy with their bodies and health, their family, friends, leisure time, and things around them. But they do not consider school, their influence, or safety from violence to be as good. They are in good physical health, but significant and increasing health problems are allergies, diabetes, obesity, and mental health problems. In self-reports, most young people consider their health to be good (Children's Ombudsman, 2005). In the HBSC survey from 2005/2006, "have you been bullied" is one of the questions put to the 11, 13, and 15 year olds. The rate of affirmative answers ranges from 2% to 37% across all countries. Swedish adolescents report low occurrence of bullying, between three and five percent for all age groups, girls and boys (Currie *et al.*, 2008). From an international perspective, young people in Sweden are in very good health, but the prevalence of mental and psychosomatic symptoms is increasing (Hjern, 2006).

Young people in Sweden have access to advanced health and medical care. But their health is affected by their families' material situation, in what area they grow up, whether they grow up with one or two parents, and if they belong to an ethnic minority (Hjern, 2006). According to the Children's Ombudsman (2005), Swedish adolescents think that their parents listen to what they have to say, and they have a positive view of the future. Young people in Sweden have a relatively strong position in society. The Swedish Parliament has declared one of eleven public health targets for health to be "Secure and favourable conditions during childhood and adolescence" (Swedish National Institute of Public Health, 2007). In legislation, one example of children's rights is the act against corporal punishment, which was introduced in Sweden in 1979. This legislation has been altered (law 1983:47), but is now a part of the Children and Parent Code (SFS 1949:381). The law states that children are to be treated with respect and not punished physically or in any other way treated insultingly or abusively. All over the world legislation against corporal punishment of children in the home is being discussed. Sweden was the first country to pass such legislation, but as of today 25 countries have prohibited corporal punishment in the homes. Most of these countries are situated in Europe, but lately New Zealand, Uruguay, Venezuela, and Costa Rica have passed similar legislation (Freeman, 2008). The CRC (United Nations, 1989) de-

clares that all forms of violence against children should not be accepted. Most children and adolescents in Sweden are content with their lives, but some threats to their health can be recognized.

### **ADOLESCENTS AT RISK**

Children and adolescents at risk for abuse or neglect live in circumstances that put them at risk of mental health problems. Four primary types of child abuse are most often mentioned: physical abuse, sexual abuse, emotional abuse, and neglect (Jaffe-Gill, Jaffe, & Segal, 2007). In the United States, child abuse and neglect is defined as “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (Jaffe-Gill, Jaffe, & Segal, 2007). In the same article the researchers report that the US government has figures showing that 1.2 per cent of American children, almost 900,000 in all, suffered abuse by adults, mostly parents, in 2005. It is estimated that for every incident of child abuse or neglect that gets reported, two others go unreported. In 2007 around 15,100 children and adolescents were subjects of 24-hour measures by the social authorities in Sweden (Statistik Socialtjänst, 2008).

Studies from the western world show that 10-30% of all young people grow up in a family with alcohol problems. An American study shows that 15% (9.7 million) of all young people live in a household where at least one of the adults is classified as alcohol dependant, and as many as one young person out of three is believed to have a parent with alcohol problems (Zucker & Wong, 2006). In a study from southern Wales, in nine schools with a total of 1744 adolescents, 18% were classified as adolescents with a family with alcohol problems (Chalder, Elgar, & Bennett, 2005). In a study from the US 22% identified themselves as belonging to a family with alcohol problems (Mylant, Ide, Cuevas, & Meehan, 2002). Sweden estimated in 1994 that 10-15% of all children in Sweden had a parent with alcohol problems (SOU 1994:29). Later new calculations were made, and the estimated figure was 200,000 children (Ungdomens nykterhetsförbund, 2006). In a report from the Swedish National Institute of Public Health (2008a) the figure has been doubled (to about 385,000), and now it is calculated that 20% of all children and adolescents in Sweden have families with alcohol problems. What is known is that alcohol problems in the family are a problem of

enormous proportions. Probably, three to five children in each group of 25 grow up in a family where alcohol is a problem, and this will affect the child.

Life in a family with alcohol problems is usually described as chaotic and unpredictable, and the children are at risk of developing mental health problems and other problems (Brunnberg, Eriksson, & Tinnfält, 2007). Parents act strangely, they are sometimes aggressive and sometimes silent, but the child has no chance to know in advance (see a literature review by Velleman & Orford, 1999). Children and adolescents in families with alcohol problems also have a higher risk than others of being taken into the care of the social authorities and of being subjected to violence (Nygaard Christoffersen & Sothille, 2002). Even though some of these children are okay, life can be very stressful for them, and alcohol problems within the family have a great impact on mental health problems and other problems.

## **MENTAL HEALTH AMONG GIRLS AND BOYS**

### **THE CONCEPT OF MENTAL HEALTH**

“Mental health” and “health” are multidimensional and complex concepts, which are regarded by researchers as dimensions or scales with varying positions. Both laypersons and researchers often regard health as something to strive for and something one wishes for one’s loved ones, but sometimes the expressions “good health” or “bad health” are used, which indicates that negative as well as positive health is included in the concept (Brülde & Tengland, 2003). According to Medin and Alexandersson (2000), health can be seen as the opposite of disease, or as a continuum from health to disease, which means the more the health, the less the disease or illness. A third way of looking at health is to regard health and illness as two independent dimensions that co-exist at the same time. In this thesis mental health is regarded this way.

Tengland (1998) discusses positive, or acceptable, mental health as the ability to attain basic vital goals. Interest in the perceptions of laypeople has increased. Armstrong, Hill, and Secker (2000) conducted interviews with children, 12 to 14 years old, in Scotland about their understanding of mental health. These children described mental health as absence of illness, being happy and confident, being “normal”, and having a positive self-image, sense of belonging, and support. Having family and friends, people to talk to, personal achievements, and feeling good about oneself were also de-

scribed. A study from the UK of emotional understanding among 4 to 11 year-olds showed that emotional understanding changes during development and is closely linked to language skills (Pons, Lawrence, Harris, & de Rosnay, 2003).

Mental ill-health can be divided into two or three separate concepts: first, mental illness, which includes psychoses and other serious problems where the person's sense of reality is disturbed; second, mental illness, which also includes other serious mental problems; and third, mental health problems where self-reported problems are also included (National Board of Health and Welfare, 2001; SOU 2006:77).

### **MENTAL HEALTH IN ADOLESCENTS IN GENERAL**

Children's mental health is an important component of overall health, and this is recognized worldwide (Belfer, 2004). In Sweden, mental health problems are major public health threats to young people (Hjern, 2006). High and growing levels of mental health problems such as behavioural and emotional problems among young people have been reported from many countries, for example the UK, Russia, and Norway (Collishaw, Maughan, Goodman, & Pickles, 2004; Goodman, Slobodskava, & Knyazev, 2005; Heyerdahl, Kvernmo, & Wichstrom, 2004). The HBSC study from the 2001/2002 survey reports high levels (11.9 – 65.6 percent) of young people in Europe, the US, and Canada experiencing two or more subjective health complaints more than once a week (Torsheim, Välimaa, & Danielson, 2004). In the latest survey from 2005/2006 53% of the 15 year-old girls and 29% of the boys in Sweden reported multiple health complaints (Currie *et al.*, 2008). Mental health problems seem to be even higher among children with disabilities, for example, deaf and hard-of-hearing children (van Eldik, 2005; van Eldik, Treffers, Veerman, & Verhulst, 2004). Especially those children with more than one disability have been shown to be at higher risk of emotional and behavioural problems (Bond, 2000; Brunnberg, Lindén Boström, & Berglund, 2007). Deliberate self-harming behaviour, mainly suicide attempts, is an important cause for girls 15-19 years old in Sweden to be treated in hospital. Suicide attempts have increased during the last decade among both girls and boys – mostly among girls – but not suicide (National Board of Health and Welfare, 2008).

The CRC emphasizes the rights and needs of children: physical, mental, spiritual, and social (United Nations, 1989). Activities designed to promote mental health in young people should have high priority in Europe (WHO, 2005), and Sweden plans

to screen all children 13 and 16 years of age for mental health every year. A pilot study with standardized questionnaires was conducted in 2004 in 153 schools in 21 different municipalities in Sweden (National Board of Health and Welfare, 2005). The pupils participating in this pilot study answered multiple-choice questions about their mental health. These questions included topics about school, leisure time, family, friends, psycho-somatic complaints, money, mood, physical health, bullying, personality, smoking, alcohol use, etc.

### **MENTAL HEALTH IN ADOLESCENTS AT RISK**

A serious risk factor for mental health and other problems among children and adolescents is alcohol abuse in the family (see Hansson, 2007; Ståhlbrandt, 2008). In the US neglect seems to be becoming more prevalent, which is a kind of abuse from which children in families with substance abuse problems suffer (Bonner, 2008). Protective factors can decrease the risk, however, and some of these children and adolescents are doing well. Evidence for three groups of children and adolescents in families with alcohol problems is shown in a literature review; those who have serious problems, those who have less problems, and those who are doing alright (Johnson & Leff, 1999). Many factors cooperate to make the risk higher or lower: risk factors and protective factors (see e.g., Haugland, 2003). A literature review of being a young person having at least one parent with alcohol problems showed a higher risk of four kinds of problems: emotional problems; adaptive and behavioural problems; cognitive problems and trouble at school; and earlier onset and greater alcohol consumption (Brunnberg, Eriksson, & Tinnfält, 2007). The *emotional problems* that were reported were for example feelings of guilt, depression, tiredness, low self-esteem, and anxiety (Byholm Christensen & Bilenberg, 2000; Edwards, Preuss, Schukit, Smith, Barnow & Danko, 2002; Das Eiden & Leonard, 2006; Morey, 1999; Mylant, Ide, Cuevas & Meehan, 2002; Rydelius, 1997). *Adaptive and behavioural problems* could be for example problems in relations to peers and adults, adolescent criminality, or attention problems (Byholm Christoffersen & Bilenberg, 2000; DeLucia, Belz & Chassin, 2001; Haugland, 2003; Hussong, Zucker, Wong, Fitzgerald & Puttler, 2005; Johnson & Leff, 1999; Morey, 1999; Mylant, Ide, Cuevas & Meehan, 2002; Nygaard Christoffersen & Sothille, 2002; Poon, Ellis, Fitzgerald & Zucker, 2000; Rydelius, 1997). *Cognitive problems and trouble at school* that were reported were for example differences in scholastic achievement, and greater learning difficulties than others (Casas-Gil &

Navarro-Guzman, 2002; Johnson & Leff, 1999; Leonard & Das Eiden, 2002; Poon, Ellis, Fitzgerald & Zucker, 2000; Rydelius, 1997). *Earlier onset and greater alcohol consumption* were reported, including these adolescents more often drinking alone and for the reason of forgetting about problems, and more often having alcohol problems as adults (Chalder, Elgar & Bennett, 2005; Coffelt, Forehand, Olson, Jones, Gaffney & Zens, 2006; DeLucia, Belz & Chassin, 2001; Johnson & Leff, 1999; Nygaard Christoffersen & Soothille, 2002; Wong *et al.*, 2006).

Children and adolescents with families with alcohol problems and other children at risk of abuse and neglect are not easy for society to identify however. Denial and secrecy are issues in the family, and the rule is not to talk or tell (Christensen, 1997; Knight, 1993; review by Kroll, 2004). Shame and guilt are factors that can increase the reluctance to disclose the family secrets (Webb, Heisler, Call, Chickering, & Colburn, 2007). Children might not understand that their situation is not the situation of every child. Young people of all ages can repress or dissociate the problem (Svedin & Back, 2003). Hence, not all children and adolescents with families with alcohol problems are conscious of the problem, others will be reluctant to tell, and some, for various reasons, will be identified. For sexually abused children, the disclosure process has been studied in several studies during the past few years, and is described in terms of purposeful disclosure, indirect disclosure, eyewitness detection, and accidental detection (Collins, Griffiths, & Kumalo, 2005). The disclosure process or identification of children and adolescents with families with alcohol problems is not described very often, but seems to “take some time and have a ‘one step forward, two steps back’ quality” (Kroll, 2004, p. 137). It is a challenge to find children and adolescents who are abused and neglected (Mathews & Bros, 2008), and many barriers have to be overcome before they can be identified.

## **PROMOTING ADOLESCENTS’ MENTAL HEALTH**

The public sector as well as the civil sector can support families and young people in general. Activities aimed at promoting young people’s mental health should have high priority as young people are vulnerable (WHO, 2005). In the civil sector, organizations are active in many different areas, for example in sports, music, and in church activities. In the public sector the social authorities have the responsibility for the welfare of

all children, and the ultimate responsibility for children at risk of abuse and neglect (SFS 2001:453). Sweden offers support at family centres, child health care centres, youth health care centres, youth recreation centres, and more. School and the local social services are described in this thesis as important settings for adolescents in general and for adolescents at risk.

What is known as the “population paradox” speaks in favour of targeting the whole population in order to reduce the risk for all, also the risk groups (Blair, Stewart-Brown, Waterston, & Crowther, 2003). In the whole population there are more people who will suffer from a problem than people coming from a risk group. So, in many situations there will be a greater reduction of problems if a program includes the whole population. Reducing the risk for a whole population can be more effective than to targeting a risk group. This constitutes an argument for universal interventions. On the other hand, targeted interventions can be more efficient. To provide universal programs, and still give those with the greatest need more support is feasible (Blair, Stewart-Brown, Waterston, & Crowther, 2003). In the schools, all children and adolescents can be reached, adolescents in general, those at risk of abuse and neglect, and those with mental health problems. The cooperation between the social authorities and school is very important in promoting health for children and adolescents. In 2006 additional legislation in Sweden (SFS 2001:453) placed the responsibility for cooperation on the social authorities.

Programs can be used to promote mental health in adolescents. They can be divided into universal, selective, and indicated programs (Ferrer-Wreder, Stattin, Cass Lorente, Tubman, & Adamson, 2005). Universal programs target the whole population, for example an entire school class. Selective programs target pupils who are in a situation with higher risk of mental health problems. Indicated programs target pupils who already suffer from problems, for example low self-esteem, drinking, or aggressive behaviour. All programs can be promotive and preventive. Health promotion is described as “...the process of enabling people to increase control over, and to improve, their health” (WHO, 1986). Prevention is “... to prevent or reduce the possibility of a health problem...” (Modeste, 1996). In this thesis health promotion is used to describe how adolescents with or without problems, and adolescents who are at risk of getting

problems, can be supported and promoted. The support can be directed to one single person or to a group of children or adolescents.

#### **SCHOOL AND SCHOOL HEALTH SERVICES**

In Sweden, children start school at the age of 6 or 7, and compulsory school ends at 16. The Education Act and the curriculum for compulsory school regulate the system (Ministry of Education and Science, 1994; SFS 1985:1100). Most adolescents attend secondary school, which ends at the age of 19 (in special schools for adolescents with disability, at 21). A Swedish governmental commission has declared that schools are required to be safe and stimulating as well as to be able to promote mental health in young people. Because all children and adolescents spend a large amount of time at school, school is a very important factor in the promotion of mental health (SOU 1998:31). Schools should be a place where pupils want to be. If they get the opportunity to participate, they will be empowered, and this will lead to better learning and increased health protective behaviour (Leger, Kolbe, Lee, McCall, & Young, 2007). The CRC declares that children should be asked about their views in matters concerning them (United Nations, 1989). School is a setting where children and adolescents should be part of the decision-making process and be asked about their views.

The pupils in Swedish schools are entitled to school health care free of charge. The aims of the national school health care are to monitor the development of the pupils and to protect and promote their mental and physical health and healthy habits of living. The pupils should be offered at least three general health examinations with the school medical officer or the school nurse during compulsory school, and they are entitled to consult school health care whenever necessary (SFS 1985:1100). The health examinations have several objectives including identifying health problems and risk behaviour, and using the health examination as a dialogue about the pupils' experiences of health and illness. A health guide with questions that the pupils answer in advance should be used to focus on different health problems (National Board of Health and Welfare, 2004). This health guide is not the same for all schools. Such a health guide can include questions about psychosomatic complaints, friends, school, etc. In a study from Denmark, pupils from lower social classes seemed to assess the health dialogue to be more beneficial to them than pupils from higher social classes (Borup & Holstein, 2004). They had more often followed the school nurse's advice, and they

more often revisited the school nurse. Studies by Borup (1995) show that the health dialogue can be used individually or in groups. The family is not often involved in school when dealing with children's or adolescents' mental health problems (Clausson & Berg, 2008). In a study employing family nursing interventions, positive results were found. The school nurse had three sessions with each of four families with girls. The families reported positive affective, behavioural, and cognitive changes after the sessions (Clausson & Berg, 2008).

Providing mental health services in schools can involve school psychologists, social workers, counsellors, nurses, and teachers (Doll & Cummings, 2008). In Swedish schools, there are social workers and psychologists who contribute to the pupils' health as children's confidants, as consulting advisors to the teachers, and as therapists. The school nurse seems to be a natural local resource for mental health service (Backlund, 2007) and she has genuine knowledge of the pupils' health (Clausson, Köhler, & Berg, 2008). It is not clear that schools provide the pupils with support from school social workers and psychologists, however (Backlund, 2007). Most school psychologists work with younger pupils, and the school social workers with the older pupils. But a new trend is to organize the support for pupils at school in the form of support teams, where the school nurse, social worker, and psychologists are integral parts. Over time the school social worker has played an important role as the link between the school and the social services (Backlund, 2007). WHO (2008) states that "An effective school health programme can be one of the most cost effective investments a nation can make to simultaneously improve education and health. WHO promotes school health programmes as a strategic means to prevent important health risks among youth and to engage the education sector in efforts to change the educational, social, economic and political conditions that affect risk."

### **THE SOCIAL SERVICES**

The local authorities have the responsibility for the welfare of all children in the municipality, and a special responsibility for children at risk of abuse and neglect. They should work for safe conditions for children and adolescents, and for their development (SFS 2001:453). The social workers meet clients or groups of clients who need interventions to change or improve their situation. The social work should rely on evidence-based methods. In social work for children, different kinds of interventions are

possible (Bergmark & Lundström, 2006). Most of the methods regarding children and adolescents involve the whole family, and a positive development for both the young person and family can be achieved (Börjesson, 2008). The social service's measures can include institutional or non-institutional care outside the home under the Social Service Act (SFS 2001:453) or care under the Young People Act (1990). The non-institutional out-of-home care measures can be structured non-institutional care programmes, personal support, back-up person/family, contact person, and treatment. Foster homes are the most common form of placement among young people taken into care. It is unclear how many of these young people are children or adolescents in families with alcohol problems (Statistik Socialtjänst, 2008). According to Börjesson (2008) a wide range of activities are offered, promoting and protecting the child or adolescent at risk. A prevalent activity in the Swedish municipalities is to provide support groups for children and adolescents with families with alcohol or psychiatric problems, or in families with domestic violence (Save the Children, 2006). Most often the social authorities run these support groups.

Few studies focus on social work supporting children or adolescents with families with alcohol problems although social workers have the utmost responsibility for children at risk. In a review of all doctoral dissertations in Sweden in Social work (Brunnberg & Larsson Sjöberg, 2006), just one dissertation reported support to these children (Malmros, 1993). The support could, for example, take the form of the child receiving a contact family, a contact person, or a foster family. In evaluations and studies about child-at-risk interventions, the young people do not seem to be identified as children with families with alcohol problems, and it is unclear what support they get and whether they get the support they need.

#### **PROMOTING MENTAL HEALTH IN ADOLESCENTS IN GENERAL**

To promote all adolescents' mental health or prevent mental health problems, schools can provide programs for the pupils. Such programs are surveyed in a book which describes programs that have been evaluated in the US and in Europe (Ferrer-Wreder, Stattin, Cass Lorente, Tubman, & Adamson, 2005). One program that has been internationally disseminated and can be used as a universal, selective, and indicated program is the Strengthening Families Program (Kumpfer, Pinyuchon, Teixeira de Melo, & Whiteside, 2008). The Swedish National Institute of Public Health (2008b) provides

schools with evidence-based programs that they recommend teachers and other health providers to use to promote pupils' health. For example, SET, Social and Emotional Training (Kimber, 2005), which is a universal program, is recommended. The program is adapted to the Swedish context.

#### **PROMOTING MENTAL HEALTH IN ADOLESCENTS AT RISK**

Adolescents at risk of abuse and neglect may need support of different types, promotive, preventive, and reactive. There seem to be very few studies about promotive and preventive work (Cuijpers, 2005) and a lack of research on effective treatment interventions (Brunnberg & Larsson Sjöberg, 2006), especially on emotional abuse (Bonner, 2008). Universal and selective programs at school for adolescents can be preventive, but there are few indicated programs at schools specifically for children or adolescents in families with alcohol problems (Ferrer-Wreder, Stattin, Cass Lorente, Tubman, & Adamson, 2005).

Several studies recommend support groups for children in families with alcohol problems, to be conducted at school or outside school (Black, 2007; Lambie & Sias, 2005). Few studies evaluate this support. In those studies the conclusion is clear however: the children and adolescents achieve better self-esteem, can cope in a better way with their situation, do not feel as lonely as before, and know more about alcohol and its effects (Brunnberg, Eriksson, & Tinnfält, 2007; Gance-Cleveland, 2004; Lindstein, 1997, 2001; Peleg-Oren, 2002a, b; Riddle & Bergin, 1997; Zetterlund, et al., 1999). Few children and adolescents growing up in Sweden with families with alcohol problems will get support from support groups, however. Of all Swedish municipalities, only 53% offered support in the form of support groups. Approximately 1% of children and adolescents in families with alcohol problems received this support in 2005 (Save the Children, 2006).

#### **RATIONALE**

In summary, mental health is an important part of child public health. Increasing mental health problems among adolescents in general, especially among girls, call for promoting initiatives from adults and society for all young people. Mental health is essential for positive development of the individual, and is a human right (Jané-Llopis & Braddick, 2008). The UN has declared that children and adolescents have the same rights as adults, and research is needed on girls' and boys' perspectives on different

matters. Inequalities in health persist, and some groups of children and adolescents are at higher risk of mental health problems than other. One of these groups is children and adolescents with families with alcohol problems, and their perspective is needed, as well as that of adolescents in general, so that society can offer the support that they need and want.

Many studies describe mental health in young people, but there seems to be a lack of research studying girls' and boys' perspectives on mental health and on promoting initiatives. Most often experts, parents, or other adults have given their points of view on children's and adolescents' behaviour, and what they need. Also, the questionnaires that children and adolescents answer are constructed by adults, and with adults' views on vocabulary and meaning of words and concepts. In this thesis the perspective of adolescents is in focus.

## AIMS

The overall aims of the thesis are to explore girls' and boys' perspectives on mental health and on mental health promoting initiatives, and to deepen the knowledge about disclosure and support for adolescents at risk of abuse and neglect.

The specific aims are:

- to describe the prerequisites of a mental health-promoting dialogue with the school nurse from the perspective of young people, and to explore what they believe are important dimensions for achieving such a desired dialogue (study I),
- to analyse the concept of mental health from the perspective of adolescent girls and boys (study II),
- to describe what girls and boys regard as being important determinants of mental health (study II),
- to describe adolescent children of alcoholics' experiences of disclosure and support (study III), and
- to explore how small grants for children at risk of abuse and neglect distributed to small municipalities by the Swedish government have an impact on the implementation of the UN Convention on the Rights of the Child (study IV).



# MATERIALS AND METHODS

## DESIGN

A qualitative descriptive design was chosen for this thesis (Table 1). In three of the studies (Studies I, II, and III), adolescents in Sweden at school and in support groups for adolescents with families with alcohol problems were interviewed individually and in focus-groups, and in one study (Study IV), officials and politicians in nine municipalities in Sweden were interviewed. In addition, in study IV the design involved documents and a survey. Several types of data were used for triangulation (Patton, 2002; Tritter, 2007). The findings were analysed qualitatively using content analysis (Studies I and III) and with a phenomenographical approach (Study II). In Study IV an in-depth analysis of multiple cases was conducted, primarily content analysis.

**Table 1. Overview of the design, participants, data collection, and analyses of the four studies.**

Study	Design	Participants	Data collection	Analysis
I	Qualitative, descriptive design	n=26 5 focus-groups with 4-7 adolescents, 1 with only girls/boys, and 3 mixed, altogether 15 girls and 11 boys, 15 years old, at school.	Focus-group semi-structured interviews.	Content analysis.
II	Qualitative, descriptive and comparative design.	n=48 - 7 focus-groups with 2-7 girls or boys, altogether 20 girls and 10 boys, 13 and 16 years old. - 10 girls and 8 boys individually, 13 and 16 years old, at school.	Focus-group and individual semi-structured interviews.	Phenomenographical approach.
III	Qualitative, descriptive design.	n=27 - 7 focus-groups with 2-4 adolescents, 6 with only girls, and 1 mixed, altogether 20 girls and 2 boys. - 4 girls and 1 boy individually. All 12-19 years old in support groups for adolescents with families with alcohol problems.	Focus-group and individual semi-structured interviews.	Content analysis.
IV	Qualitative, descriptive multiple-case design.	n=25 16 officials and 9 politicians in 9 municipalities.	Mixed methods: - Individual semi-structured interviews on site. - Telephone interviews. - Home pages of the municipalities. - Applications for grants. - Questionnaire from the Children's Ombudsman.	In-depth analysis of multiple cases.

## **PARTICIPANTS**

### **STUDY I**

Twenty-six adolescents (15 girls and 11 boys, all aged 15 years) were interviewed in focus-groups. All 26 were in the 8<sup>th</sup> grade and were attending four schools in a medium-sized town in Sweden. Each of five focus-groups contained four to seven teenagers, one with only girls, one with only boys and three mixed. Four schools – one from a rural area, one from a wealthier part of the town, one from a less wealthy part and one from the town centre – were selected by the head school nurse of the municipality.

### **STUDY II**

The participating adolescents were selected from two schools in two small towns in central Sweden. These schools were included in the National Pilot Study of Mental Health in 2004 for pupils in grades 6 and 9, that is 13 and 16 years old (National Board of Health and Welfare, 2005). Included in Study II were 48 adolescents, 18 aged 13 and 30 aged 16. Among them were 30 girls and 18 boys. About six months previously, all the participants had answered the questionnaire in the National Pilot Study about their mental health. The adolescents were interviewed either individually or in focus-groups, not both, according to their own choice.

### **STUDY III**

The participating adolescents were recruited from existing support groups for adolescents with families with alcohol problems in four Swedish municipalities. In these support groups mostly girls attended. All adolescents who attended the support groups, altogether 28, were invited to participate in the study. Only one declined, a girl. Included in the studies were 24 girls and 3 boys, aged 12 to 19. The adolescents were interviewed either individually or in focus-groups, not both, according to their own choice. Five adolescents chose to be interviewed individually, the rest (n22) in seven focus-groups. Two to five adolescents participated in each focus-group.

### **STUDY IV**

All nine municipalities that received small grants, 4,000€, from the Swedish government for interventions for children at risk were included in Study IV. They were located all over the country and were relatively small, ranging from 3,000 to 99,000 inhabitants. Each of them is treated as a case. In the study they were categorized into two

groups: very small (n=6), where the number of inhabitants was 3,000 to 17,500 and small (n=3), where the number was 50,000 to 99,000.

In each of the nine municipalities one to three officials from the local authority or school (in total four men and twelve women), and one politician were interviewed. The officials were interviewed on site, and the politicians on the telephone. The politicians (four men and five women) were responsible for children at risk, and represented the political majority of the municipality. Altogether 16 officials and 9 politicians were interviewed individually. In addition, documents and a survey from the Children's Ombudsman were analysed.

## **DATA COLLECTION**

Individual as well as focus-group interviews have been used in the data collection. The semi-structured interview is a widely used tool in qualitative research. The researcher strives to obtain descriptions from the life worlds of the interviewees with the aim of interpreting the meaning of phenomena (Kvale, 1996). Interviews are also commonly used in data collection in phenomenographical studies (Larsson, 1986). Focus-groups are homogenous regarding the research question, and most often four to twelve persons participate (Krueger, 1994). Four to six groups are often enough to capture the variations of the phenomenon (Morgan, 1996). Traditionally the participants should not know each other, but on the other hand the participants can feel more at ease if they know each other in advance (Stjerna & Marttila, 1999). In this thesis the adolescents knew each other more or less. In the focus-groups in Studies I and II the participants were from the same school. In Study III the adolescents attended the same support group, and had the opportunity to choose who they wanted to discuss with. The researcher is not looking for consensus (Krueger, 1994); instead it is the variations that are interesting in the focus-groups, which will be seen in discussions between the participants. The mixture of individual interviews and focus-group interviews has led to even more variations. In Study IV a qualitative, descriptive multiple-case design was chosen, and a triangulation of methods was used: in-depth individual interviews, telephone interviews, analyses of documents, and analyses of a national survey from the Children's Ombudsman.

## **STUDY I**

The school nurse asked one of the classes in grade 8 in the selected schools if they were willing to let the interviewer inform them about the study. Adolescents who were interested were thereafter invited to the interview. Focus-groups were used in the data collection in Study I. All participants were of the same age and had recently had a health dialogue with the school nurse. In the opening question in Study I, the moderator asked the adolescents about their experience of the health dialogue and what was important in the dialogue. Follow-up questions were asked, with all discussions being tape-recorded and transcribed verbatim. These questions, which could vary, were asked to encourage the adolescents to talk more and to discuss the issue in question amongst themselves. The moderator wrote field notes after the sessions; in two of the sessions an external observer participated and took notes in order to gain a better understanding of the data analysis.

## **STUDY II**

All the pupils from the two selected schools, 13 and 16 years old, were invited to participate in individual or focus-group discussions on the subject of mental health. Among those who were interested many dropped out before the interviews started, and finally 48 adolescents participated. The interviews, both individual and in the focus-groups, were semi-structured, and all were tape-recorded and transcribed verbatim. The main question, which was the same in the individual interviews and in the focus-groups, was: "What do you think of when I say 'mental health'?" Follow-up questions were asked, such as: "Can you tell me more?", "Please describe what you mean". Specific questions were asked on different mental health topics, which were taken from the questionnaire in the National Pilot Study that all the adolescents had previously answered. Some of the adolescents brought these issues up, but not others. These questions were semi-structured and concerned topics such as: being nervous and afraid, being satisfied with yourself, and the future. The analysis of these specific topics is not included in this study. An external observer attended two of the focus-groups' sessions, and discussions were held between the moderator and the observer after the interviews. The adolescents' perceptions of mental health were analysed as well as what the interviewees thought about the differences between girls and boys, which was asked specifically in the individual and focus-group interviews.

### **STUDY III**

The group leaders of the support groups for adolescents with families with alcohol problems in the four municipalities asked the adolescents for permission for the interviewer to inform them about the study. All the adolescents who attended the support groups were invited to participate in the study. The interviews were conducted in a secluded place at the premises of the support group. The interviews, both individual and in focus-groups, were semi-structured, and were tape-recorded and transcribed verbatim. Notes were taken after each interview. The main question, “How do you think that adults should identify, behave towards, and help children who have family problems?” was the same in all the interviews. Follow-up questions were asked, which could, however, differ, depending on the discussion in the group or between the informant and interviewer. Follow-up questions were for example: “What should an adult do who knows that there are problems at home?” or “What support can school give?”

### **STUDY IV**

Interviews were organized with the local alcohol and drug coordinator, the head of the responsible department of the local authorities, and the project leader. Officials were interviewed individually on site, and politicians responsible for children at risk by telephone; all interviews were tape-recorded and transcribed. A semi-structured interview-guide was used and follow-up questions were asked. The interviews lasted between half an hour and an hour. The respondents were all asked about previous and current activities to support children at risk and about the implementation of the CRC. The officials received questions about strengths, weaknesses, opportunities, and threats for the work for children at risk. The politicians received questions about how the children at risk are prioritized.

Interviews were the primary data source, but as a complement to the interviews documents were analysed, to get an overview. The applications and the answers from the government were studied, as were the home pages of the municipalities. The answers from a survey conducted by the Children’s Ombudsman about the implementation of the CRC were included. The documents were obtained from the Alcohol Committee (The Ministry of Health and Social Affairs), and from the municipalities’ home pages, and the survey was obtained from the website of the Children’s Ombudsman.

## **ANALYSIS**

Content analysis was used in three of the studies in the thesis, and phenomenographical approach in one. Content analysis is the method most commonly used to analyse focus-group interviews (Krueger, 1994), and it is also widely used for analysing individual interviews. The purpose of the studies was to get the views from the respondents. It seemed important to stick close to the adolescents way of speaking, and to show the variety of their perspectives. Content analysis makes it possible to show variety in people's ways of viewing the world around them, and it seemed to be the best way of analysing most of the data. Different ways of conducting content analysis can be found in the literature (see e.g., Downe-Wamboldt, 1992; Graneheim & Lundman, 2004; Kvale, 1996, Polit & Beck, 2004). In Study II however, the aim was to get the perceptions of the adolescents on the concept of mental health. The purpose in phenomenography is to investigate people's qualitatively different ways of understanding a phenomenon or aspect of the world (Marton & Pong, 2005). According to Marton and Booth (1997), phenomenography is not a theory or a method, but an approach for identifying and understanding a certain type of research question. People handle situations and the world in relation to how they experience the world. The focus of interest is on revealing and describing variations within phenomena. What is important is to find the variations between different perceptions or experiences.

### **CONTENT ANALYSIS**

In all the studies in this thesis the interviews were tape recorded and transcribed, and the interviews were read thoroughly in order to become familiar with the text. The process of categorizing the text, coding it, and finding common categories or themes is described by many authors (see e.g., Downe-Wamboldt, 1992; Graneheim & Lundman, 2004; Kvale, 1996; Polit & Beck, 2004). In the studies in this thesis the analyses have initially started with manifest content analysis by sticking close to the informants' way of speaking. Later in the analysis, latent content analysis is used, and the categories or themes are more abstract (Graneheim & Lundman, 2004). In Study I, the interviews were divided into meaning units, coded, categorized, and finally presented in two major groups where subcategories can be found. The meaning units of three of the interviews were coded and categorized inductively on the basis of content. A scheme was drawn up after the categorization of the three interviews, whereby the rest of the

interviews were coded and categorized deductively. For each of the categories, several subcategories were formed. These subcategories were compared in order to find relations, a process that eventually led to the formulation of two major groups.

In Study III the respondents were interviewed individually and in focus-groups. The different ways of interviewing were analysed separately. The individual interviews were analysed first, thereafter the focus-group interviews, and finally they were compared. Meaning units were formed in each interview, and in the focus-group interviews they were condensed into short sentences where the wording was kept close to the adolescents' way of speaking. The meaning units were thereafter coded and divided into categories. Contrastive comparisons between the categories were made, where differences and similarities between the categories were described, borders were established and subcategories were found. Finally the categories and subcategories from the individual and the focus-group interviews were compared. In the analysis of the focus-group interviews the use of interaction is specific (Kitzinger & Barbour, 1999), and the way the participants interacted was taken into account. Comments were analysed according to intensity, changes of opinions and the dynamics of the group (Krueger, 1994; Morgan, 1997).

In Study IV the interviews were condensed into two parts: one about the grants, and one about the CRC. The interviews with the officials were kept separate from the politicians at the beginning. After that the meaning units were coded and categorized using content analysis. The documents were analysed for the purpose of deepening and broadening the understanding of the narratives. In the questionnaires from the Children's Ombudsman, the municipalities answered questions about documents used in the municipality, about children's points of view in general and in decisions regarding the child, and about consequences for children.

#### **PHENOMENOGRAPHICAL APPROACH**

In the analysis of Study II a phenomenographically inspired approach was used. Meaning units were formed in each interview and condensed into short sentences where the wording was kept close to the adolescents' way of speaking. Eight groups of condensed interviews were formed, where gender, age, and interview methods were treated separately. The condensed meaning units were divided into categories answering the different research questions, and comparisons were made within the groups of interviews.

The way the participants interacted in the focus-groups was taken into account (Kitzinger & Barbour, 1999). Comments were analysed according to the intensity and the dynamics of the group. Views agreed on by all the participants in the focus-group were considered more important. Variations as well as commonalities were considered in the analysis. Categories were found for each research question within the eight selected groups of participants. Contrastive comparisons between the categories were made, where differences and similarities between the categories were described, borders were established, and subcategories and conceptions were found. A comparison was made between the boys – boys to boys – and between the girls – girls to girls – and, finally, a more general comparison was made between all the girls and the boys. The comparisons finally led to descriptive categories (Marton & Booth, 1997). These were structural or referential (Marton & Pong, 2005), answering the questions of how the phenomenon is conceived and its meaning.

#### **CASE STUDY**

Case studies can be performed with one case or with multiple cases. Context is very important, and in the analysis the cases are described (Merriam, 1998; Yin, 2003). In Study IV nine municipalities were studied and a multiple-case design was chosen. All municipalities that received the grants from the government were included in the study. The strength of a multiple-case design is that evidence from more than one case is often regarded more robust (Yin, 2003). Each of the nine municipalities was described in terms of its projects for children at risk. After the within-case analysis, a cross-case analysis was performed, in which similarities and differences are described (Merriam, 1998; Yin, 2003). The methods used in case studies are often mixed (Tritter, 2007), and in Study IV analyses of in-depth interviews with the officials, telephone interviews with the politicians, documents from the municipalities, and of a survey from the Children's Ombudsman were conducted.

#### **ETHICS IN THE STUDIES**

##### **STUDY I**

The principals of the four schools had given their consent to participation in the study, and a letter informed the parents of the participating pupils about the purpose of the study. The adolescents were asked if they would be willing to participate, and each of them was given a letter informing them that they could terminate their participation at

any time. All the participants were assured of complete confidentiality when the outcome of the study was reported.

#### **STUDY II**

The principals of the schools were asked for their consent. All 16-year-old pupils in the two schools were asked if they wanted to participate in a focus-group interview or in an individual interview with the interviewer, and all 13-year-old pupils in one of the schools were invited to participate. Written information was sent to interested pupils and their parents by mail, and the parents were asked for their written (active) consent. Ethical approval for the study was granted by the ethics committee of Örebro University (Dnr CF 2003/780).

#### **STUDY III**

The group leaders of the support groups informed the adolescents from twelve years of age briefly about the study. They asked for permission for the interviewer to visit the group to provide further information. The interviewer thereafter visited the support group, gave information about the study, and asked if the adolescents were willing to participate. Those who were interested in participating signed up, and were later contacted by means of a letter asking the custodian (most often a parent) to give his or her consent to the interview if the girl or boy was under 15 years old, in accordance with the guidelines of the regional ethics committee. If the adolescent was 15-18 years old, the custodian was informed. Ethical approval of the study was given by the regional ethics committee in Uppsala (Dnr 2007/161).

#### **STUDY IV**

We asked the regional ethics committee for guidance on ethical issues, and they could find no objections to conducting the study. The respondents received full information.

### **INTERVIEWING YOUNG PEOPLE**

Doing research where young people are involved raises a number of ethical issues, for example access, power relations, and consent (Lewis, 2004). Children and adolescents themselves cannot decide entirely whether they can participate in research. Adults act as gatekeepers, which has the positive function of protecting them. Researchers have to think about maximising the benefits and minimising the risks for the children and adolescents participating. However, gatekeepers can use their power to censor young peo-

ple (Masson, 2004). Tones and Green (2004) describe paternalism as people being seen as not being able to take responsibility on their own. There is a high risk of young people being subjected to paternalism. Parents have a responsibility for their children's wellbeing and are supposed to take into account the child's will based on his/her age and maturity (SFS 1949:381). Accordingly, parents have to give their consent, actively or passively, to research involving their children. This is also stated in the Swedish law on ethics in research. Parents have to give their consent if the young person is under the age of 15 (SFS 2003:460). As children mature, parental control diminishes (Masson, 2004), and the researcher and the ethics committees have to consider the benefits as well as the risks for the young people involved in research. It is important to reflect on how to not only ask young people about their views, but also how to make these views really matter (Minkler & Pies, 2005). The CRC emphasizes in article 12 the rights of children to express their views, and that it should "be given due weight" in accordance to age and maturity (United Nations, 1989). "Due weight" can in relation to research mean that they are to be asked about their opinion on various matters, but also that it is important to disseminate the findings from young people, to young people and to adults. Article 19 in the CRC is also important in the discussions on young people participating in research. The article emphasizes the protection of the child, and children and adolescents have to be protected from research that they do not understand or can be harmed from, which is also declared in the Swedish law (SFS 2003:460).

The belief that adults have superior knowledge sustains unequal power relations between adults and children. But it is the young person who is the expert on what it is like to be young. Much research with and on children and adolescents is conducted at school, as young people spend a great deal of time there. However in school environments there is an imbalance in the power between adults and children. Adults control young people's time and space in school. This might influence school-based research (Robinson & Kellet, 2004). Additionally, power is an issue among children and adolescents; on the playground, power relations are important (Brunnberg, 2005). Most often, the young person is not the main giver of consent to research. Consent depends on the notion of competence; who is competent and who is not is often defined by adults (France, 2004). To be able to give informed consent, young people need very detailed information about the research, and especially about the right to withdraw at any time

(Alderson, 2004; France, 2004). Young people must be protected in research, which means that risk and harm must be minimized. A research strategy should be incorporated that deals with any problem that might occur (France, 2004). In the present studies, research was conducted with the adolescents as informants. The exception was study IV, where adults gave their views on how to support children and adolescents at risk of abuse and neglect.



# SHORT SUMMARY AND MAIN RESULTS STUDY I-IV

## STUDY I

The aim of the first study was to describe the prerequisites of a mental health-promoting dialogue with the school nurse from the perspective of young people. A further aim was to explore what adolescents believe are important dimensions for achieving such a desired dialogue. Twenty-six adolescents were interviewed, divided into five focus-groups with four to seven adolescents in each. In one of the focus-groups there were only girls, in one only boys, and in three both girls and boys.

The study shows that the prerequisites for a mental health-promoting dialogue with the school nurse include what issues to discuss in the dialogue and where the dialogue should take place. From the adolescents' perspective, the questions should be about "physical things", such as their body, and "psychological things" such as personal problems. Topics that were considered important included the adolescents' body, things they are ashamed of, bullying, the future, their home and family life, love, imprudent things they have done in their life, female stuff, serious personal problems, anorexia, pregnancy, sex, drugs, alcohol, advice, personal problems, and so on.

How school is, how you're doing and if you have any personal problems.

When starting the dialogue the school nurse might talk about general issues, like talking about herself and reminding the pupils that she has a professional obligation not to disclose any confidential information about the pupil. The dialogue between the nurse and the adolescents could occur in a variety of places in addition to her office. What was most important was the way the school nurse interacted with the pupils and what she was like as a person.

The dimensions of the dialogue include what the adolescents think is most important in the dialogue with the school nurse. These dimensions are trustiness, attentiveness, respectfulness, authenticity, accessibility during school hours, and continuity (Table 2).

**Table 2. Six dimensions that adolescents think are important in a mental health-promoting dialogue with the school nurse.**

Dimensions	Content
Trustiness	Trust
	Professional confidentiality
	Knowledgeable
Attentiveness	Matching gender, age
	Listen
	Care
	Understand
Respectfulness	Remember
	Take others seriously
	Be honest
Authenticity	Private
	Interested
Accessibility	Be there
	Fewer pupils
Continuity	See each other
	Be known
	Be a friend

Trust seemed to be the most important factor, trust in the school nurse not to disclose confidential information, and trust in her professionalism.

... I can say anything I like to her because I trust her. It's not like she talks to everybody else about what I've told her.

Attentiveness included being “seen”, which was important to the respondents. The adult should listen and show an interest in what the adolescent has to say. Caring, showing sensitivity to the needs of the pupils and remembering the adolescent were important parts of this dimension. The respondents expressed a need to feel respected as an individual, to be taken seriously and not to be treated like a child.

G 1: To know that this person takes you seriously...

G 2: ... not treat you like a 5-year-old because that's degrading.

The school nurse should be personable, sensitive, and willing to listen to the concerns and ideas of others. The authenticity dimension included the nurse talking about her own interests and experiences, and that the dialogue should be a didactic encounter between the pupil and the nurse. The school nurse should be accessible during school

hours and the findings in this study clearly show the importance of continuity in the encounters.

## STUDY II

The aims of the second study were to analyse the concept of mental health from the perspective of adolescent girls and boys and to describe what they regard as important determinants of mental health. Focus-groups and individual interviews were conducted with 48 adolescents: 30 girls and 18 boys. In the seven focus groups, where girls and boys were separated there were 20 girls and 10 boys. Ten girls and eight boys were interviewed individually. The adolescents were 13 or 16 years old.

The adolescents perceived mental health as an emotional experience (Table 3). Positive and negative health is part of the concept, according to the adolescents:

... feeling well in your brain, that people care; then you feel happy. (Focus group, 16 years, girls).

Feeling sad is part of mental health. If you feel bad you can be very unhappy. (Focus group, 16 years, boys).

Emotions could be internal feelings or feelings towards other people. The older girls and boys related mental health mostly to themselves, while the younger girls and boys described their feelings more in relation to other people. The *internal* positive emotions the adolescents described were: a feeling of being happy, which included laughter and having fun; and a feeling of harmony, where not feeling stress was part of the category.

**Table 3. Mental health from the perspective of adolescents, perceived as an emotional experience. Descriptive categories.**

	Emotions	
	Positive	Negative
Internal	A feeling of being happy. A feeling of harmony. A feeling of being a good person. A feeling of having good self-confidence.	A feeling of being unhappy. A feeling of lack of meaning and hope. A feeling of being stressed. A feeling of having poor self-confidence
Relational	A feeling of being liked. A feeling of being loved by your parents. A feeling of having people to talk with.	A feeling of not being liked and being lonely. A feeling of being unhappy at home

In addition, the feeling of being a good person, for example doing a good deed, and of having good self-confidence, including doing well in sports and having good looks, were positive internal categories. Girls and boys sometimes expressed the same things, but there were some differences of expressions, which could also be seen between ages. Positive emotions could be *relational*, and were divided here into three categories; a feeling of being well liked, where friends played an important role, of being loved by your parents and having people to talk with, for example at school.

I know that I always have my parents and my siblings; that they are always there for me. (Individual, 16 years, girl.)

What the teen-agers brought up as *internal* negative emotions within the concept of mental health were: a feeling of being unhappy, which was described in the form of a number of expressions, of lack of meaning and hope, which was mostly mentioned by the older girls but also in connection with bullying.

It feels like there is no use, it would not matter if somebody ran me over now or something. (Individual, 16 years, girl.)

Feelings of being stressed and of having negative self-confidence were categories of negative internal emotions. Negative emotions were also linked to *relations*; a feeling of not being liked and being lonely, which was strongly linked to bullying, and being unhappy at home. There is a relation between the positive and negative, internal and relational emotions. The positive emotions most often have a contradictory feeling in the negative emotion. These relations form the outcome space (Marton & Booth, 1997).

The adolescents mentioned family, friends, and school as the three most important determinants of mental health. Family was the most important determinant for young people's mental health, closely followed by friends. Girls and boys wanted to have a good dialogue at home, although negative issues such as alcoholism and fighting were also described. Good friends were very important for feeling good, and a good friend is kind and trustworthy, according to the interviewees. The younger adolescents mentioned bullying more than the older adolescents as something negative.

If I could change two things in the world, it would be to stop bullying and war, because I find those things bad. (Individual, 13 years, girl.)

To the adolescents, school is most of all a place to meet friends, but also a place where bullying occurs. The girls and the boys mentioned negative as well as positive aspects of family, friends, and school. This indicates that a mental health determinant can lead to a positive as well as a negative emotional experience.

Neither girls nor boys believed that there were any major differences in mental health between girls and boys. Age differences seemed to be more important than gender in the adolescents' perception of the concept mental health. All of the informants could see more similarities than differences between girls and boys.

I think girls... they think they know better, even though they do not, just to feel, oh we are stronger than boys, mentally. (Individual, 16 years, boy).

The differences concerned openness, where girls are assumed to be more talkative and emotional, and boys more introverted, silent and tough.

### **STUDY III**

The aim of the third study was to describe adolescent children of alcoholics' experiences on disclosure and support. Twenty-seven adolescents, aged 12 to 19, were interviewed in focus-groups or individually. Five of the adolescents chose to be interviewed individually, and the rest in seven focus-groups, with two to five adolescents in each. Three boys and 24 girls participated.

The findings reveal a disclosure process among children and adolescents with families with alcohol problems. The adolescents have a desire to tell, and fear of telling. Trust and distrust are the second theme in the findings. The disclosure process is described as consisting of several steps, but can for the individual child or adolescent be quite different. The steps are not sequential. The process can be described as showing internalizing or externalizing symptoms, describing the situation in words, telling a stranger about the problem, telling a peer (sibling or friend), indirectly communicating with an adult, directly communicating with an adult, and asking for help.

Some of the adolescents deliberately hid all signs of problems, and behaved extra well at school. But in the process of disclosure a first sign could be externalizing or internalizing symptoms, for example aggressive or deliberate self-harming behaviour. Self-harming behaviour was done primarily for anxiety reduction. Other ways of start-

ing to reveal problems at home were to write in diaries or on the internet, privately or for a stranger.

“... just to get it all out of me somehow.” (Girl in focus-group).

A step in the process could be to talk to older siblings or to a close friend. This friend could be a facilitator for disclosure to an adult by encouraging the person to talk to someone.

If it was my friend, I'd try to help her with things I can do myself, and I'd rather try to get her to tell someone rather than doing it myself. Because it's better if she does it herself, because I don't know every detail of how she feels, but then if she refuses and more things start happening so it gets worse... but then I wouldn't go to a teacher, I'd go to the school social worker. (Focus-group, girls.)

Another step that some of the adolescents described was to write about it in an essay at school, or to choose to read a book about children with families with alcohol problems. In those cases the adolescents wanted the teacher to understand and ask them about their home situation. The last steps included actually speaking to an adult; some adolescents thought that the teacher was the best person to talk to, others thought that the school nurse or school social worker was better suited for these dialogues. The adolescents thought that the person they would choose to talk with had to be trustworthy.

One of the most important things an adult can do to help adolescents is to ask about the home situation. The adolescents emphasized that adults should ask, especially when they thought that something was not right.

... our school nurse asked, because she could see that something wasn't right about me. Then I talked with her... (Girl, individual interview.)

The adolescents also thought that the school nurse should include questions about children's and adolescents' home situation in the recurrent dialogues and in the health guide that she uses in the health dialogue. Suggestions for support included informing adults and pupils about alcohol, alcoholism, and life in a family with alcohol problems. Personal support included cooperation between adult and child or adolescent when it came to what to do about the young person's problems, and it was most important

that adults listen. The support group was very important to these adolescents, and they thought that information about these support groups had to be made available to all pupils, and especially to those who are in need of it. Disclosure and support are essential for promoting mental health in children and adolescents in families with alcohol problems.

## STUDY IV

The aim of the fourth study was to explore if and how small grants distributed by the Swedish government to municipalities with a small number of inhabitants have an impact on the implementation of the Convention on the Rights of the Child. It addresses the municipalities' activities and support for children at risk of abuse and neglect. A descriptive multiple case design was chosen with a total of nine cases. In each municipality, or case, interviews were conducted with officials, telephone interviews held with politicians, and documents and a survey were analysed.

The results of the study show that even small grants (here 4,000€) from the government appear to be valuable for municipalities' efforts to support children and adolescents at risk of abuse and neglect. In the nine municipalities in Sweden that are described in the study, all had on-going work for children and adolescents at risk of abuse and neglect. The officials and politicians in the very small municipalities had the advantage of knowing the people in the municipality well. On the other hand there are some disadvantages, for example believing they do not have any problems. Another weakness is that in the protective work, children of alcoholics might feel singled out. Cooperation with other very small municipalities is positive for these children and adolescents who may get access to more activities this way. The recognition from the government was very valuable, and children and adolescents at risk of abuse and neglect were prioritized in the municipalities.

It demands that this question be prioritized, ... that this group of children should be prioritized ... I don't think they would have paid attention to this group otherwise ... (Official, very small municipality.)

The municipalities used the grants for children at risk of abuse and neglect mostly to provide special training to personnel. Children or adolescents did not participate in planning and decision-making. In general, they were asked about their points of

view in matters concerning social welfare and school, and sometimes other areas that personally concern them. The respondents were well aware of the importance of implementing the CRC. They described that the children were in focus, that concern for the well-being of children permeated the municipality.

One premise of this job is what's best for children; that's what we're working for. (Official, very small municipality).

It feels like it [the CRC] is behind everything right now. (Official, small municipality).

Children and adolescents seldom participated in planning and decision-making, however. The activities that were promoted by the grants neither involved children or adolescents, nor were they planned or discussed by children or adolescents. This could have been a valuable way for the municipalities to benefit young people in line with the CRC, and to help the development of individuals.

## GENERAL DISCUSSION

The overall aims of the thesis are to explore adolescents' perspectives on mental health and on mental health promoting initiatives, and to deepen the knowledge about disclosure and support for adolescents at risk of abuse and neglect. The goal was to give voice to adolescents' perspectives on mental health, with special regard to adolescents at risk of abuse and neglect. A point of departure for the thesis is that childhood is important in its own right. Four studies have dealt with the aims. In three of them (Studies I, II, and III), adolescents' perspective is in focus. In one study (IV) society's support to adolescents at risk of abuse and neglect, and the implementation of the CRC is in focus.

The main findings are:

that adolescents find it most important for a mental health-promoting dialogue with adults that the adult is trustworthy, able to listen carefully, and asks questions about the home situation among other things (Studies I, II, and III),

that adolescent girls and boys want and need good relationships with adults (Studies I, II, and III),

that friends are confidants and supportive, and can act as facilitators when adolescents need help and support (Studies II and III),

that "mental health" can be positive and negative to adolescent girls and boys, and that relationships are an important part of mental health (Study II),

that relationships with family and friends are regarded by girls and boys as the most important determinants for mental health (Study II),

that children and adolescents at risk of abuse and neglect make a risk assessment of who to trust before they decide if, when, and how they will disclose the family secret (Study III),

that girls and boys do not perceive the differences between girls' and boys' mental health to be as large as previous studies show (Study II),

that adolescent girls and boys want to participate in decision-making (Study III), but that adults do not ask for children's or adolescents' participation in planning or decision-making (Study IV).

### **ASPECTS OF IMPORTANCE FOR ADOLESCENTS' MENTAL HEALTH**

Taken together, the studies in this thesis show that most important factors for adolescents' mental health are relationships between adolescents and adults, foremost parents, and between adolescents and friends. Relationships between adolescents and adults are primarily the responsibility of adults. In addition, gender and age, adolescents' perspective and participation, and society's support, including the implementation of the CRC, have an impact on adolescents' mental health – for adolescents in general and for adolescents at risk of abuse and neglect.

### **RELATIONSHIPS BETWEEN ADOLESCENTS AND ADULTS**

When describing mental health in Study II, the adolescents included relational emotions as being very important, and the main determinant for mental health according to the adolescents is the family, closely followed by friends. Mayall (2002) writes that the studies of children's lives most of all is the study of child-adult relationships. A positive emotion was to be loved by your parents, according to the adolescents in Study II, and the adolescents wanted support from their parents. That family is the most important support a child can have is reported in many studies (Pedersen, Alcón, Rodriguez, & Smith, 2004; Werner & Johnson, 2004; WHO, 2005). According to Bronfenbrenner (1979), the dyad between the parents and the child is the most important factor in the development of the individual. The relationships of childhood, especially to parents are very important in developing resilience, together with later experiences in life (Rutter, 2007). Clausson, Köhler, & Berg (2008) report that family sessions seemed to be a good tool for promoting young people's mental health at school. The 16-year-old girls in Study II were very clear about the family's importance to them, more so than the younger adolescents (13 years old). This might be explained by the changes that happen in puberty (Aldgate, 2006; Bailey, 2006; Skoog, 2008). In Study III some of the adolescents said that you may not understand that other families are different when you are younger, which was also reported from studies on sexually abused children (Svedin & Back, 2003). For parents it might be a surprise that adolescents find them to be so important.

A negative relational emotion that the adolescents reported (study II) was to be unhappy at home. Families with alcohol problems might fail to provide supportive relationships. Children and adolescents who have a parent with alcohol problems, are at increased risk of mental health problems (Brunnberg, Eriksson, & Tinnfält, 2007). These children and adolescents are at high risk of being neglected, which is a serious form of abuse (Bonner, 2008). A parent, alcoholic or non-alcoholic, can be a facilitator for a child or an adolescent in seeking support outside the family, for example by joining a support group, as Study III shows. When a person in the micro system changes, a change might also happen to the developing individual, according to Bronfenbrenner (1979). This would mean that if a parent admits that there are alcohol problems in the family, the child or adolescent gets the chance to disclose the family secret, and might get support outside the family. Development of the person is promoted. Mental health is probably promoted as the family secret is no longer a secret, and feeling of shame and guilt may decrease. Denial and secrecy are issues in the family, and the rule is not to talk or tell (Christensen, 1997; Knight, 1993; review by Kroll, 2004). Shame and guilt are factors that can increase the reluctance to disclose the secrets in the family (Webb, Heisler, Call, Chickering, & Colburn, 2007).

Adolescents who live in a family with alcohol problems want and need support from other adults (Study III). Adolescents can be benefited by adults outside the family. An important adult can produce resiliency if warmth and rules are combined and if the child or adolescent is accepted unconditionally (Werner & Johnson, 2004). To have good relationship experiences through life, in childhood, in adolescence, and in adulthood in spite of abuse in childhood produces resiliency (Collishaw, Pickles, Messer, Rutter, Shearer, & Maughan, 2007). If young people do not have positive encounters with their parents, other adults become more important. The adolescents in Studies I, II, and III had views on what enables positive encounters. Trust in adults was the most important prerequisite for supporting mental health in adolescents (Study I). Trust was the main thing that adolescents demanded of the school nurse, when having a mental health-promoting dialogue. For the school nurse, the professional code of ethics, which means that she is not entitled to reveal any information given in confidence (SFS 1980:100), is one important component of trust. The adolescents in Study III were very anxious to be able to trust adults not to disclose any information about them to others, if they disclosed their family secret. This is an ethical issue for school personnel in Swe-

den, as there is mandatory reporting to the social authorities in cases of suspected abuse and neglect (SFS 2001:453). This is also reported from the US as an ethical issue (Solum & Schaffer, 2003). Discussions are going on around the world about the benefit of mandatory reporting, and Mathews and Bros (2008) argue that it is important because otherwise some children's and adolescents' situations might never be disclosed. On the other hand, according to the adolescents in Study III, the fact that school personnel have mandatory reporting requirements could be an important factor for not disclosing your situation to an adult. In Sweden many children and adolescents "disappear" during the process from report to treatment and do not get the support they need (Wiklund, 2006).

Adolescents demand that adults, for example the teacher, the school nurse, or the school social worker, first and foremost listen, and do not jump too quickly to conclusions or contact the social authorities too fast. In Studies I and III the adolescents emphasized the importance that adults listen. They said that it is not necessary for adults to do anything, but that they have to listen. In some of the focus-groups in Study III, the adolescents discussed the importance of young people being participants in the decision-making on what was going to happen after disclosure. The adolescents have to be made partners in the decisions on what to do. The participation is very important in these cases, but at the same time, the protection of the adolescent is the adult's responsibility. Adults have to be very sensitive and have a real urge to participate, but take the responsibility for the matter, and not leave that to the adolescent. Participation and protection are parts of the CRC, articles 12 and 19 (United Nations, 1989). There seems to be a conflict between the two articles here (Sandbaek, 1999). Article 12 establishes the participation of children and article 19 their protection. The adolescent probably knows best most of the time, but there might be situations where an adult has to overrule the adolescent's desire for secrecy. The adolescents in Study III said that friends sometimes had to talk to adults, even though this includes disclosing secret information. In cases where the person is at serious risk, for example is being beaten, they obviously found it important that adults took responsibility. Adolescents want and need support from adults, which includes trusting them. Trust includes being confident that adults will help when help is needed. It must be of the greatest importance that a child or an adolescent who reveals problems can feel fully supported, and have full knowledge of what will happen after disclosure. They have the right to be heard

(United Nations, 1989), and to receive complete information. Development and learning are promoted if the balance of power between important adults and the child or adolescent is gradually shifted in favor of the child (Bronfenbrenner, 1979). Maybe trust means to know that an adult will do what is in the best interest of the child or the adolescent, and in cooperation with him or her. The key articles in the CRC declare this, so it is expected of adults both by the UN and by adolescents.

In addition to trust, the adolescents in Study I considered attentiveness, respectfulness, authenticity, accessibility, and continuity to be important dimensions of a mental health-promoting dialogue. Attentiveness included making the adolescent feel seen and listened to. Respectfulness, from Study I, can be found in Study II where the adolescents said that whether their teachers showed respect determined whether or not school was a good place to be. Respect is one of the main principles in the CRC (United Nations, 1989), and respect implies a mutual understanding between equal persons, which is what the adolescents in study I, II, and III were seeking, and is what Buber (1994) calls the authentic encounter. In Study I, the adolescents said that the encounters with the school nurse were important, not only meeting her as a nurse, but also as a private person. In Study II, the adolescents perceived that the encounter and dialogue with their parents were extremely important. To let the adolescent be a partner or to participate in decision-making is another way of respecting the adolescent. In Study III, the adolescents are very clear about being the most important person when it comes to dealing with a problematic situation, when disclosing a family secret. Adolescents have to be respected.

## **FRIENDS**

Friends are very important to young people. In Study II they were one of three important determinants for mental health, together with family and school. Part of the concept of mental health in Study II is being liked by your friends. A feeling of being liked includes not feeling lonely and being seen and listened to by your friends. The HBSC study defines peers as a contextual factor related to young people's health, and it is crucial to have friends (Settertobulte & Gaspar de Matos, 2004). Major life events, such as meeting a supportive friend were important to the resilient adults who had grown up in families with alcohol problems (Werner & Johnson, 2004), and to develop resilience good relationships with friends in adolescence are important (Collishaw,

Pickles, Messer, Rutter, Shearer, & Maughan, 2007). When looking at the bioecological model, where contextual factors are important to people's development, friends are situated in the micro system (Bronfenbrenner, 1979). Thus, friends are important not just for feeling well, but also for the individual's development. According to the adolescents in Study II, friends, or peers, could be a positive or a negative determinant. It is positive to have a close friend, and boys in Study II said that having many friends was beneficial for mental health. Friends are the ones that many adolescents choose to talk with when they are troubled. For the adolescents in Study III talking to a close friend could be an early step in the disclosure process. The adolescents even said that it might be important that a friend spoke to an adult, even if it meant disclosing a secret, if it was very important to keep the person safe (Study III). Friends appear to be very important persons to adolescents, and act as important confidants and sometimes facilitators for disclosure, so it would be important to include friends in activities to promote the well-being of adolescents at risk of abuse and neglect and with mental health problems.

One of the problems that the adolescents talk quite a lot about however, and a negative determinant for mental health, is bullying among peers at school. Especially the younger ones (13 years old, in Study II) talked a lot about this issue. When the adolescents in Study I reported what issues should be included in a mental health-promoting dialogue, they mentioned bullying among other subjects. Bullying is a serious problem at school, and an evidence-based preventive program exists (Olweus, 1994), though it is little used in Sweden (SOU 2006:77). Bullying is a problem for young people with a disability (Brunnberg, 2003, 2005), which is highlighted by the Committee on the Rights of the Child (2005). The adolescents in Study III were also concerned about what might happen if they disclosed that they had a parent with alcohol problems. Maybe they would be bullied or peers would give them nick-names and tell jokes about alcoholics. Children and adolescents are more exposed to violence than adults, but there are weaker norms and less sanction when they are victimized (Finkelhor, 2008). One might ask what would happen if adults were kicked at when walking past, got their things destroyed, and were called names at their working places. Friends are micro systems, important for development (Bronfenbrenner, 1979). What does it mean for the development of a child or an adolescent if he or she is bullied? Three of

the contextual factors linked to mental health are family, school, and peers (WHO, 2004), and all three factors interact when it comes to bullying at school. These are also the factors that the adolescents discuss as important determinants of mental health in Study II. One of the girls in Study II said that bullying, together with war, were the things she would like to change in the world. As the Swedish governmental committee has stated, school has to be safe and stimulating and promote mental health (SOU 1998:31). School health dialogues with the school nurse seem to be beneficial for children and adolescents who are bullied (Borup & Holstein, 2007). However, bullying does not seem to be a prevalent problem in Sweden, according to the HBSC study from 2005/2006. There were no differences between girls and boys, or between ages (Currie *et al.*, 2008). Even if bullying is not prevalent in Sweden, it is obviously an important and complex problem that all adults, at school and at home, should work together with children and adolescents to solve.

#### **GENDER AND AGE**

The studies in this thesis show that gender and age can make a difference. The girls and boys in Study II did not think that mental health differs so much between girls and boys. This is somewhat surprising since many studies show a difference between girls and boys in self-reported mental health problems, with girls reporting more complaints than boys (e.g., Currie *et al.*, 2008). The girls and boys in Study II said that there were different expectations on girls and boys: girls should be talkative and emotional, and boys silent and tough. This might explain some of the differences in the answers that adolescents give on mental health questionnaires, but probably not all of them. There seems to be a difference in girls' and boys' mental health, and the explanation for this is probably to be found in biological differences as well as in the social gender construction (Hammarström, Härenstam, & Östlin, 1996, SOU 2006:77). Genes and the environment matter according to Rutter (2006). In the studies in this thesis (I, II, and III) more girls than boys have participated. This can be seen as showing that girls are more interested in, or better at discussing mental health issues. However the boys that were interviewed were no different from the girls in terms of their ability to talk about mental health or the mental health-promoting dialogue with the school nurse (Studies I and II), or about the disclosure process (Study III). They were all quite ordinary boys, and differed amongst themselves. In Study II boys said that they felt different from other boys because of their ability and courage to talk about these issues. The differ-

ence in number between girls and boys in the studies in this thesis is probably due to the social gender construction, where boys are not supposed to be interested in discussing matters like mental health. Adults need to find ways to involve boys, as well as girls, in discussions on various matters, as this is part of participating, and having your voice heard, in line with the CRC (United Nations, 1989).

During adolescence puberty arrives, and this means changes in the person (see e.g., Skoog, 2008). The adolescents were quite aware of this, as they said that when you were younger you might not understand that things are not okay at home (Study III). This is acknowledged in studies on disclosure of sexual abuse (Svedin & Back, 2003). Puberty means that the identity is developing and that the person starts perceiving his or her place in society (Bailey, 2006; von Tetzchner, 2001). It is a time when change is possible (Aldgate, 2006). This makes puberty a positive phase of development, when adolescents who have experienced an adverse childhood get the opportunity to make a change for the better. In the bioecological model Bronfenbrenner (1979) states that when one of the participants in the micro system changes concerning development, it will affect the other one. This would imply that puberty, with its developmental changes, will affect the parents, who in their turn might change. Maybe the reciprocal effect that parents and children have on each other (Troost, 2002) can lead to a change in families with alcohol problems. It is important then that adults understand that the signals from adolescents, whether they are in the form of internalizing or externalizing symptoms, or writing an essay, or disclosing a family secret in some other way (as in Study III), become possible for the adolescent when he or she reaches puberty, and may not have been before. Adults should understand that this can be a cry for help, but also that it might be a first step in dealing with problems, and that this is positive for the adolescent. Adults need to be there to give support that the adolescent want and need.

#### **ADOLESCENTS' PERSPECTIVE AND PARTICIPATION**

In Study III some of the adolescents emphasized how important it is that the young person be included in the decision-making and planning, when it comes to supporting a child or adolescent at risk of abuse and neglect. Article 12 in the CRC is very clear on this point. It provides the child or adolescent with the right to be heard in judicial and administrative proceedings affecting him or her (United Nations, 1989). This covers a

wide range of proceedings affecting the child for example with regard to social issues and at school (Hodgkin & Newell, 2002). In one focus-group the girls said that some adults are in such a hurry to report to the social authorities that the child might be afraid what will happen and withdraw. The social authorities are responsible for the protection and welfare of all young people, and school personnel are obliged to report any suspicion of abuse or neglect (SFS 2001:453). The adolescents in Study III were not knowledgeable about the social authorities and what they might do, and were afraid of what might happen if they disclosed information about their family situation. It seems important to teach children and adolescents at school about the role of the social authorities, and what they can do to help and support. It also seems to be important to teach adults about children and adolescents at risk of abuse and neglect, and their situation. To achieve these tasks children and adolescents have to be included in planning and decision-making in matters concerning them on all levels, the micro, exo, and macro level (Bronfenbrenner, 1979). To empower young people in this way is an important way of promoting mental health (Blair, Stewart-Brown, Waterston, & Crowther, 2003).

Planning and decision-making for young people should take place on all levels in society. The bioecological model gives a tool for looking at the different levels with the development of the individual in mind (Bronfenbrenner, 1979, 2000). On the micro level, the adolescent relates to her or his family, to friends, and to other close relations in life. It is important for the adolescent to have a voice in these systems. Swedish adolescents in general think that their parents listen to what they have to say, but they are not as happy about their possibility of making their voices heard at school when it comes to planning and decision-making (Children's Ombudsman, 2005). The Committee on the Rights of the Child (2005) is critical of Sweden and concerned that some young people do not feel they have any real influence in matters concerning them in society. Study IV shows that Swedish children and adolescents are heard in some matters concerning them, mostly on social issues. The Committee on the Rights of the Child (2005) suggests that decisions should contain information on how the views of the children and adolescents were solicited and how these views were taken into account. The participation of the young person is of major interest, if the adult is going to be the trusted person that the adolescents are looking for (Studies I, II, and III). The meso level in the bioecological systems model requires cooperation between the micro

systems. It is a challenge for schools and parents to reach this cooperation in the best interest of the child and adolescent, and to also include the child or adolescent in the cooperation.

Three of the included articles in the thesis deal with adolescents' perspectives on the main topic, mental health. In the fourth of the articles (Study IV), the officials and politicians in the municipality (the exo level) gave their perspective on support to children and adolescents. The officials and the politicians said that the perspective of young people is important, but they did not ask for young people's ideas when deciding how to use grants from the government. The government grants were destined to children and adolescents at risk of abuse and neglect, and most of the money was used for training personnel in working with these children and adolescents. But no children or adolescents were invited to discuss how to use the grants in the best way, even though they were the targets of the intervention. Children's right to have their views respected and taken into account is not prioritized by the states that have ratified the Convention (Stern, 2006). According to Stern (2006, p. 257) "the right to participation as an issue of democracy is apparently not considered to be as important for children as it is for adults". The respondents in Study IV, especially the politicians, used the phrase "in the best interests of the child", and the concept of "children's perspective". But "children's perspective" did not mean to actually ask the children or adolescents, but merely to have the best interests of the child in mind as an adult. This is of course very important and is stated in Article 3 in the CRC (United Nations, 1989), but it does not rule out that the perspective of young people is very important, which is emphasized by the CRC, Article 12. The rhetoric of "children's perspective" is used politically to drive through a decision, because it is unifying (Halldén, 2003). Adults have to get better at making young people into partners, and finding possibilities to meet with young people in discussions about matters concerning them.

### **SOCIETY'S SUPPORT**

Not only on the micro and meso level, but also on the exo and the macro level, support is essential for adolescents' mental health. School is part of the micro and the exo systems, and the social authorities can also be so. If young people lack meaningful and constructive encounters with their parents, school probably becomes even more important when it comes to enabling encounters and dialogue between young people and

adults to take place. The adolescents in Study III had suggestions for how adults should treat them and support their special needs. If pupils at school are to have the opportunity to take part in such encounters and dialogues with adults, they need to be accessible so that continuity can be maintained, which the adolescents in Study I reported as an important dimension in mental health-promoting dialogues with the school nurse. Teachers are the adults that pupils see the most of at school, and teachers are very important people for the young (Werner & Johnson, 2004). But schools need to provide young people with many adults able to communicate well with them and meet them in authentic encounters. In a study from Scotland (Armstrong, Hill & Secker, 2001) in which young people were interviewed about mental health issues, the participants missed not having someone at school to talk with. They suggested that a nurse or a social worker should be employed for this special task. In Sweden, the pupils have the opportunity to talk to the school nurse and the social worker, as well as other adults at school, but they are not always as accessible as the adolescents might wish. The adolescents in Study I were concerned about not finding the school nurse when they needed her most.

Programs can be used to promote children's and adolescents' mental health. They can be universal, selective, or indicated (Ferrer-Wreder, Stattin, Cass Lorente, Tubman, & Adamson, 2005). The "population paradox" speaks in favor of promoting the well-being of the whole population in order to reduce the risk for all, and thereby also the risk groups (Blair, Stewart-Brown, Waterston, & Crowther, 2003). This would mean using universal programs. When municipalities received grants for projects for children and adolescents at risk (Study IV), the municipalities used the grants in different ways. Personnel learned about Aggression Replacement Training (ART), and Variety and Dialogue (MOD). The first program is targeted towards aggressive children and adolescents and can be called indicated, and the second targets all pupils and is universal. The personnel also learned about support groups for children and adolescents in families with alcohol or other problems (selective), and self-harming behavior (indicated). It is possible to provide universal programs and still give those with special needs more support (Blair, Stewart-Brown, Waterton, & Crowther, 2003), but this would mean using different programs, or using programs that are both universal and selective, or indicated. When municipalities received grants for promoting the well-being of children and adolescents at risk of abuse and neglect, they used them univer-

sally for all, and specifically for children and adolescents who are at high risk of, or have displayed, mental health problems.

Some of the issues, which the adolescents wanted to discuss with the school nurse, according to the adolescents in Study I, could be asked about in a health guide with questions that the pupils answer in advance. This health guide can be used for discussing and learning about health (Borup, 2000. 2002). It is a difficult task to consider what issues to discuss in a guide with questions as a starting point. In Study III the adolescents thought it was very important to be asked about their family situation. This was one of the most obvious findings in the study. And they thought that the school nurse and the school social worker are better suited than the teacher to ask questions about their family life. In a study asking midwives about disclosure of violence against pregnant women, they were positive towards including questions on abuse in their consultations with pregnant women (Edin & Högberg, 2002). As of today they could probably only disclose a few, even though they had good knowledge about the signs and symptoms. The authors conclude that domestic violence will probably remain hidden if questions are not asked and included in the standard antenatal care forms. It is important that adults indicate to the adolescents that they are prepared to talk about sensitive issues, from a positive as well as a negative perspective. Questions about the home situation should be included in the health guide that is used in the health dialogue between the school nurse and the pupil.

In the exo system we find the social authorities. The social authorities have the ultimate responsibility for children and adolescents at risk of abuse and neglect (SFS 2001:453). One of the methods for promoting mental health of these children and adolescents is to run support groups. Support groups are recommended in several studies (e.g., Black 2007). The adolescents in Study III, who all attended such a support group, recommended these groups to other children and adolescents in similar situations as theirs. Support groups seem to be a meeting place that has proved to become a micro system that is important to the adolescents (Brunnberg, Eriksson, & Tinnfält, 2007). More should have the opportunity to attend these groups. It is also important to offer other forms of support for these children and adolescents. In the support groups in Study III, there were mostly girls. Only three boys took part out of 28 participants. When so few boys attend the support groups, questions are raised: why are there not

more boys? Where are the boys? Is the support mostly for girls? What support do boys want and need? In the municipalities (Study IV) some activities seemed to be arranged more for boys than for girls, for example Aggression Replacement Training, but some were more targeted towards girls, for example when personnel learned about self-harming behaviour. In the exo system civil organizations can be found, together with schools and social authorities. A range of services must be provided by different organizations to meet adolescents' needs (Lynch, 2008). Procedures in society can promote the rights of children, if adults are sensitive to children's views and needs (Littlechild, 2000). Support has to be offered in different ways, so that girls and boys can find the form of support that best suits them.

According to Bronfenbrenner (1979) information is very important for easing the transition to a new setting. This is also what the adolescents in Study III wished that adults at school, in particular the school nurse and the school social worker, would provide. Most important is information given in one setting about another (Bronfenbrenner, 1979), and that is probably one of the reasons why it was important to adolescents to receive information from their parents about the support group. The meso system binds the micro systems together (Bronfenbrenner, 1979). The support group needs to cooperate with the family if the meso system is to help the adolescent to develop. It should perhaps also cooperate with the micro system at school, for example with a friend, the teacher, the school nurse, the school social worker or some other person who is important to the adolescent.

The macro system that is involved in adolescents' lives and part of society's support, and studied in this thesis, is the Swedish government. In Study IV governmental grants were distributed to nine municipalities for support to children at risk of abuse and neglect, especially children and adolescents with families with alcohol problems. A wide range of programs were underway in the municipalities or were started with the grants. The respondents thought that the grants were very valuable. Of course everyone tends to be thankful for funding, but even the small amount of money had an impact on the work for children at risk of abuse and neglect. Most important was the recognition from the government that the municipalities are doing important work. This meant that children at risk of abuse and neglect were prioritized. The officials felt stimulated and strengthened. The government at the national level has to be explicit

about how it intends to implement the CRC as this will lead to more activities at the local level (Englundh, 2008). The government (in the macro system) influenced the municipalities (the exo system) with recognition and money, which in turn influences the child. But in the process of implementation the micro level was not involved. This seems to be a difficulty in the implementation process, and probably one of the reasons why it takes so long to implement the CRC. Children are supposed to be involved in the process on all levels, according to Article 12 of the CRC. But the activities that were promoted by the grants in Study IV neither involved young people, nor were planned or discussed by children or adolescents.

The CRC can also be viewed as part of the macro system. It is a tool for strengthening young people on all levels in society and in all matters concerning them. Children's and adolescents' health is a matter for the CRC, and so is their protection. The context is important, and one of the key articles emphasizes participation, which is an important indicator for mental health. The UN Convention on the Rights of the Child and Child public health walk hand in hand.

## **METHODOLOGICAL CONSIDERATIONS**

### **LIMITATIONS AND STRENGTHS**

There are certain limitations and strengths in this thesis. First, there were more girls than boys participating in the studies. This is due to the fact that more girls than boys were interested in being interviewed about mental health (Studies I and II). In Study III all adolescents that were attending the support groups except one (a girl) agreed to participate in the discussions. But only three boys attended the support groups. It would have been satisfactory to reach boys, but the attempts to find groups with boys failed. In Study II the participating boys saw themselves as different from other boys, because they could talk about mental health issues. But they appeared to be quite ordinary boys. In Study I, no comparison is made between girls and boys, because there were too few focus groups to make such a comparison. It is a drawback for the thesis that there are so few boys in relation to girls in the studies.

Second, the focus groups have sometimes been very small. According to Krueger (1994) there are most often four to twelve persons in a focus group. But in Study II and III some of the focus groups were smaller. It seemed important that the respondents be allowed to choose how to be interviewed, since they belonged to a vulnerable group.

The discussions were lively however, even when there were only two participants. Perhaps the discussions would have been deeper, and the adolescents would have felt more secure, if the focus-groups had met more than once. In Study III that would not have been possible, however, since the support groups met for a limited time during one term. But it could have been possible to meet the adolescents to validate the results later, which has not been done.

Third, the respondents do not represent the population. A purposeful sampling has led to respondents who have chosen to participate in the studies (Studies I and II). More adolescents were asked in studies I and II, but the participants are only those who were interested. The aim of Study III was to ask adolescents with families with alcohol problems about their views on their situation. To obtain respondents, support groups were contacted. Obviously, adolescents who are not known to adults outside the family and who have not disclosed their situation could not be invited to participate. Nor were adolescents who received support from some other source invited. Almost all the adolescents in the selected support groups were interested in participating; only one girl declined.

Fourth, in Study IV officials answered questions about on-going activities in the municipality. These officials were mostly from the social services, and they did not have an overview of activities going on in other sectors of the municipality. Thus the results do not cover all activities. But the respondents had full insight into the grants and what they were used for, which was more important in the study than the on-going activities. The documents that were analysed were obtained from the respondents and from the home pages of the municipalities, which means that the documents might have been chosen to present a certain view of the municipality. The included survey from the Children's Ombudsman was not biased in this way, however.

Some strengths can also be identified. First and foremost, it is a strength that adolescents have given their views on matters concerning them, in line with the CRC. The implementation of the CRC around the world has led to a desire on the part of researchers, politicians, and others to include adolescents in research. A growing number of studies are presented in which children and adolescents participate. This thesis contributes to the knowledge on adolescents' views on mental health issues.

In Study IV all municipalities that received grants from the government are included, which is a strength of the study.

Individual and focus-group interviews have been used in this thesis. The adolescents have been able to choose how to be interviewed. This has led to their feeling safe, either by being interviewed alone or with friends. The triangulation has led to more variations in the adolescents' views on the different issues.

Being a school nurse means having knowledge and experience of meeting with young people, which has been a strength in the interviews with the adolescents, and in the analysis. Being a school nurse combines nursing, public health, and social work in a natural way, and this thesis brings the three subjects together.

#### **REFLECTIONS ON ETHICS IN INTERVIEWING YOUNG PEOPLE**

A child is an expert on what it is like to be a child. But adults still act as gatekeepers when it comes to asking children and adolescents about their views. It is very important to protect young people, and it is important to give them the chance to express their views. Sometimes adults may be protecting themselves, and not the child or adolescent, when declining participation for them. As young people mature, parental control diminishes (Masson, 2004); the question is *when* adolescents are old and mature enough to consent to research on their own. Swedish law on ethics in research on human beings states that parents have to give their consent if the young person is under the age of 15 (SFS 2003:460). It seems unclear, however, if any form of consent is required from parents when the adolescent is between 15 and 18. In Study III, the ethics committee required passive consent from parents for this age group, which means that they could change the decision to participate of the adolescent. This is an ethical question. Is it ethical not to let young people who are older than 15 have the responsibility to decide for themselves if they want to participate in research regarding their own life? In the CRC, the focus is on the child's maturity, not her/his age (United Nations, 1989).

In all three studies where adolescents were asked about their views, they were very eager to do so. All the adolescents were very interested. They were from different backgrounds, having for example different countries, genders, and social experiences. But all were attentive and had a great desire to communicate their views. Especially in

Study III, where the adolescents had experiences from families with alcohol problems, they expressed a desire that the results of the study should be disseminated to adults, so that other children and adolescents in similar situations as theirs would benefit from their stories. The same experience from interviews with children experiencing domestic violence was reported from a study in Norway (Heltne, 2008). Probably in these two studies it was important to see the children and adolescents as important informants and not as victims.

In this thesis adolescents from 12 to 19 have been included. They have received information verbally and in letter form. Before the interviews began they were all informed about the study again and reminded that they have the right to withdraw. Parents, school nurses, school principals, department-heads and officials at the social services, and ethics committees have been gate keepers. They have regarded the studies as relevant.

#### **ASSESSING THE TRUSTWORTHINESS OF THE FINDINGS**

In qualitative research, credibility, confirmability, dependability, and transferability are often used to describe trustworthiness (Lincoln & Guba, 1985). The trustworthiness of this thesis will here be discussed in terms of credibility, dependability, and transferability (Graneheim & Lundman).

Credibility depends on how well data and analysis fit the focus of the study: which respondents that participate, and how the data is gathered. To have a variety of respondents gives a richer variety of views on the matter in question and can increase the credibility of the study. It is also important to use the best available method for collecting data. Representative quotations can be used to illustrate the credibility of the analysis. Another way can be to seek agreement from co-researchers and participants (Graneheim & Lundman, 2004). The participating adolescents in Studies I, II, and III were of different ages and from different areas, and both girls and boys were involved. This contributed to a broader variation in the description of the phenomena. To obtain young people's views on phenomena in their world we need to ask them, and qualitative research seem to be the right method to gain access to the adolescent's world. In Studies I, III, and IV the interviews were analysed with content analysis, which was chosen to achieve variations in the findings. In Study II, a phenomenographical approach was used to gather the perceptions of the adolescents. In each of the four stud-

ies quotations from interviews show the relevance of the categories. Co-researchers have agreed with the categorizations, but the respondents have not been asked to confirm the findings.

Dependability deals with the data, for example alterations in the researcher's decisions on the analysis of the data. Graneheim and Lundman (2004) suggest that these issues can be addressed by the research team. The description of the analysis in the studies gives the reader an opportunity to judge the dependability of the findings. In the four studies, dependability has been established by asking all the respondents in the same study the same research questions. There has been a discussion in the research team in the four studies about the analyses, and the processes of analysing the data are described.

Transferability refers to the question of whether the findings can be transferred to other settings or other groups of people. The author can give suggestions, but it is up to the reader to decide. If the reader is to be able to decide, it is important that the studies are described in terms of context, participants, data collection, analysis, and quotations to show the relevance of the findings (Graneheim & Lundman, 2004). Young people all over the world need to be respected and involved in matters concerning them, and mental health issues are important everywhere. This applies as well for especially vulnerable groups, for example adolescents at risk of abuse and neglect. Adolescents with families with alcohol problems have a stressful situation all over the world, and are at risk of abuse and neglect and mental health problems.

## **IMPLICATIONS**

The findings in this thesis have implications for the future promotion of adolescents' mental health. Valuable information is provided for professionals who meet adolescents in general, and adolescents at risk of abuse and neglect. For politicians and officials who address issues concerning adolescents, the findings should also provide useful information.

- Friends are very important in supporting an adolescent. A good friend is often the person that an adolescent confides in when he or she is troubled. This friend can also sometimes act as a facilitator, and help an abused or neglected adolescent tell an adult about the situation. Friends should be included in activities to

assist adolescents at risk of abuse and neglect, and adolescents with mental health problems.

- Bullying is obviously an important and complex problem at school. Even though it does not seem to be a prevalent problem in Swedish schools (Currie *et al.*, 2008), adolescents find it to be a serious problem. Adolescents think parents need to be involved in problem-solving at school. All adults, at school and at home, should work together with children and adolescents to prevent bullying, and to solve the problem if it arises.
- Adults need to understand that signals from adolescents, whether they come in the form of internalizing or externalizing symptoms, writing an essay, or disclosing a family secret in some other way, become possible for the adolescent when he or she reaches puberty. Adults should understand that this can be a cry for help, but also that it might be a first step in dealing with problems, and that this is positive for the adolescent. Adolescents want and need support from adults, and adults who know how important they are for adolescents, will probably be more open to giving support and help. Hence, more information and education for adults about adolescents and puberty is needed.
- Adolescents with families with alcohol problems thought that adults in general know too little about alcohol, alcoholism, the home situation in these families, and about the support available to children and adolescents. Education is needed on these issues.
- The adolescents had suggestions on what a health dialogue with the school nurse should include to help promote mental health. The adolescent with families with alcohol problems strongly felt that the school nurse should ask about the home situation. The school nurses should take these opinions seriously and use a guide for health dialogues that is in line with the suggestions from the adolescents.
- Adolescents want to participate in matters concerning them, and they demand to be partners in decision-making when it concerns disclosure of family secrets. Even if the adolescent cannot decide what to do, it is of the greatest importance

that the adolescent be informed of planning and of all measures taken. Social workers and others who work with families with problems have to involve children and adolescents in the measures taken much more than is done today.

- Girls seem to participate more than boys in matters concerning mental health. Adults need to find ways to involve boys, as well as girls, in discussions on various matters. This is part of participating, and having your voice heard, which is in line with the CRC.
- The adolescents had vague ideas about the role for school personnel when they suspect that a child or an adolescent is at risk of abuse or neglect. The adolescents with families with alcohol problems were afraid of disclosing the family secret, because they did not know what could happen after disclosure. They were most afraid of being taken away from their family. It seems important that schools teach children and adolescents about the mandatory reporting statutes of school personnel, and about the role of the social authorities – what they can do to help and support.
- Children and adolescents were not involved in the planning and decision-making on how to use grants distributed by the Swedish government. Adults in general, and especially adults in leading positions, should be educated in how to make children and adolescents participants. One idea is that the question should always be raised whether children or adolescents can be asked as soon as matters concerning them are discussed.

## **FUTURE RESEARCH DIRECTIONS**

The perception of “mental health” seems to be somewhat different among adolescents than adults. Questionnaires are used to ask young people about their mental health, and they might not perceive the concepts used in the questionnaires in the same way as adults do. More research is needed on adolescents’ perceptions of concepts that are used in questionnaires that young people answer.

Girls’ and boys’ perceptions of mental health have been addressed in this thesis. They see more similarities than differences between girls and boys. But the differences they see concern expectations of girls and boys respectively. More research on differ-

ences and similarities between girls' and boys' perceptions are needed on various matters. The gender perspective should be included in all research on adolescents. It seems important that gender researchers step into the arena of mental health for girls and boys.

In the support groups for adolescents with families with alcohol problems mostly girls attended. Few studies are done to investigate what support these children and adolescents receive. There is no reason to think that girls have more need of support than boys. But there may be a difference in girls' and boys' support needs. This issue should be addressed in research.

Adolescents have ideas on how schools can promote and support children and adolescents at risk of abuse and neglect, and those who have mental health problems. More research is needed where children and adolescents give their views on how to promote mental health. Research is also needed where young people are involved in the whole research process, and indeed participate by choosing the research question, collecting the data, and analysing the data.



## CONCLUSIONS

Adolescents see family and friends as the most important determinants for their mental health. The determinants can be positive and negative. They find adults to be very important persons to them, especially their parents. They look for trustworthy adults in whom they can confide when the family situation is problematic. The adolescents assess the risks for trusting an adult.

Friends are very important people who work as confidants and sometimes as facilitators for seeking support from adults.

Adolescents want cooperation with adults, as is their right, and to be looked upon as equal partners in dialogues about their health and their problems.

Girls and boys perceive that they are different in terms of what is expected of them, but they do not show any differences when talking about mental health issues or about family problems. However, girls seem to be more interested in participating in research about these matters, and they also more often participated in support groups for adolescents in families with alcohol problems.

In adolescence, girls and boys become more aware of their family situation as they grow older. Differences in age seem to matter when it comes to perceiving what mental health is.

Children and adolescents at risk of abuse and neglect and mental health problems need different kinds of support and promoting initiatives. Girls and boys may have different needs. Even small grants from the government appear to be valuable for municipalities' efforts to support these children and adolescents.

Society has to become better at empowering young people and listening to them, and give them the opportunity to participate in matters concerning them.



# SAMMANFATTNING PÅ SVENSKA

## UNGDOMARS PERSPEKTIV

### – PÅ PSYKISK HÄLSA, ATT VARA I RISKZON, OCH FRÄMJANDE ÅTGÄRDER

Barn och ungdomar i Sverige har de senaste två decennierna rapporterat ökad psykisk ohälsa. Det uppfattas som ett allt större folkhälsoproblem, speciellt bland flickor. En annan grupp som är särskilt utsatt för psykisk ohälsa är barn och ungdomar i problematiska familjesituationer eller som befinner sig i andra risksituationer. Bland dem finns barn och ungdomar i familjer med alkoholproblem, vilket uppskattningsvis kan vara upp till vart femte barn. I FN:s konvention om barnets rättigheter poängteras rätten till skydd och stöd, och rätten att få göra sin röst hörd. I denna avhandling har ungdomar intervjuats om sina uppfattningar om psykisk hälsa, och om hur vuxna kan stödja och främja psykisk hälsa. Ungdomar i familjer med alkoholproblem har fått ge sin syn på hur de kan berätta om sin familjehemlighet, och vilket stöd de önskar. Dessutom har användningen av medel som delats ut av Alkoholkommittén (Socialdepartementet) till projekt för barn i riskzonen i nio kommuner analyserats. Den utvecklings-ekologiska modellen, beskriven av Bronfenbrenner (1979, 2000), har använts i analysen av resultaten.

Det övergripande syftet med avhandlingen är att undersöka ungdomars perspektiv på psykisk hälsa och förutsättningarna för att främja ungdomars psykiska hälsa, samt att fördjupa kunskapen om upptäckt och stöd till barn och ungdomar som riskerar att fara illa. En kvalitativ deskriptiv design valdes. I tre av studierna (I, II och III) har ungdomar i skolan och i stödgrupper för ungdomar i familjer med alkoholproblem intervjuats. I den fjärde studien (IV) valdes en multiple-case-study design, där tjänstemän intervjuades på plats, politiker per telefon och dokument analyserades, liksom en enkät till kommunerna som genomförts av Barnombudsmannen, BO. I avhandlingen har använts olika analysmetoder. Induktiv kvalitativ innehållsanalys har använts i studie I och III, och i studie II analyserades intervjuerna med en fenomenografisk ansats. I studie IV var kvalitativ innehållsanalys den huvudsakliga analysmetoden.

Resultatet i studie I visar att förutsättningarna för att hälsosamtalen med skol-sköterskan ska vara psykiskt hälsofrämjande innefattar vad som diskuteras i ett hälso-

samtal och var samtalet äger rum. Hälsosamtalen bör innehålla samtalsämnen om både den psykiska och den fysiska hälsan, enligt ungdomarna. Samtalet mellan eleven och skolsköterskan kan hållas på många platser, men är samtalet av känslig natur, bör en avskild plats väljas. Vad som är viktigt i samtalet med skolsköterskan är förtroende, lyhörddhet, respekt, äkthet, tillgänglighet, och kontinuitet. Det innebär att det är viktigt för ungdomarna att kunna lita på skolsköterskan, dels att hon respekterar tystnadsplikten, dels att hon är kunnig inom sitt område. Att lyssna var ett annat krav från ungdomarna. Resultatet i studie II visar att ungdomar uppfattar psykisk hälsa som en känslomässig upplevelse, där både positiva och negativa aspekter ingår. Psykisk hälsa innefattar känslor inombords, men också relationer. Bestämningfaktorer för psykisk hälsa visade sig vara föräldrar och kompisar, samt skolan. Dessa faktorer kunde inverka såväl positivt som negativt på den psykiska hälsan, enligt ungdomarna. Positivt var att kunna samtala med sina föräldrar och att ha kompisar som man kan lita på. Negativt var att det kunde vara problem i familjen, till exempel alkoholmissbruk, och att bli mobbad. Ungdomarna tillfrågades om sin uppfattning om skillnaden mellan flickor och pojkar. Ingen av dem ansåg att skillnaden var stor, utom i förväntningar på hur man ska vara. Flickor förväntas vara känsligare och pratsamma, medan pojkar förväntas vara tysta och tuffa.

I studie III visar resultatet att ungdomar tycks göra en riskbedömning huruvida de kan lita på en vuxen och våga berätta för denne om sin situation hemma. En process beskrevs av ungdomarna, där stegen innefattade att visa inåtagerande eller utåtagerande beteende, att beskriva sin situation i ord (till exempel i en dagbok), att berätta för en okänd (till exempel på Internet), att berätta för en kompis eller syskon, att ha indirekt kommunikation med en vuxen (till exempel skriva en uppsats i skolan), att berätta direkt för en vuxen, och att be om hjälp. Kompisar kunde fungera som ett stöd i den processen genom att se till att en vuxen blev informerad, om situation blev för allvarlig. Kompisar fungerar även som stöd och förtrogen. Ungdomarna gav också förslag på annat stöd som de önskar och behöver. Resultatet i studie IV visar att även små medel som delades ut till kommuner för stöd till projekt för barn i riskzonen hade stor betydelse för aktiviteterna i kommunerna. Tjänstemännen kände sig uppmuntrade, och kände att de gjorde ett viktigt arbete som blev legitimerat. Det ledde till att projekt kom igång som annars dröjt eller fått en mindre omfattning. Även politikerna ansåg att arbetet för barn i riskzonen blev prioriterat på grund av medlen. Dock var inte barn-

konventionen implementerad i den utsträckning de önskade, och inga barn eller ungdomar var involverade i planeringen eller i besluten kring hur de utdelade medlen skulle användas.

Sammantaget visar studierna att vad som är viktigt för ungdomars psykiska hälsa är relationer till vuxna, främst föräldrar, och till kompisar. Dessutom spelar följande aspekter roll för den psykiska hälsan: genusaspekter och ålder, att ungdomars perspektiv tas till vara och att de blir hörda om sådant som är viktigt för dem, samhällets stöd samt implementeringen av barnkonventionen. Alla nivåer i det utvecklingsekologiska systemet spelar roll för utvecklingen och den psykiska hälsan hos barn och ungdomar. Att lyssna visade sig vara ett viktigt krav på vuxna, och att de inte ska avslöja förtroenden. Ibland ställs dock vuxna inför ett etiskt dilemma, då anmälningsplikten medför att vuxna måste kontakta de sociala myndigheterna. Ungdomarna poängterade hur viktigt det då var att de blev fullt informerade och delaktiga i vad som skedde. När det gäller att stödja ungdomar som far illa har kompisar en viktig roll, och de bör göras delaktiga i stödet till dessa ungdomar.

Resultaten leder till implikationer för vuxna: att lära sig mer om ungdomsåren och om puberteten. Vuxna behöver också lära sig mer om familjesituationen för barn och ungdomar som riskerar att fara illa. Det är viktigt att vuxna lyssnar mer till förslag som barn och ungdomar har, till exempel bör skolsköterskor ställa frågor om barns och ungdomars hemsituation i hälsosamtalet. Barn och ungdomar ska höras i alla frågor som rör dem, vilket också barnkonventionen poängterar. De vill vara, och ska vara, delaktiga i planering och beslut om sådant som är viktigt för dem. Flickor och pojkar kanske behöver göras delaktiga på olika sätt, vilket är något vuxna behöver beakta.



## REFERENCES

- Alderson, P. (2004). Ethics. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, C. Robinson (eds.) *Doing research with children and young people*. London: Sage publications.
- Aldgate, J. (2006). Children, development and ecology. In: J. Aldgate, D. Jones, W. Rose, & C. Jeffrey (eds). *The developing world of the child*. London: Jessica Kingsley Publishers.
- Ambjörnsson, F. (2003). *I en klass för sig. Genus, klass och sexualitet bland gymnasie-tjejer. (In a special class. Gender, class and sexuality among girls in high school.* [Swedish]). Doctoral thesis. Stockholm: Ordfront.
- Armstrong, C., Hill, M., Secker, J. (2000). Young people's perceptions of mental health. *Children & Society, 14*, 60-72.
- Backlund, Å. (2007). *Elevvård i grundskolan – resurser, organisering och praktik.* (Pupil welfare in Swedish schools: Resources, organization and practice. [Swedish]). Doctoral thesis. Stockholm: Stockholm University.
- Bailey, S. (2006). Adolescence and beyond: twelve years onwards. In: J. Aldgate, D. Jones, W. Rose, & C. Jeffrey (eds). *The developing world of the child*. London: Jessica Kingsley Publishers.
- Balen, R., Blyth, E., Calabretto, H., Fraser, C., Horrocks, C., & Manby, M. (2006). Involving children in health and social research 'human becomings' or 'active beings'?. *Childhood, 13(1)*, 29-48.
- Barry, MM., Patel, V., Jané-Llopis, E. Raeburn, J. & Mittelmark, MB. (2007). Strengthening the evidence base for mental health promotion. In: DV. McQueen & CM. Jones (eds). *Global perspectives on health promotion effectiveness*. New York: Springer.
- Belfer, ML. (2004). Child and adolescent mental health around the world: challenges for progress. *Journal of Indian Association for Child and Adolescent Mental Health, 1(1)*, 31-36.

- Bergmark, Å. & Lundström, T. (2006). Metoder i socialt arbete – vad är det? In: A. Meeuwisse, S. Sunesson, & H. Swärd (red.). *Socialt arbete. En grundbok*. (Methods in social work – what are they? In: Social work. [Swedish]). Stockholm: Natur och Kultur.
- Black, C. (2007). *COA support groups*. Retrieved at [www.nacoa.org/coasupp.htm](http://www.nacoa.org/coasupp.htm). 2007-05-15.
- Blair, M., Stewart-Brown, S., Waterson, T., & Crowther, R. (2003). *Child public health*. Oxford: Oxford university press.
- Bond, D. (2000). Mental health in children who are deaf and have multiple disabilities. In: P. Hindley, N. Kitson, (eds.) *Mental health and deafness*. London: Whurr publishers Ltd.
- Bonner, B. (2008). *Advances in mental health. Interventions for abused and neglected children*. Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective 2008-09-07--10.
- Borup IK. (1995). *Sundhetssamtaler med skoleborn* [master dissertation]. [Health dialogues with school children [master dissertation]. (Danish).] Göteborg: Nordic School of Public Health.
- Borup IK. (2000). Danish pupils' perceived satisfaction with the health dialogue: Associations with the office and work procedure of the school health nurse. *Health Promot Int.*, 15(4), 313-320.
- Borup IK. (2002). The school health nurse's assessment of a successful health dialogue. *Health Soc Care Community*, 10(1),10-19.
- Borup, IK. & Holstein, BE. (2004). Social class variations in schoolchildren's self-reported outcome of the health dialogue with the school health nurse. *Scandinavian Journal of Caring Sciences*, 18, 343-350.
- Borup, IK. & Holstein, BE. (2007). Schoolchildren who are victims of bullying report benefit from health dialogues with the school health nurse. *Health Education Journal*, 66(1), 58-67.

- Bronfenbrenner U. (1979). *The ecology of human development: experiments by nature and design*. Cambridge, Massachusetts: Harvard University Press.
- Bronfenbrenner U. (2000). Ecological systems theory. In A. Kazdin (ed), *Encyclopedia of psychology* (pp.129-133). Oxford University press: Washington DC.
- Brülde, B., & Tengland, P-A. (2003). *Hälsa och sjukdom – en begreppslig utredning* (Health and disease – a conceptual investigation [Swedish]). Lund: Studentlitteratur.
- Brunnberg, E. (2001). Vinjettstudie av socialt arbete med barn i Sverige och England (A vignette study of social work with children in Sweden and in England. [Swedish]). *Sociionomen*, 3, *Forsknings supplement*, 13, 1-16.
- Brunnberg, E. (2003). *Vi bytte våra hörande skolkamrater mot döva! Förändring av hörselskadade barns identitet och självförtroende vid byte av språklig skolmiljö* (We changed our hearing schoolmates for deaf ones! Hearing-impaired children's change of identity and confidence when changing language in the school environment. [Swedish]). Doctoral thesis. Örebro studies in social work. Örebro: Örebro University.
- Brunnberg, E. (2005). The school playground as a meeting place for hard of hearing children. *Scandinavian Journal of Disability Research*, 7(2), 73-90.
- Brunnberg, E., Eriksson, C., & Tinnfält, A. (2007). *Att ha minst en förälder som missbrukar alkohol. Om psykisk ohälsa och utvärderade interventioner*. [Having at least one parent who abuses alcohol. About mental health problems and evaluated interventions.] Stockholm: Socialstyrelsen.
- Brunnberg, E., Lindén Boström, M. & Berglund, M. (2007). Self-rated mental health, school adjustment, and substance use in hard-of-hearing adolescents. *Journal of Deaf Studies and Deaf Education Advance Access*, 13, 324-335.
- Brunnberg, E., Sjöberg, K. Larsson (2006). *Barnrelaterade avhandlingar i socialt arbete*. (Child-related dissertations in Social work 1980-2006. [Swedish]). Örebro University. [www.oru.se/BUS](http://www.oru.se/BUS).
- Buber M. (1994). *Jag och du*. (I and Thou [Swedish]). Ludvika: Dualis förlag.

- Bygholm Christensen, H., & Bilenberg, N. (2000). Behavioural and emotional problems in children of alcoholic mothers and fathers. *European Child and Adolescent Psychiatry*, 9, 219-226.
- Börjesson, B. (2008). *Förstå socialt arbete*. (Understanding social work. [Swedish]). Malmö: Liber
- Casas-Gil, M.J., & Navarro-Guzman, J.I. (2002). School characteristics among children of alcoholic parents. *Psychological Report*, 90, 341-348.
- Ceci, S.J. (2006). Urie Bronfenbrenner (1917-2005). *American Psychologist*, 61(2), 173-174.
- Cederblad, M. (2003). *Från barndom till vuxenliv. En översikt av longitudinell forskning*. (From childhood to adulthood. A review of longitudinal research [Swedish]). Göteborg: Förlagshuset Gothia.
- Chalder, M., Elgar, F.J., & Bennett, P. (2005). Drinking and motivations to drink among adolescent children of parents with alcohol problems. *Alcohol & Alcoholism*, 41(1), 107-113.
- Children's Ombudsman (2005). *Öppna för gränser* (Open for limits [Swedish]). Stockholm.
- Christensen, E. (1997). Aspects of preventive approach to support children of alcoholics. *Child Abuse Review*, 6, 24-34.
- Clausson, E. & Berg, A. (2008). Family intervention sessions. One useful way to improve schoolchildren's mental health. *Journal of Family Nursing*, 14(3), 289-313.
- Clausson, E., Köhler, L., & Berg, A. (2008). Schoolchildren's health as judged by Swedish school nurses – a national survey. *Scandinavian Journal of Public Health*, 36, 690-697.
- Coffelt, N.L., Forehand, R., Olson, A.L., Jones, D.J., Gaffney, C.A., & Zens, M.S. (2006). A longitudinal examination of the link between parent alcohol problems and youth drinking: The moderating roles of parent and child gender. *Addictive Behaviours*, 31, 593-605.

- Collins, S.J., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South African Journal of Psychology*, 35(2), 270-285.
- Collishaw, S., Maughan, B., Goodman, R., & Pickles, A. (2004). Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry*, 45(8), 1350-1362.
- Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C. & Maughan, B., (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect*, 31, 211-229.
- Commission on Social Determinants of Health (2008). *Closing the gap in a generation. Health inequity through action on the social determinates of health*. Copenhagen: WHO.
- Committee on the rights of the child (2005). *Considerations of reports submitted by states parties under article 44 of the convention*. Retrieved at [www.unicef.se/barnkonventionen](http://www.unicef.se/barnkonventionen) 2007-02-25.
- Cuijpers, P. (2005). Prevention programmes for children of problem drinkers: A review. *Drugs: Education, Prevention and Policy*, 12(6), 465-475.
- Currie, C., Gabhainn, S.N., Godeau, E., Roberts, C., Smith, R., Currie, D., Picket, W., Richter, M., Morgan, A., & Barnekow, V. (2008). *Inequalities in young people's health. HBSC international report from the 2005/2006 survey*. Copenhagen; WHO.
- DeLucia, C., Belz, A., & Chassin, L. (2001). Do adolescent symptomatology and family environment vary over time with fluctuations in paternal alcohol impairment? *Developmental Psychology*, 37(1), 207-216.
- Doll, B. & Cummings, J.A. (2008). *Transforming school mental health services*. Thousand Oaks: Sage Publications Ltd.
- Downe-Wamboldt, B. (1992). Content analysis: methods, applications, and issues. *Health Care for Women International*, 13, 313-321.
- Edin, KE. & Högberg, U. (2002). Violence against women will remain hidden as long as no direct questions are asked. *Midwifery*, 18, 268-278.

- Edwards, EP., Das Eiden, R., & Leonard, KE. (2006). Behavior problems in 18- to 36-month-old children of alcoholic fathers: secure mother-infant attachment as a protective factor. *Development and Psychopathology*, 18, 395-407.
- van Eldik, T. (2005). Mental health problems of Dutch youth with hearing loss as shown on the youth self report. *American Annals of the Deaf*, 150(1), 11-16.
- van Eldik, T., Treffers, PA., Veerman, KW., & Verhulst, FC. (2004). Mental health problems of deaf Dutch children as indicated by parents' responses to the child behavior checklist. *American Annals of the Deaf*, 148(5), 390-395.
- Engdahl, E. (2004). *A theory of the emotional self. From the standpoint of a neo-Meadian*. Doctoral thesis. Örebro: Örebro University.
- Englundh, E. 2008. *Folkrätt för barn som pedagogiskt åtagande. Statligt ansvar – regionalt lärande?* [International law on children as an educational commitment. National obligations – regional learning?]. Doctoral thesis. Stockholm: Stockholm University.
- Eriksson, C. (2000). Learning and knowledge-production for public health: a review of approaches to evidence-based public health. *Scandinavian Journal of Public Health*, 28, 298-308.
- Ferrer-Wreder, L, Stattin, H., Lorente, CC., Tubman, JG., & Adamson, L. (2005). *Framgångsrika preventionsprogram för barn och unga. En forskningsöversikt*. (Successful prevention and youth development programs: across borders. [Swedish]). New York: Kluwer.
- Finkelhor, (2008). *New opportunities for child protection: Declines in child abuse in the US*. Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective, 2008-09-07--10.
- France, A. (2004). Young people. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, & C. Robinson, (eds.) *Doing research with children and young people*. London: Sage Publications.

- Fraser, S. (2004). Situating empirical research. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, & C. Robinson, (eds.). *Doing research with children and young people*. London: Sage Publications.
- Freeman, M (2008). *Can we conquer child abuse if we don't outlaw physical chastisement of children?* Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective, 2008-09-07--10.
- Gabhainn, SN. (2004). Summary. In: WHO. *Young people's health in context. Health behaviour in school-aged children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen: WHO.
- Gance-Cleveland, B. (2004). Qualitative evaluation of a school-based support group for adolescents with an addicted parent. *Nursing Research*, 53(6), 379-386.
- Garbarino, J (2008). *Opening presentation*. Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective, 2008-09-07--10.
- Goodman, R., Slobodskava H., & Knyazev, G. (2005). Russian child mental health. A cross-sectional study of prevalence and risk factors. *European Child and Adolescent Psychiatry*, 14(1), 28-33.
- Göthlund, A. (1997). *Bilder av tonårsflickor. Om estetik och identitetsarbete*. (Images of teen-age girls. [Swedish]). Doctoral thesis. Linköping: Linköping University.
- Graneheim, UH., Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105-112.
- Hagquist, C.E.I. (2006). Health inequalities among adolescents – the impact of academic orientation and parents' education. *European Journal of Public Health*, 17(1), 21-26.
- Halldén, G. (2003). Barnperspektiv som ideologiskt eller metodologiskt begrepp (Children's perspective as an ideological or methodological concept. [Swedish].) *Pedagogisk forskning i Sverige*, 8(1-2), 12-23.

- Hammarström, A., Härenstam, A., & Östlin, P. (1996). Kön och ohälsa - begrepp och förklaringsmodeller (Sex and ill-health – concepts and explanations [Swedish]). In: P. Östlin, M. Danielsson, A. Härenstam, G. Lindberg (eds.) *Kön och ohälsa – en antologi om könsskillnader ur ett folkhälsoperspektiv* (Sex and ill-health - an anthology about differences in sex from a public health perspective [Swedish]). Lund: Studentlitteratur.
- Hansson, H. (2007) *Interventions in adult children and spouses of alcoholics. Randomized controlled trials of mental health and drinking pattern*. Doctoral thesis. Lund: Lund University Clinical Alcohol Research, Department of Health Sciences.
- Haugland, BSM. (2003). Paternal alcohol abuse: relationships between child adjustment, parental characteristics, and family functioning. *Child Psychiatry and Human Development*, 34(2), 127-146.
- Heltne, UM. (2008). *In their own voices: In-depth interviews with children exposed to domestic violence*. Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective, 2008-09-07--10.
- Heyerdahl, S., Kvernmo, S., & Wichstrom, L. (2004). Self-reported behavioural/emotional problems in Norwegian adolescents from multiethnic area. *European Child and Adolescent Psychiatry*, 13(2), 64-73.
- Hjern, A. (2006). Children's and young people's health. *Scandinavian Journal of Public Health*, 34(suppl 67), 165-183.
- Hodgkin R, Newell P. (2002). *Implementation handbook for the Convention on the Rights of the Child*. New York: UNICEF.
- Hussong, AM, Zucker, RA, Wong, MM, Fitzgerald, HE., & Puttler, LI (2005). Social competence in children of alcoholic parents over time. *Developmental Psychology*. 41(5), 747-759.

- Jaffe-Gill, E., Jaffe, J., & Segal, J. (2007). *Child abuse and neglect: Types, signs, symptoms, causes and getting help*. Retrieved at [http://www.helpguide.org/mental/child\\_abuse\\_physical\\_emotional\\_sexual\\_neglect.htm](http://www.helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm) 2008-10-02.
- Jané-Llopis, E. & Braddick, F. (eds) (2008). *Mental health in youth and education*. Consensus paper. Luxembourg: European communities. Retrieved at <http://ec.europa.eu/health/> 2008-09-26.
- Johnson, J.L. & Leff, M.(1999). Children of substance abusers: Overview of research findings. *Paediatrics Supplement*, 103, 1085-1099.
- Karlsson, I. (2003). *Könsgestaltningar i skolan. Om könsrelaterat gränsupprätthållande, gränsuppluckrande och gränsöverskridande*. (Formations of gender in school. About maintaining, loosening and crossing gender-related boundaries. [Swedish]). Doctoral thesis. Linköping: Linköping University.
- Kimber Birgitta (2005). *Att främja barns och ungdomars utveckling av social och emotionell kompetens: teori och praktisk tillämpning för pedagoger*. (To promote the development of social and emotional competence of children and adolescents [Swedish]). Solna: Eklunds förlag.
- Kitzinger, J., Barbour, R. (1999). Introduction: the challenge and promise of focus groups. In: R. Barbour, J. Kitzinger, (eds.) *Developing focus group research. Politics, theory and practice*. Thousand Oaks: Sage Publications, Inc.
- Knight, S.M. (1993). Identifying and labelling school-aged children of alcoholics: insights voiced by academic attainers who are daughters of alcoholics. *Journal of Health Education*, 24(4), 196-202.
- Köhler, L. (1998). Child public health. A new basis for child health workers. *European Journal of Public Health*, 8, 253-255.
- Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child and Family Social Work*, 9, 129-140.
- Krueger, RA. (1994). *Focus groups. A practical guide for applied research. Second edition*. Thousand Oaks: Sage Publications, Inc.

- Kumpfer, K.L., Pinyuchon, M., Teixeira de Melo, A., & Whiteside, H.O. (2008). Cultural adaptation process for international dissemination of the Strengthening Families Program. *Evaluation & the Health Professions*, 31(2), 226-239.
- Kvale, S. (1996) *InterViews: an introduction to qualitative research interviewing*. Thousand Oaks: Sage Publications, Inc.
- Lagerberg, D., & Sundelin, C. (2000). *Risk och prognos i socialt arbete med barn. Forskningsmetoder och resultat*. (Risk and prognosis in social work with children. Research methods and results [Swedish]). Göteborg: Förlagshuset Gothia.
- Lambie, G. & Sias, S. (2005). Children of alcoholics: Implications for professional school counseling. *Professional School Counseling*, 3, 266-273.
- Larsson, S. (1986). *Kvalitativ analys – exemplet fenomenografi*. (Qualitative analysis – the example phenomenography. [Swedish]). Lund: Studentlitteratur.
- Leger, Kolbe, Lee, McCall, & Young, 2007. School health promotion. Achievements, challenges and priorities. In: DV. McQueen & CM. Jones (eds). *Global perspectives on health promotion effectiveness*. New York: Springer.
- Leonard, KE., & Das Eiden, R. (2002). Cognitive functioning among infants of alcoholic fathers. *Drug and Alcohol Dependence*, 67, 139-147.
- Lewis, V. (2004). Doing research with children and young people: an introduction. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, & C. Robinson, (eds.). *Doing research with children and young people*. London: Sage Publications.
- Lincoln, YS. & Guba, EG. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.
- Lindström, B. (2001). The meaning of resilience. *International Journal of Adolescents Mental Health*, 13(1), 7-12.
- Lindstein, T. (1997). *Unga vid Vändpunkten. Att arbeta med ungdomar vars föräldrar missbrukar*. [Young people at Vändpunkten. Working with adolescents whose parents are substance abusers]. Stockholm: Förlagshuset Gothia.

- Lindstein, T. (2001). *Vändpunkten – ur barnens och ungdomarnas perspektiv*. [Vändpunkten – from the perspective of the children and adolescents]. Stockholm: Förlagshuset Gothia.
- Littlechild, B. (2000). Children's rights to be heard in child protection processes – law, policy and practice in England and Wales. *Child Abuse Review*, 9, 403-415.
- Lynch, M. (2008). *Advances in child protection systems*. Paper at XVII ISPCAN International Congress on Child Abuse and Neglect in Hong Kong: Towards a caring and non-violent community: a child's perspective, 2008-09-07--10.
- Magnusson, D., & Stattin, H. (2006). The person in the environment: Towards a general model for scientific inquiry. In R. M. Lerner (Ed.), *Theoretical models of human development. Volume 1 of handbook of child psychology (6th ed.)*. (pp. 400-464). New York: Wiley.
- Malmros, U. (1993). *Missbruk och samhällsåtgärder i ett flergenerationsperspektiv – en 20-årsuppföljning av barn och ungdomar som ombändertogs för samhällsvård i Stodckholm 1970* (Drug abuse and society interventions in a multiple generation perspective. [Swedish]). Stockholm University: Socialhögskolan.
- Marton, F. & Booth, S. (1997). *Learning and awareness*. New Jersey: Lawrence Erlbaum Associates, Inc., Publishers.
- Marton, F. & Pong, WY. (2005). On the unit of description in phenomenography. *Higher Education Research and Development*, 24(4), 335-348.
- Masson, J. (2004). The legal context. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, & C. Robinson, (eds.). *Doing research with children and young people*. London: Sage Publications.
- Masten, AS., & Coatsworth, JD. (1998). The development of competence in favourable and unfavourable environments: lessons from research on successful children. *American Psychologist*, 53(2), 205-220.
- Mathews, B. & Bros, D. (2008). Mandated reporting is still a policy with reason: Empirical evidence and philosophical grounds. *Child Abuse & Neglect*, 32, 511-516.

- Mayall, B. (2002). *Towards a sociology for childhood. Thinking from children's lives*. Buckingham: Open University Press.
- Medin, J. & Alexandersson, K. (2000). *Begreppen hälsa och hälsofrämjande – en litteraturstudie*. (The concepts of health and health promotion – a literature review [Swedish]). Lund: Studentlitteratur.
- Merriam SB. 1998. *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass Publishers.
- Ministry of Education and Science (1994). *Läroplaner för det obligatoriska skolväsendet, förskoleklassen och fritidshemmet (Lpo 94)*. (Curriculum for the compulsory school system, the preschool class and leisure-time centre. Lpo 94 [Swedish]). Stockholm: Ministry of Education and Science.
- Ministry of Health and Social Affairs (2008). *Folkhälsa och sociala förhållanden. Lägesrapport 2007*. (Public health and social conditions. Progress report 2007. [Swedish].) Socialstyrelsen. Retrieved at [www.socialstyrelsen](http://www.socialstyrelsen) 2008-08-26.
- Minkler, M., Pies, C. (2005). Ethical issues and practical dilemmas in community organisation and community participation. In: M. Minkler (ed.) *Community organizing and community building for health, 2<sup>nd</sup> ed*. New Jersey: Rutgers University press.
- Modeste, N.N. (1996). *Dictionary of public health promotion and education. Terms and concepts*. Thousand Oaks: Sage Publications.
- Morey, C.K. (1999). Children of alcoholics: a school-based comparative study. *Journal of Drug Education*, 29(1), 63-75.
- Morgan DL. (1997). *Focus groups as qualitative research*. Newbury Park: Sage Publications Inc.
- Mylant, M., Ide, B. Cuevas, E., & Meehan, M. (2002). Adolescent children of alcoholics: vulnerable or resilient? *Journal of the American Psychiatric Nurses Association*, 8, 57-64.
- National Board of Health and Welfare (2001). *Folkhälsorapport 2001*. (Report on public health 2001. [Swedish]). Stockholm: National Board of Health and Welfare.

- National Board of Health and Welfare (2002). *Skolhälsovården i 10 kommuner i Syd-sverige*. (School health care in 10 communities in the southern part of Sweden [Swedish]). Stockholm: National Board of Health and Welfare.
- National Board of Health and Welfare (2004). *Socialstyrelsens riktlinjer för skolhälsovården*. (Guide lines from the National Board of Health and Welfare for the National school health service. [Swedish]). Stockholm: National Board of Health and Welfare.
- National Board of Health and Welfare (2005). *Mätning av barns och ungdomars psykiska hälsa – förslag till nationella och återkommande undersökningar*. (Screening for children's and adolescents' mental health – suggestions for national and reoccurring investigations. [Swedish]). Stockholm: National Board of Health and Welfare.
- National Board of Health and Welfare (2008). *Skador och förgiftningar behandlade i slutenvård 2006*. (Injuries and poisoning treated at hospitals. [Swedish]). Retrieved at [www.sos.se](http://www.sos.se) 2008-09-18.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) (2008). *Epidemiology of alcohol problems in the United States*. Retrieved at <http://pubs.niaaa.nih.gov/publications/Social/Module1Epidemiology/Module1.html>. 2008-10-30.
- Nilsson, K.W., Alm, P.O., Leppery, J., Orelund, L., Sjöberg, R. & Öhrvik, J. (2006). Interaktioner mellan gener och miljö. Predicerar kriminalitet, depression och alkoholberoende (Interactions between genes and environment. Predict criminality, depression, and alcohol dependency). [Swedish]. *Läkartidningen*, 39(103), 2859-2863.
- Nygaard Christoffersen, M., & Soothill, K. (2002). The long-term consequences of parental alcohol abuse: a cohort study of children in Denmark. *Journal of Substance Abuse Treatment*, 25, 107-116.
- Olweus, D. (1994). Bullying at school: basic facts and effects of a school based intervention program. *Journal of Child Psychology and Psychiatry*, 35(7), 1171-1190.
- Pattman, R. & Kehily, M.J. (2004). Gender. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, C. Robinson, (eds.) *Doing research with children and young people*. London: Sage Publications.

- Patton MQ. (2002). *Qualitative research & evaluation methods*. Thousand Oaks: Sage Publications, Inc.
- Pedersen, M., Alcón, M.C.G., Rodriguez, C.M., & Smith, R. (2004). Family. In: WHO: *Young people's health in context. Health behaviour in school-aged children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen: WHO.
- Peleg-Oren, N. (2002a). Drugs – not here! – model of group intervention as preventive therapeutic tool for children of drug addicts. *Journal of Drug Education*, 32(3), 245-259.
- Peleg-Oren, N. (2002b). Group intervention for children of drug-addicted parents – using expressive techniques. *Clinical Social Work Journal*, 30(4), 403-418.
- Pilgrim, D. (2005). *Key concepts in mental health*. London: Sage Publications.
- Polit, DE. & Beck, CT. (2004). *Nursing research: principles and methods*. Philadelphia: Lippincott Williams & Wilkins.
- Pons, F., Lawson, J., Harris, P., & de Rosnay, M. (2003). Individual differences in children's emotion understanding. Effects of age and language. *Scandinavian Journal of Psychology*, 44:347-353.
- Poon, E., Ellis, D., Fitzgerald, H.E., & Zucker, R.A. (2000). Intellectual, cognitive, and academic performance among sons of alcoholics during the early school years: differences related to subtypes of familial alcoholism. *Alcoholism. Clinical and Experimental Research*, 24(7), 1020-1027.
- Preuss, UW., Schukit, MA., Smith, TL., Barnow, S., & Danko, GP. (2002). Mood and anxiety symptoms among 140 children from alcoholic and control families. *Drug and Alcohol Dependence*, 67, 235-242.
- Riddle, J. & Bergin, J.J. (1997). Effect of group counseling on the self-concept of children of alcoholics. *Elementary School Guidance & Counseling*, 31(3), 192-203.
- Rigby, M.J., Köhler, L., Blair, M., & Metchler, R. (2003). Child health indicators for Europe. A priority of a caring society. *European Journal of Public Health*, 13(3), 38-46.

- Robinson, C, Kellett, M. (2004). Power. In: S. Fraser, V. Lewis, S. Ding, M. Kellett, C. Robinson, (eds.). *Doing research with children and young people*. London: Sage Publications.
- Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316-331.
- Rutter, M. (2006). *Genes and behaviour. Nature-nurture interplay explained*. Malden, MA: Blackwell Publishing.
- Rutter, M. (2007). Resilience, competence, and coping. *Child Abuse & Neglect*, 31, 205-209.
- Rydellius, PA. (1997). Annotation: Are children of alcoholics a clinical concern for child and adolescent psychiatrists of today? *Journal of Child Psychology and Psychiatry*, 38 (6), 615-624.
- Sandbaek, M. (1999). Adult images of childhood and research on client children. *International Journal of Social Research Methodology*, 2(3), 191-202.
- Save the Children (2006). *Barnets bästa kräver resurser! – om kommunernas ansvar för barn som far illa. Rapport 4. När samhället sviker barn som far illa*. [The best interest of the child demands for resources! – about the municipalities responsibility for children at risk of abuse and neglect.] Retrieved at [www.rb.se](http://www.rb.se) 2006-09-29.
- Settertobulte, W. & Gaspar de Matos, M. (2004). Peers. In: WHO: *Young people's health in context. Health behaviour in school-aged children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen: WHO.
- SFS 1949:381. *Föräldrabalken*. (Children and Parent code [Swedish]). Retrieved at [www.lagrummet.se](http://www.lagrummet.se). 2007-01-02.
- SFS 1980:100. *Sekretesslag*. (The official secrets act. [Swedish]). Retrieved at [www.riksdagen.se](http://www.riksdagen.se) 2008-10-07.

- SFS 1985:1100. *Skollagen*. (The education act [Swedish]). Retrieved at [www.lagrummet.se](http://www.lagrummet.se). 2007-01-02.
- SFS 2001:453. *Socialtjänstlagen*. (The social welfare act [Swedish]). Retrieved at [www.riksdagen.se](http://www.riksdagen.se). 2007-01-02.
- SFS 2003:460. *Lag om etikprövning av forskning som avser människor*. (Law about ethics in research on people [Swedish]). Retrieved at [www.lagrummet.se](http://www.lagrummet.se). 2008-10-07.
- Skoog, T. (2008). *On the developmental significance of female pubertal timing*. Doctoral thesis in psychology. Örebro: Örebro University.
- Solum L, & Schaffer M. (2003). Ethical problems experienced by school nurses. *Journal of School Nursing*, 19(6), 330-7.
- SOU 1994:29. *Barn, föräldrar, alkohol*. (Children, parents, alcohol. [Swedish]) Alkoholpolitiska kommissionen. Stockholm: Social Department of the Government.
- SOU 1998:31. *Det gäller livet. Stöd och vård till barn och ungdomar med psykiska problem. Slutbetänkande av Barnpsykiatrikommittén*. (About life. Support and care for children and adolescents with mental problems. [Swedish]). Stockholm: Social Department of the Government.
- SOU 2006:77. *Ungdomar, stress och psykisk hälsa. Analyser och förslag till åtgärder* (Young people, stress and mental health. Analyses and suggestions [Swedish]). Stockholm: Social Department of the Government.
- Spencer, N. (2005). Social equalization in youth: evidence from a cross-sectional British survey. *European Journal of Public Health*, 16(4), 368-375.
- Statistik Socialtjänst (2008) *Barn och unga – insatser år 2007*. (Children and young people - measures subjected 2007). Stockholm: The National Board of Health and Welfare (Official statistics, Social services).
- Stern R. 2006. *The Child's Right to Participation -- Reality or Rhetoric?* Doctoral thesis. Uppsala: Uppsala University.

- Stjerna M-L. & Marttila A. (1999). Hur få ett innehållsrikt material vid fokusgruppintervjuer – erfarenheter från en studie med ungdomar. [How to get a rich material in focus group interviews – experiences from a study with adolescents (Swedish)]. *Socialmedicinsk tidskrift*, 76(4), 332-339.
- Ståhlbrandt, H. (2008). *Alcohol use in Sweden. Interventions, drinking trajectories, social climate and cross-cultural influence*. Doctoral thesis. Lund: Lund University Clinical Alcohol Research, Department of Health Sciences.
- Svaleryd, K. (2002). *Genuspedagogik*. (Gender pedagogics [Swedish]), Stockholm, Liber.
- Swedish National Institute of Public Health (2007). *Public health policy*. Retrieved at [www.fhi.se](http://www.fhi.se) 2007-01-30.
- Swedish National Institute of Public Health (2008a). *Barn i familjer med alkohol- och narkotikaproblem. Omfattning och analys*. (Children in families with alcohol- and drug problems [Swedish]). Östersund: Statens Folkhälsoinstitut.
- Swedish National Institute of Public Health (2008b). *Skolan förebygger. Om hälsa, lärande och prevention i skolan*. (School prevention. On health, learning, and prevention at school. [Swedish]). Retrieved at [www.fhi.se](http://www.fhi.se) 2008-09-16.
- Svedin, C.G., & Back, C. (2003). *Varför berättar de inte? Om att utnyttjas i barnpornografi*. [Why don't they tell? To be abused in child pornography. Swedish] Stockholm: Save the children.
- Tengland, P-A. (1998). *Mental health: a philosophical analysis*. Doctoral thesis. Linköping: Linköping University.
- von Tetzchner, S. (2001). *Utvecklingspsykologi. Barn- och ungdomsåren*. (Developmental psychology. Childhood [Swedish]). Lund: Studentlitteratur.
- Tones, K., Green, J. (2004). *Health promotion. Planning and strategies*. London: Sage Publications Ltd.

- Torsheim, T., Välimaa, R., & Danielson, M. (2004). Health and well-being. In: WHO. *Young people's health in context. Health behaviour in school-aged children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen: WHO.
- Tritter, J. (2007). Mixed methods and multidisciplinary research in health care. In: M. Saks & J. Allsop (eds.). *Researching health. Qualitative, quantitative and mixed methods*. London: Sage Publications.
- Trost, K. (2002). *A new look at parenting during adolescence: Reciprocal interactions in everyday life*. Doctoral thesis. Örebro: Örebro University.
- Ungdomens nykterhetsförbund (UNF) (2006). *Barn till missbrukare*. (Children of substance abusers [Swedish]. Retrieved at [www.unf.se](http://www.unf.se) 2006-09-29.
- UNICEF (2008). *Convention on the Rights of the Child*. Retrieved at [www.unicef.org/crc](http://www.unicef.org/crc) 2008-07-17.
- United Nations (1989). *UN Convention on the Rights of the Child*. Retrieved at [www.un.org](http://www.un.org) 2008-03-07.
- Velleman, R., & Orford, J. (1999). *Risk and resilience. Adults who were the children of problem drinkers*. The Netherlands: Overseas Publishers Association.
- Webb, M., Heisler, D., Call, S., Chickering, S.A., & Colburn, T.A. (2007). Shame, guilt, symptoms of depression, and reported history of psychological maltreatment. *Child Abuse & Neglect*, 31, 1143-1153.
- Webster's New World Dictionary (1988). *Adolescent*.
- Webster's New World Dictionary (1988). *Perspective*.
- Werner, EE. & Johnson, JL. (2004). The role of caring adults in the lives of children of alcoholics. *Substance Use and Misuse*, 39(5), 699-720.
- WHO (1986). *Ottawa charter for health promotion*. Retrieved at [www.euro.who.in/About WHO](http://www.euro.who.in/About%20WHO). 2006-12-28.

- WHO (2004). *Young people's health in context. Health behaviour in school-aged children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen: WHO.
- WHO (2005). *The European health report 2005. Public health action for healthier children and population*. Copenhagen: WHO.
- WHO (2008). *Health promotion. School and youth health*. Retrieved at [www.who.int/healthpromotion/en/](http://www.who.int/healthpromotion/en/) 2008-09-22.
- Wiklund, S. (2006). Signs of maltreatment. The extent and nature of referrals to Swedish child welfare agencies. *European Journal of Social Work*, 8(1), 39-58.
- Wong, M.M., Nigg, J.T., Zucker, R.A., & Puttler, L.I., Fitzgerald, H.E., Jester, J.M., Glass, J.M., Adams, K. (2006). Behavioral control and resiliency in the onset of alcohol and illicit drug use: a prospective study from preschool to adolescence. *Child Development*, 77(4), 1016-1033.
- Yin R.K. (2003). *Case study research. Designs and methods 3<sup>rd</sup> ed.* Thousand Oaks: Sage Publications.
- Young people's act (2008). *Lag (1990:52) med särskilda bestämmelser om vård av unga*. Retrieved at [www.riksdagen.se](http://www.riksdagen.se) 2008-09-19.
- Zetterlund, U., Ekdahl, H., Hansson, K., Sonestedt, J., Ljungblad, R., Eklöf, V., & Åberg-Örbeck, K. (1999). Gruppsamtal för barn till missbrukare. [Group discussions for children of substance abusers.] *Socialmedicinsk Tidskrift*, 1, 98-103.
- Zucker R.A., & Wong M.M. (2006). Prevention for children of alcoholics and other high risk groups. In M. Galanter (ed), *Alcohol problems in adolescents and young adults. epidemiology, neurobiology, prevention, and treatment*. New York: Springer Science Business Media, Inc.



PUBLIKATIONER i serien ÖREBRO STUDIES IN CARING SCIENCES

1. Gustafsson, Margareta (2003) *Konsekvenser av en akut traumatisk handskada. En prospektiv studie av patientens situation under det första året efter olyckan.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
2. Jackson, Karin (2005) *Att vara förälder till ett för tidigt fött barn – en prospektiv studie om upplevelsen av föräldraskap och möten med vården.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
3. Odencrants, Sigrid (2005) *Måltidsrelaterade situationer och näringsstillstånd ur patienters med kroniskt obstruktiv lungsjukdom och sjuksköterskors perspektiv.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
4. Göransson, Katarina (2005) *Emergency department triage – a challenging task for Swedish emergency nurses.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
5. Eldh, Ann Catrine (2005) *Patienters upplevelser av och uttryck för fenomenet delaktighet i hälso- och sjukvård.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
6. Florin, Jan (2005) *Clinical judgement in nursing – a collaborative effort? Patient participation and nurses' knowledge.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
7. Ekwall, Ewa (2006) *Women's Experiences of Primary and Recurrent Gynecological Cancer.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
8. Pettersson, Ingvor (2006) *Significance of Assistive Devices in the Daily Life of Persons with Stroke and Their Spouses.*  
Doktorsavhandling/Doctoral thesis with focus on Occupational Therapy.
9. Carlsson, Eva (2006) *Understanding persons with eating difficulties and communication impairment after stroke – patient experiences and methodological issues in qualitative interviews.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
10. Göransson, Katarina (2006) *Registered nurse-led emergency department triage: organisation, allocation of acuity ratings and triage decision making.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.

11. Eldh, Ann Catrine (2006) *Patient participation – what it is and what it is not.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
12. Isaksson, Ann-Kristin (2007) *Chronic sorrow and quality of life in patients with multiple sclerosis.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
13. Florin, Jan (2007) *Patient participation in clinical decision making in nursing – a collaborative effort between patients and nurses.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
14. Johansson, Agneta (2007) *Adolescents' perspective on mental health and health-promoting dialogues.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
15. Frisk, Margot (2007) *Asthma and respiratory symptoms related to the housing environment.*  
Doktorsavhandling/Doctoral thesis with focus on Occupational Therapy.
16. Forslund, Kerstin (2007) *Challenges in prehospital emergency care – patient, spouse and personnel perspectives.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
17. Odenrants, Sigrid (2008) *The complexity of nutritional status for persons with chronic obstructive pulmonary disease – a nursing challenge.*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
18. Tollén, Anita (2008) *Vardagen och förväntningar på dagrehabilitering – en studie i äldre personers uppfattningar.*  
Vetenskaplig uppsats för licentiatexamen/Academic essay.
19. Dwyer, Lise-Lotte (2008) *Dignity in the end of life care – what does it mean to older people and staff in nursing homes?*  
Doktorsavhandling/Doctoral thesis with focus on Nursing.
20. Lidskog, Marie (2008) *Learning with, from and about each other: Inter-professional education on a training ward in municipal care for older persons.*  
Doktorsavhandling/Doctoral thesis.
21. Tinnfält, Agneta (2008) *Adolescents' perspectives – on mental health, being at risk, and promoting initiatives.* Doktorsavhandling/Doctoral thesis with focus on Public Health.